

TAX-ASSISTED APPROACHES FOR HELPING CANADIANS MEET OUT-OF-POCKET HEALTH-CARE COSTS

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SUMMARY

Canadians are not saving for the inevitable costs of drugs and long-term care which they will have to pay for out of pocket in their old age, and these costs could potentially be financially devastating for them. Later in life, when out-of-pocket health-care costs mount, those who previously enjoyed the security of a workplace insurance plan to cover such expenses will face a grim financial reality. Many aspects of care for older Canadians aren't covered by this country's single-payer health-care system. Besides prescription drugs, these include management of chronic conditions by ancillary health professionals, home care, long-term care, and dental and vision care.

Statistics show that in 2012, Canadians' private spending on health care totaled \$60 billion, with private health insurance covering \$24.5 billion of that amount. Coverage of health-care costs that don't fall under Medicare's purview is at present rather piecemeal. The non-refundable federal Medical Expense Tax Credit covers expenses only after the three-per-cent minimum, or first \$2,171, of out-of-pocket costs have been paid by the individual. The Disability Tax Credit is available to those with a certified chronic disability, and these individuals are eligible for further support via the Registered Disability Savings Plan. A Caregiver Tax Credit is also available.

The federal government has a golden opportunity to provide an incentive for Canadians to set aside money to pay not only for the often catastrophic medical and drug costs that can come with aging, but also to save so they can afford long-term care, or purchase private health insurance. Too many Canadians, unfortunately, believe

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that the federal government picks up the tab for long-term care. In fact, provincial subsidies are provided on a means-testing basis, thus leaving many better-off Canadians in the lurch when they can no longer live alone and must make the transition to long-term care.

Providing more generous tax treatment of current and future out-of-pocket health costs, including insurance premiums, is an obvious way for the federal government to support Canadians to meet their health care needs and improve their well-being. Two existing vehicles can play an essential part of this plan. The government can change the currently non-refundable Medical Expenses Tax Credit and the refundable Medical Expenses Supplement so that out-of-pocket health-care costs are eligible from the first dollar. This would place no added burden on government if the exemption of employer-provided health benefits from employees' taxable income were removed.

Making an altered METC available to Canadians who pay their out-of-pocket costs from a registered health savings vehicle, which could be created within an RRSP to avoid extra administrative burdens, would provide them with an incentive to save. They could then either self-insure for future out-of-pocket health costs, or purchase private health insurance. A grant component could be added for lower-income families to make such savings incentives more widely diffuse.

Treating health benefits as taxable income subject to the modified Medical Expenses Tax Credit would address efficiency and equity issues with the existing tax treatments of health-care costs while extending tax assistance for out-of-pocket costs to more of the population. When the onus for decision making about payments and insurance purchases is placed on consumers, cost containment in health care and quality improvement incentives naturally follow.

An aging Canadian population is confronting a situation where more of its health-care needs fall outside the coverage of the Medicare basket – single-payer public coverage of physician and hospital services. Management of chronic conditions by non-physician providers, prescription medications, home care, long-term care, vision care and dental care all represent rising costs for aging individuals at a time when their personal incomes, and availability of third-party private health insurance, are generally declining due to withdrawal from paid employment. Compounding this problem is the likely reduction in the generosity of Medicare coverage of medical treatment costs associated with physician care and hospital-based services, as more services are moved out of the hospital setting and more health-care needs are met by non-physician providers.

It could be desirable to have Canadians save more while working to meet these out-of-pocket non-Medicare expenses and the federal government could play a role in providing incentives for Canadians to save for the costs of meeting some of their own health-care needs.¹ More ambitious proposals call for compulsory collective savings approaches through payroll tax-financed benefits along the lines of the Canada Pension Plan.² These proposals really amount to an increase in taxes, albeit designated for increased incomes at higher ages and/or covering health-care costs. Alternatively, it is worth considering following the lead of other tax-supported voluntary savings schemes like registered retirement savings plans (RRSPs), tax-free savings accounts (TFSA), registered education savings plans (RESPs) for post-secondary education and the Registered Disability Savings Plan (RDSP) for meeting disabled Canadians' care needs. RRSPs and TFSA offer incentives for saving generally to increase a household's capacity to meet future health-care costs, along with other needs like income in retirement. The RESP and RDSP were established to support families and individuals to address the higher costs of post-secondary education following the shift to higher fees, and to address the future care needs of disabled persons. The RRSP model has also been modified to allow for borrowing the principal from the RRSP to pay for a house down payment or to cover post-secondary education costs. Blomqvist and Busby (2014, 21) propose that a similar accommodation with RRSPs could be made for meeting the costs of long-term care (LTC) whereby some portion of RRSPs could be transferred tax free at the time of retirement to be used for the purchase of LTC insurance. Presumably, similar accommodations could be introduced for out-of-pocket health-care costs.

Our study explores the potential for the federal government to use tax-supported measures to help Canadians meet out-of-pocket health-care costs. First, we will review the existing tax-support measures for health-care costs, including the tax deductibility of medical expenses and tax-exempt employment-based coverage of health-care costs. We will present

¹ The problem of out-of-pocket health-care expenses and the sufficiency of retirement savings and retirement income is an identified concern for retirees and near-retirees. Particular concerns include being in long-term care longer than they are financially prepared for and not having sufficient health-care coverage or ability to afford nursing or assisted-living care. <http://business.financialpost.com/2015/02/04/were-not-prepared-health-care-shockers-threaten-yourretirement/> A BMO Wealth Institute report found only 27% of Canadians 50 and over who were surveyed have purchased additional health insurance. Fourteen per cent said they planned to buy health insurance. Fifty-nine per cent said they did not have or intend to buy health insurance.

² See Ontario's policy to introduce the Ontario Retirement Pension Plan, mandatory for workers who do not have a company pension plan, in 2017, or Quebec's proposed autonomy insurance to address out-of-pocket costs for meeting care needs (for example, see <http://www.theglobeandmail.com/life/health-and-fitness/health/whyquebecs-shift-in-home-care-policy-is-important/article15982867/>)

statistics on the extent of coverage of the population, the amounts of coverage typically provided, and assess what the current arrangements are not addressing in terms of health-care costs. Second, we will describe several models for a potential registered health-care savings plan (RHSP) that arise from existing tax-supported savings accounts in Canada, including RRSPs, TFSAs, RESPs and the RDSP. Third, we will be interested in assessing whether the creation of a new savings vehicle, e.g., a registered health-care savings plan (RHSP), would be preferable to modifying the terms and conditions of existing vehicles like the RRSP or the TFSA. We will need to consider whether a tax-assisted savings account would be a complement to, or substitute for, existing tax-supported private insurance which includes health-spending accounts; whether the proposed tax-supported savings vehicle will be targeted, or perhaps grant-supported like an RESP or RDSP, to increase the extent of uptake, particularly among the non-employed or low-income groups with limited capacity to save. For example, one could imagine an income-contingent annual grant where government saves on behalf of low-income Canadians. We will consider how to define what will be covered and conditions under which funds can be withdrawn from the account, how it could be administered and other logistical issues that we identify through our research. Finally, we will evaluate the costs of the four savings vehicle options against the projected impact that they would have for meeting Canadians' out-of-pocket health-care needs.

OUT-OF-POCKET COSTS FOR HEALTH CARE

The Canadian Institute for Health Information (CIHI) (2005, 6) defines out-of-pocket payments as costs directly met by consumers. CIHI identifies three categories for grouping out-of-pocket payments. First, direct payment refers to payments for goods and services that are not covered by any form of pre-payment insurance, including public insurance. Cost sharing (or co-payments) refers to payments where the consumer pays for part of the costs of goods or services received. Finally, informal payments are unofficial or “under the table” payments for goods and services.

CIHI (2014, 37-40) reported that in 2012, private spending on health care in Canada was \$60 billion, roughly 30 per cent of all health-care spending. Private health-insurance payments were \$24.5 billion of that amount, while \$29 billion were covered by Canadians paying out of pocket.³ Non-consumption spending accounted for the remaining balance of \$6.5 billion.⁴ The biggest categories of expenditure by insurance companies were drugs (\$10 billion), dental care (\$7 billion), administration (\$3.7 billion) and hospital accommodation (\$1.5 billion). The most important categories for out-of-pocket costs were prescribed drugs (\$6.4 billion), dental care (\$4.7 billion), nursing homes and other institutions (\$6 billion), vision care (\$2.6 billion), over-the-counter drugs (\$2.9 billion) and personal health supplies (\$2 billion).

³ These expenditures out of pocket and from insurance have almost doubled in nominal terms since 2002. CIHI, *Exploring the 70/30 Split: How Canada's Health System is Financed*, 37, reported that in 2002, private spending on health care in Canada was \$34 billion, roughly 30% of all health-care spending. Private health-insurance payments were \$14 billion of that amount.

⁴ CIHI, *Ibid.*, 6, defines non-consumption expenditures as including donations to hospitals, parking lots, investments and other sources. Jeremiah Hurley and G. Emmanuel Guindon, *Private Health Insurance in Canada*, 9, describe “non-consumption spending” as including non-patient revenues to hospitals (ancillary operations, donations, investment income), expenditures on research and capital expenditure in the private sector.

Sanmartin, Hennessy, Lu and Law (2014) use Survey of Household Spending data to examine trends in out-of-pocket health care spending between 1997 and 2009. For the median-income household, expenditures on dental, drugs and health-care premiums represent 70 per cent of total out-of-pocket expenditures. They show that the median household in Canada in 2009 had out-of-pocket health-care expenditures of just under \$2,000 (four per cent of after-tax income), up from \$1,450 (3.5 per cent of after-tax income) in 1997 (2009 purchasing power). Out-of-pocket health-care expenditures increase with income level and age, but represent a smaller share of income as income rises, and a smaller share of total health-care spending for seniors. Sanmartin et al. find that out-of-pocket health-care expenditures as a percentage of after-tax income increased for households in all income quintiles, but the increase was greatest for households in the lowest income quintile. In 2009, the average out-of-pocket health spending in the highest income quintile was almost \$3,000, compared to an average of \$1,000 for households in the lowest income quintile. Over 40 per cent of households in the lowest income quintile spent more than five per cent of after-tax income on out-of-pocket health-care costs in 2009, compared to only 14 per cent of households in the highest income quintile.

