



Tax Policy Center

Urban Institute and Brookings Institution
www.taxpolicycenter.org

February 14, 2007

The President's Proposed Standard Deduction for Health Insurance: An Evaluation

Len Burman
Jason Furman
Greg Leiserson
Roberton Williams

President Bush's FY 2008 budget proposes major changes in tax incentives for health insurance and health care. His plan would eliminate most current tax exclusions and deductions for health insurance premiums and out-of-pocket costs; for the first time, employer contributions to health insurance would be included in taxable income. In place, the plan creates a separate standard deduction for health insurance in the federal income and payroll taxes for all taxpayers who obtain qualifying health insurance. The plan's intent is to increase the tax incentive to purchase some form of insurance while eliminating the current system's bias in favor of insurance provided through employers and reducing the current tax incentives for over-consumption of health care services and the commensurate under-consumption of other goods and services.

The president's plan also contains several health proposals that lie outside the tax sphere and are not discussed in detail in this analysis. The plan has a vague proposal to allow states greater flexibility to redirect their existing uncompensated care funds to support greater access to affordable health insurance for those with low incomes or chronic health conditions. There are few details on how this would be accomplished. The president also repropose his Association Health Plan initiative to allow small businesses to purchase health insurance through trade associations and other groups without being subject to state insurance regulations.

The tax proposal is innovative and a step in the right direction, but without substantial expansions and revisions the plan as a whole would weaken existing pooling arrangements and create substantial risks for the current system of health insurance coverage. The proposal

Burman is director of the Tax Policy Center and senior fellow at the Urban Institute; Furman is senior fellow and director of the Hamilton Project at the Brookings Institution; Leiserson is a research assistant at the Urban Institute; Williams is principal research associate at the Urban Institute. The authors thank Henry Aaron, Katherine Baicker, Linda Blumberg, Robert Carroll, Sonia Conly, Doug Elmendorf, Robert Greenstein, Jeanne Lambrew, Mark McClellan, Laura Remson Mitchell, Edwin Park, Robert Reischauer, Kim Rueben, Eugene Steuerle and Phillip Swagel for helpful discussions of the president's proposal. Views expressed are those of the authors and do not necessarily reflect those of the Urban Institute, the Brookings Institution, the Hamilton Project, their boards, or their funders.

implicitly acknowledges that there are no easy answers and spells out some tough choices. It attempts to move forward on the twin problems of the rising number of uninsured and rising health spending without increasing total tax subsidies for health insurance; in fact, as proposed it would even reduce the long-run deficit.

The president's plan effectively turns the existing tax subsidy for health insurance into a kind of voucher. It would increase the amount of tax relief that subsidizes acquisition of some health insurance while eliminating the tax advantages at the margin for increased consumption of health care over all other goods. The proposal will almost certainly encourage some people who currently lack insurance, particularly middle-income families, to get it. And the core of the new proposal is not biased towards the provision of favored forms of insurance (e.g., high deductible policies) over other forms of insurance that could reduce spending (e.g., managed care or plans with higher copayments).

However, as under current law, the subsidy will be more valuable for high-income people than for those with lower incomes who most need help. In fact, low-income households with no income tax liability would get very little help, as is true under the current structure. These limitations could easily be addressed by converting the proposed standard deduction into a flat credit or even a sliding-scale credit that is larger for low-income families.

A more fundamental concern about the plan, as proposed, is that the standard deduction would be available to all who obtained qualifying insurance, whether through an employer or as an individual. That would level the playing field between employer-sponsored insurance and insurance purchased in the individual market. But removing the existing advantage for employment-based plans would lead some employers, especially small and medium-sized businesses, to stop offering health insurance to their employees, exacerbating a trend that is already well underway. Assuming that employers raise wages when they stop offering health insurance, healthy employees will often be able to use their wage boost to purchase inexpensive health insurance in the individual nongroup market, but many who have health problems, especially those with low incomes, will find health insurance unaffordable. Mitigating or remedying these problems would require some combination of expanded public programs, new pooling arrangements, fundamental reform of the individual market, or additional subsidies for targeted groups, such as small employers that offer health insurance, people with chronic health conditions, and low-income households.

The administration proposes to provide states with incentives to address the problems in the nongroup market, but those promises may not be backed by adequate funding. Moreover, the tax changes would go into effect regardless of whether or when states created the complementary programs to expand the nongroup market.

This paper summarizes the proposal and its likely effects on the health insurance market and the level and distribution of tax burdens. We also recommend some modifications that could transform the proposal from a risky change that might destabilize existing insurance into a proposal that would reduce the ranks of the uninsured without collateral costs for vulnerable workers.

Summary of the President's Health Tax Proposal

Standard deduction for health insurance and inclusion of employer premium

contributions. Taxpayers who obtain qualifying health insurance would be allowed a standard deduction of \$15,000 for family coverage or \$7,500 for single coverage. The deduction would come before calculation of adjusted gross income (AGI) and personal exemptions and other deductions on federal income tax returns. The new standard deduction would be in addition to the existing standard deduction available to taxpayers who do not itemize deductions. Unlike the existing standard deduction, the health insurance deduction would not be a "preference item" under the individual alternative minimum tax (AMT), meaning that its value would not depend on AMT status. Family coverage would be defined as any policy covering more than one person. The deduction would be allowed regardless of the cost of the health insurance policy (subject to minimum quality requirements) and whether the qualifying insurance comes through an employer or is purchased in the individual nongroup market. The deduction would be pro-rated for those who only have insurance for part of the year. The value of health insurance premiums paid by employers or through flexible spending accounts or cafeteria plans would be included in taxable compensation for individuals who receive health insurance at work.

Exemption from payroll tax (both employer and employee portion) and inclusion of employer premium contributions. Taxable payroll, both for the purposes of calculating Social Security and Medicare taxes and for the purpose of calculating Social Security benefits, would be redefined as earnings plus employer contributions to health insurance minus the new standard deduction. Employers would adjust taxation and withholding accordingly. Individuals who purchase qualifying nongroup coverage could certify to employers that they have purchased insurance and employers would exempt them from payroll taxes on the first \$15,000 of earnings for family coverage (\$7,500 for single coverage). Individuals with multiple employers would reconcile under- or over-payments on their income tax returns (as individuals who pay payroll taxes on more than capped earnings do now). Such reconciliation would presumably also apply for individuals whose employers do not provide the exclusion.

Effective date. The effective date would be January 1, 2009.

Who is affected. The administration estimates that the average premium will be about \$14,000 for family coverage in 2009, and that 75 to 80 percent of policies will have premiums below the deduction amount. By the tenth year of the proposal, the administration projects that about 60 percent of plans would fall under the standard deduction assuming that people do not change the type of insurance they purchase. (We discuss the distributional effects of the proposal in more depth below.) Plans with premiums that exceed the deduction will be especially generous, be in areas with high health care costs, or be covering groups with especially high risks (e.g., chronic illnesses). The deduction will be indexed for inflation using the CPI for all goods and services. That broad price measure has historically been less than the CPI for health care costs, which has itself historically been substantially less than premium growth that reflects both rising prices and higher health consumption.

Effect on revenues. The Treasury Department estimates that the proposal would reduce tax revenues in the near term (when the deduction covers most premiums) and would raise revenues in later years (because the deduction will rise more slowly than premiums). Over the 10-year budget window, Treasury estimates that the proposal would reduce revenues by \$32.8 billion (including \$37.9 billion in additional refundable tax credits, which are technically scored as outlays). Over the long term, the proposal would aid the solvency of the Social Security and Medicare trust funds (assuming Congress does not raise the deduction faster than called for in the proposal).

Replaces most existing and proposed tax subsidies; Health Savings Accounts (HSAs) would be continued. Workers could no longer use flexible spending accounts (FSAs) to pay either the employee portion of premiums or out-of-pocket health care expenses. Only Medicare beneficiaries could claim the existing itemized deduction for medical expenses in excess of 7.5 percent of AGI. HSAs, however, would continue to exist and contributions, accumulation and qualifying withdrawals would remain tax-free as under present law. The proposal would also relax eligibility rules for the high-deductible health plans (HDHPs) that are required for HSA contributions. The president's FY 2008 budget proposal does not contain the refundable tax credits for low-income people included in previous budgets.

Qualifying insurance. Insurance would have to meet minimal standards to qualify for the deduction. The out-of-pocket maximum could not exceed limits set for HDHPs eligible for HSAs. Plans would have to cover a "reasonable" amount of annual and/or lifetime benefits, including both in-patient and out-patient medical services, and be guaranteed renewable. The details would be worked out in drafting and regulations, but the intent is to prevent the sale of worthless insurance simply to qualify for the deduction.

