Health Reform Through Tax Reform: A Primer

Tax reforms can expand coverage and reduce health spending, but poorly designed reforms can have perverse consequences.

by Jason Furman

ABSTRACT: Tax incentives for employer-sponsored insurance and other medical spending cost about $200 billion annually and have pervasive effects on coverage and costs. This paper surveys a range of proposals to reform health care, either by adding new tax incentives or by limiting or replacing the existing tax incentives. Replacing the current tax preference for insurance with an income-related, refundable tax credit has the potential to expand coverage and reduce inefficient spending at no net federal cost. But such an approach by itself would entail substantial risks, so complementary reforms to the insurance market are essential to ensure success. [*Health Affairs* 27, no. 3 (2008): 622–632; 10.1377/hlthaff.27.3.622]

JUST ABOUT EVERY HEALTH INSURANCE REFORM proposed by the major presidential candidates in the 2008 campaign has accorded a central role to taxes, as do numerous proposals by members of Congress and policy analysts. For some, the goal is to expand insurance coverage—which requires, inter alia, subsidies to reduce the cost of health insurance to enrollees. For others, the principal focus is on reducing what is perceived as excessive health spending by the currently insured, either by reducing current tax incentives that encourage spending or by creating new tax incentives intended to reduce spending. Some reforms simultaneously try to achieve both mutually reinforcing goals.

Part of the motivation for making tax changes an important part of health reform stems from the fact that the tax system already plays a major role in shaping health insurance. Another motivation is that tax subsidies can build on the existing infrastructure for tax administration, making it a familiar and administratively simple way to achieve the goals of health reform—and in particular, to target assistance based on income. Finally, policymakers from both political parties have also been attracted to using the tax code for health reform because of the perception that the public prefers measures described as "tax cuts" to substantively similar measures that are treated in budgetary conventions as "spending increases."

This primer starts with a brief description of the impact of the existing tax sys-

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tem on the extent and nature of health insurance today. It then reviews and analyzes four types of tax reforms: (1) new tax incentives designed to expand coverage through the individual market; (2) new tax incentives as part of a more comprehensive plan to provide universal access or coverage; (3) new tax incentives designed to reduce spending (such as expansion of health savings accounts, or HSAs); and (4) removing or replacing existing tax incentives. The discussion focuses on the underlying economic issues and does not address the essential issue of how different forms of tax credits would be administered to ensure timely and accurate payments for beneficiaries and prevent fraud.

Ultimately, the evaluation of these alternative tax reforms hinges on several factors: the goals one has for health reform, empirical judgments about the likelihood of achieving these goals and the risks of unintended consequences, and how one evaluates the uncertainty about the impact of a given policy and the prospects of other reforms to limit that uncertainty.

How The Tax System Affects Health Insurance Today

The federal government will provide about $200 billion in tax subsidies for health care in fiscal year 2008, the same amount it spends on Medicaid.[1] Most of this tax subsidy stems from the fact that the tax code allows employers to deduct their contributions for health insurance premiums (just as they are allowed to deduct wages and other expenses) but simultaneously allows employees to exclude the value of these contributions from their income for tax purposes (unlike wages and other fringe benefits that are included in income).

This federal tax exclusion, combined with a state and local tax exclusion, which also has a substantial cost, has a major effect on the $800 billion expected to be spent in 2008 on private insurance.[2] Relative to a system with no tax exclusion, the current system has the following features, some of which are unambiguously positive or negative, and some of which are ambiguous or debatable.

■ **More coverage through employers than through the individual market.** The tax exclusion effectively reduces the price of employer-sponsored insurance relative to insurance purchased through the individual market. As a result, it increases the take-up of employer insurance and reduces the take-up of individual insurance. The upside of this preference is that it can help resolve the market failures associated with adverse selection in the individual market by pooling various risks. The flip side, however, is that it reduces competition and choice for enrollees that could otherwise lead to better-designed insurance plans. In addition, employer-sponsored insurance, in the absence of universal coverage, can promote job lock, inhibiting workers' mobility and reducing productivity.[3]