For seniors, the out-of-pocket expenditures may be three times higher than for non-seniors (<65 years of age) (Health Canada, Health Expenditures by Age and Sex, 1980-81 to 2000-01). For 2001, using a different data source than the Statistics Canada study, in 2009 purchasing power, per capita private-sector expenditures on hospitals, other institutions, physicians, other professionals, drugs, home care and other expenditures were \$1,093 for all age groups. Those expenditures were \$801 for Canadians younger than age 65 and \$2,710 for Canadians 65 and over. These per capita numbers are comparable to the average expenditures for third quintile households in the 2001 SHS, excluding expenditures on health-care premiums, presented by Sanmartin et al.

Finally, it is important to note that the preceding statistics are for current out-of-pocket expenditures on health care and do not include the non-insured future health-care liabilities of individuals. For example, households without sufficient savings or third-party insurance coverage for long-term care, critical-illness care or drug coverage, all face risks of high costs in these spending categories that are not accounted for in household budgets. In the case of long-term care, Blomqvist and Busby (2014) report that the average cost per recipient is around \$60,000, 3/4 of which is covered by provincial payers, leaving \$15,000 in annual out-of-pocket costs.⁵ More Canadians require home-care services for more of their lifespans, which are mostly covered out of pocket. Formal home-care costs are \$18,000 per year per recipient and informal home-care costs often provided by family members have been valued at \$21,000 per year. As most households lack sufficient savings and pension-plan provisions to meet even income needs, and as most households do not have insurance coverage for long-term care, these are costs that could arise which are not supported by an expected funding source.

⁵ Åke Blomqvist and Colin Busby, *Paying for the Boomers*, 4, report that stays in institutional LTC are typically after age 75 and can last two to four years. For conditions like Alzheimer's and other dementia, LTC costs can deplete entire wealth holdings.

TAX SUPPORTS FOR HELPING FAMILIES COVER HEALTH-CARE EXPENSES

The largest tax-supported arrangement for households to meet private health-care costs is the tax treatment of health benefits provided to employees. According to Hurley and Guindon (2008, 24), the federal government and all provincial governments allow employers to deduct the cost of health benefits provided to employees when corporate taxes are levied. The federal government, and all provinces except Quebec, exclude the value of health benefits provided through employment from taxable income.⁶ The projected value of this tax expenditure for the non-taxation of business-paid health and dental benefits is \$3.4 billion for 2012⁷ which is roughly equal to the 2012 expenditures on administration for private health and dental insurance in Canada and around 14 per cent of total private health-insurance expenditures in 2012.

Private health-insurance coverage accounts for around 12 per cent of all health spending in Canada and around 45 per cent of all private health spending. Hurley and Guindon (2008, 15-22) estimate that “a large majority of Canadians hold some form of private health insurance” and the majority of this coverage is for workers and their families who are covered by employer-sponsored plans.⁸ Private insurance coverage is most common for workers in large firms, with full-time rather than part-time work, with higher wages, and in unionized workplaces. Extended health-care insurance, which covers services not publicly insured, including hospital services, prescription drugs, non-physician providers, vision care, travel insurance and other miscellaneous services, is the most commonly provided

⁶ See Mark Stabile, *Private Insurance Subsidies and Public Health Care Markets*, Table 1, and Amy Finkelstein, *The Effect of Tax Subsidies*, Table 1, for estimates of the tax prices of employer health and dental coverage in Quebec versus the other nine provinces. According to Hurley and Guindon, a number of provincial governments have attempted to remove this tax provision as late as 1994. Only Quebec in 1993 succeeded. Hurley and Guindon report that most provinces as of 2008 levied a premium tax of 2% to 4% of premium costs incurred by employers. This is not exactly what these payroll taxes are. Ontario’s employer health tax (<http://www.fin.gov.on.ca/en/tax/eh/>) and Manitoba’s health and post-secondary education tax levy (<http://www.gov.mb.ca/finance/taxation/taxes/payroll.html>) are taxes on employer payroll over an exemption limit. The payroll on which the taxes are based includes wages, salaries and benefits, but in neither Manitoba nor Ontario are health benefits directly tied to the tax. The only link of these payroll taxes to employer contributions to health benefits is really an indirect one as the tax is largely levied on larger-payroll employers where health benefits are most commonly provided. Finkelstein, *Ibid.*, 311, in her calculations of tax prices of employer-provided health benefits, accounts for consumption tax through premium and sales taxes that are applied to group health-insurance benefits but not to other services an employee could purchase.

⁷ Department of Finance Canada, *Tax Expenditures and Evaluations 2012*, <http://www.fin.gc.ca/taxexp-depfisc/2012/taxexp1201-eng.asp>. It is interesting to note that the projected tax expenditures for 2012 of \$3.4 billion are substantially higher than the projected \$1.995 billion for 2012 in the 2013 projections. It turns out that the 2013 projections reflect the tax expenditure that would occur if employer health benefits were treated as taxable income but subject to the Medical Expenses Tax Credit discussed below. So the 2013 projection is not based on the policy at this time. Footnote 23 reads: “The methodology used to calculate this tax expenditure was changed to assume that employer-paid health premiums would be eligible for the Medical Expenses Tax Credit if they were taxable.” Department of Finance Canada, *Tax Expenditures and Evaluations 2013* <http://www.fin.gc.ca/taxexp-depfisc/2013/taxexp1301-eng.asp#toc>. 2014 projections from Finance show similar tax expenditure of non-taxation of employer health benefits to 2013, but there is no footnote describing if the methodology is the same as 2013. See <http://www.fin.gc.ca/taxexp-depfisc/2014/taxexp1401-eng.asp#toc7>

⁸ Around 60% of workers and their families have coverage through employer-sponsored plans; 26% of retirees over age 65 have coverage through an employer-sponsored plan. Individually purchased private insurance coverage is relatively rare. Stabile reports that in 1998, 68% of full-time workers in Canada had private health-insurance coverage.

private insurance coverage in Canada.⁹ Dental coverage is also provided in many group insurance contracts. Many Canadians also have private insurance coverage for long-term disability, accidental death and dismemberment.

The two private insurance products that have not had much uptake are long-term care insurance and critical-illness insurance. These products appear to have no representation in employment-based group insurance coverage, leaving them to individuals to purchase (Hurley and Guindon 2008, 18, Table 5). Blomqvist and Busby (2014, 19-20) suggest that the low uptake of these insurance contracts is attributable to Canadians' widespread mistaken belief that long-term care is already covered by the government. They also argue that the targeted subsidies for long-term care that the provinces do provide are means-tested in a way that co-payments for home care or institutionalized care are greater if individuals have insurance coverage than if they do not. This crowding out of private insurance coverage benefits reduces the demand for LTC insurance. Consequently, LTC insurance will tend to be bought by individuals and families with high income and assets that they wish to preserve and pass on to later generations.

Targeted public payment for non-Medicare services is provided by the provinces to address the needs of families reliant on social assistance and Canadians aged 65 and over. For drugs, the provinces provide some coverage for persons aged 65 and over, and for persons on social assistance (CIHI 2008, Hurley and Guindon 2008, Busby and Pedde 2014). For other non-Medicare expenses like dental, vision and rehabilitation services, provinces provide targeted coverage, usually based on income or social assistance receipt. Where premiums are levied, they are not necessarily tax exempt.¹⁰ Deductibles and co-payments may be incurred.

The Medical Expenses Tax Credit (METC) provides a non-refundable tax credit for persons who have sustained "substantial" medical expenses for themselves or certain of their dependants.¹¹ The METC reduces taxes owed by the amount of allowable medical expenses minus the lesser of \$2,171 or three per cent of net income, times 15 per cent, the lowest

⁹ Other services can include relatively flexible health-spending plans (HSPs) which define a maximum amount per year for which allowable health expenses can be reimbursed. HSPs can include provisions for unspent amounts to carry forward and even rolled over into instruments like RRSPs.

¹⁰ If they are levied as part of the provincial health insurance or hospital insurance schemes, they are paid out of after-tax income of the individual. If the individuals pay premiums through a third-party insurer like Blue Cross, then the premiums could be eligible for the Medical Expenses Tax Credit. See Canada Revenue Agency Medical and Disability-Related Information 2014 <http://www.cra-arc.gc.ca/E/pub/tg/rc4064/rc4064-14e.pdf>

¹¹ Canada Revenue Agency, Income Tax Folio S1-F1-C1: Medical Expenses Tax Credit (Effective as of Sept. 3) <http://www.cra-arc.gc.ca/tx/tchncl/ncmtx/fls/s1/f1/s1-f1-c1-eng.html#N111E5> See also Canada Revenue Agency Medical and Disability-Related Information 2014 <http://www.cra-arc.gc.ca/E/pub/tg/rc4064/rc406414e.pdf>

tax rate.¹² This amount is not dependent on employment status, and since 2011, there is no cap on expenses eligible for the METC. The federal tax expenditure for the METC was projected to be \$1.425 billion in 2014.¹³