Nongroup market. States would have incentives to organize nongroup pools providing renewable and affordable plans. States could use Disproportionate Share Hospital (DSH) funds under Medicaid to provide subsidies for pooling arrangements, including subsidies for families with income below 200 percent of the federal poverty level and with chronic health care conditions to purchase private health insurance. States could also apply to the Department of Health and Human Services for supplemental grants to fund such programs. The funds could not be used for public programs like Medicaid and the State Children's Health Insurance Program (SCHIP).

Reduced phase-out rate for earned income tax credit. The rate at which the earned income tax credit (EITC) is phased out for families with children would be reduced to 15 percent (from 15.98 percent for families with one child and 21.06 percent for families with two or more children). That would lower the potential loss of EITC that low-income workers could incur when health insurance premiums are counted as earnings. Because the lower phase-out rate would match the phase-in rate for refundable child credits, over some income ranges the increased child credit would just offset the lower EITC.¹ The proposal, however, would cause

¹ See Elaine Maag, "Tax Credits, the Minimum Wage, and Inflation," Washington, DC: The Urban Institute: *Tax Policy Issues and Options* Brief 17, 2007, for discussion of phase-ins and phase-outs of the child tax credit and EITC.

some low-income families to get more credits than under current law while others, including many families with only one child, would get less. (See Appendix 4.)

Analysis

Effect on the Health Market

The proposal would have important effects on both health insurance coverage and the form of health insurance. The administration's proposal would approximately maintain the amount of money currently provided through the tax code to subsidize health insurance. However, it redirects that money so that it would all go to encourage families to acquire some form of coverage and none would be used to encourage them to purchase more generous insurance.

Health Insurance Coverage

The proposal would affect coverage three ways:

- **The new insurance-conditioned standard deduction would increase the demand for both employer-sponsored insurance and individual market insurance.** The fixed tax deduction would increase the incentive to acquire insurance relative to the incentive under current law, increasing the demand for both employer-sponsored insurance and individual market insurance. For example, under current law, employees whose employers contribute \$5,000 towards family health insurance coverage can exclude the \$5,000 contribution from taxable income.² Under the proposal, such households could exclude \$15,000—providing three times the tax incentive to acquire insurance coverage.

In addition, the design of the proposal could have a powerful behavioral incentive. Tax returns would have a line that in effect says “did you have qualified private health insurance?” If the answer is yes, a family would get to deduct \$15,000 from their taxable income. The desire to get this deduction would increase the incentives for households to demand insurance from employers or purchase it.

- **The level playing field would increase the demand for nongroup insurance and decrease the demand for group insurance.** Under current law, individuals are generally denied tax benefits if they purchase insurance on their own through the nongroup market (except self-employed workers who can deduct the cost from income taxes but not payroll taxes). The administration's proposal would level the playing field, increasing the demand for nongroup insurance and decreasing the demand for group insurance.
- **The indirect on health care spending could increase the demand for both group and nongroup insurance.** If the plan succeeded in reducing the growth of health spending,

² Note that employees may also pay for their portion of premiums with pre-tax dollars if they have access to a cafeteria (section 125) plan.

as discussed in the next section, premiums would be lower. Lower premiums encourage more people to acquire insurance coverage.

The net effect of these three forces would be to increase coverage in the individual market. Some have speculated that the individual market would function better if more households purchased their insurance in that manner. But even though a larger market would likely yield some improvements, in the absence of regulations it would not provide the sort of risk pooling afforded by employers, especially large ones.

The effect on employer-sponsored coverage is ambiguous and depends on the relative magnitudes of the three responses above. Although it is difficult to predict accurately the effects of system-wide changes that go well beyond the small changes observed historically, it is likely that the net effect would reduce group coverage, both as individuals opt out of coverage offered by employers and as some small- and medium-sized employers drop coverage.

Note that the president's proposal goes beyond some other proposals in completely leveling the playing field between group and nongroup insurance. For example, a recent proposal by John Cogan, Glenn Hubbard, and Daniel Kessler touted a more level playing field, but deliberately retained a tax advantage for employer-provided insurance to keep it from unraveling too quickly:

Although deductibility would mitigate the bias against individual insurance (because both employer-sponsored and individual insurance could be acquired with pretax dollars), [the proposal] still would retain major incentives for the purchase of insurance and for the purchase of employer-sponsored insurance. Because the tax change would allow the deduction of the cost of individual insurance from the income tax base *but not from the payroll tax base*, the proposed policy would retain a tax incentive for the purchase of employer-sponsored insurance. Spending on insurance purchased through an employer would, as under current law, still be excludable from both the income and the payroll tax bases. For this reason, deductibility would be unlikely to increase the number of uninsured people by inducing employers to stop offering insurance to their employees.³ (emphasis added)

That is, the Cogan, et al, plan would continue to allow an exclusion from payroll tax only for employment-based health insurance, while extending similar income tax benefits to both employment-based and individually purchased health insurance. In addition to preserving an incentive for employers to offer insurance, limiting the payroll tax exclusion to employment-based insurance would also be simpler for employers.⁴ The administration's current plan offers no such safeguards.

³ John Cogan, Glenn Hubbard, and Daniel Kessler, "Making Markets Work: Five Steps to a Better Healthcare System," *Health Affairs* 24(6), November/December 2005.

⁴ Administering a payroll tax exclusion for nongroup insurance could impose significant new burdens on employers, insurers, and/or employees. To properly implement the exclusion, employers would have to get monthly certifications that employees are covered by qualifying insurance and that the type of insurance had not changed. Employees would either be responsible for notifying employers about relevant changes in status in a timely way, or insurers would have to transmit that information directly to employers. The possibility of frequent

Smaller employers often face very high premiums for health insurance, a major reason why they are least likely to offer coverage now. In addition, their employees tend to have lower incomes, making the value of a tax-free fringe benefit low, and those employees cannot afford to give up much in wages to get insurance. That situation would not change under the proposal. What is more, business owners and managers would no longer have to offer insurance to their employees for the workers to qualify for a tax break on their own health insurance. They could simply purchase insurance in the nongroup market. Some employers who now offer health insurance might “cash out” this benefit, boosting their workers’ wages by what they spent on health insurance and telling those who want to retain coverage to buy it in the individual market. Some healthy employees would prefer that their employers stop offering insurance, because they would be able to get a better deal in the nongroup market, where healthy people face very low premiums. Many firms, particularly larger ones, would still offer insurance because of the combination of convenience, administrative cost savings, and pooling afforded by large groups of people subject to relatively little adverse selection. But firms currently near the margin between retaining and dropping insurance would be likely to drop.

The adverse effect on the employer-sponsored system raises concerns not just because of fragmented risk pools and adverse selection. It is also likely that many individuals only sign up for coverage because it is easy and virtually automatic through their employers. Put them in the individual market and they might make the short-sighted choice to forgo insurance (and potentially impose costs on others). This is an issue that already arises with the current trend of small employers dropping insurance coverage. Individual mandates are one way to solve this problem. In fact, the administration’s proposal is very much like the Massachusetts mandate—in effect everyone would get a \$7,500 or \$15,000 deduction and the “punishment” for not getting health insurance would be to lose the deduction. However, since the deduction is worth very little to low-income people who are least likely to be insured, it is a poorly targeted inducement to participate.

The administration estimates that changes in the group and nongroup markets would, on net, reduce the number of uninsured by 3 to 5 million. The Lewin Group has estimated that it would cover 9 million uninsured and cost proportionately more as well.⁵ Other models, such as that of MIT economist Jonathan Gruber, have generally assumed that substantially more employers would drop plans; those models would likely show only a small reduction—or even an increase—in the number of uninsured. In any case, the total effect masks an adverse change in the composition of the insured as the households that would lose insurance would tend to be sicker, older, or poorer, and thus unable to purchase coverage in the individual market as it is

changes in payroll tax status would significantly complicate payroll processing, which could create an especially onerous burden on small employers. If employers are not notified of changes in status, employees might be liable for significant taxes (and possibly penalties) at the end of the year. Those taxes might be difficult to collect from lower-income individuals who have little or no savings. It might also be difficult to prevent employees with multiple employers from cheating—claiming the payroll tax deduction from more than one employer. The cheaters could be caught at tax time assuming adequate information reporting, but collecting the tax due might be problematic in many cases.

⁵ John Sheils and Randy Haught, “President Bush’s Health Care Tax Deduction Proposal: Coverage, Cost and Distributional Impacts,” The Lewin Group, 2007.

now structured, while the households that would gain insurance would tend to be healthier, younger, and better off.