■ **More coverage overall.** Not surprisingly, people tend to purchase more of items that are subsidized, and health insurance is no exception. Illustrating this point, the elimination of the tax exclusion for employer-sponsored supplemental insurance in Quebec, Canada, led to "a decrease of about one-fifth in coverage by em-

ployer-provided supplementary insurance...but the increase in the non-group market offset only 10–15 percent of the decrease in coverage through an employer."[4] If this same pattern held in the United States, where the tax subsidy for insurance is of a similar magnitude to what it is in Quebec, then thirty-five million people would be dropped from employer-sponsored insurance, of whom only five million would buy coverage in the individual market. (These numbers may be an overestimate because the Quebec experience concerned the purchase of supplementary insurance, while the relevant question in the United States is the purchase of primary insurance.)

■ **More of an incentive for higher-income workers than for lower-income workers.** The value of the tax exclusion is larger for higher-income workers than for lower-income workers. For example, consider an employer contributing $8,000 for a family policy and requiring the worker to contribute $2,000. A low-income worker facing a marginal tax rate of 10 percent (the typical marginal tax rate for a worker at the thirtieth percentile) would effectively have to give up $9,200 in after-tax income for this policy—effectively an 8 percent subsidy for insurance.[5] In contrast, a high-income family might be in the 40 percent marginal rate and thus have to give up $6,800 in after-tax income for this policy—effectively a 32 percent subsidy for insurance. If the lower-income worker receives a smaller tax-advantaged employer contribution for insurance, the disparity will be even greater. This not only is unfair, it also leads firms with disproportionate numbers of lower-income workers to be less likely than others to offer insurance or to pay a large fraction of the premium, both of which lead to less insurance coverage for lower-income workers.[6] If the goal of the tax subsidy is to increase the number of Americans with insurance, then this form of provision is inefficient because the current subsidy is evidently too small to encourage low-income people to demand insurance and is likely higher than it needs to be to ensure that high-income people are covered.[7]

■ **More of an incentive to spend on health care.** The exclusion and other tax benefits for health care reduce the after-tax cost of that spending, leading to more spending on health care and less spending on everything else than would be the case without these incentives. The design of the current tax incentive magnifies this effect because the combination of the employer exclusion with the general lack of a tax deduction for out-of-pocket expenses leads to insurance plans with lower copayments and deductibles and thus higher spending. Two studies suggest that eliminating the tax exclusion for premiums could result in a 41–65 percent increase in the coinsurance rate, which could lead to a 9–38 percent reduction in health spending by the privately insured.[8] Both economic theory and evidence from the RAND Health Insurance Experiment (HIE) and other studies suggest that such a reduction in spending would result in little if any worsening in health outcomes.[9]

Reforming The Tax Treatment Of Health Care

Proposals to reform the health care system place different emphases on the goals of increasing health insurance coverage and reducing health spending. They

also differ in terms of their means. Some proposals maintain the existing tax structure and add new tax breaks—to avoid either disrupting the parts of the system that already seem to work or transparently creating large numbers of winners and losers.[10] Other proposals reform or reduce the existing tax incentives to reduce their perverse incentives and finance reforms. Different combinations of goals and means are shown in Exhibit 1 and discussed in the remainder of this paper.

■ **Strategy: new individual coverage tax incentives.** This first group of reforms rely primarily on new tax incentives for the purchase of individual coverage. A number of variants of this strategy have been proposed, including making premiums for individual coverage tax-deductible, providing a fixed deduction or tax credit for anyone who purchases qualified insurance in the individual market, providing sliding-scale tax credits for the purchase of individual coverage that are larger for low-income workers and phased out for higher-income workers, or tax benefits that are linked to the purchase of high-deductible plans.

One goal of these approaches is to move toward a more level playing field between employer and individual coverage, which is seen as improving competition, improving the functioning of both markets, and reducing job lock. This in turn is intended to accomplish a more fundamental goal: reducing the number of uninsured people. Finally, another stated objective is to achieve tax equity between people who receive insurance through their employers (and get a tax break) and those who purchase it in the individual market (who generally do not get a tax break). How do these reforms perform on all three objectives?

