

Economic Challenges Facing Middle Class Families

Testimony of C. Eugene Steuerle

Senior Fellow, The Urban Institute

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Mr. Chairman and Members of the Committee:

Thank you for the invitation to testify before you today on economic challenges facing middle-class families. I appreciate especially your effort to first gather information in a bipartisan way. Facts—the base on which we start—shouldn't have a political party. I am engaged with the Pew Foundation in a project that includes researchers from the Urban Institute, the Heritage Foundation, the Brookings Institution, and the American Enterprise Institute on a related topic: mapping the status of economic mobility. We will be glad to report those results to you as they become available.

Background on Income Distribution

The subject of this hearing is a difficult one. There are many things we do not understand about what is happening in the economy and, more specifically, to the middle class. It is fairly clear that, beginning in the late 1970s, income distribution has become more unequal, and that income at the very, very top—particularly among executives, the famous, and some professionals—has been growing significantly faster than income at most other income levels. Some explanations relate to the extraordinary economies of scale in fields such as entertainment, prescription drugs, and information technology.

But much else is also occurring. The growth in single-parent families, long correlated with poverty among the young, is changing family structure as we know it; single-adult families are more vulnerable to the whims of the labor market than are two-adult families. Recently, some aspects of life have become more risky and some less. To mention only two, some very recent mortgage-lending practices have put more middle-income families in danger of losing their housing. Yet, unemployment due to recessions has waned over the past three decades relative to most of our history.

In my testimony, I would like to focus on one of the major risks facing American families: the cost and availability of health insurance. Current law schedules Congress to spend more on health care than in any other area. Under Congressional Budget Office projections of current law, moreover, a majority of the increase in federal revenues that would accrue to government in the next four years would be spent on additional health expenditures and health tax subsidies (figure 1). Unfortunately, we are likely spending more on health care in a way that increases rather than decreases the number of uninsured. As a consequence, the way our health budget is evolving has two major effects:

- (1) By absorbing most future revenue growth, health policy embedded in current law is deterring Congress from doing very much about the risks facing middle-class families;
- (2) Within the health system itself, current policy is likely adding to risks—including the risks of being uninsured—rather than reducing them.

To clarify these two effects, let me lay out some basic figures and facts:

- Health goods and services now comprise one-sixth of the U.S. economy—perhaps soon one-fifth at current rates of growth. The total amount spent in 2006 was about \$2.2 trillion, of which government provided about \$1.3 trillion (figure 2).
- Per household, total health spending is about \$19,000, while government subsidizes health care and health insurance to the tune of about \$11,000 per household (figure 3).
- To cover \$11,000 of costs per household, government effectively assesses taxes of \$11,000 per household, although with deficits, some of those tax liabilities are passed on, with interest, to future generations (figure 3).
- Federal, state, and local governments in the United States spend as large a share of GDP and significantly more in real dollars on health care than most Western European governments with which they are often compared.
- There is little evidence we are getting much better health care for the much larger real dollar expenditures.
- By about 2010, government spending and tax subsidies are scheduled to grow in real terms by another \$2,000 per household to about \$13,000 or by more than \$1/4 trillion when compared to 2006 (figure 4).
- These government benefits are distributed very, very unevenly. Workers, particularly middle-income families with modest health insurance packages, get very little. Benefits tend to go toward the elderly, those in high-cost states, and to higher-income workers with more expensive health plans.
- Many of these *additional* expenditures and tax subsidies—that is, the scheduled increases—are so badly designed that they likely lead to an increase in the number of uninsured, largely among working families.
- Most of the data reported on income security tend to ignore this large portion of total income. For instance, income of workers or retired individuals is often reported net of the value of health insurance policies.
- Even if added in, this additional income would not dispute the fact that, among the working-age population, the middle class has still not seen the income gains accruing at the very top of the income distribution.
- Among the retired, the issue is more complex. If health care is counted, the average household is now retiring with a Social Security and Medicare package that will pay benefits for more than a quarter of a century. If purchased out of a 401(k) account at age 65, the package would be worth more than \$3/4 million,

rising for retirees in 2030 to well over \$1 million in today's dollars (figure 5). Cost-wise, newly retiring middle-class families are getting more and more benefits every year. Because so many benefits are paid to those in late middle age (that is, with significant remaining life expectancy), however, the truly old are often left in much more precarious circumstances.