Making these tax changes without risking a significant reduction in health insurance coverage would require states to come up with effective means of providing insurance for those with low incomes or health problems. The proposal's details on this score are sketchy. Administration representatives have signaled a willingness both to allow existing funds to be channeled to state coverage initiatives through waiver programs and to authorize additional grants, but the level of funding and distribution among the states is unspecified. Without adequate funding, many people could lose access to affordable health insurance. In addition, the proposal would bar the use of funds for public programs like Medicaid and SCHIP that are often one of the most effective ways of providing insurance to low-income, chronically ill people.

To the extent that the new tax subsidy induces more healthy people to purchase insurance in the nongroup market, the adverse selection problems endemic to that market might be reduced, making the development of effective pooling arrangements outside of employer-sponsored insurance more feasible. However, states vary substantially both in the size of their vulnerable populations and in their ability to subsidize them. That disparity could leave many families in some states without adequate coverage.⁶

One possible improvement in the president's proposal would be to tie the tax deduction for nongroup insurance to the development of effective pooling arrangements or subsidy schemes to guarantee that low-income people and those with high health costs can obtain affordable insurance. Insurers in states that establish an appropriate safety net would be allowed to sell insurance that qualifies for the standard deduction. Insurers in other states would not.

Alternatively, or as a complement to state efforts, insurers who wished to sell insurance that qualifies for the standard deduction could be required to offer insurance that is fully renewable and portable. (See Box.) Individuals who maintained continuous coverage through employer-sponsored insurance or qualifying insurance offered on the nongroup market would be guaranteed that they could purchase insurance from any participating insurer at the lowest rates available, even if their health status worsens. This proposal would give healthy people a strong incentive to purchase insurance, which would be amplified by the generous tax subsidy. This strong incentive for healthy people to participate would help to keep premiums for qualifying insurance relatively low, as they are in large employer groups. Insurers might undermine the pooling arrangement by attempting to cherry-pick healthy individuals, but that might be deterred by federal or state regulation of qualifying insurance.

⁶ Another differential in health insurance comes from varying costs of providing care across states and within states. Because costs can be significantly greater in high-cost areas, the proposal could affect similar taxpayers in different regions much differently. A policy in a low-cost area could have a premium well below the deduction and generate substantial tax savings while a policy providing identical coverage in a high-cost area could have a premium that exceeds the deduction and thus lead to a tax increase. The standard deduction might be modified to vary with regional cost differences, but that change would raise a number of new issues.

Overall, even the administration's estimates of 3 to 5 million newly insured are relatively modest compared to the 47 million uninsured. And the proposal itself could easily result in shifting millions of people who are currently insured into the ranks of the uninsured.

Box. Making Pooling Work in the Nongroup Market

A key factor in the success or failure of the president's proposal would be whether effective pooling mechanisms would develop in the nongroup market. The proposal envisions that states ensure pooling through regulation and targeted subsidies. An alternative approach would tie eligibility for the tax subsidy to voluntary reforms in the nongroup market. Leonard Burman and Amelia Gruber proposed requiring that qualifying nongroup insurance be fully portable and renewable.* Individuals who purchased insurance when they were healthy and who retained continuous coverage—either through an employer or through qualifying insurance purchased in the nongroup market—would be able to purchase insurance from any participating provider at the lowest premium available within the relevant age class.

This would solve a major problem in the nongroup market. Currently, most insurance sold in the nongroup market is “renewable”—as the president's plan would require—but premiums can still increase dramatically for people who develop health problems. Premiums are based on the health experience of people within the pool of individuals who purchased insurance at the same time. Since eligibility for insurance is generally conditioned on good health, the initial pool consists of people who are healthier than average. Inevitably, some people get sick and premiums within the pool increase. Facing higher premiums, healthy people leave the pool to get cheaper insurance elsewhere, sometimes from the same insurer. Departure of healthy people from the pool raises the average cost of covering the remaining members, which pushes up premiums, and induces still more people to opt out. Eventually, only the very ill remain in the pool, and even they may find continuing their coverage to be unaffordable.

Under the Burman and Gruber proposal, this insurance premium “death spiral” would not happen because people who purchased insurance when healthy would be guaranteed of the lowest premium available from any qualifying insurer as long as they maintained continuous coverage. Since premium increases would be relatively moderate, there would be no incentive for healthy people to drop their coverage. Furthermore, healthy people would have a strong incentive to purchase and maintain continuous coverage, since it would be the only way to guarantee access to affordable health insurance in the event that they or a family member becomes ill. This too would tend to keep premiums relatively low.

The Burman and Gruber proposal might sound like community-rating, because people who maintained continuous coverage would be guaranteed of the same rate as everyone else in the same category, but it avoids the main pitfall of that approach. Community rating encounters the problem of adverse selection: health insurance is most attractive to those who expect to incur high health care costs. Such selection makes community-rated insurance expensive, which further discourages healthy people from participating, which further escalates premiums. Under the Burman and Gruber proposal, however, healthy people would have a very strong incentive to participate, because it would be the only way to guarantee affordable coverage if they get sick. (In purely community-rated systems, healthy people know that they can purchase insurance for the same premium as everybody else when they become ill, even if they do not

contribute to the pool when they are healthy.) With more healthy people in the pool, premiums will tend to remain low.

A number of issues would need to be worked out, but this proposal has the advantage of dealing with the problems in the nongroup market via incentives for voluntary industry self-regulation rather than extensive governmental regulation (governmental regulation may still be necessary to prevent insurers from “cherry-picking” the healthiest individuals). It thus incorporates the spirit of those who see the market as providing solutions without being blind to the market’s inherent weaknesses.

* Leonard E. Burman and Amelia Gruber, “First, Do No Harm: Designing Tax Incentives for Health Insurance,” *National Tax Journal*, September 2001, 473-493.

Health Spending

The current tax system provides three incentives to consume more health care and less of all other goods: (1) an overall tax benefit for consuming health care over all other goods; (2) a tax benefit for spending on insurance rather than out-of-pocket that leads to insurance with less cost sharing; and (3) a tax benefit for more generous insurance plans that use less managed care techniques to control costs.

The administration’s proposal would retain the overall tax benefit for consuming health care over all other goods, but would eliminate any marginal tax incentives to purchase additional health insurance. This would level the playing field, at the margin, between insurance and out-of-pocket spending. And it would not discourage managed care techniques to control costs. As a result, individuals would have to decide which is more valuable: \$1 in additional health insurance (to pay for either lower cost sharing or fewer managed care restraints) or \$1 in additional spending for food, rent, clothing, consumer electronics, and other desired goods.

In addition, the administration’s proposal could have a powerful psychological effect because it would make these choices more transparent. Employees would see their employer’s contributions to their health insurance on their W2s, along with their wages. As a result, it would be easier to understand the tradeoff between wages and benefits and make better choices.

Note that this proposal would likely have a greater effect on total health spending than other tax proposals like HSAs for several reasons. First, the proposal would affect *everyone* with private health insurance, while HSAs only affect spending for the tiny minority of people who actually have high-deductible plans. Second, unlike HSAs or the recent proposal by Cogan, Hubbard, and Kessler, the proposal would not provide *new* tax incentives for health spending in an attempt to cure the problems with the old incentives. Those other proposals run the risk of increasing the total tax favoritism for health care and thus increasing health spending. Finally, the proposed standard deduction does not favor a particular cost containment strategy; instead any combination of cost sharing, managed care, and other techniques would generate the same tax savings.

Unfortunately, the proposal would also retain and even expand the existing tax breaks for HSAs. In the context of the administration’s proposal, a deduction for HSAs would create a

strong bias in favor of high-deductible health plans as a cost containment strategy over other approaches. (Appendix 1 illustrates why this is the case.) This runs counter to the basic theme of the proposal to level the playing field and could easily be corrected by repealing tax benefits for HSAs. That would have the additional virtue of making revenue available to deal with some of the problems in the individual market.

Distribution of tax benefits

The distribution of tax benefits is an important part of analyzing any tax proposal. But it does not capture every aspect of fairness or of efficiency. For example, taxing people who receive insurance through their employer or purchase it in the individual market in the same way represents an improvement in fairness, albeit one that may be more than offset by the reductions in the efficiency associated with pooling and the increase in the number of uninsured. Also, distribution tables do not capture the potential reduction in undervalued health insurance benefits and increase in other valued consumption.

The current tax exclusion for employer-provided insurance is regressive, providing the largest tax benefits to families with larger employer contributions to insurance and to families in higher tax brackets. The administration's proposal appears to make the provision of employer-sponsored insurance somewhat more progressive as all families would get the same deduction, regardless of how much their employers contribute to health insurance. Since higher-income families generally get larger employer premium contributions as well, the fact that the proposal does not increase benefits with the generosity of employer contributions also increases progressivity somewhat. The value of the proposed deduction, however, rises with a person's tax bracket. Thus, the subsidy for employer-sponsored health insurance remains poorly targeted and regressive under this proposal, although less so than under current law.