■ **Estimated impact.** There is no question that these policies would achieve their primary goal: shifting insurance coverage from the employer-sponsored system to the individual market. Although large employers would likely continue to offer coverage because they can take advantage of economies of scale to reduce administrative costs and facilitate employee enrollment, smaller employers are more sensitive to the relative price of insurance and more likely to either drop coverage or reduce their contribution. Estimates of the magnitude of the shifting depend on the extent of the plan and, more importantly, on firms' controversial and uncertain be-

EXHIBIT 1
Typology Of Alternative Tax Reforms

	Adding new tax incentives	Reforming/reducing existing tax incentives
Primarily motivated by expanding coverage	Tax credits/deductions for the individual market Tax credits as part of a universal insurance plan	Capping the existing deduction or replacing it with a flat deduction or credit
Primarily motivated by reducing costs	Health savings accounts; tax-deductible expenses	Capping the existing deduction or replacing it with a flat deduction or credit

SOURCE: Author's analysis.

havioral responses. Given the large number of people covered by employer-based insurance, even small changes can affect many people—if 5 percent switch out of employer-sponsored insurance, that equals nine million people.

Whether one evaluates this influx into the individual market as good or bad depends on the complex and highly uncertain evaluation of the individual market—in particular, the extent of underwriting and risk pooling. Although some evidence suggests that current requirements such as guaranteed issue contribute to substantial risk pooling in the aggregate, there is serious doubt about whether these results are relevant to new entrants into the insurance market.[11] This is particularly important because the individual market functions poorly for people with chronic conditions, who make up nearly half of all uninsured nonelderly adults, according to the Henry J. Kaiser Family Foundation—a rate that is higher than for the insured population.[12] In addition to traditional pooling arguments, behavioral considerations also make employer-based insurance important as an easy way for even healthy workers to enroll in coverage who might otherwise not get around to doing so.

The evaluation of the extent of employer-coverage dropping and the functioning of the individual market also has an important impact on the evaluation of how these reforms affect total insurance coverage. The Congressional Budget Office (CBO) has estimated that a sliding-scale tax credit for low-income families could help 2.2 million uninsured people purchase insurance while leading only 0.2 million to move out of employer-sponsored insurance to become uninsured.[13] In contrast, if tax subsidies are made universal, they will lead to more employer-coverage dropping and could even increase the total number of uninsured people. Jonathan Gruber estimates that a universal tax credit and deduction for the purchase of high-deductible plans in the individual market would result in 2.4 million uninsured people buying new insurance plans, but 3.9 million people previously covered by employers would become uninsured. The net effect is an increase of 1.5 million in the number of the uninsured people—in spite of spending a sizable amount of money on a new tax incentive for insurance.[14] Analysts and policymakers with different beliefs about the key parameters in the health system should be concerned about any new tax-subsidy proposal that has a major chance of increasing the number of uninsured people.

Finally, the tax-equity arguments for a "level playing field" that grants tax benefits to the purchase of individual coverage are overstated or misguided because labor markets tend to adjust before-tax wages to equalize after-tax wages and benefits in different jobs, taking into account the tax treatment.[15]

■ **Strategy: tax incentives with broader reforms.** Another potential reform, enacted in Massachusetts and proposed by all of the leading Democratic presidential candidates in 2008, is to make income-related tax subsidies for the purchase of insurance broadly available and combine them with two other elements: new pooling mechanisms (for example, modeled on the Federal Employees Health Benefits

[FEHB] program or another public program like Medicare) and some form of mandates (for example, individual mandates or an employer play-or-pay requirement). In these plans, the impact of new tax incentives depends critically on its interaction with other policies. Employer-coverage dropping is less of a concern if the policy is combined with play-or-pay provisions, and the functioning of the individual market is less of a concern if a new pooling mechanism is established.

■ **Estimated impact.** An effective mandate could lead to a large increase in insurance take-up for any given set of tax subsidies.[16] Gruber, for example, estimates that the same set of tax subsidies would cover forty-five million uninsured people at an annual cost of $124 billion with an individual mandate, compared with covering only twenty-three million at a cost of $102 billion without a mandate. Note that these estimates show that the mandate leads to nearly twice as many people being covered at less than a one-quarter increase in cost.[17] Those who would prefer not to purchase insurance but were forced to do so because of the mandate, however, might at least perceive themselves to be worse off.