The Tax Break for Employer-Provided Insurance

Let me now provide more details on the primary subsidy for middle-class families—the exclusion from tax of benefits provided through employer insurance. This tax break raises a number of concerns. The nation spends over \$200 billion annually on tax subsidies for health and the number is rising fast. Nonetheless, 47 million people lack coverage. By any standard, we aren't getting our money's worth.

These tax subsidies favor higher-income over lower-income employees—and many poor people get no help at all. Higher-income households sometimes receive as much as \$3,000 or more in reduced taxes for buying health insurance, while many moderate-income taxpayers get very little. The existing tax break is also most valuable to those who buy the most expensive insurance: the more one buys, the more subsidy one receives.

Even worse, the subsidy—like many health subsidies—is open-ended. Every year billions more are spent, without a vote by Congress or the public to spend money this way rather than some other way. According to one estimate, from about 2006 to 2010, the cost will grow by an extra \$58 billion.

This extra money not only won't buy more insurance coverage, it most likely will increase the number of uninsured. The subsidy encourages insured people to buy more high-cost insurance, which encourages more use of high-cost health care, which helps drive up health costs, which, in turn, leads to a decline in insurance coverage. Many individuals and employers simply decline to pay those high-insurance costs.

Starting from scratch, it seems to me that almost no one would propose *spending more in this extremely regressive manner to increase the number of uninsured* and to encourage the excessive use of health care and health insurance. Yet that is exactly what the current system offers—only it takes place automatically and without a vote by Congress.

None of this suggests that determining how to spend federal dollars on health is easy. One can sometimes hide choices in a socialized bureaucracy so they aren't so apparent to the public, but that doesn't make them any easier. The primary problem is not that choices are hard, it's that automatic growth in health care spending programs prevents some hard choices from being made at all. As for the open-ended tax break for employer-provided health insurance, it is the largest federal tax break and it is also the largest health subsidy in the tax or expenditure systems for the non-elderly and non-disabled. Those facts alone make it worthy of attention.

The president recently proposed to tackle this issue by providing what is closer to an equal subsidy for everyone. At the same time, there would be no additional subsidy if we bought more expensive health insurance. He does this by suggesting a fairly significant tax break simply for buying some minimal policy, but otherwise taking away a tax break—as under current law—that is related to the amount of insurance we buy. I believe we should accept his call to improve both fairness and efficiency of the medical marketplace, but follow the challenge to its logical conclusion.

Once we agree on pursuing a more equally distributed subsidy and one more likely to expand insurance coverage, then we need to figure out how to amend his proposal to best achieve those goals. Yes, his proposal would give everyone the same income tax deduction as long as they purchased health insurance—that's fairer than current law. Social Security tax breaks would certainly be more evenly distributed. But because deductions are worth more the higher one's tax bracket, higher-income people could still get income and Social Security tax subsidies worth over \$5,000 while many moderate-income workers could at best get about \$2,300 in Social Security tax reduction. Some would do even worse. Thus, while the president's proposals would reduce the disparity in tax subsidies between rich and poor, it would not remove them. Why not simply follow the logic of the reform and grant vouchers or tax credits of equal size for every adult and child?

The efficiency of the subsidy must also be improved. As currently structured, the proposal would turn existing health subsidies upside down by granting an additional tax benefit only to those people who put money into something called Health Saving Accounts or HSAs. Effectively, individuals would be subsidized more if they did NOT join with others in an insurance pool to cover health costs over and above catastrophic amounts. Thus, a person enrolled in a health maintenance organization (HMO) could only get a tax deduction of \$15,000. But someone enrolled in an HSA could get \$15,000 *plus*, say, \$3,000 put into the account—really a double deduction. This would discriminate against certain forms of insurance and favor those who could most easily come up with the cash or afford the risk associated with high deductibles. Whatever one thinks of HSAs, it goes against the original argument of HSA proponents for greater neutrality between expenses paid by an individual and those paid out of an insurance pool.

Much stronger incentives are also needed to deter people from signing up for insurance that is cheaper because it excludes sick people and those with chronic conditions. The administration is willing to provide states some money to deal with these issues, but it wants to redistribute money that is already earmarked for health spending. It is unclear how much it could buy as a result. We need more work on this front.