For example, suppose an employer contributes \$20,000 to the health insurance plans of two workers. Under this proposal both workers would see their taxable income go up by \$5,000, resulting in a larger tax increase for the higher-income worker. Conversely, if two workers both get \$10,000 in health insurance from their employer, both will see a \$5,000 reduction in their taxable income—which would be worth more to the high-income worker than the low-income worker.

The 35 percent of households under age 65 who do not owe any income tax would likely get little tax benefit for purchasing health insurance in the individual market because much of their current reduction in payroll taxes would be offset by reduced Social Security benefits in retirement. For example, if a low-income worker purchased insurance in the individual market, his payroll taxes under the proposal would go down by \$1,148 (or the 15.3 percent rate multiplied by the \$7,500 exclusion). But, his future Social Security benefits would also go down by nearly as much in present-value terms as the current payroll tax savings.⁷ (This is an important distinction from the president's previous proposal to provide a \$1,000 tax credit for the purchase of insurance. Both proposals provide about \$1,000 up front but the current proposal is, in effect, combined with a Social Security benefit cut of similar magnitude.)

⁷ The proposal's far reaching effects on Social Security—changing both taxes and benefits—warrant further and more detailed analysis.

Figure 1 shows how poorly targeted the current-law exclusion for employer-sponsored insurance is. The cost of premiums paid for employer-sponsored insurance (under the assumption that employees pay for insurance through reduced wages) declines dramatically with income, from 47 percent of income for those earning less than \$10,000 in 2009 to 9 percent for those earning \$100,000 to \$200,000. But the tax subsidy has the opposite pattern; it is worth the most to those facing the lowest premium burdens. The tax savings (including payroll taxes) constitute only 8 percent of premiums for those in the lowest income category, compared with 37 percent for the high-income household.

As noted, reduced Social Security taxes translate into lower benefits, especially for those with the lowest incomes, excluding Social Security (but not Medicare) taxes. The subsidy rate is lower at all income levels shown, although the effect is smallest for those with very high incomes who usually earn more than the Social Security cap (not shown). Strikingly, the “subsidy rate” is actually negative for those with incomes under \$10,000, because their loss of refundable tax credits due to the income tax exclusion more than offsets the small savings in Medicare taxes. The basic story is the same: low-income families get little or no help while those with high incomes get a significant share of their premiums rebated in tax savings.

The proposal would make the subsidy for employer-sponsored health insurance more generous across the board in 2009, because the new standard deduction would exceed current income tax exclusions for most taxpayers (see Figure 2). The difference is most dramatic for low-income taxpayers, who would see an average subsidy (excluding social security taxes) equal to about 5 percent of premiums. The subsidy is larger than the combined employer and employee Medicare tax rates (2.9 percent) because the standard deduction is much larger than premiums for low-income households. Households with incomes between \$20,000 and \$30,000 would get virtually the same average subsidy rate as they do under current law because, although some would gain from the larger deduction amount, others would see a reduction in their EITC caused by the higher taxable income. Of course, most households with nongroup insurance, who get no tax benefit under current law, would see a significant increase in the applicable subsidy rate (not shown on the figure).

The subsidy rates decline between 2009 and 2017, reflecting the fact that the standard deduction rises more slowly than health insurance premiums.

The overall effect of the proposal on the distribution of tax burdens, measured as a percentage of after-tax income, is to make the tax system somewhat more progressive.⁸ In 2009, the bottom four quintiles see tax cuts equal to 0.6 percent of income or more (see Figure 3). The change for the top 20 percent is negligible. By 2017, however, all but the bottom quintile would pay more taxes, with significant increases for the top 40 percent of taxpayers. The average tax unit in the bottom 20 percent would still pay less taxes in 2017 (by about 0.6 percent of income) under the proposal than under current law.

⁸ By longstanding convention, these distributional estimates are “static,” meaning that they do not consider any changes in behavior (such as some individuals’ acquiring insurance and others losing it, or any effect on health insurance premiums).

Figure 4 shows the same distribution, but excludes changes in Social Security taxes. The qualitative picture is similar, but tax cuts in 2009 are smaller and tax increases in 2017 are larger.⁹

Not everyone would benefit from the proposal. Obviously people who have no health insurance would be unable to claim the deduction; at least some of them would still find coverage prohibitively expensive, even with the tax savings, either because their health status would cause high premiums or because their income is too low. Some low-income households that owe no income tax and pay little or no payroll tax would receive only small or no tax savings, even if they do obtain insurance coverage. And people whose employers pay health insurance premiums above the deductible amount would see both their income and Medicare taxes rise and possibly their Social Security taxes as well. The biggest winners (controlling for income) would be those who already purchase their own health insurance: they could claim the deduction without incurring higher taxes on employer-paid premiums.

The distribution of winners and losers under the proposal would change over time for two reasons. First, to the extent that state and federal action makes health insurance more affordable and the deduction reduces the net cost of coverage, more households will obtain insurance and qualify for the deduction. Second, however, because it is indexed to the overall CPI and not the cost of health care, the deduction will be less than employer-paid premiums for more and more workers over time. That discrepancy will swell the ranks of taxpayers who pay more because they get good health insurance through their employers, even though the same insurance plan would yield tax savings, not a tax increase, in 2009.

Both the share of tax units who would receive income tax cuts and the fraction that would see their income taxes rise increase with income (see Figure 5). Among units with income below \$10,000, just 7 percent would pay lower income taxes and 3 percent would pay more (primarily because they would lose EITC when employer-paid premiums move them into the phaseout range of income).¹⁰ Middle-income households would be more likely to both benefit and lose under the proposal: about 60 percent of units with income between \$40,000 and \$75,000 would see their income taxes fall while about one in five would pay more. The share of households whose income taxes would not change falls sharply with income, following the same pattern as the likelihood of lacking health insurance coverage (see Figure 6). Three out of every five tax units with cash income between \$10,000 and \$20,000 lack health insurance coverage as do about one-third of those with income between \$20,000 and \$40,000. In contrast, less than 10 percent of tax units with income above \$75,000 have no health insurance. Without successful efforts by both the federal and state governments to guarantee the availability of affordable to everyone, the tax proposal will fail to attain universal coverage.

The bottom line is that, although the new proposals would increase the progressivity and targeting of health insurance tax subsidies, they would still be worth relatively little to low-income families who most need help. Indeed, the administration's current proposal is

⁹ Much more detail on these estimates is available at the Tax Policy Center web site. See http://www.taxpolicycenter.org/newsevents/events_health_deduction.cfm.

¹⁰ Appendix 4 shows the income ranges over which a low-income married couple with children and employer-provided health insurance could become worse off under the proposal than under current law.

significantly less progressive than proposals the president has made in previous budgets. In the past, the administration proposed refundable tax credits for low- and moderate-income families that would benefit all qualifying families—regardless of tax liability. In addition, unlike the new proposal, the refundable tax credits would not trigger changes in future Social Security benefits.

Revenue effects

Treasury estimates that the proposal would decrease tax revenues (including outlay effects) by about \$33 billion over the 10-year budget window, 2008–2017. Revenues would fall in the short term because the standard deduction is greater than the premiums most people pay for insurance obtained at work, and those who purchase insurance outside of work would get a large new tax benefit. The standard deduction, however, would grow at a much slower rate than health care spending—and thus the cost of health insurance.¹¹ As a result, the subsidy for health insurance would decline over time. The proposal would also save money by eliminating various other tax breaks for health insurance. On net, the proposal would increase income tax revenue toward the end of the budget window and in all subsequent years.

These estimates of revenue change are highly uncertain; they depend on predictions about future health care expenditure growth, employers' behavior under current law and under the proposal, and the extent to which uninsured people acquire coverage. If the proposal is especially successful in inducing more people to purchase health insurance coverage, it will likely lose more revenue than expected.

Beyond the budget period, the proposal would raise more revenue, making funds available to reduce the deficit, increase subsidies for vulnerable uninsured, or meet other needs. Similarly, the proposal would bolster the Social Security and Medicare trust funds over time (after initially depleting them somewhat), in part by increasing tax revenues but also by reducing benefits paid to some future retirees.

In addition, the proposal retains a generous subsidy for HSAs. Contributions to HSAs are deductible and earnings and withdrawals to pay for health care are tax-free. Retaining that subsidy would favor HDHPs and HSAs over other insurance, an inconsistency with the proposal's apparent attempt to equalize health care costs, regardless of form. The result could be a large shift of taxpayers out of traditional insurance arrangements into HDHPs with the lavishly subsidized HSAs and consequently a large increase in revenue losses over the long term.