The coverage expansions associated with policies that combine income-related tax incentives with pooling mechanisms and mandates are both larger and much more certain than the coverage impacts of individual-market tax incentives that are not combined with such interrelated policies. The biggest downside of this approach, however, is the greater cost. With the long-run deficit already large, $124 billion in the first year—growing at the same rate as health spending in subsequent years—is a substantial new federal commitment. At the same time, such a coverage expansion—by itself and ignoring other policies with which it might be combined—would do nothing to reduce national health spending. If anything, the expansion in insurance would almost certainly increase such spending.

■ **Strategy: new tax breaks to reduce spending.** The third type of tax reform proposal is to provide new tax incentives to encourage people to spend less on health care. One set of examples involves health savings accounts (HSAs), which provide a tax-advantaged savings opportunity for people who get coverage through a qualified high-deductible plan. To proponents of those plans, their virtue is that the tax preferences they provide for out-of-pocket costs will make them more attractive to enrollees, while the high-deductible health insurance design (and rollovers of account balances) will encourage more-prudent spending.

Some proposals would expand HSAs through larger account contributions or increased tax benefits.[18] Other proposals are more ecumenical about the insurance option—allowing tax-preferred accounts to be paired with any form of insurance or making all out-of-pocket health expenses tax-deductible in an effort to eliminate the tax bias in favor of policies that have lower cost sharing and higher premiums.[19] Note that although the primary focus of most of these proposals is on cost containment, they are also all intended to lower the cost of insurance and thus could modestly increase the number of insured people.

■ **Estimated impacts.** Proponents of these approaches generally begin with the

reasonable premise that the existing tax code encourages too much spending on health care. Instead of taking away the existing tax breaks, which may be considered politically infeasible or even undesirable, these approaches instead try to add a new tax break in the hope that it will cancel out the existing tax break; in other words, the premise of these proposals is that "two wrongs make a right."[20] Some also believe that consumers make rational choices about health care while making irrational choices about health insurance. In this case, removing the existing distortions is not sufficient, and the solution is tax subsidies for government-favored plans.

Some new tax breaks to encourage enrollment in high-deductible plans can accomplish their stated goal of leading to reductions in health spending. The RAND HIE found that people in plans with high, income-related deductibles spent 31 percent less on health care than people in plans with no cost sharing.[21] Based on the current parameters of health insurance, I have estimated that if all nonelderly, privately insured people switched to typical high-deductible plans, it would reduce total health spending by 14 percent.[22] The RAND evidence suggests that these cost savings would be achieved with no negative health outcomes for all except low-income families with chronic conditions, although it is debatable whether results from more than twenty-five years ago are still relevant today.[23] This, together with the fact that low-income families are less able to bear risk, is a downside of high-deductible plans that impose the same cost sharing on a family making $20,000 as on a family making $200,000.

Although HSAs may have resulted in some reduction in health spending, efforts to add new tax benefits to expand them run into a dilemma. Proposals to increase tax favoritism for HSAs encourage new people to enroll in HSAs (reducing spending) but also make it more attractive for people who already have HSAs to enroll in health plans with lower deductibles or increase out-of-pocket spending (increasing spending). The net effect on health spending is thus ambiguous.[24]

The proposal by John Cogan and colleagues to make all out-of-pocket health expenses tax-deductible would also have ambiguous effects on health spending.[25] On the one hand, it would increase the total tax favoritism for health spending, thus increasing spending. On the other hand, it would reduce the bias against plans with more cost sharing, thus reducing spending. Although some general theoretical results find that the result is unambiguously to reduce spending if people make fully rational choices about their insurance, in Cogan and colleagues' model it depends on an empirical parameter summarizing the actual sensitivity of coinsurance rates in private insurance to the tax code.[26] Plausible parameters show that such a plan is as likely to increase spending as it is to reduce it.[27] Spending increases would be exacerbated if out-of-pocket expenses that are not currently covered by insurance were made tax-deductible.

Finally, like all of the tax approaches discussed so far, these approaches have another downside: a potentially high budgetary cost. Moreover, much of the benefit of this cost will go to higher-income households, who are most able to save money

in tax-favored accounts and are in higher tax brackets and thus get larger benefits from the use of tax deductions. To be sure, both the distributional and budgetary problems could be alleviated by combining these proposals with progressive tax increases, but such combinations are rarely proposed.

