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The President's Health Insurance Proposal—A First Look*

Len Burman
Jason Furman
Roberton Williams

In his State of the Union address, President Bush will propose 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 and in their place substitute a separate standard deduction in the federal income tax for all taxpayers who obtain qualifying health insurance. This special deduction would also apply to earnings subject to payroll taxes. 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 thus under-consumption of other valued goods like food and shelter).

In some respects, the plan is very innovative and a step in the right direction. It acknowledges that there are no easy answers and spells out some tough choices. The plan attempts to move forward on the twin problems of the rising number of uninsured and rising health spending without increasing the deficit—and in fact as proposed it would even reduce the long-run deficit. The president's plan effectively turns the tax subsidy for health insurance into a kind of voucher. It would increase the amount of tax relief that subsidizes acquisition of health insurance while eliminating the tax advantages 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

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* 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; Williams is principal research associate at the Urban Institute. The authors thank Henry Aaron, Katherine Baicker, Linda Blumberg, Robert Greenstein, Jeanne Lambrew, Mark McClellan, Edwin Park, 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.

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 virtually no 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.

Because the standard deduction would be available to all who obtained qualifying insurance, whether through an employer or as an individual, the proposal would level the playing field between employer-sponsored insurance and insurance purchased in the individual market. The plan 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. Even if such employers increase wages by the amount of the firm's previous contribution, this would fragment risk pooling and insurance, forcing some higher-risk people, especially those with low incomes, into the ranks of the uninsured. Mitigating or remedying these problems would require some combination of expanded public programs, new pooling arrangements, fundamental reform of the individual market, or additional tax subsidies for small employers that offer health insurance.

The administration does propose to provide states with incentives to address the problems in the nongroup market, but those promises may not be backed by adequate funding to deal with the serious challenges facing those in the nongroup market. Moreover, the tax changes would go into effect regardless of whether or when states adopted the complementary changes to the nongroup market.

This brief paper summarizes the proposal based on information that we have available as of noon on January 23, 2007. (It will be updated if new information becomes available.) It also briefly analyzes some of the likely effects of the proposal and makes some recommendations for transforming it into a proposal that would genuinely reduce the ranks of the uninsured without collateral costs for vulnerable workers.

Summary

Standard deduction for health insurance and inclusion of employer premium contributions. Taxpayers who purchase 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. 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 and whether the qualifying insurance comes through an employer or is purchased in the individual nongroup market. The value

of health insurance premiums 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 of $7,500 for individuals or $15,000 for family coverage. 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 do 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 $13,500 for family coverage in 2009, and that 75 to 80 percent of employer premium contributions will come in under the deduction amount. By the tenth year of the proposal about 60 percent of plans would fall under the standard deduction. 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 less than premium growth that reflects both rising prices and higher health consumption.

Revenue neutral over 10 years. The Treasury Department estimates that the proposal would reduce income and payroll taxes in the near term (when the deduction covers most premiums) and would raise revenues in the out years (because the deduction will rise more slowly than premiums). Beyond ten years, the proposal would aid the solvency of the Social Security and Medicare trust funds (assuming Congress does not succumb to pressure to raise the deduction faster than specified by statute).

Replaces other existing and proposed tax subsidies. 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. Health savings accounts (HSAs) would continue to exist and contributions to them would qualify for the same deduction/exclusion as under present law. The president's FY 2008 budget proposal will not contain the refundable tax credits for low-income people contained in previous budgets on the argument that low-income people will benefit from the payroll tax

exclusion and states will have incentives to subsidize their health care, as discussed below.

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 high-deductible health insurance plans (HDHPs) eligible for HSAs. Plans would have to have maximum lifetime benefits of at least $700,000 and cover both in-patient and out-patient medical services. The details would be worked out in drafting, 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 Medicare to provide subsidies for families with income below 200 percent of the federal poverty level and to encourage pooling arrangements.