FIGURE 1 TAXES PAID ON INCOME USED FOR OUT-OF-POCKET HEALTH CARE COSTS BY INCOME LEVEL

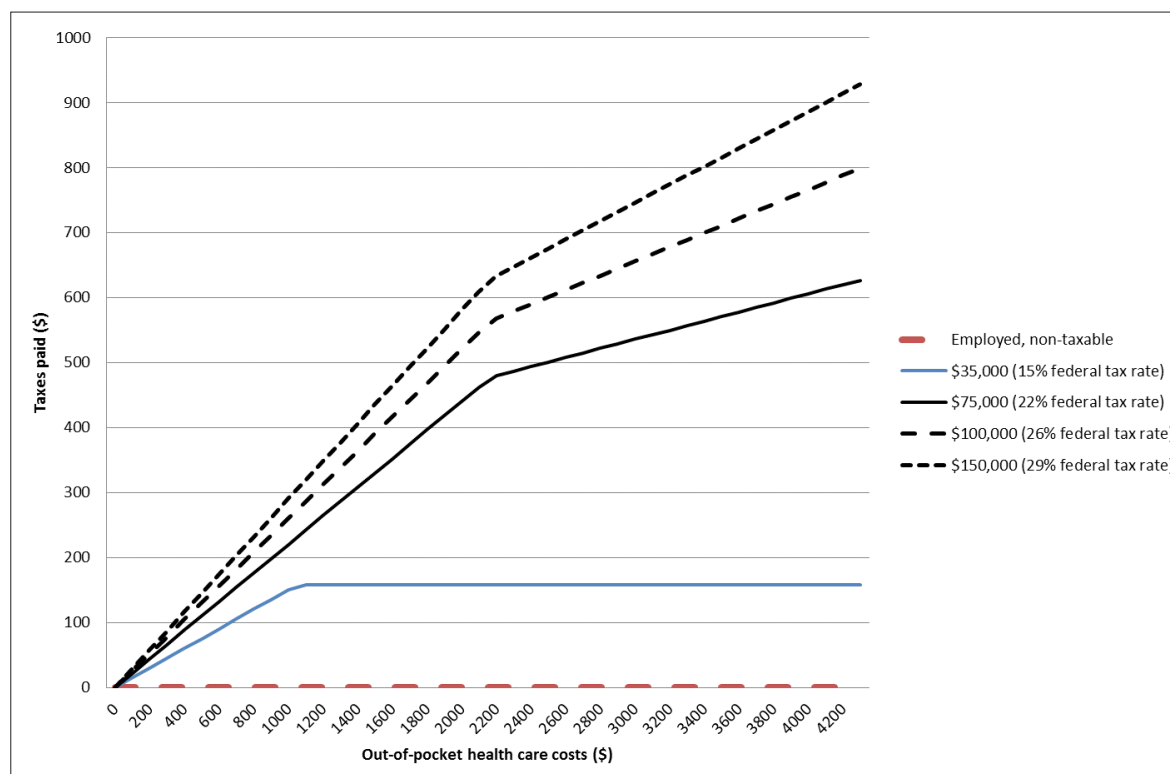


Figure 1 illustrates how the Medical Expenses Tax Credit influences federal taxes paid on income used to meet eligible out-of-pocket health costs by income level. For comparison, consider that employment-based health benefits are effectively an expenditure from income where no tax is paid (red dashed line). The \$35,000 income earner facing a 15 per cent federal income-tax rate pays 15 per cent tax on the income needed to cover out-of-pocket health-care costs up to three per cent of their income, \$1,050, after which they pay no tax on the incremental expenditure above that threshold. At the higher income levels, they pay the applicable tax rate for their income up to \$2,171 of health-care costs, above which incremental expenditures are taxed at net of their federal tax rate less 15 per cent for the METC.

¹² Medical expenses above 5% of income were deductible for the purposes of determining taxable income from at least 1942. Malcolm G. Taylor, *Financial Aspects of Health Insurance*, 33-34, notes that the 3% of income threshold dates from 1953 when it was lowered from 4% of income. The tax treatment in the 1950s was not as a non-refundable tax credit; it was a deduction of medical expenses from taxable income at a time when the effective marginal tax rate was 18%. Taylor noted that the limitations of the tax deductibility of medical expenses included no relief for health costs below the threshold, no benefit for those who pay no tax and a benefit that grows in value with the taxable income of the household, resulting in some regressivity.

¹³ Department of Finance Canada, *Tax Expenditures and Evaluations 2014* <http://www.fin.gc.ca/taxexp-depfisc/2014/taxexpl401-eng.asp#toc7>.

Low-income individuals aged 18 or older (income, including that of co-habiting spouse or common-law partner less than \$25,278 for 2013 and indexed annually) with earnings or business income of at least \$3,333 in 2013 (and indexed annually) are eligible for the refundable Medical Expenses Supplement. Calculated on the same basis as the Medical Expenses Tax Credit, the maximum value of the supplement for a given year is \$1,142 for 2013 (indexed annually), and reduced five per cent of the excess of adjusted income over \$25,278.

There are two other non-refundable tax credits related to out-of-pocket health-care needs for Canadians with a medically certified long-term disability – the Disability Tax Credit and the Caregiver Tax Credit.¹⁴ Further financial support is available to Canadians eligible for the Disability Tax Credit to invest in meeting future income and care needs through the Registered Disability Savings Plan. The projected 2014 federal tax expenditure on these credits is \$0.75 billion for the Disability Tax Credit and about \$0.1 billion for caregiver credits.

It is also important to recognize that health-care services provided by a range of professionals, medical devices and products, prescription drugs and hospital parking are GST/HST-exempt.¹⁵ The GST-exemption tax expenditure of these items is projected to be \$2.44 billion in 2014.¹⁶

Tax assistance for meeting health-care costs should also be considered in terms of supports for income and savings vehicles, including one's principal residence. From one perspective, many of the out-of-pocket expenses for health-care needs reflect age-related increases in the cost of living, distinct from short-term budget shocks of an acute health event. As such, the challenge of meeting higher expected health-care expenses after age 65 can be addressed by strategies aimed at enhancing income in retirement or wealth (Blomqvist and Busby 2014, 21). The non-refundable age credit is a maximum of \$6,196 for 2014 federal taxes for Canadians born in 1949 or earlier. This income-tested credit is not directly tied to health, but provides tax relief, hence more after-tax income to seniors with a net income of less than \$35,000 who would be expected to have higher health-care needs. The projected tax expenditure on the age credit for 2014 is \$2.955 billion.

Pension plans through the workplace, RRSPs, TFSAs and non-taxable treatment of capital gains on one's principal residence are all examples of tax support for improving incomes and wealth at older ages that allow Canadians to meet their out-of-pocket health-care costs.

¹⁴ There is also a Disability Supports Deduction that provides a non-refundable tax credit for expenses incurred for the disabled individual to work or operate a business. The Children's Fitness Tax Credit and the Disability Tax Credit are also listed as tax expenditures on health: <http://www.fin.gc.ca/taxexp-depfisc/2013/taxexp1301-eng.asp#toc9>

¹⁵ For a list of GST/HST-exempt items, see Schedule VI (Subsection 123(1)) Zero-Rated Supplies of the Excise Tax Act <http://laws-lois.justice.gc.ca/eng/acts/e-15/page-330.html#h-161> . For a discussion of exempt health-care services see: <http://www.thehstblog.com/2011/06/articles/health-care-sector/canada-revenue-agency-provides-list-of-exempt-and-taxable-health-care-service-providers/> . For Quebec's treatment under QST, see <http://www.revenuquebec.ca/en/salle-de-presse/nouvelles-fiscales/2012/2012-04-04.aspx> . See also, Andre Picard, *Tax on tampons is sexist and illogical*, The Globe and Mail, March 10, 2015, <http://www.theglobeandmail.com/globe-debate/tax-on-tampons-is-sexist-and-illogical/article23383379/>

¹⁶ Department of Finance Canada, *Tax Expenditures and Evaluations 2014* <http://www.fin.gc.ca/taxexp-depfisc/2014/taxexp1401-eng.asp#toc7>.

A recent Financial Post article recognized that to meet the often very high costs of long-term care, Canadians will out of necessity rely on their house equity to cover those costs.¹⁷

WHAT SHOULD BE COVERED THROUGH A TAX-ASSISTED SAVINGS VEHICLE?

Answering this question requires consideration of three issues. First, what kind of expenditures require, or are suitable for, self-insurance through savings or current income versus pooling of risks through insurance contracts? Second, what health-care costs are currently not addressed through some form of favourable tax treatment or third-party or government coverage? Third, what health-care expenses should be eligible for favourable tax treatment?

At this time in Canada, it would appear that the use of a tax-assisted savings vehicle should be considered for meeting gaps in other forms of coverage of out-of-pocket costs. The need is for meeting first-dollar costs up to the thresholds where favourable tax treatment or other public coverage currently exists, and for addressing co-payments and other features of private insurance that leave households with out-of-pocket costs. For the larger catastrophic costs like long-term care, the discussion should be around how to extend insurance coverage for this contingency to more of the population, which could include using tax assistance to create incentives for the purchase of private insurance contracts.

What kinds of costs are suitable for self-insurance out of current income or a savings vehicle?

Savings as a source of self-insurance is an appropriate vehicle for smaller, predictable costs and perhaps for larger expected, but predictable costs. A savings vehicle for meeting out-of-pocket health-care costs should not be designed to meet catastrophic costs. However, for the costs of getting an extra bath per week in long-term care or other services, savings can be a useful tool to augment whatever insurance coverage is already held. For infrequent, potentially catastrophic health-care costs, pooling risks through insurance contracts is more appropriate.¹⁸ For example, Blomqvist and Busby (2014, 15) identify the large potential gains from risk pooling to meet the costs of LTC. They note that the annual average LTC costs across all individuals in Canada (\$1,930 per capita total spending) suggest a manageable cost, but the financial burden is not evenly distributed in the population: “Only

¹⁷ Housing equity in a principal residence is also a source of finance for meeting out-of-pocket health expenses, particularly of the catastrophic variety. See Blomqvist and Busby, 19, and *‘We’re not prepared’: Health care shockers threaten your retirement*, Financial Post, Feb. 4, 2015. <http://business.financialpost.com/2015/02/04/were-not-prepared-health-careshockers-threaten-your-retirement/>

¹⁸ See Raisa B. Deber, Kenneth C. K. Lam and Leslie L. Roos, *Four Flavours of Health Expenditure*, for a discussion of four categories of health-care expenditures and the appropriate methods of finance for them. See Blomqvist and Busby, 14-15, for a discussion of why long-term care costs are suited to risk pooling/insurance finance. Indeed, this is not within the scope of the discussion in this paper, but public coverage is largely used for small, regular health-care costs like the basic doctor’s office visit, rather than larger, less predictable costs like long-term care. Victor Fuchs, *From Bismarck to Woodcock*, describes the choice to use public coverage for shallow coverage of a broad array of predictable smaller expenses, rather than deeper coverage of infrequent catastrophic losses, as representing an irrational use of insurance. However, using savings to cover the shallow costs to which current income and savings might be suited to shift coverage to catastrophic costs not associated with physician services or hospital-based care would require completely redesigning Canadian Medicare and likely eliminating the accessibility condition of the 1984 Canada Health Act.

a minority will ever receive LTC in an institution, and many will die after only a relatively short period of illness. But for the minority who do need LTC for a long time, whether in an institution or at home, the financial burden can be very large.”¹⁹

Who needs assistance covering out-of-pocket costs?