■ **Strategy: reforming or replacing existing tax benefits.** The fourth category of health tax reform is proposals to reform, replace, or even repeal the existing tax benefits for health insurance. These proposals range from making employer contributions to health insurance taxable above some cap (and potentially using the savings to finance other health reforms) to making employer contributions entirely taxable and giving a separate tax benefit to encourage people to purchase insurance through either the individual market or their employers.

This approach has the potential to remedy many of the downsides of the other three types of tax reforms. Unlike all three categories of reform described above, reforming or replacing the existing employer exclusion need not cost any additional money and could even be designed to save money. As a result, proposals along these lines have the potential to have effectively infinite bang for the buck by reducing the number of uninsured people at no budgetary cost. Another upside is that this approach is likely to reduce health spending and thus premiums for those who already have insurance, although a well-designed policy would have the deliberate effect of raising health spending by the newly insured.

■ **Estimated impact.** At a minimum, putting a cap on the existing exclusion would eliminate any tax incentive to purchase more-expensive insurance at the margin.[28] In part this would happen because it would raise the after-tax cost of going from generous health insurance to very generous health insurance, or even from decent health insurance to generous health insurance if the cap were set at a lower level. Perhaps even more important, it would make employer contributions to health insurance more transparent and could result in psychological and institutional changes that would reduce the generosity of insurance plans. Unlike HSAs, however, the policy would not require a specific, government-favored form of health insurance. Instead, people would have equal incentives to save money with, say, a health maintenance organization (HMO) as a high-deductible plan.

A more radical approach would be to make existing contributions to employer coverage entirely taxable and instead give everyone who purchased insurance either a standard deduction (as proposed by President George W. Bush in his FY 2008 budget), a uniform refundable tax credit (as proposed by Sen. John McCain [R-AZ] in his 2008 presidential campaign), or a sliding-scale credit that falls as income rises (the de facto approach of the Wyden-Bennett bill).[29]

There are several advantages to all of these approaches over capping the deductability of health insurance premiums. First, they target assistance at those who probably need it most and thus would have a larger effect on coverage for any given amount of funds available for subsidies. Second, such proposals use all of those dollars to subsidize people going from no insurance to minimally acceptable

insurance and none of those dollars to subsidize people going from minimally acceptable insurance to anything more. As a result, it provides more incentive to purchase insurance than the current system or even a capped exclusion and less incentive to purchase more generous, expensive insurance. Estimates of the president's proposal to replace the existing tax exclusion with a standard deduction for health insurance of $7,500 for individuals and $15,000 for families found that it would reduce the number of uninsured people by seven to nine million, although the aggregate number masks some of the shift in the composition of coverage with higher-income, healthier households gaining coverage, while lower-income, chronically ill households get dropped by their employers and find themselves unable or unwilling to purchase insurance in the individual market.[30]

A deduction, however, has a number of flaws, the most dramatic of which is the fact that a sizable fraction of the uninsured have no tax liability and thus would not get any benefit from a deduction.[31] This is an example of a broader issue: a tax deduction gives larger benefits to households in higher tax brackets, which is not just inequitable but is also inefficient because it provides too little money to encourage low-income families to purchase insurance and more money than is needed to influence high-income families. As a result, economists and policy analysts from across the political spectrum have generally preferred uniform refundable credits or progressive income-related credits on the grounds that they are both more equitable and more efficient.[32]

Eliminating the employer exclusion and leveling the playing field between employer and individual coverage would cause a large number of employers, especially smaller employers, to drop coverage. There would be a serious risk that the individual market would not be able to handle the new influx of people, risk pooling would be diminished, and the number of uninsured people would rise. As a result, policies that curb or replace the existing tax exclusion are much more likely to succeed in boosting coverage if they are combined with policies to enhance pooling—such as some combination of an individual mandate, regulation of insurance plans, the establishment of a new publicly sponsored pool, the expansion of Medicaid or the State Children's Health Insurance Program (SCHIP), reinsurance, high-risk pools, or allowing people to buy into public plans.