A properly designed voucher is a much better vehicle for getting at so many of these issues. It can be extended to people who pay little or no tax, it can be integrated with state Medicaid and related children's insurance for the poor, and, if it were worth the same amount per person, it would be much easier to administer by employers and insurance companies alike.

Medicare and Medicaid

It may seem strange that in a hearing on economic challenges to the middle class, I would raise concerns with the direction of our direct spending programs as well—in particular, Medicare. Analysis of recent Congressional Budget Office data reveals that, under current law, revenues would increase by about \$340 billion absent any increase in the cost of health tax subsidies. Because so much built-in growth is contained in health expenditures and tax subsidies, however, these existing programs by themselves would automatically absorb the majority of that growth (figure 1).

This, of course, leaves the Congress—and, in particular, the Ways and Means Committee—little flexibility to determine how to allocate additional revenues to meet the most important needs of the nation, including new risks to the middle class. Existing health policy essentially has put this Committee in a straightjacket. The odds that programs designed years ago would efficiently and fairly meet the needs of tomorrow—before tomorrow has arrived—is slim indeed.

It is not just that there is reduced flexibility to meet non-health needs or to reduce associated risks. The growth in existing health spending programs and tax subsidies consumes resources that might otherwise go to expanding coverage for the uninsured, achieving 100 percent immunization rates, enhancing frail-elderly services, or increasing the budget of the Centers for Disease Control and Prevention. Two or three years' worth of Medicare growth could pay for a decent health insurance package for all children, and a few years' worth of growth in the tax subsidies for health insurance, which mainly benefit higher-earning employees, could pay for a modest credit for insurance for households at all income levels.

In addition, the retirement from the workforce of such a large portion of our population significantly reduces revenues to government and puts much additional tax pressure on middle-class families to make up the difference. Meanwhile, since middle-class couples retiring on Social Security and Medicare can now expect benefits for well over two decades, they effectively spend down much of their public and private assets long before they reach old age, as defined by a short remaining life expectancy and larger health needs.

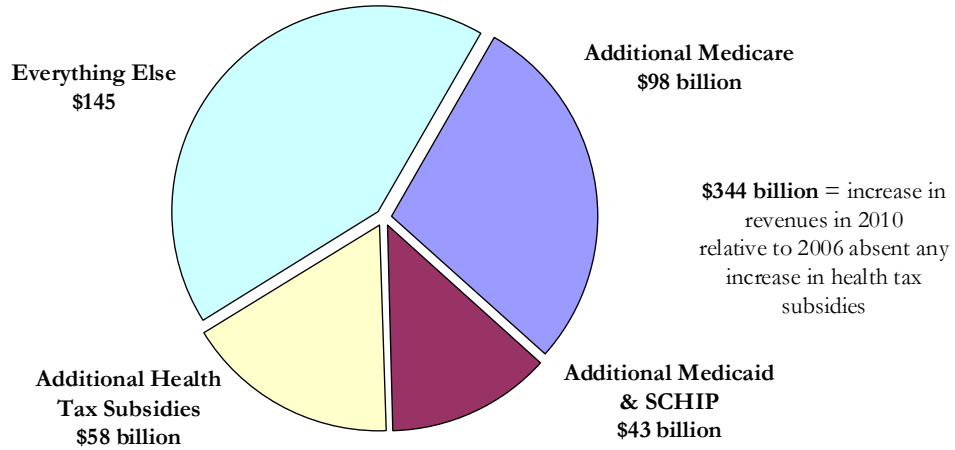
Conclusion

Middle-class families do face many economic challenges. Some risks have been reduced and some increased. An extremely important question is whether past government tax and expenditure policy can be taken off of autopilot and redirected to help meet the needs of today and tomorrow in the fairest and most efficient way possible.

A very large portion of additional government spending and tax subsidies is already destined under current law to go toward the provision of health care. By absorbing so much of future revenue growth, they deter Congress from doing very much