The gap in coverage or capacity to pay for out-of-pocket health costs would seem to be for non-disabled retired persons, self-employed persons who opt not to purchase third-party insurance coverage, and persons not employed or working in arrangements without health-care benefits. Disabled Canadians, Canadians with low incomes or dependent on social assistance from provinces, and Canadians 65 and over will have some coverage for non-Medicare expenses for drugs, vision, dental and home care. In some cases, the coverage terms are stipulated and known while in others, coverage may be provided on a discretionary basis. Co-payments are often required and in the case of drugs, and possibly dental care, it is believed that the co-payments result in eligible individuals facing a barrier to taking advantage of the coverage that they have.

How can we define what out-of-pocket costs are eligible for tax assistance?

A pragmatic approach would be to define eligible health-care expenses allowable for favourable federal tax treatment to be the expenses currently eligible for the Medical Expenses Tax Credit and currently covered under employment-based health spending accounts. Having the coverage match current employer-provided benefits would simplify transition health-cost coverage from employment to non-employment. As with the non-refundable tax credit and the health-spending plans, all claims must be supported by receipts. Eligible expenses should only be expenses not covered by private health-benefit plans and those beyond coverage limits of private health-services plans.

There are categories of products and services in the realm of health promotion and chronic disease prevention that cannot be claimed against the METC. Health programs presumably not provided by the approved list of health-service providers, and vitamins and supplements, even if prescribed by a medical practitioner, may be worth adding to the list of claimable items for the METC, to balance the favourable tax treatment of treating and curative health care, in the interests of improving population health and preventing chronic diseases.

Finally, provincial health-care premiums are not eligible for the Medical Expenses Tax Credit. When employers pay the premiums for employees, the premiums are considered a taxable benefit. British Columbia and Ontario have health-care premiums and it is possible that more revenue-constrained provincial governments may start to rely on health-care

¹⁹ Long-term care costs can be as high as \$150,000 per year, which would require considerable savings and assets to meet. In contrast, an insurance contract of \$2,100 per year for long-term care coverage provides \$52,000 in annual benefit. Based on numbers in *'We're not prepared': Health care shockers threaten your retirement*, Financial Post Feb. 4, 2015 <http://business.financialpost.com/2015/02/04/were-not-prepared-health-careshockers-threaten-your-retirement/>

premiums for revenue. It might be worth considering making these premiums eligible as an allowable cost for a tax-assisted savings vehicle.²⁰

How much coverage do people need for meeting out-of-pocket health-care costs?

There are at least two possible approaches to setting the amount that can be part of annual expenditures on out-of-pocket health costs eligible for favourable tax treatment. First, and perhaps simplest, is to choose some value, as is currently done with the employment-based health-spending accounts – e.g., \$750, \$800, \$1,000 or more. Indeed, one could just recreate the health-spending account structure within a tax-assisted savings vehicle. The second way would be to assess the expected out-of-pocket health-care costs, perhaps by age, and use that to set an annual allotment for eligible costs. This amount could be age-adjusted to reflect higher needs at higher ages. The former approach has appeal in that the budgetary impact is defined so long as expenditures must be incurred in the tax year and not carried over to subsequent years. The latter approach may be better for meeting the levels of needs, but could be far more costly to provide and it will still not fund the full levels of needs.

It is important to recognize that to an extent, the contingency of high out-of-pocket costs is already addressed by the medical expenses tax deduction and provincial coverage for those in need. The METC provides some tax relief for substantial health-care costs. Further, governments typically do provide some relief for more catastrophic levels of health-care costs following traumatic events like a stroke. Blomqvist and Busby (2014, 13) discuss how provincial governments guarantee access to LTC services according to an individual's ability to pay. As discussed above, even if there is not sufficient coverage for meeting the high-cost health-care needs, you would not necessarily want to use a savings vehicle to cover the residual uncovered costs. Pooling through insurance is the more sensible approach for a society to take.

WAYS IN WHICH FEDERAL TAX ASSISTANCE CAN SUPPORT CANADIANS IN MEETING OUT-OF-POCKET HEALTH COSTS

There are several ways in which tax assistance could encourage greater capacity of households to meet out-of-pocket health expenses. First, tax treatment of these expenditures can be addressed to reduce the costs. That is, tax treatment can be used to provide relief to households incurring these costs. Second, to make purchases of private health insurance more affordable, tax treatment of health-care premiums can be used to create incentives for households to purchase contracts to indemnify the losses. Third, tax treatment of health-care costs can be structured to provide incentives for households to save more to improve their capacity to meet out-of-pocket health-care costs. This approach could also be part of

²⁰ Premiums for government health-insurance programs are not eligible for the Medical Expenses Tax Credit in 2014. Canada Revenue Agency, Medical and Disability-Related Information 2014, RC4064(E) Rev. 14. Page lists “provincial and territorial plans such as the Alberta Health Care Insurance Plan and the Ontario Health Insurance Plan (for a complete list of non-eligible plans, go to www.cra.gc.ca/medical)” as expenses that cannot be claimed using the Medical Expenses Tax Credit.

an attempt to address other issues around ensuring the adequacy of retirement incomes or the efficiency of the tax treatment of health-care costs.

Tax relief

Perhaps the simplest way to address predictable out-of-pocket health-care costs would be to treat the first \$E (e.g., \$1,000) of allowable medical expenses to be eligible for the METC. Because health-care expenditures that are greater than the minimum of three per cent of income or \$2,171 are already subject to favourable tax treatment under the Medical Expenses Tax Credit²¹, the need is for some vehicle to cover the expenses below this threshold – some or all of the first minimum{\$2,171, three per cent of income} worth of expenditures. For example, if the first \$1,000 of health-care expenses were to be METC-eligible, then that would result in a \$150 non-refundable tax credit (15 per cent). Eliminating the threshold for the METC entirely would create a maximum non-refundable tax credit of \$326 for the first \$2,171 of out-of-pocket health-care costs.

One consideration that can arise with this change is the administrative burden or cost of expanding a credit for receipt-supported expenditures with more health-care expenditures for the credit and a potentially large number of receipts to be scrutinized for a much larger number of claimants. It is uncertain what the added administration cost would be, but one solution would be to unconditionally give a health-expense amount towards non-refundable tax credits to all tax filers to account for expected, uncovered out-of-pocket costs. The disadvantage of this approach is that it is not actually tied to health needs or health-care use.

Creating incentives for purchasing insurance

Another approach to supporting households in making choices to address out-of-pocket health-care costs is for governments to consider introducing incentives for individuals without employer-provided coverage to purchase private health-insurance coverage. For example, making the first \$1,000, or first \$2,171, of out-of-pocket health spending eligible for the METC, with private health-insurance premiums as eligible expenses, would reduce the effective cost of private insurance coverage.

Alternatively, a larger subsidy could be provided by extending the non-taxable treatment of employee health and dental benefits to all individuals. Blomqvist and Busby (2014, 21) propose a targeted variant of the tax-exempt treatment of long-term care insurance. They suggest that Canada should consider a proposal in the U.K., where the income-tax system has similar tax deferral and exemption provisions to Canada, to allow a tax-free, lump-sum pension transfer taken at retirement that could be used to purchase LTC insurance.

Other incentives for insurance purchase include mandates for purchase. For example, in 1997, Quebec introduced a compulsory prescription-drug insurance plan using a social insurance model that achieved universal coverage through a mixture of private insurance plans, largely employment-based, and a public plan (see Hurley and Guindon 2008, Box 1,

²¹ Caregiver costs are addressed with the Caregiver Tax Credit.

page 12). In Australia in 1997, under the Private Health Insurance Incentives Scheme, a one-per-cent medical levy surcharge was applied to taxpayers with incomes greater than \$50,000 (singles) or \$100,000 (families) and who opted not to purchase private health insurance (typical premium of \$1,800 (Butler 2002).

It is not at all clear that these types of tax-supported incentives for private health-insurance coverage by individuals are effective for increasing uptake of the coverage. Stabile (2001) finds that the tax-price elasticity of employer-provided health insurance ranges from -0.3 to -0.6, with dental coverage showing greater tax-price sensitivity. Using Stabile's estimates, in 1995, if Ontario, with the lowest tax price for employer health benefits followed Quebec and included employer health benefits in taxable income, the probability of holding supplemental health insurance would be 10 percentage points lower. Finkelstein (2002), in examining the change in employer-provided health benefits in Quebec relative to other provinces after the benefits were no longer excluded from taxable income, found the tax-price elasticity of employer health coverage was -0.5. She found that the reduction in tax subsidy with the 1993 change in tax treatment of employer-provided health benefits coincided with a 13- to 14-percentage point decrease in workplace coverage, of which maybe one percentage was offset by increases in purchases of insurance in the non-group market. The decrease in employer coverage was most pronounced in small firms where the subsidy through tax treatment is more critical than for large firms. Greater scale economies for insurance associated with larger pools of employees with compulsory participation in a group plan allow for lower premium costs than for individuals purchasing the same coverage on a voluntary basis.

In Australia, the one-per-cent medical surcharge levy led to some negative tax expenditure but was ineffective for increasing the extent of private health-insurance coverage. Subsequently, the Australian government introduced a direct 30-per-cent subsidy for purchase of private health insurance. Butler (2002) describes how this policy had only a small impact on uptake of private insurance and amounted to annual tax expenditure of around \$1 billion in 2000/01, suggesting that private health insurance has inelastic demand.