TAX CHANGES ARE LIKELY TO BE AN IMPORTANT COMPONENT of any future health reform. One set of tax changes would add new tax incentives to the existing incentives. In considering these tax changes, one must weigh the budgetary cost against the benefits of the proposal. For proposals whose effects are highly uncertain or even counterproductive, such as untargeted tax incentives for the purchase of individual coverage or tax incentives to reduce spending, this trade-off might not be worthwhile. For other proposals that complement new tax changes with reforms to create robust pooling options, it could be a trade-off worth making.

But there is a route with an even greater upside: tax reforms that expand coverage while reducing inefficient health spending at no net budgetary cost. Current tax expenditures for health care provide a pool of $200 billion that could be used to finance expanded or even universal coverage, with additional resources potentially left over for debt reduction or tax cuts. Instead of a budgetary trade-off, policymakers would have to balance the benefits of a potentially better system against the risks of disrupting what works now. Additional reforms that lie outside the arena of tax policy, such as creating new private pools, expanding public coverage, or reforming the regulation of insurance markets, could help minimize these risks and make it more likely that tax reforms will succeed.

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NOTES

1. Author's estimate based on Office of Management and Budget, *Budget of the United States Government Fiscal Year 2009: Analytical Perspectives* (Washington: U.S. Government Printing Office, 2008), Table 19.1; and Bureau of Economic Analysis, *National Income and Product Accounts*, Table 7.8 (Washington: BEA, 1 August 2007). The total income tax expenditure for health insurance is $164 billion. In addition, the tax exclusion reduces payroll taxes by about $85 billion, for a total contemporaneous cost of $250 billion. This contemporaneous cost is partially offset by the fact that excluding employer contributions to Social Security from taxable earnings results in lower future Social Security benefits. Taking this into account, the net present value cost of the tax exclusion in fiscal year 2008 is about $200 billion.
2. CMS, "National Health Expenditure Projections 2006–2016," http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf (accessed 12 December 2007).
3. J. Gruber and B. Madrian, "Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature," in *Health Policy and the Uninsured*, ed. C. McLaughlin (Washington: Urban Institute Press), 97–178.
4. A. Finkelstein, "The Effect of Tax Subsidies on Employer-Provided Supplementary Health Insurance: Evidence from Canada," *Journal of Public Economics* 84, no. 3 (2002): 305.
5. These marginal tax rates are consistent with the ones estimated by Congressional Budget Office, "Effective Marginal Tax Rates on Labor Income" (Washington: CBO, 2005). The CBO estimates are adjusted to reflect the additional Social Security benefits accrued as a result of having a higher taxable income. This is the economically correct treatment and is also consistent with the budgetary treatment of Social Security used in estimating the $200 billion cost of the tax expenditures for health care.
6. This tax incentive is compounded by the availability of Medicaid and SCHIP to lower-income workers or their dependents.
7. L. Batchelder, F. Goldberg, and P. Orszag, "Efficiency and Tax Incentives: The Case for Refundable Tax Credits," *Stanford Law Review* 59, no. 23 (2006): 23–76.
8. The coinsurance estimates are from M. Feldstein and B. Friedman, "Tax Subsidies and the Rational Demand for Insurance and the Health Care Crisis," *Journal of Public Economics* 7, no. 2 (1977): 155–178; and W. Jack and L. Sheiner, "Welfare-Improving Health Expenditure Subsidies," *American Economic Review* 87, no. 1 (1997): 206–221, respectively.
9. J.P. Newhouse and the Insurance Experiment Group, *Free for All: Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993); and J. Gruber, "The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond" (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, October 2006).
10. New tax credits must also be paid for, at least eventually, with tax increases or spending cuts. As a result, these proposals also have winners and losers—but who the losers are is often less clear, especially if the proposal itself does not specify the source of contemporaneous or future financing.
11. B. Herring and M. Pauly, "The Effect of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market," NBER Working Paper no. 12504 (Cambridge, Mass.: National Bureau of Economic Research, August 2006).