Recommendations

Various modifications could improve the likelihood that the proposal would meet its stated goals of improving health coverage while reducing total health spending. Many of these changes are essential complements to any proposal that levels the playing field between employer-sponsored insurance and individual market insurance.

¹¹ Recall that the deduction is indexed by the CPI for all goods and services, which has historically increased at a much slower rate than the cost of health care.

(1) The deduction could be replaced with a progressive refundable tax credit or a voucher that provides as much (or more) assistance to low-income families as it does to those with higher incomes. This would not only be more economically efficient but would also be fairer. The result, by itself, would be substantially more coverage because low-income families would have a greater incentive to get coverage while higher-income families would likely still retain their coverage. In addition, converting the proposal to an income tax credit would allow it to maintain a tax advantage for employer-sponsored insurance, in the form of a payroll tax exclusion for employer contributions to health insurance, that would help mitigate the unraveling of the employer-sponsored system.

(2) Eligibility for the voucher or credit in the individual nongroup market could be made conditional on states establishing effective pooling and/or subsidy mechanisms that guarantee availability of affordable health insurance in the nongroup market. This might include state premium taxes on qualifying insurance, the proceeds of which would be used to make affordable insurance available to those with low incomes or chronic health conditions. Alternatively, eligibility for the credit might be conditioned on voluntary insurance market reforms that guarantee that people who are continually insured can purchase insurance at the same low rate as everyone else, even if they develop chronic health conditions.

(3) Additional funds could be dedicated to complementary programs including a combination of the following: expand public programs like Medicaid and SCHIP, increase subsidies for employer-sponsored insurance by small businesses, increase carrots or sticks for states to adopt innovative techniques to ensure affordable access for all, and subsidize pooling arrangements like buy-ins to programs modeled on a (possibly less generous version of) the Federal Employees Health Benefit Plan. All of these efforts could be funded by scaling back the tax deduction or credit or by raising additional money.

(4) Tax subsidies for health savings accounts, which would be expanded under the president's budget, should be eliminated. Otherwise, high-deductible health plans will be heavily tax-favored over other kinds of insurance arrangements, which would only qualify for the standard deduction.

(5) One advantage of the proposal is that it would limit the growth of tax subsidies for health insurance by indexing the subsidy to the rate of overall inflation rather than the more rapid rise in health spending and therefore improve the long-run fiscal outlook. The flip side, however, is that the subsidy for insurance would diminish over time, potentially increasing the number of uninsured. If the latter is a significant concern, two possibilities could address it. First, Congress could, from time to time, decide to raise the voucher or credit amount based on evidence, priorities, and the fiscal outlook. Alternatively, the voucher or credit could be indexed to the health CPI or even the rate of growth of overall health spending.

Conclusion

Despite its limitations, the president's proposal marks an encouraging departure from current policies that underprovide incentives to purchase insurance and encourage families to be over-insured and underpaid. But it also marks a significant risk of undermining existing pooling

arrangements. The tax reform itself is ambitious but it is not combined with a similarly ambitious plan to cover a substantial fraction—or even all—of the 47 million Americans who currently lack insurance. Adoption of a substantially revised and expanded version of the proposal could increase insurance coverage and help stem the rapid rise in American expenditures on health care.

Appendix 1. How the HSA Subsidy Distorts Health Insurance Choices under the President's Proposal

Consider two health insurance policies that are equally effective at controlling health costs and differ only in that one (a qualifying high-deductible health plan or HDHP) has a lower premium and a deductible of \$5,000 while the other (a health maintenance organization or HMO) has a higher premium but no deductible. Premium savings on the HDHP are deposited in an HSA, funds from which will eventually be used to cover qualifying medical expenses and therefore be entirely tax-free. Finally, assume that premiums reflect only expected health care costs—that is, there are no commissions or other costs associated with insurance—and the hypothetical insured person is indifferent to risk.

Under these assumptions, the following statements will be true:

1. An individual who is indifferent to risk won't care which plan she has: her expected costs are the same under each plan.
2. If premiums are deductible, but out-of-pocket expenses are not, she favors the more comprehensive (and more expensive) HMO (Policy 1).
3. If premiums and HSA contributions are deductible, she is again indifferent between the two options (Policy 2).
4. If there is a standard deduction for health insurance and no tax break for HSAs, she also values the two options equally (Policy 3.)
5. If there is a standard deduction for health insurance and HSAs are deductible, however, she will favor the HSA (Policy 4).

Assumptions			
Individual has a 90 percent probability of good health with healthcare costs of \$2,000 and a 10 percent probability of poor health with costs totaling \$40,000. HDHP has \$5,000 deductible while HMO has no deductible.			
Health care costs	HDHP	HMO	Diff.
Good health (90% probability)	\$2,000	\$2,000	
Poor health (10% probability)	\$40,000	\$40,000	
Out-of-pocket costs (OOP)			
Good health	\$2,000	\$0	
Poor health	\$5,000	\$0	
Expected out-of-pocket cost (= 90% * healthy OOP + 10% * sick OOP)	\$2,300	\$0	\$2,300
Health Insurance Premiums	\$3,500	\$5,800	-\$2,300
Expected total cost (before tax)	\$5,800	\$5,800	\$0
HSA contribution (= premium difference)	\$2,300	---	\$2,300
Tax rate equals 25 percent			
Policy 1: Deductibility of premiums only			
Tax savings (= tax rate x premium)	\$875	\$1,450	-\$575
Policy 2: Premiums and HSA contributions deductible			
Tax savings (= tax rate x premium + tax rate x HSA contribution)	\$1,450	\$1,450	\$0
Policy 3: \$7,500 deduction, no HSA tax break			
Tax savings (= tax rate x deduction)	\$1,875	\$1,875	\$0
Policy 4: \$7,500 deduction plus HSAs			
Tax savings (= tax rate x deduction + tax rate x HSA contribution)	\$2,450	\$1,875	\$575

The example illustrates why allowing deductibility of health insurance premiums but not out-of-pocket expenses tilts the balance in favor of more comprehensive insurance, as the administration argues. A taxpayer saves \$575 under that approach (Policy 1) by choosing an HMO over an HDHP, even though the two plans are economically equivalent. Clearly, tax deductibility would lead some people to shun high-deductible plans even if they would be preferable absent taxes. But allowing deductibility of HSA contributions (Policy 2) redresses that balance. With deductibility of both premiums and HSA contributions, the two insurance options are again economically equivalent.

The president's proposal *without HSAs* (Policy 3) would also level the playing field. Allowing a standard deduction that doesn't depend on premiums equalizes the expected after-tax cost of both options. However, combining HSAs with the standard deduction (Policy 4) tilts the balance decidedly in favor of the HDHP. The distortion is exactly the same as that caused by allowing deductibility of premiums and no HSAs, but in the opposite direction. Under the president's proposal, people would tend to favor HDHPs even if the HMO does a better job of controlling costs.

The example is obviously oversimplified in many ways: insurance commissions and overhead costs might differ between the plans; risk-averse individuals might prefer the more comprehensive insurance option; if individuals can contribute more than the difference in expected costs to the HSA, as allowed under current law, the HDHP is more attractive; and individuals might choose the HDHP simply because they object to the cost-containment strategies used by the HMO (such as limited provider networks or pre-certification requirements). Nevertheless, the point of the example still applies: neutral treatment of different insurance options requires only that each receive the same tax subsidy. Given that the standard deduction for health insurance already levels the playing field, providing an additional tax subsidy for HSAs would be an unwarranted interference in the operation of the insurance market.

Appendix 2. Examples of How the President's Proposal Affects Income and Payroll Taxes

The President's health insurance proposal would include employer-paid health insurance premiums in taxable income but allow a \$15,000 standard deduction (\$7,500 for single filers) against both income and payroll taxes for taxpayers who have qualifying health insurance. Depending on the taxpayers circumstances, that could raise or lower tax liability as shown in the following table. Calculations use 2007 tax parameters, assume that taxpayers claim the standard deduction and all personal exemptions, and assume that Congress acts to limit AMT liability as in recent years.^a For simplicity, families are assumed to claim no tax credits.