Aside from the uncertainty over the effectiveness of subsidies for private health-insurance purchases by individuals, other considerations reduce the appeal of focusing on only increasing private insurance purchases. First, according to CIHI (2005), Canada already has very high reliance on private health insurance compared to other OECD countries. To the extent that this could reflect the high effective subsidy to private coverage through Canada's favourable tax treatment of employer-provided health and dental benefits, it is not clear how much higher the extent of coverage can go.

Second, there is a case to be made that extending private health-insurance coverage for extended health benefits does not address Canadians' emerging needs. According to Hurley and Guindon (2008, 26), the usual coverage for extended health benefits in Canada is structured to provide shallow coverage of health-care costs. The policies cover occasional use of providers of routine services as opposed to covering the costs of "regular, on-going, more intensive care." In other words, extended health benefits provided through private health insurance tend to cover modest and predictable health-care costs which could be met through self-insurance via savings or current income.

If incentives are to be created for insurance purchases, then they should be for the purchase of coverage for catastrophic health-care costs associated with drugs or long-term care. Purchases of these insurance contracts have not been widespread, even though many of the challenges and liabilities for provincial governments are related to these needs in an aging population. Blomqvist and Busby (2014, 21) propose that Canada follow the lead of other countries and use favourable tax treatment of retirement savings to create incentives for the purchase of long-term care insurance.

HOW BIG ARE THE INCENTIVES IF WE CHANGE THE METC?

Given the tax treatment of health-insurance premiums and out-of-pocket health-care expenses under the METC, we can consider how the METC provides relief and/or incentives to purchase private insurance coverage. To show this, we consider four scenarios for the treatment of out-of-pocket health-care expenses. The first two we consider are illustrations of the status quo tax treatment of health-care expenses in Canada.

First, consider the tax treatment of health-care benefits obtained through employment. Let E =out-of-pocket health expense (\$); $t\%$ is federal tax rate for person with income I . As a non-taxable benefit, there are no taxes paid on the E dollars of health-care benefit for the employee:

$$\text{Taxes paid} = 0\% \cdot E$$

Next, for out-of-pocket costs not covered by employment-based coverage, we have E covered with after-tax income with the tax credit provided for “substantial health-care costs.” Note this would be the tax treatment for employment-based benefits if the tax treatment of employee health benefits were changed to make health benefits to be taxable. So if E is a taxable benefit, or after-tax income is used for medical expenses:

$$\text{Taxes paid} = t\% \cdot E - 15\% \cdot \max(E - \min\{3\% \cdot I, 2171\}, 0)$$

Consider two alterations to the Medical Expenses Tax Credit that would apply to any out-of-pocket costs for eligible health expenditures. First, the first \$1,000 of out-of-pocket costs could be added as eligible for the METC:

$$\text{Taxes paid} = t\% \cdot E - 15\% \cdot (\min\{E, 1000\} + \max\{E - \min\{3\% \cdot I, 2171\}, 0\})$$

Second, all out-of-pocket costs from the first dollar are METC-eligible:

$$\text{Taxes paid} = t\% \cdot E - 15\% \cdot E$$

Figure 2 illustrates the taxes paid on income used to cover out-of-pocket health-care costs for a tax filer subjected to the highest federal tax rate of 29 per cent (federal taxable income > \$136,270). For tax filers with health and dental benefits fully covered through their workplace benefits, there would be no taxes paid on the health-care spending (green line is on horizontal axis). Obviously, compared to the non-taxable treatment of employment-

based health benefits, treatment of health benefits as taxable, or having persons use after-tax income to cover health-care costs, results in more in tax paid on income (red line). Allowing the first \$1,000 of *E* to be METC-eligible drops taxes paid on income to meet those expenses in almost half (29 per cent-15 per cent) (black dashed line). Making all out-of-pocket health-care costs METC-eligible provides sizeable, and growing, reductions in taxes paid up to \$2,171 in expenses, above which the tax reduction compared to the status quo is fixed in size (dashed blue line). The size of tax relief under the more generous treatment of out-of-pocket health-care costs is 14 per cent of expenditures below \$1,000, or \$2,171. While the dollar values of taxes paid differ for persons with taxable income greater than \$43,953 and less than \$87,907 (22 per cent federal rate) and greater than \$87,907 and less than \$136,270 (26 per cent federal rate), qualitatively, the picture in Figure 1 holds for these income levels. There is a very different impact, however, for Canadians with taxable incomes below \$43,953 (15 per cent federal rate).

Figure 3 shows the taxes paid on income used for out-of-pocket health-care expenses for Canadians who face this lowest federal tax rate. If these Canadians have taxes owing, they only pay 15 per cent on the first \$1,000 of health-care expenses covered with taxable income. That amount owing in tax is fixed for all expenditures \$1,000 or greater. If the first \$1,000 of health-care costs were METC-eligible, then no tax would be paid on income used to cover the first \$1,000, but the effectively lump-sum payment would be borne once expenditures surpassed the METC threshold. Making out-of-pocket costs first-dollar eligible for the METC would result in these persons paying no tax on income needed for covering out-of-pocket health-care costs. This change would address the current regressive feature of the METC where the first three per cent of income worth of expenses are not claimable. This means that taxes owing on the income used for as much as \$1,050 of out-of-pocket health-care costs are a larger share of income for low-income households than for the higher-income households facing higher tax rates. Making the first \$1,000 of health-care costs, or all out-of-pocket health-care costs, METC-eligible would remove this regressive feature of the METC threshold.

Some thought may need to be given to whether persons with tax-exempt employment-based coverage for health costs should be eligible for these revised treatments. Employer-provided coverage is already a big source of disparity in health-care coverage and adding more favourable treatment of out-of-pocket costs for those with employer-based coverage would potentially increase the size of the disparity.

FIGURE 2 TAXES PAYABLE FOR INCOME USED FOR OUT-OF-POCKET HEALTH CARE EXPENSES, 29% FEDERAL TAX RATE 2014 (TAXABLE INCOME > \$136,270)

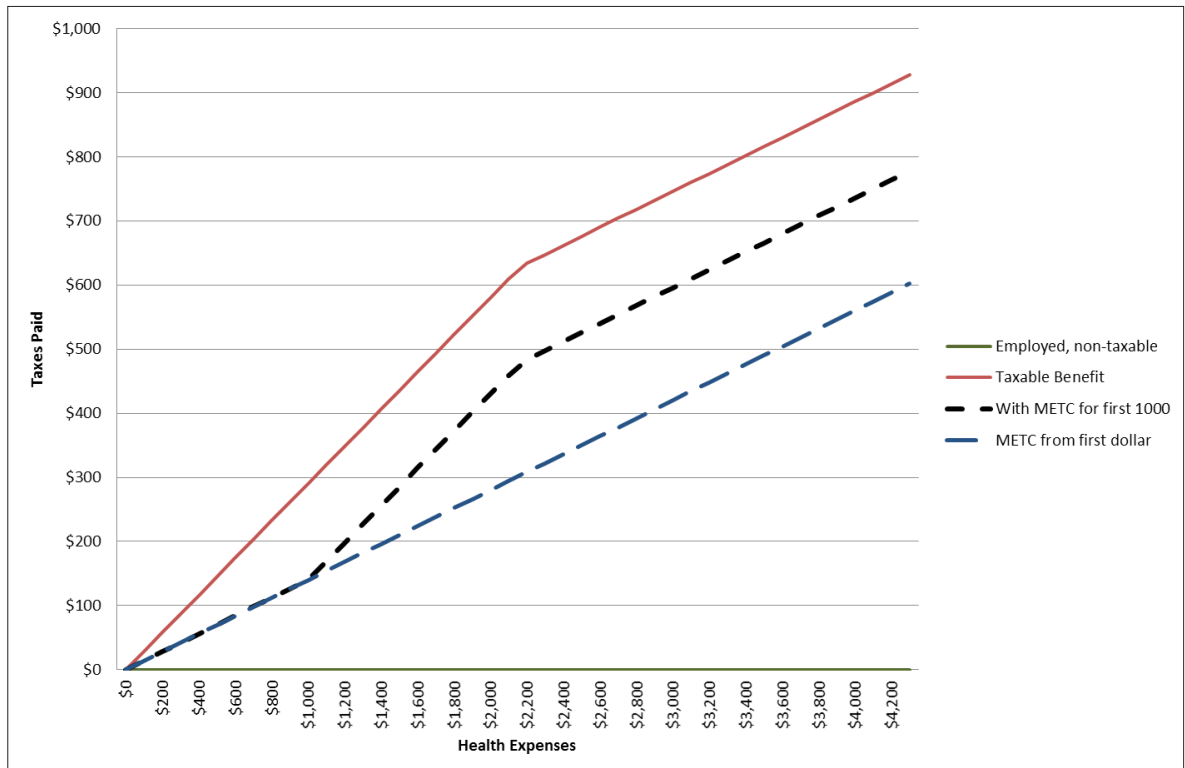
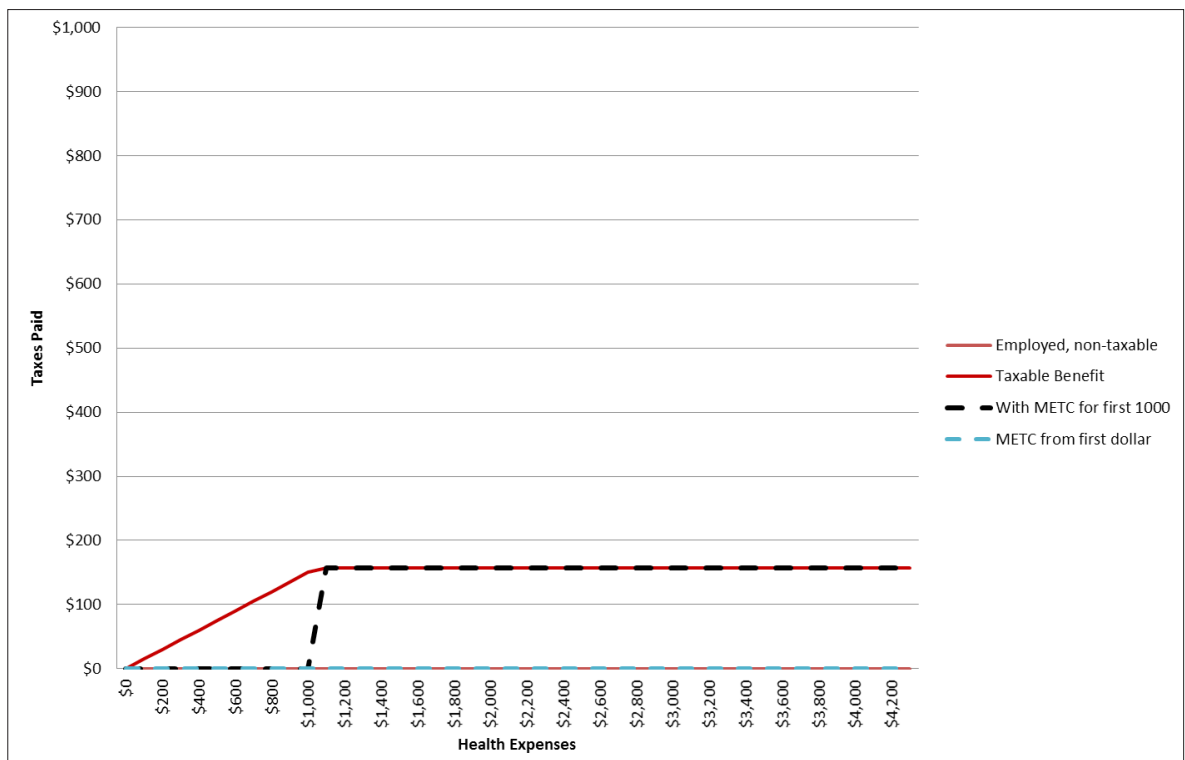