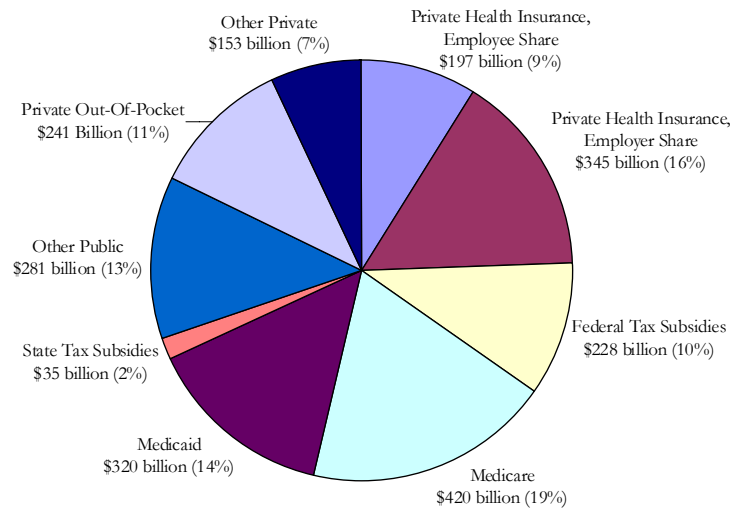
about new risks facing middle-class families. In addition, within the health system itself, some of the additional amount spent on these tax subsidies and direct expenditures are likely adding to risks—including the risks of being uninsured—rather than reducing them.

Figure 1: How Future Increases in Revenue Have Already Been Spent on Healthcare
 2010 versus 2006
 (Current Law, \$2006)



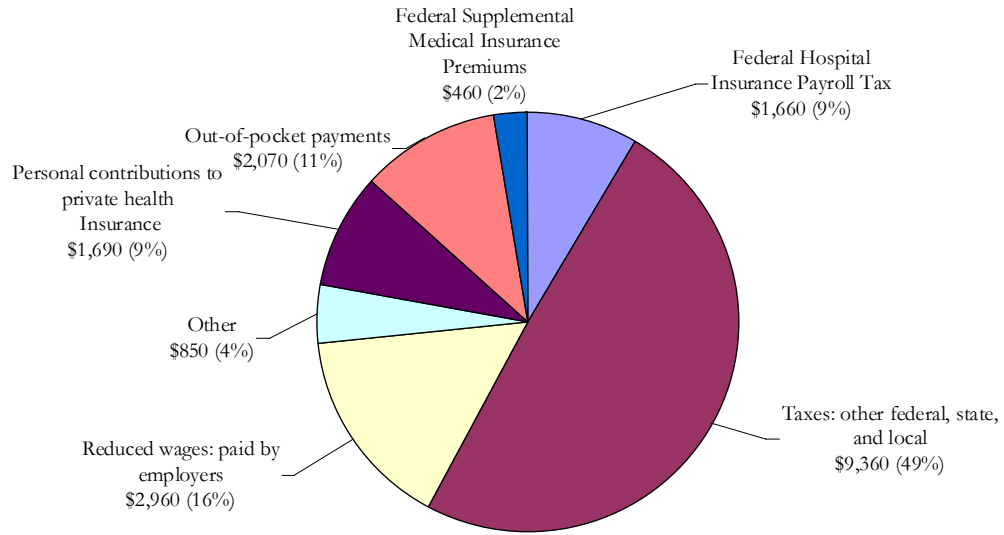
Source: C. Eugene Steuerle and Gillian Reynolds, The Urban Institute. Based on data from CBO "Budget and Economic Outlook 2008-2017" and Analytical Perspectives FY2007, Table 19.1

Figure 2: Estimated Sources of Financing for U.S. Health Care Expenditures, Calendar Year 2006
 (Total = \$2.22 Trillion, Government Sources = \$1.28 Trillion)