Married couple with two children

		Income Tax before Credits								
		Current Law		Health Proposal			Payroll Tax ^b			Total Tax Change ^d
Income ^c	Insurance Premium	Taxable Income	Tax	Taxable Income	Tax	Tax Change ^d	Current Law	Health Proposal	Tax Change ^d	
60,000	10,000	35,700	4,573	30,700	3,823	-750	4,590	4,208	-383	-1,133
80,000	15,000	55,700	7,573	55,700	7,573	0	6,120	6,120	0	0
100,000	20,000	75,700	11,773	80,700	13,023	1,250	7,495	7,568	73	1,323

Single Individual

		Income Tax before Credits								
		Current Law		Health Proposal			Payroll Tax ^b			Total Tax Change ^d
Income	Insurance Premium	Taxable Income	Tax	Taxable Income	Tax	Tax Change ^d	Current Law	Health Proposal	Tax Change ^d	
30,000	6,000	21,250	2,796	19,750	2,571	-225	2,295	2,180	-115	-340
50,000	7,500	41,250	6,736	41,250	6,736	0	3,825	3,825	0	0
70,000	9,000	61,250	11,736	62,750	12,111	375	5,355	5,470	115	490

Source: Tax Policy Center

a. If Congress does not increase the AMT exemption, the two higher-income married couples in the example will be subject to AMT in 2007. The AMT would not affect the tax change for the couple with \$80,000 of income but would increase by an additional \$5.

b. Payroll tax includes only the employee share. The employer pays an identical share and would have the same tax savings or increase.

c. Calculations assume that only one spouse earns income and therefore the Social Security tax cap (\$97,500 in 2007) limits the payroll tax liability for the couple with \$100,000 of income. If earnings are split between the two spouses, the cap would

d. Positive change represents a tax increase; negative change represents a tax cut.

Appendix 3. Imputing Health Insurance Coverage and Premiums

Income tax returns do not include information on employer-sponsored health insurance. Thus, it must be imputed from other sources. We do this in several steps. First, we match estimates of employer-sponsored health insurance coverage, nongroup health insurance coverage, insurance premiums, and employer and employee payment shares for employer-sponsored insurance based on data from the Urban Institute's Transfer Income Model (TRIM).¹² To do this, tax units in the TRIM and tax model databases are partitioned into cells based on adjusted gross income (AGI), age, filing status, and the presence and number of dependents. The overall prevalence of insurance and the distribution of values in the TRIM database are calculated for each cell, and these are used to assign values to tax units in the tax model database in the corresponding cell. This random assignment is carried out subject to two restrictions: tax units with head under age 55 may not receive employer-sponsored insurance if they do not have wages and tax units claiming the self-employed health insurance deduction must be assigned health insurance equal to the value of the deduction.

Imputed premium values are based on data from 2000 and 2001. Through 2006, the values are grown at the rate of premium growth reported in the 2006 Kaiser/HRET Employer Health Benefits Survey. Premiums are projected to grow at the rate of national medical expenditures per capita from the National Health Expenditure Accounts through 2015 and at the 2015 rate in 2016 and 2017. Coverage rates and other variables are assumed to be unchanged over the period.

After the health insurance determination, tax units with coverage are assigned to family coverage or individual coverage based on the value of the plan they have and the distribution of plans by value from the 2006 Kaiser survey. Using estimates based roughly on the 2003 Kaiser survey, a percentage of tax units based on income class are designated as having access to premium conversion plans allowing them to pay health insurance premiums on a pre-tax basis.

Lastly, tax units are assigned to full-year or part-year coverage based on the prevalence of both types of coverage as reported in the Medical Expenditure Panel Survey.

Limitations

There is inherent uncertainty in our estimates—and any estimates—of future health insurance coverage and premiums. They require projections of health insurance premium growth, which may vary systematically by income and over time. They require highly uncertain estimates of coverage by premium conversion plans, for which few data are publicly available. In future work, we plan to base our estimates on more recent and complete information about health insurance premiums and coverage. For all of these reasons, our estimates may differ from published estimates by the Department of the Treasury and other sources, and may be significantly revised in the future. In addition, Treasury estimates account for behavioral responses such as people purchasing health insurance in response to the tax incentives. We do not yet have the capability of making such estimates.

¹² For additional details on the TRIM database see Burman, Leonard E., Cori E. Uccello, Laura Wheaton, and Deborah Kobes, 2003, "Tax Incentives for Health Insurance," Tax Policy Center Discussion Paper Number 12, Washington, DC: The Urban Institute, <http://www.urban.org/publications/310791.html> (May).

Appendix 4. Effects of Proposal on Low-Income Taxpayers

The president's proposal would provide benefits to most low-income households with children if they obtain health insurance, and would particularly help those families who get insurance through their employers. Because the employer-paid premiums would count as wage income, very-low-income workers receiving those benefits would see their earned income tax credit (EITC) rise by as much as 40 percent of the premium their employer pays. Of course, few workers earning very low income currently receive health insurance from their employers.

But even if they do get employer-paid insurance, the proposal could make some low-income workers worse off than they are under current law. A married couple with two children and a health insurance policy with a \$9,000 employer-paid premium (according to a 2006 Kaiser study, 85 percent of employer-sponsored plans have premiums at least that high) will see their tax refund fall if their cash income is between about \$16,740 and \$30,100 (see the figure). The loss could be substantial: if they earn \$25,000, the couple's income tax refund would drop by more than \$800 compared with current law.