FIGURE 3 TAXES PAYABLE FOR INCOME USED FOR OUT-OF-POCKET HEALTH CARE EXPENSES, 15% FEDERAL TAX RATE 2014 (TAXABLE INCOME \$35,000)



SAVINGS AND INCOME STRATEGIES

The preceding discussion has not distinguished among sources of income that are used to meet out-of-pocket health-care costs beyond expenses covered through employment health benefits. If an objective of tax assistance for meeting out-of-pocket health costs is to encourage households to save so as to have more income to meet these costs, particularly beyond employment-based coverage, then the preceding modifications to the tax treatment of income used for meeting health costs could be restricted to income drawn from savings vehicles like an RRSP or a TFSA. In the case of tax assistance through savings vehicles, several issues must be considered. First, would savings be from before-tax income like the RRSP or would they be from after-tax income like a TFSA? Second, is it necessary to have a new, dedicated vehicle for health savings (e.g., a registered health savings plan (RHSP)) or can the health savings be accommodated within existing tax-assisted savings vehicles?

Suppose that the METC treatment for the first \$E of receipt-supported out-of-pocket health-care costs were provided only if the individual withdraws the \$E from a registered savings vehicle.²² Where the earlier discussion of the extension of the METC eligibility did not stipulate which income sources are eligible for use to pay for out-of-pocket health-care costs, with a savings approach the expenses cannot be out of current income. They must be paid for out of savings. The point of this stipulation would be that the favourable tax treatment of withdrawals from savings to meet health-care costs would create an incentive to save, with the byproduct of savings not being needed for health-care costs retained by the saver for other income needs. Without this favourable tax treatment of withdrawals for health-care purposes, there is no incentive to save beyond those in place already which include non-taxable gains in the savings account. There would also need to be some imposition of a maturation or waiting period before which funds can be withdrawn for covering out-of-pocket health costs to ensure that costs are met out of savings and not current income merely flowing through an account. Savings for health-care purposes could have deposits up to a ceiling which could accumulate and earn interest.

The next issue to consider is whether deposits to savings accounts for health purposes should be from before-tax income as with an RRSP, or from after-tax income as with an RESP, RDSP or TFSA. The current tax treatment of employer-provided health-care benefits has the benefits provided from before-tax income (non-taxable benefit of the employee) which would be the RRSP approach. In contrast, if health benefits from the workplace were treated as taxable, then after-tax income saved in an RESP, RDSP or TFSA would be the equivalent model.

With the RRSP model, consideration must be given to whether there would be an increase in the limit of what can be contributed per year to raise the potential savings amount, or whether the use of RRSPs for tax-exempt medical costs would encourage more people to contribute to RRSPs and contribute their full amount. A study from 1995 showed that

²² This tax treatment of health-care costs is less generous than seen currently with employer-provided health-care benefits, but is more in line with proposed tax treatment for employee health benefits discussed above. Indeed, if a larger incentive is needed, then the \$E withdrawn for health-care cost purposes could be directly deducted from taxable income. Should the monies be withdrawn for non-medical purposes, then they could be taxed according to the same basis as an RRSP withdrawal or repaid to the RRSP. Indeed, a condition for withdrawal could be that the funds be first rolled into an RRSP out of the RHSP.

only 30 per cent of annual RRSP room was being used, suggesting that there is ample contribution room for most Canadians to save for health-cost coverage within the existing limits. The stock of unused RRSP contribution room in Canada is \$500 billion in 2012 (Globe and Mail, Aug. 23, 2012) so on the surface, it would seem there is not a strong case for increasing the contribution limit. On the other hand, much of the unused RRSP room may be for Canadians who face lower tax rates (e.g., young workers) or higher rates on withdrawal due to growing income.²³ Their interests may be addressed by the TFSA which has a \$5,500 annual contribution limit and a cumulative contribution room of \$41,500.²⁴ For higher income households who have contributed their full RRSP contribution limit, there may be a case for adding contribution room.

Next, is it necessary to create a dedicated savings vehicle for health-care costs, or would it be better to incorporate provisions for withdrawing savings for health costs from existing vehicles like RRSPs or TFSAs? A separate, dedicated savings vehicle for health-care costs has the disadvantage of adding complexity to the tax-supported savings system, which will likely mean added administration costs.

An RHSP could be created within the RRSP along the lines seen for home buyers and lifelong learning plans, where RRSPs could be withdrawn/borrowed against for these specific purposes with no tax at the time of withdrawal, but tax on the unpaid scheduled repayments. With the RHSP model, no repayment would be required, but there would be allowance for a withdrawal for medical expenses that would be treated according to the modified METC discussed above, or perhaps not taxed at all. Some consideration would need to be made whether the withdrawal reduces RRSP contribution room as with non-repaid withdrawals from the lifelong learner's plan or the home buyer's plan, or if the withdrawn amount is returned as contribution room.

Blomqvist and Busby (2014, 21) suggest that a transfer of RRSP funds into a vehicle like an RHSP instead of transfer of funds into a RRIF at age 71 could provide an RESP-like vehicle for the elderly where the taxable withdrawals for LTC and perhaps other out-of-pocket health-care costs would be deferred to age 75 and after.

With the TFSA, because contributions are from after-tax income, withdrawals are not taxable, so the main advantage to savers would be favourable tax treatment of health costs met with funds withdrawn from the TFSA in addition to the non-taxation of the investment income on the TFSA funds. For the favourable tax treatment of $\$E$ of health costs, the taxpayer would need to withdraw that amount from a TFSA. To an extent, this TFSA withdrawal requirement would make liquidation of savings a necessary condition for the favourable tax treatment of health-care expenses.

If there were a desire to include a grant component to encourage savings for meeting health-care costs, then a dedicated health-savings vehicle as with the RESP and the RDSP,

²³ Noreen Rasbach, *TFSA or RRSP? Here's How to Decide*, The Globe and Mail, Feb. 10, 2014. <http://www.theglobeandmail.com/globe-investor/personal-finance/retirement-rrsps/tfsa-or-rrsp-it-depends/article16792559/>

²⁴ Clare O'Hara, *Liberals Detail How They Will Roll Back TFSA Contribution Limits*, The Globe and Mail, Dec. 7, 2015. <http://www.theglobeandmail.com/globe-investor/personal-finance/household-finances/liberals-confirm-rollback-of-tfsa-limit-in-2016/article27638448/> Frances Woolley, *How TFSAs fit Harper's Vision of Small Government*, The Globe and Mail, Feb. 25, 2015. <http://www.theglobeandmail.com/globe-debate/how-tfsas-fit-harpers-vision-of-small-government/article23195077/>

the RHSP could be structured as a separate savings account. With the RRSP it is possible, but more complicated, since determining at the end of the account what had not been spent on health would be more complex. The Registered Disability Savings Plan has income-contingent grants and bonds that could provide a model for health-care cost coverage. Depending on family income, contributors to an RDSP are eligible for up to \$3,500 in annual grants for \$1,500 in contributions, and up to a further \$1,000 in the RDSP through the Canada Disability Savings Bond for family incomes less than \$25,256. The lifetime (to age 49) maximum grant amount is \$70,000, and the maximum bond amount is \$20,000. The RDSP is based on eligibility defined by eligibility for the Disability Tax Credit, which in turn is based on having a medically certified disability. The RESP for helping families meet the costs of post-secondary education provides \$500 per year for \$2,500 in contributions. The maximum grant for contributions made by the eligible dependant's 18th birthday is \$7,500.

For an RHSP with a grant component for low-income individuals, there are two possible ways to structure the grant or bond component. First, if the Canada Disability Savings Bond were extended to be a Canadian health-savings bond, eligible for deposit in either an RHSP or RDSP, then for low-income families, \$1,000 per year could be deposited up to a lifetime maximum of \$20,000. Second, the Medical Expenses Supplement is currently a refundable tax benefit for low-income tax filers (family income less than \$25,278 in 2013) with a maximum value of \$1,142. If the METC were changed to have first dollar of health-care costs eligible, then the refundable Medical Expenses Supplement could be the source of the grant for the RHSP – the refundable monies must be deposited in the RHSP.²⁵ A disadvantage to this approach is that low-income Canadians who are not incurring health-care expenses would not have deposits. Second, for low-income households, they may need/prefer to have more income now than having savings reserved for meeting health expenses.