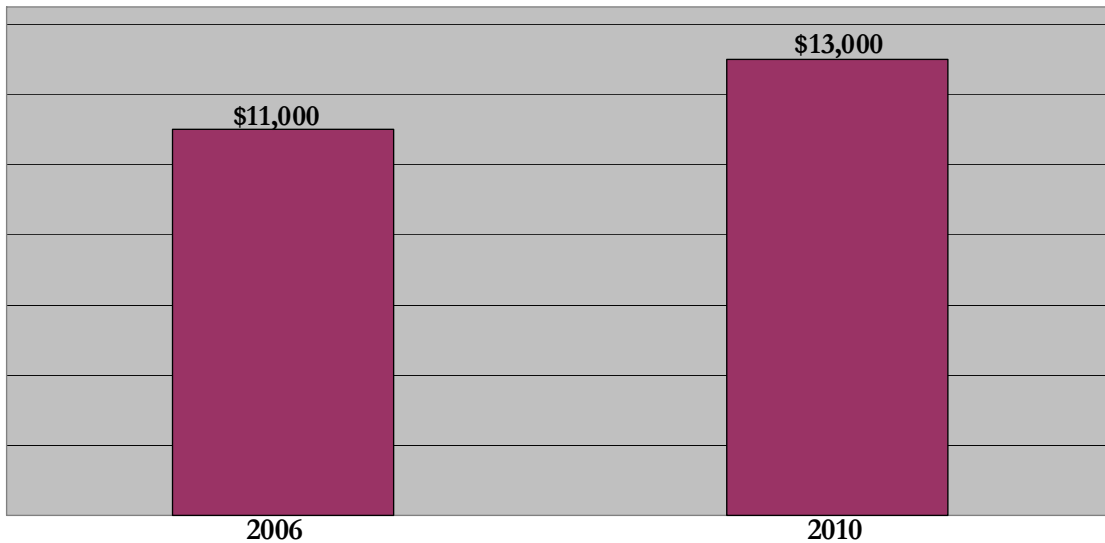
Source: C. Eugene Steuerle, The Urban Institute, 2007. Based on data from the Centers on Medicare and Medicaid and the Budget of the U.S. Government, FY 2007.

Figure 3: Average Health Care Costs Per Household By Source, 2006
(Total = \$19,050; through Government = \$11,020)



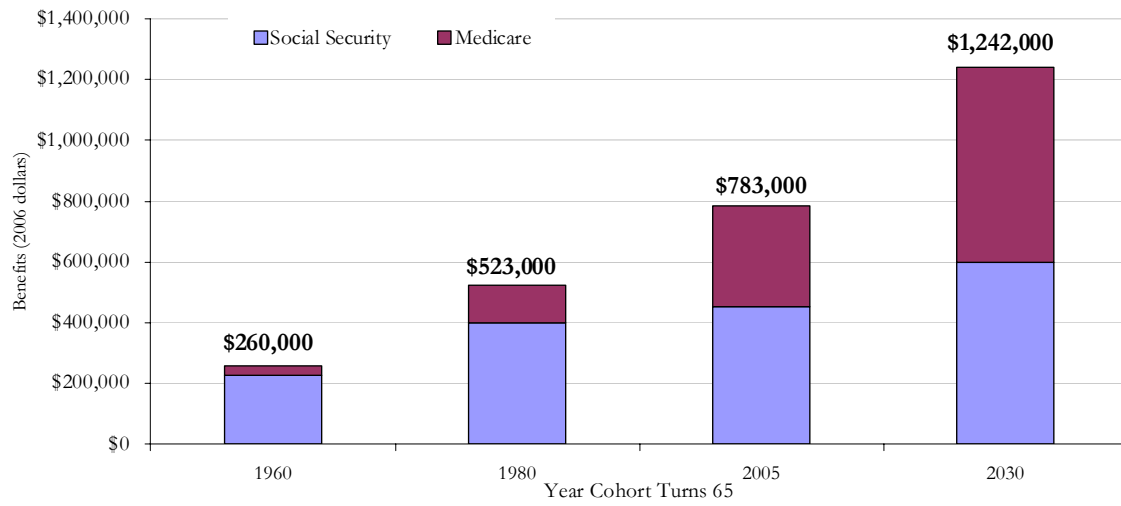
Source: C. Eugene Steuerle, The Urban Institute, 2007. Based on data from the Centers on Medicare and Medicaid and the Budget of the U.S. Government, FY 2007.

Figure 4: Total Government Expenditures & Tax Subsidies for Health Care, Per Household



Source: C. Eugene Steuerle, The Urban Institute, 2007. Based on data from the Centers on Medicare and Medicaid and the Budget of the U.S. Government, FY 2007.

Figure 5: Lifetime Social Security and Medicare Benefits*
-- Average-Wage, Two-Earner Couple (\$37.8K each) --



* Expected rather than realized benefits. Notes: The "average" hypothetical wage profiles are taken from the Social Security Administration. Lifetime amounts, rounded to the nearest thousand, are discounted to present value at age 65 using a 2 percent real interest rate and adjusted for mortality after age 65. Projections are based on intermediate assumptions of the 2006 OASDI and HI/SMI Trustees Reports. Source: Adam Grasso and C. Eugene Steuerle, The Urban Institute, 2006.