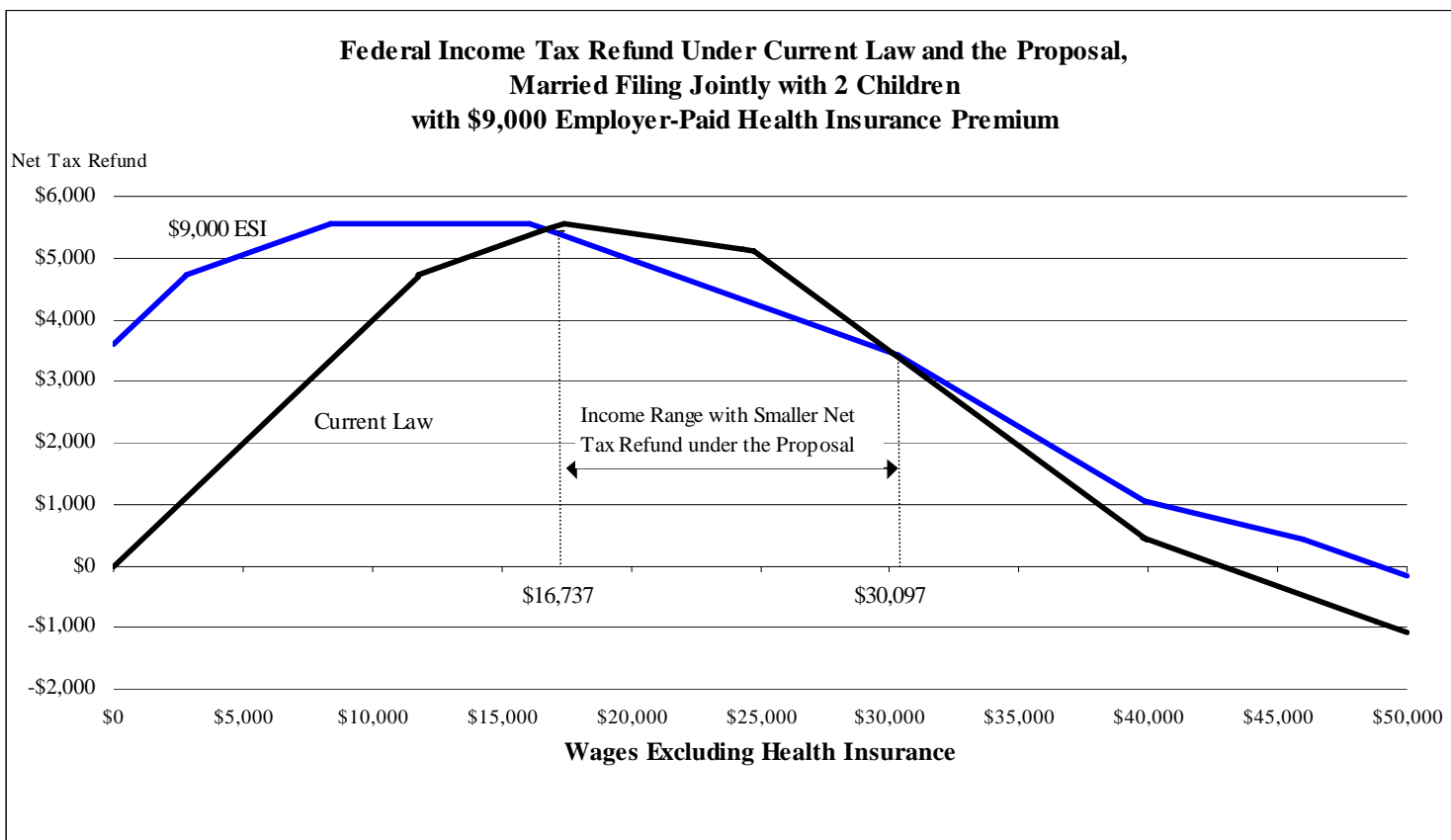


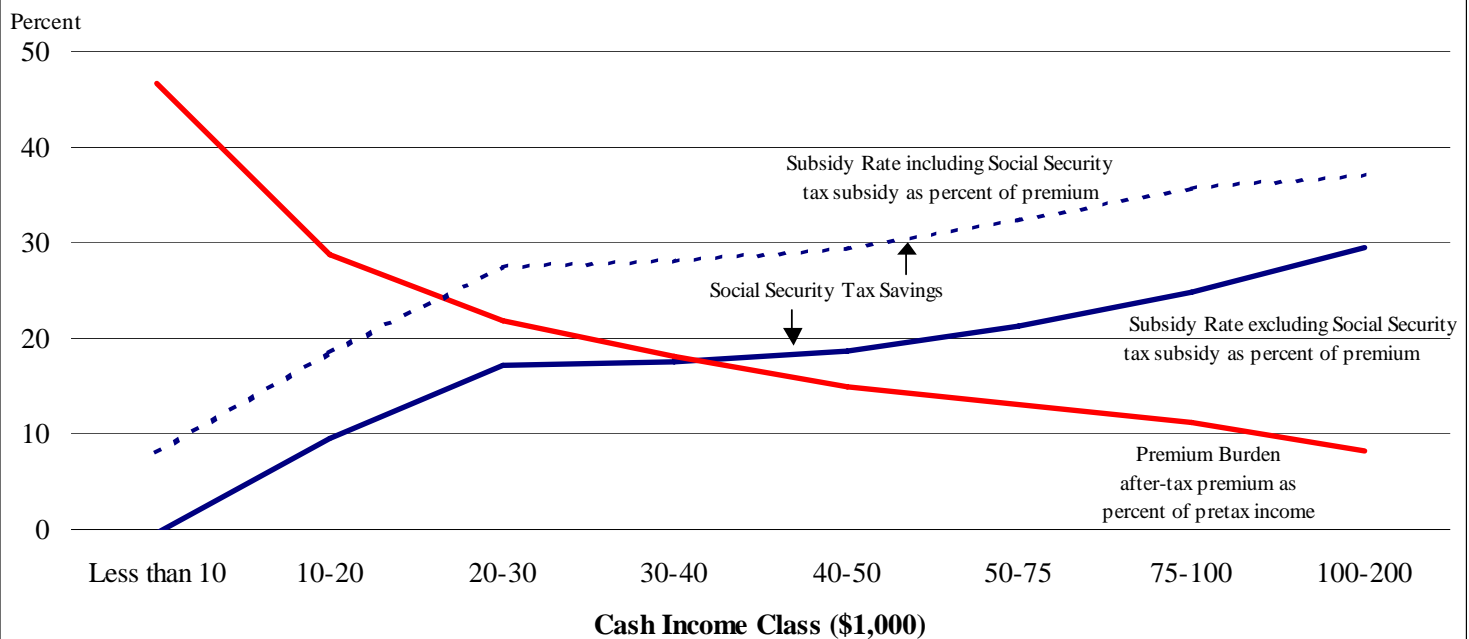
Table 1. Effect of Health Standard Deduction on Federal Tax Receipts in \$Billions, Fiscal Years 2008-2017

2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-12	2008-17
0	-31.7	-43.5	-35.5	-24.7	-11	4.1	19.9	36	53.8	-135.5	-32.7

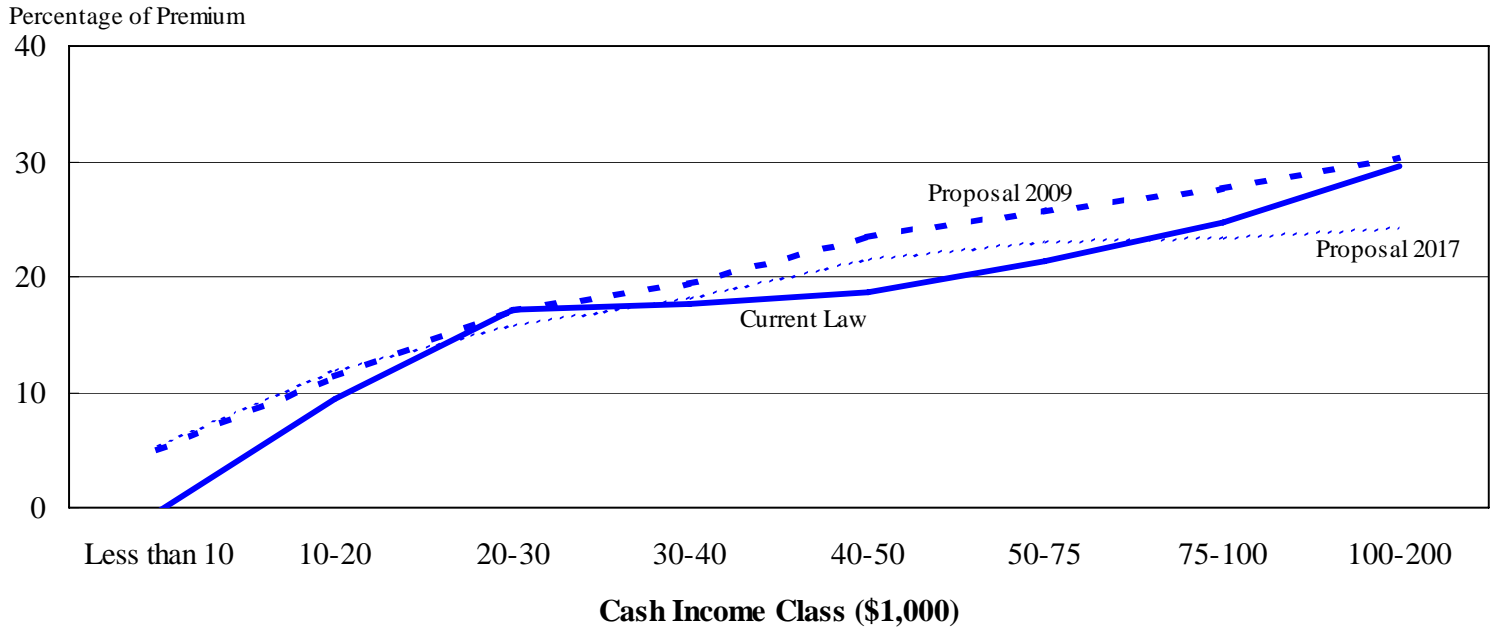
Note: estimates include an increase in outlays (refundable tax credits) of \$37.9 billion over ten years.

Source: U.S. Department of the Treasury, *General Explanation of the Administration's Fiscal Year 2008 Revenue Proposals*, February 2007, available at: <http://www.treas.gov/offices/tax-policy/library/bluebk07.pdf>.

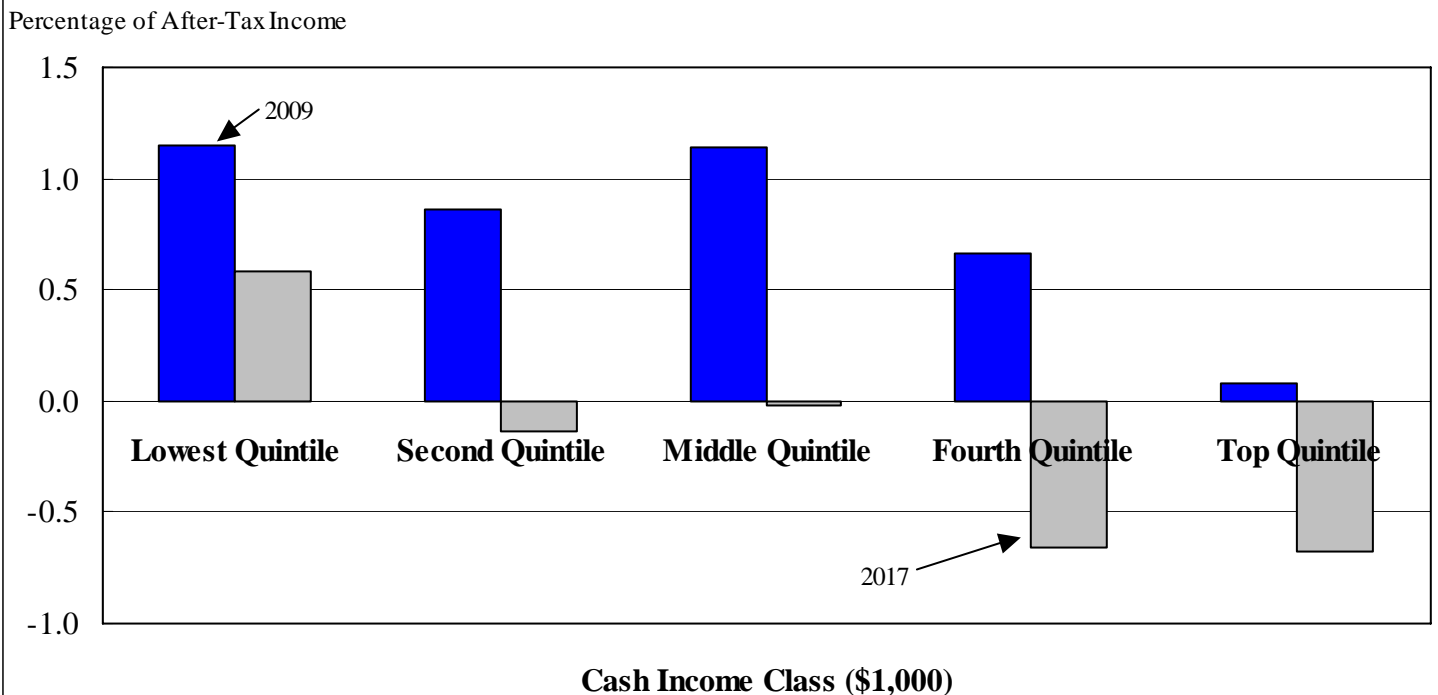
Figure 1. Current Law Tax Subsidy Rate Versus Premium Burden for Families with Employer-Sponsored Health Insurance With and Without Social Security Taxes, by Income, 2009