It is not clear how tax assistance for out-of-pocket health-care costs would influence savings behaviour. Even with a very large grant component, of 500,000 Canadians who would be eligible for an RDSP, only 69,000 as of 2013 had contributed to one.²⁶ In a recent evaluation of the proposal to double the annual contribution limit for TFSAs, based on a cursory review of the literature, the Parliamentary Budget Office makes the assumption that preferential tax treatment of savings does not induce greater levels of savings. Instead, the tax-preferred vehicles divert savings from other savings vehicles without as favourable tax treatment (Office of the Parliamentary Budget Officer 2015, 7-8). It is possible, however, that the METC treatment of TFSA withdrawals for health-care expenses as an additional incentive to save, would increase the levels of savings by Canadian households.

COSTING SOME POLICY OPTIONS

To provide some best guesses for the tax expenditures of the federal government associated with changing the tax treatment of employee health and dental benefits and changing

²⁵ During World War II, refundable tax credits were used as a form of compulsory saving. The funds were payable at the end of the war with 2% per annum interest.

²⁶ <http://www.rdsp.com/2013/05/30/canadas-disability-savings-fund-called-a-fiasco-cbc-news/>

the parameters of the METC to make first dollars of expenditures eligible, we used the SPSD/M based on 2009 data and we reviewed the 2012 to 2013 changes in the Department of Finance's projected tax expenditure on employee health and dental benefits.

A challenge with using the SPSD/M for evaluating changes in the METC is that not all Canadians would have had high enough out-of-pocket health costs to benefit from the METC, hence they may not have reported their out-of-pocket health-care expenditures. So, if all we did was change the threshold for expense eligibility, we would only have the tax expenditure change for persons who have higher expenditures and miss much of the population with low annual expenditures. Consequently, we assign all individuals in the data set at least \$1,000 of eligible out-of-pocket health spending. This assumption is conservative relative to the magnitude of median expenditures on out-of-pocket health-care costs discussed earlier. On the other hand, if out-of-pocket health-care costs are not uniformly distributed across the population, we may be overstating the change in METC tax expenditures since higher health costs would have been eligible already.

Table 1 presents some options for the tax treatment of health benefits and out-of-pocket health costs under some of the scenarios discussed above. We do not specify income sources in terms of whether current income or income from savings is used to meet the expenses, since for savings or spending out of after-tax income, the income source would not matter. It is important to consider, however, that restricting the favourable tax treatment of out-of-pocket health-care expenses to funds withdrawn from savings would likely result in lower tax expenditures than we calculate, since many households will have low, or no, balances in savings vehicles.

First, consider the tax treatment of employer health benefits, which are a non-taxable form of income, and the benefits of the coverage are also not counted in taxable income. As noted earlier, the Department of Finance projected federal tax expenditure of this tax treatment of employee health and dental benefits in 2013 to be \$2 billion, whereas it was \$3.4 billion in the 2012 projections.²⁷ Because the 2013, and later 2014, projections by the Department of Finance treat employee health and dental benefits as taxable but eligible for the METC, the difference between the 2012 and 2013 projected tax expenditures suggests that the federal government would collect an additional \$1.4 billion in tax if the benefits were to be treated as taxable income but eligible for the status quo of the METC.

Next, we consider the tax expenditure under the status quo of the METC using the SPSD/M with 2009 data. The projected tax expenditure for the status quo of the METC in 2014 was \$1.425 billion. If we were to make the first \$1,000 of health expenditures eligible for the METC, then the federal tax expenditure would increase by \$1.54 billion, assuming that all tax filers who had zero claimed health expenses actually had \$1,000 in out-of-pocket health costs (around the average for Canadians). Eliminating the METC threshold of three per cent of income for expenses would increase the total METC tax spend by \$2.36 billion.

²⁷ It appears that this net amount is after accounting for revenue that would be collected if the benefits were taxable and subject to the METC.

TABLE 1 OPTIONS FOR FEDERAL TAX ASSISTANCE TO MEET OUT-OF-POCKET HEALTH COSTS

	Policy	Federal Tax Expenditure
Employee health benefits	Not taxed (Status quo 2014)	\$3.4 billion
Out-of-pocket costs	Taxable but eligible for METC (Status quo 2014)	\$1.425 billion
	Policy	Change in federal tax expenditure
Employee health benefits	Taxable but eligible for METC on all dollars (2014)	-\$1.4 billion
Out-of-pocket costs	Taxable but eligible for modified METC, first \$1,000 eligible	+\$1.54 billion
Out-of-pocket costs	Taxable but eligible for METC, first \$2,171 eligible	+\$2.36 billion

NOTE: The status quo tax expenditures are from Department of Finance Canada, *Tax Expenditures and Evaluations 2012 and 2013* (<http://www.fin.gc.ca/taxexp-depfisc/2013/taxexp1301-eng.asp#toc9>). The changes in federal tax expenditure are generated with the SPSPD/M for changes in the METC. See the Appendix for the details on how these numbers were calculated.

DISCUSSION

Given that there currently exists favourable tax treatment for insurance vehicles for covering out-of-pocket health-care costs, the desirability of a tax-assisted savings vehicle should be considered in terms of the program’s goals. Consider that it is already possible for employers to purchase private health insurance on behalf of employees, effectively with employee before-tax income and have non-taxable benefits when costs are reimbursed. If this treatment were extended to any purchase of private health and dental insurance by individuals and not only through employment arrangements, then private insurance coverage could be extended over more of the population. Another expenditure-based approach might simply be to lower the tax-deductibility threshold for the Medical Expenses Tax Credit to be first-dollar deductible. Is the issue one of making insurance contracts lower cost, or out-of-pocket costs more affordable, through tax assistance? Or is the idea not only to meet out-of-pocket expenses today as insurance contracts are designed to do, but to meet health-care costs of the future and to encourage greater savings to improve the adequacy of income for meeting health care and other needs?

The desirability of a tax-assisted savings plan to provide for some degree of self-insurance of out-of-pocket health-care costs can be considered in terms of efficiency considerations. Evans (2004, 147-148) discusses the belief that the generosity of the subsidy of private insurance contracts through employment contracts results in over-insurance and overuse of health care; unnecessarily “high administrative overhead costs” of insurance; restrictions of coverage to those who represent “good risks” or to those with mandatory pooling through place of employment, and finally, limits the public pressure for public coverage of drugs and other out-of-pocket expenses. Hurley and Guindon (2008, 29-30) argue that private insurers largely function as passive “bill payers” which has resulted in no efforts, or stimulus towards, improvements in the quality and efficiency of health-care services in Canada. Where costs of services have increased, insurers have largely responded by relying more on demand-side cost sharing. Stabile (2001) finds that employment-based health benefits lead to increased use of physician services. Using his estimates, it would appear that there

is a one-per-cent increase in use of publicly funded physician services attributable to the favourable tax treatment of employment-based health benefits.²⁸

From the perspective of providing incentives for quality and efficiency in health-care services, self-insurance through one's own savings or through structures akin to a medical savings account where households are allocated an annual sum of money, either through government grants or through favourable tax treatment such as tax exemptions of contributions, potentially offers a way to offset these negative features of tax-subsidized insurance purchases. Self-insurance where unspent balances are retained by the individual, if not needed, creates an opportunity cost of the funds that would provide an incentive for individuals to avoid unnecessary expenditures and to potentially be more price-conscious when procuring services.²⁹

A savings vehicle for meeting out-of-pocket health costs may not be well timed for addressing the needs of the baby boom generation. For the lead edge of the baby boom who are 65 years old already, the capacity to save and take advantage of a savings instrument may not be great.³⁰ For them the main advantage would be the relief that comes with more favourable tax treatment of health expenses, even if they use RRSP and TFSA balances to do so. For Canadians aged 50 to 65, these instruments may be of considerable value, given that they are still working and at peak earnings. A great advantage may be offered for younger Canadians as well, given the likely increases in tax rates that will accompany the increase in tax expenditures on health care and pensions with the aging of the baby boom generation.

Could the introduction of a tax-assisted savings vehicle for out-of-pocket health-care costs be a first step towards improving the efficiency and equity of the tax system? If the introduction of a tax-assisted savings vehicle substituted for the favourable tax treatment of employee health and dental benefits, then the net tax expenditure for the savings vehicle would be lower, the tax treatment of health-care costs would be closer to efficient, and horizontal equity would be improved. Further, the favourable tax treatment of extended health benefits is largely a legacy of a tax policy introduced to address the costs of hospitalization and medical treatment.

The exclusion of employer-provided health benefits from taxable income was introduced in 1948 by the federal government at a time of rising extents of unionization and union

²⁸ Based on the marginal effect of the tax prices between Ontario and Quebec yielding a 10 percentage point difference in the probability of having employment-based coverage and a 10% increase in physician use for those with private health coverage compared to those with no coverage.

²⁹ While commentators such as Robert G. Evans, *Financing Health Care*; Evelyn Forget, Deber and Roos, *Financing Medical Savings Accounts*; Hurley, *Medical Savings Accounts: Approach With Caution*; and Deber, *Medical Savings Accounts: A Fine Idea Unless You're Sick*, have been critical of medical savings-account approaches to covering Medicare services (doctors and hospitals), their concerns are largely over the effective user fees they would introduce and the incidence of those fees in terms of those in poor health. For non-Medicare services currently met out of pocket, these concerns are not relevant unless one is concerned that only higher-income households stand to benefit from the favourable tax treatment.

³⁰ Blomqvist and Busby, 67, would disagree with this concern. They argue that the timing is such that many baby boomers still have a decade to adjust savings and income plans to account for retirement needs plus long-term care costs. Long-term care costs are predominantly expected after age 75 whereas other out-of-pocket costs rise after age 65 coincident with needs and loss of employment-based coverage.

bargaining power in the private sector.³¹ At the time, this favourable tax treatment of health benefits supported an expansion of coverage of voluntary insurance coverage for hospitalization and medical treatment, particularly physician services. This encouragement of voluntary insurance coverage through insurers like Blue Cross and Blue Shield was an alternative to a compulsory public insurance plan that would follow later in 1957 (for hospitals) and 1965 (physician services) (Taylor 1957, Naylor 1986, Boychuk 2008, Emery 2010). As the federal conditions for cost sharing of medical services in hospital and/or provided by a physician resulted in public payers taking over payment and administration for these health expenditures, private insurance moved into a complementary insurance role covering expenditure categories on the outside of Medicare and covering some of the gaps that Medicare may have left (Naylor 1986, 167). To some extent, this legacy has committed financial resources of households to coverage of out-of-pocket costs for needs of working-age Canadians and their families, possibly at the expense of meeting the expected needs at higher ages like drugs, long-term care and home care. Finally, the inequities in the tax treatment of private insurance based on who pays the premium (employer or the individual) has long been a criticism of tax support for voluntary insurance coverage. Malcolm Taylor (1957, 35) identified early on that the favourable tax treatment of private insurance premiums covered by one's employer provided a large advantage over persons who did not have access to employer-provided coverage.

