CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

September 21, 2009

Honorable Paul Ryan
Ranking Member
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

This letter responds to questions you asked about how two policy options you presented would affect the budget deficit over the long term. One option would replace the current tax exclusion for premiums for employment-based health insurance with a tax credit that would grow over time at a rate less than that of health care inflation. The other option would convert Medicaid into a defined-contribution program with federal outlays increasing over time at a rate less than that of health care inflation. In the Congressional Budget Office's (CBO's) view, both options would reduce future budget deficits, relative to projections under current law, by amounts that increased over time. The analysis presented in this letter covers only the two general policy concepts described here and does not represent an analysis of any particular legislation.

Replace the Income Tax Exclusion for Employment-Based Insurance with a Tax Credit

Under current law, although premiums paid by employers for health insurance are part of employees' total compensation, they are exempt from individual income taxes and payroll taxes and are thus excluded from employees' taxable earnings and income. In addition, employees of firms that offer "cafeteria plans"—plans that allow employees to choose between taxable cash wages and nontaxable fringe benefits—may pay their share of premiums for employment-based health insurance with pretax earnings. The tax-preferred treatment of employment-based insurance is effectively a subsidy for purchasing insurance; the subsidy is generally larger for individuals with higher income because they are in higher tax brackets.

The first option you posed would repeal the current income tax exclusion (but not the payroll tax exclusion) for premiums paid for employment-based insurance (and, presumably, other favorable treatments of health insurance premiums, such as the treatment of cafeteria plans) and replace it with a tax credit of a fixed amount per person. The amount of that credit would be set so as to result in no change in government revenues in the initial year and would grow more slowly than health care inflation in subsequent years.

Compared with arrangements under current law, that option would result in higher federal revenues in future years and, thus, lower budget deficits. Under current law, CBO estimates, spending on health care and spending on health insurance will continue to grow faster than gross domestic product (GDP). The income that remains untaxed because of the exclusion of premiums for employer-sponsored insurance from taxable income will grow at a rate similar to that for health care spending. If the current system was replaced with a tax credit that was budget neutral for the initial year and set to grow more slowly than general health care inflation, the resulting revenues forgone because of the credit would be less than the revenues forgone under the current income tax exclusion. The amount of additional revenues would increase over time because of the continuing expected divergence between the growth rate of the tax credit and the growth rate of health care spending.

The option would also alter the incentives facing firms and their workers regarding decisions to purchase health insurance. Under current law, more comprehensive and costly insurance packages receive greater subsidies through the tax exclusion. If a firm is choosing between providing $100 more in cash compensation or $100 more in health insurance benefits, for example, a worker facing a 30 percent marginal tax rate (through the combined effects of the income and payroll taxes) would, in the former case, receive only $70 in additional after-tax income but would, in the latter case, receive the full $100 of insurance benefits. Under the option you specified—a fixed dollar credit and elimination of the income tax exclusion—that $30 advantage to compensating the worker with health insurance as opposed to wages would be substantially reduced because income (although not payroll) taxes would have to be paid on the income represented by the additional insurance premiums. As a result, employment-based policies would become less comprehensive, on average, than under current law because the effective after-tax price of a more comprehensive policy would be higher.

Insurance policies could be less comprehensive along a variety of dimensions. They could cover a narrower scope of benefits (for example, by reducing or eliminating vision insurance), or they could require greater cost sharing by beneficiaries through higher deductibles or copayments. If those changes occurred, then enrollees would face higher prices for certain types of health care and would spend less on such care. Alternatively, insurance policies might allow for closer management of the utilization of health care services, which would also reduce spending on health care.

Convert Medicaid to a Defined-Contribution Program

Federal payments for the Medicaid program result from the services provided to enrollees. Within federal guidelines, states have flexibility in determining eligible populations, covered services, and payments for those services, and the federal government pays a share of the resulting expenditures. The federal share averages 57 percent but varies among states depending on states' per capita income; the federal share is higher for states with lower incomes. (There have been times when the federal government has increased its share on a temporary basis, as is the case now.) Under current law, federal spending on Medicaid will grow from 1.5 percent of GDP in 2008 to 2.8 percent of GDP in 2035, CBO projects. Two factors contribute to that rise: continued growth in health care spending per person at a rate that exceeds the growth in per capita GDP (so-called excess cost growth) and the aging of the population.

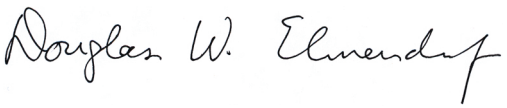
The second option you presented would convert Medicaid from its current form to a program based on a defined federal contribution. For the initial year of the new system, that contribution would be set at the estimated amount of federal Medicaid spending under current law. In future years, the federal contribution would grow at a rate less than that of health care inflation.

Under the option, federal outlays would be expected to grow more slowly than under current law. By setting a fixed federal contribution that would grow more slowly than health care inflation, the proposal (relative to the current program) would realize savings. If, for example, the federal contribution to each state was allowed to grow only with changes in its eligible population under current law and changes in the average of the general consumer price index and a medical price index, then federal spending would be a significantly smaller share of GDP in 2035 than is projected under current law.

How such a reduction in federal Medicaid spending would affect the health care system is unclear. If states did not make up for the full amount of reduced federal spending by increasing their spending on Medicaid enrollees, then combined federal and state spending on Medicaid would be lower than under current law. That reduction in spending could be accomplished by achieving efficiencies in the delivery of health care, covering fewer services, reducing the number of enrollees, increasing enrollees' copayments, paying less to providers of Medicaid services, or some combination of those changes.

I hope you find this assessment useful. If you have any further questions, please contact either me or my staff. The CBO staff contact is Jim Baumgardner.

Sincerely,



Douglas W. Elmendorf
Director

cc: Honorable John M. Spratt Jr.
Chairman
Committee on the Budget