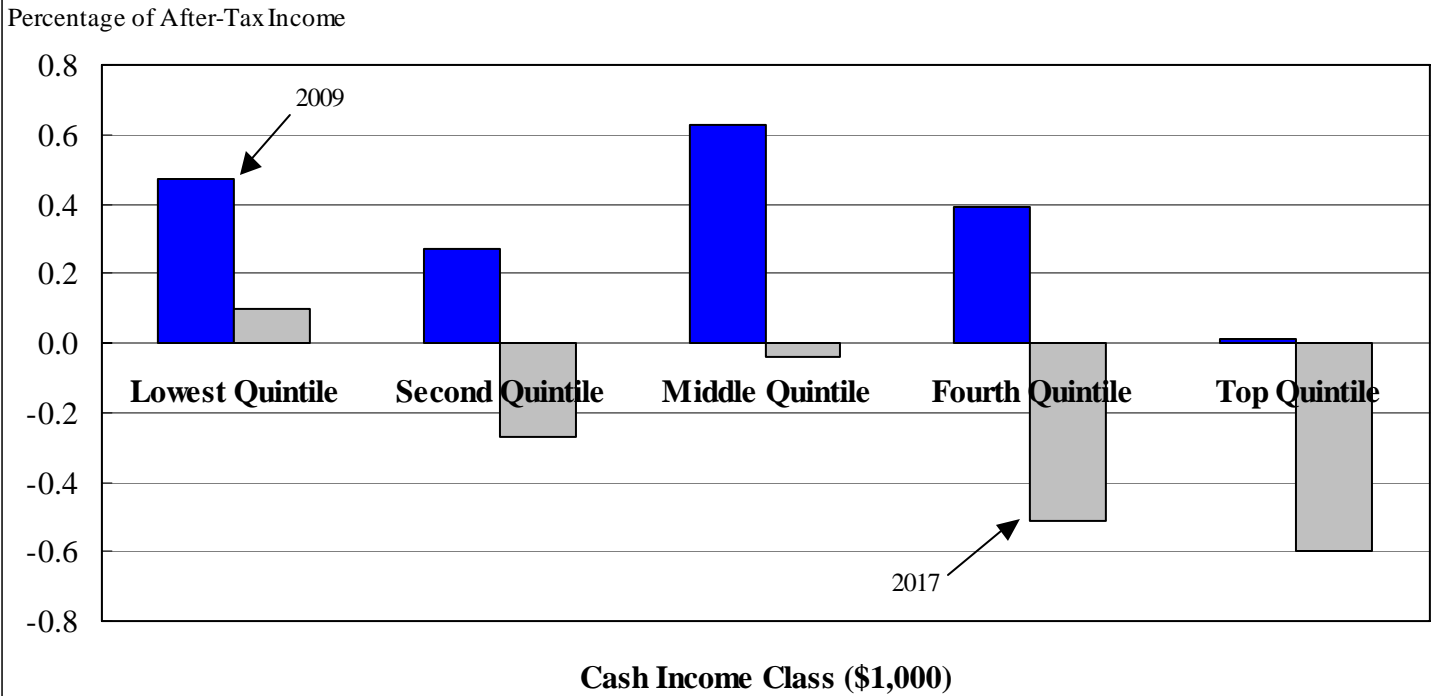
**Figure 2. Effect of the Proposal on Subsidy Rates
for Families with Employer-Sponsored Health Insurance,
Excluding Social Security Taxes, by Income**



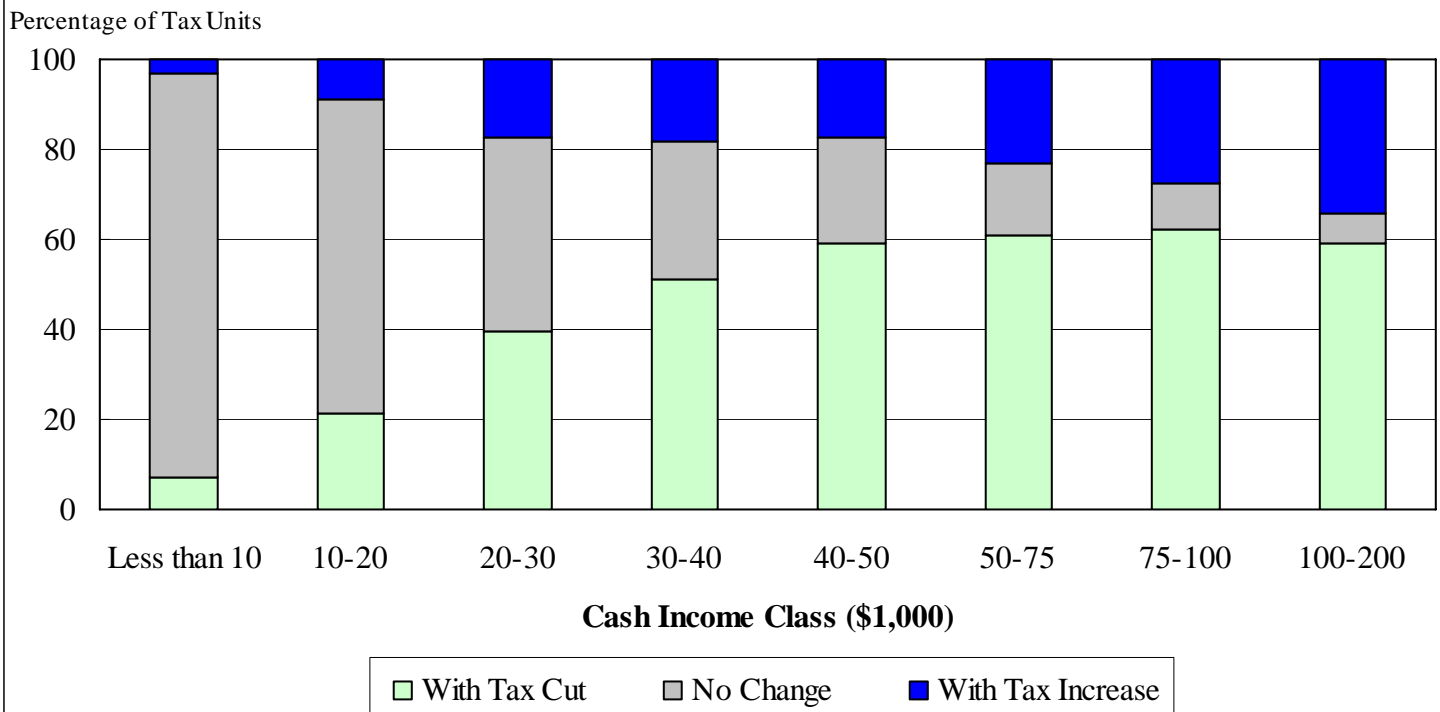
**Figure 3. Distribution of Tax Change
2009 and 2017**



**Figure 4. Distribution of Tax Change
Excluding Social Security, 2009 and 2017**



**Figure 5. Tax Units with Income Tax Increases and Decreases
Under the Proposal, 2009**



**Figure 6. Percentage of Tax Units
with Private Health Insurance, Projected 2009**

Percentage of Tax Units