In the 1981 federal budget, then-Finance minister Allan MacEachen proposed to end the tax exemption for a number of benefits provided to employees, including employer contributions to private health-service plans and dental plans on behalf of employees, effective Jan. 1, 1982. MacEachen said that “the tax-free status of these benefits is inequitable for employees who cannot receive them, and encourages the substitution of these benefits for taxable forms of remuneration for no particular business purpose but at a cost to the federal treasury. The tax exemption for these benefits is also concentrated in the larger corporations since employees of small businesses typically receive most of their remuneration in the form of wages and salaries which are fully taxable.” The proposed changes would have resulted in employer contributions to private health-service plans and dental plans on behalf of employees being treated in the same way as employer contributions to government health-insurance plans where, as a taxable benefit, the contributions to private health-insurance plans would be counted as part of the employee's medical expenses which are deductible to the extent they exceed three per cent of his/her income. This proposal was just one of many never enacted in the end from the extremely unpopular 1981 budget. Opposition from stakeholders like the insurance industry was alleged to have been strong.

³¹ The timing of 1948 coincides with the passing of the Income Tax Act that replaced the legislation for a wartime income tax and with the 1948 Industrial Relations and Disputes Act. This timing is five years later than in the U.S., suggesting different reasons for having the exemption. For the U.S., Jill Quadagno, *One Nation Uninsured*, 50, discusses how employer contributions to private health plans and pension plans were exempted from the calculation of profit, and how they would not be counted as income for the employee, and were implemented during World War II. The former was to address concerns of firms with the excess profits tax of 80% to 90% on corporate profits higher than pre-war levels to prevent wartime profiteering. The latter arose due to the no-strike provisions of unions limiting their ability to demand higher wages. The 1943 National War Labor Board decision not to treat health and pension benefits as part of income encouraged bargaining over benefits in collective agreements instead of wages. Canada also had a wartime excess profits tax and life insurance premiums and compulsory savings were exempt from taxable income, but not health benefits until 1948. The 1945 federal White Paper on Employment and Income discussed the need to restrain consumption in the aftermath of the war to avoid price inflation and to ensure resources were directed at investment. Perhaps the encouragement of non-wage benefits instead of wage increases was considered useful for that purpose.

Since 1993, Quebec has included employer-provided health insurance in taxable income (Stabile 2001, Finkelstein 2002). If the rest of Canada were to follow Quebec, what would the impacts on private health-insurance coverage be? With no change in the METC, Finkelstein (2002) found that coincident with the change in the tax treatment of employment-based health benefits, supplementary health-insurance coverage fell on net between 10 and 15 percentage points. Stabile's (2001) estimates suggest that the impact of including employer health and dental benefits in taxable income would reduce the probability of having coverage by around 10 percentage points. If the METC were changed to make all out-of-pocket costs METC-eligible, then the impact on private insurance coverage is less clear. It could fall by a lesser amount or even increase. For income earners in the lowest tax bracket, if all out-of-pocket expenses were METC-eligible, then there would be little change in the tax price of private health and dental benefits. For the highest-income earners, the METC treatment of out-of-pocket costs would cut the increase in the tax price of health and dental benefits estimated by Stabile and Finkelstein by 50 per cent. To the extent that the METC treatment of first-dollar out-of-pocket costs would be extended to more of the population, it is possible that this introduction of a subsidy to Canadians without employment-based coverage would result in an increase in demand for private insurance coverage.

Consider that in Table 1, the elimination of the treatment of employee health benefits as not taxable would almost offset the costs of making at least the first \$1,000 of out-of-pocket health-care expenses eligible for the METC. This would broaden the favourable tax treatment of out-of-pocket health costs beyond workplace coverage to the population and equalize the treatment of health-care costs across sources of coverage. The broader treatment of health-care spending would reduce the strong incentive to purchase employer-based extended health-care coverage in favour of purchasing other insurance products like long-term care insurance.

CONCLUSIONS

At this time, there is a lack of tax assistance for individuals without workplace health benefits to meet the first \$2,171 of out-of-pocket expenses, including insurance premiums. To address the catastrophic costs of drugs and long-term care, Canadians should be provided with incentives to purchase private insurance contracts. To encourage and support Canadians to save so as to have the capacity to self-insure for these predictable costs and/or to purchase private insurance coverage, the non-refundable Medical Expenses Tax Credit, and the refundable Medical Expenses Supplement could be changed to make out-of-pocket health-care costs eligible from the first dollar when funds for these costs are withdrawn from a registered savings vehicle. The federal tax expenditure under this revised credit and supplement could be covered by the elimination of the exemption of employer-provided health benefits from employee taxable income. Treating health benefits as taxable income subject to the modified Medical Expenses Tax Credit would address efficiency and equity issues with the existing tax treatments of health-care costs while extending tax assistance for out-of-pocket costs to more of the population. With decisions about payments for costs and purchases of insurance consumer-directed, incentives for quality improvement and cost containment are created.

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APPENDIX: MARGINAL EFFECTIVE TAX RATES AND COSTING BY PROVINCE FOR TABLE 1 OF REPORT

First, we wish to estimate the change in federal taxes collected if employee health and dental benefits were taxable benefits. These amounts may be inestimable with SPSD/M since employer-provided health benefits are not reported by individuals. Consequently, we rely on the tax-expenditure projections for the tax treatment of employee health and dental benefits from the Department of Finance for 2012 (non-taxable treatment) and 2013 (taxable but eligible for the METC). The box with “\$2 billion” is taxing employee health benefits but treating them as eligible for the METC. That situation is a net gain for the government, as it reduces the \$3.4 billion in the box directly above.

Next, we estimate the change in federal tax expenditure if after-tax income used for out-of-pocket health-care expenses were eligible for a modified METC. Case 1 below is the top row of the two, labelled “Taxable but eligible for modified METC, first \$1,000 eligible”; this is the scenario we have been calling “the corridor”. Case 2 below is the bottom row of the two, labelled “Taxable but eligible for METC, first \$2171 eligible”.

Case 1: The Corridor

The corridor estimates come from two distinct runs of the program which we refer to as “low spend” and “high spend”. These names refer to simulating changes in tax treatment of out-of-pocket health expenditures on either end of the corridor.

The low spend scenario models those who would benefit under the new corridor regime by spending up to \$1,000. To mimic this with the existing tax system, we replaced the actual amount of eligible medical spending with \$1,000 if:

- a) An individual had \$0 to \$1,000 in medical spending; or
- b) An individual had > \$1,000 in medical spending but received no actual credits (because their income is too high).

Anyone else was given a value of \$0 for medical spending. That means all the high spenders were treated like \$0 spenders in the low spend scenario.

This scenario is highly conservative. We are imagining that everyone who claimed \$0 in medical spending actually claimed \$1,000. Those who claimed a value greater than \$0 were given extra spending to bring them to \$1,000 (e.g., those with \$800 were given \$200). Those who claimed greater than \$1,000 in the old regime and received nothing were given \$1,000 in credits under the corridor scheme.

Since everyone now has an artificial total of \$1,000 in medical spending, we ran the simulation so that medical expenses were eligible from the first dollar for the METC.

That left out the high spenders, so we ran the high spend scenario for them. Individuals who spent more than \$1,000 on medical expenses and received credits in the old system would receive those credits plus \$1,000 in the new corridor design. So we gave those people

\$1,000 extra in eligible medical expenses and gave the people in the low spend scenario \$0.

The overall impact of the corridor is the sum of the low spend and the high spend simulations. The difference between the status quo and the corridor (by province, in millions of dollars) is:

	NFLD	PEI	NS	NB	QUE	ONT	MAN	SASK	ALTA	BC	CAN
Total tax change	-13.6	4.1	-30.1	-20.8	-134.2	-593.6	-44	-28.8	-192.3	-180.4	-1233.7
Federal tax change	-18.6	-0.9	-39.4	-29.5	-233.3	-684.4	-54	-42.8	-217.2	-215.6	-1535.7
Provincial tax change	5	5	9.3	8.8	99	90.8	10	13.8	24.8	35.2	302

The provincial tax change increasing is a function of provincial taxes in the low spend situation increasing by a large amount. We have no good explanation why the next change in provincial tax revenue would be positive, but we have a hypothesis. The SPSD/M is complicated and there is an entire part of the program simulating spending on commodities, basically taxed goods. When we give the low spenders an increase in medical spending of \$1,000 that is interpreted by the SPSD/M as \$1,000 more spent on medical goods, which in turn triggers additional simulation changes in an input-output model.

Case 2: First-dollar eligible

This was easier to simulate: We gave everyone who had less than \$1,000 in medical spending \$1,000. Those who had more were left as is. Then, we made medical spending eligible from the first dollar. The difference between the status quo and the first-dollar eligible scenario with this conservative behavioural response (by province, in millions of dollars) is:

	NFLD	PEI	NS	NB	QUE	ONT	MAN	SASK	ALTA	BC	CAN
Total tax change	-34.9	-9.9	-65.8	-54.1	-568.3	-922.3	-84.9	-70.3	-292.8	-320.6	-2423.8
Federal tax change	-35.9	-9.8	-66.7	-54.7	-470.6	-943.3	-83.1	-71.7	-292.9	-334.3	-2363
Provincial tax change	1	-0.1	1	0.6	-97.6	21	-1.8	1.3	0.1	13.7	-60.8

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