12. Kaiser Family Foundation, *The Uninsured: A Primer* (Menlo Park, Calif.: Kaiser Family Foundation, October 2007).
13. CBO, *CBO's Health Insurance Simulation Model: A Technical Description*, October 2007, Table B-1, http://www.cbo.gov/ftpdocs/87xx/doc8712/10-31-HealthInsurModel.pdf (accessed 12 March 2008).
14. J. Gruber, "The Cost and Coverage Impacts of the President's Health Insurance Budget Proposals" (Washington: Center on Budget and Policy Priorities, 15 February 2006).
15. This is a specific example of the broader shortcomings of arguments based on "horizontal equity," the idea that the tax system should treat similarly situated people in a similar manner. For a broader exposition, see L. Kaplow, "Horizontal Equity: Measures in Search of a Principle," *National Tax Journal* 42, no. 2 (1989): 139–154.
16. S. Glied, J. Hartz, and G. Giorgi, "Consider It Done? The Likely Efficacy of Mandates for Health Insurance," *Health Affairs* 26, no. 6 (2007): 1612–1621.
17. J. Gruber, "Covering the Uninsured in the U.S.," NBER Working Paper no. 13758 (Cambridge, Mass.: NBER, January 2008).
18. For example, see the President's FY 2007 Budget proposal, http://www.whitehouse.gov/omb/budget/fy2007/budget.html (accessed 11 March 2008).
19. M. Cannon, "Large Health Savings Accounts: A Step towards Tax Neutrality for Health Care" (Washington: Cato Institute, 27 February 2007); and J.F. Cogan, R.G. Hubbard, and D.P. Kessler, *Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System* (Washington and Stanford, Calif.: American Enterprise Institute Press and Hoover Institution, 2005).
20. J. Furman, "Two Wrongs Do Not Make a Right," *National Tax Journal* 59, no. 3 (2006): 491–508.
21. Note that "high-deductible" actually refers to plans in which people paid 95 percent of the cost of medical care until they reached their out-of-pocket limit, which is almost the same as a high-deductible plan in which people would have to pay 100 percent of the cost of medical care until they reached their out-of-pocket limit.
22. J. Furman, "The Promise of Progressive Cost Consciousness in Health Reform," Hamilton Project Discussion Paper no. 2007-05 (Washington: Brookings Institution, April 2007).
23. See Gruber, "The Role of Consumer Copayments," for an up-to-date survey.
24. Furman, "Two Wrongs."
25. Cogan et al., *Healthy, Wealthy, and Wise*.
26. Jack and Sheiner, "Welfare-Improving Health Expenditure Subsidies."
27. Furman, "Two Wrongs."
28. This was proposed by the President's Advisory Panel on Federal Tax Reform, *Simple, Fair, and Pro-Growth: Proposals to Fix America's Tax System*, November 2005, http://www.taxreformpanel.gov/final-report (accessed 12 March 2008).
29. See R. Wyden and B. Bennett, "Finally, Fixing Health Care: What's Different Now?" *Health Affairs* 27, no. 3 (2008): 689–692.
30. The CBO estimated seven million, the Treasury Department estimated eight million, and the Lewin Group estimated nine million, with all three stressing the considerable uncertainty around estimates of systemic changes. See CBO, "An Analysis of the President's Budgetary Proposals for Fiscal Year 2008" (Washington: CBO, 2007); U.S. Department of the Treasury, "General Explanations of the Administration's Fiscal Year 2009 Revenue Proposals" (Washington: Treasury Department, 2009); and J. Sheils and R. Haught, "President Bush's Health Care Tax Deduction Proposal: Coverage, Cost, and Distributional Impacts" (Falls Church, Va.: Lewin Group, 2007).
31. These families would potentially benefit from a reduction in their payroll taxes. But this reduction would also lead to an automatic reduction in future Social Security benefits, which in present-value terms would often exceed the payroll tax reduction.
32. L. Burman et al., "An Evaluation of the President's Health Insurance Proposal," *Tax Notes* 114, no. 10 (2007): 1013–1028; and S.M. Butler and N. Owcharenko, "Making Health Care Affordable: Bush's Bold Health Tax Reform Plan," Heritage Foundation Web Memo no. 1316, http://www.heritage.org/Research/HealthCare/wm1316.cfm (accessed 12 March 2008).