Reduced phase-out rate for earned income tax credit. The rate at which the earned income tax credit (EITC) is phased out for married couples with two or more children would be reduced from 21.06 percent to 15 percent. 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. The proposal, however, would result in some low-income families getting more credits than under current law while others, including many families with only one child, would get less.

Preliminary Analysis

Effect on the Health Market

The proposal would have important effects on both health insurance coverage and the form of health insurance. Fundamentally, the amount of money available to subsidize the purchase of health insurance will be limited under the proposal in contrast to the open-ended nature of the subsidy under current law. The administration's proposal would use *all* of that money to encourage families to acquire some form of coverage and *none* of that money to encourage them to purchase more generous insurance.

Health Insurance Coverage

The proposal would have two effects on coverage:

- **The new insurance-conditioned standard deduction increases 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 health insurance

premiums can exclude the $5,000 contribution from taxable income. Under the proposal, such households could exclude $15,000—providing three times the tax incentive to go from no insurance to insurance.

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 increases the demand for nongroup insurance and decreases 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 net effect of these two 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 two responses above. Although it is difficult to predict with confidence 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 group coverage and as some small- and medium-sized employers drop coverage. 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, employers will no longer have to offer insurance to their employees for the workers to qualify for a tax break on their own health insurance. They can 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 will prefer that their employers stop offering insurance, because they will be able to get a better deal in the nongroup market, where healthy people face very low premiums.

The contribution to the employer-sponsored system is a serious issue not just because it fragments risk pools and contributes to 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 not to purchase 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.

The administration estimates that changes in the group and nongroup markets would, on net, reduce the number of uninsured by 5 million. 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 either case, the total effect masks an adverse change in the composition of the insured as the households that lose insurance tend to be poorer, sicker, or older and thus unable to purchase coverage in the individual market as it is now structured while the households that gain insurance tend to be richer, healthier, and younger.

The success of the proposal will depend critically on whether states 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, but it appears to make no additional money available to aid pooling in the nongroup market—it simply redistributes current subsidies. If that is the case, many people may lose adequate health insurance. To the extent that the new 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 plan more feasible. However, states vary substantially in their ability to subsidize low-income and sick individuals. A shortage of funds in some states could leave some families without adequate coverage.

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; and (3) a tax benefit for more generous insurance plans that use less managed care techniques to control costs.

The administration's core 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 Health Savings Accounts (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 a recent proposal by John Cogan, Glenn Hubbard, and Ronald Kessler, the proposal would not provide *new* tax incentives for health spending in an attempt to cure the problems with the old incentives. Those 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, by retaining special tax breaks for HSAs, a strong bias would exist in favor of high-deductible health plans as a cost containment strategy over other approaches. 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, which would make 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. In this case, the allocation of tax subsidies affects not only fairness but also the efficiency of the proposal. For example, if a proposal is designed to encourage the purchase of insurance, but most of the subsidies go to high-income families that would be most likely to purchase insurance anyway, it would have relatively little effect on health insurance coverage.

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 less regressive 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 likely increases progressivity somewhat. The value of the proposed deduction, however, still rises with a person's tax bracket.

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 no tax benefit for purchasing health insurance because their current reduction in payroll taxes would be largely 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.

It is important to note that most of the people who save on payroll taxes would receive smaller Social Security benefits in retirement. For low- and middle-income families that gain health insurance (and a $15,000 reduction in Social Security earnings), this could translate into a very substantial drop in retirement living standards.

The Tax Policy Center hopes to release distributional tables based on the proposal within the next day.

Revenue effects

According to Treasury estimates, the proposal would neither increase nor decrease tax revenues over the 10-year budget window, 2008–2017. In the short term, the proposal would reduce revenues 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. 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 in the later years. Beyond the budget period, the proposal would gain more and 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).

Whether things actually play out that way is uncertain. As the deduction continues to lose ground relative to the size of average health insurance premiums, policymakers would face great pressure to raise it. If they do so, the proposal could increase the deficit over the long- as well as the short-term.

In addition, the proposal retains a generous subsidy for HSAs. Contributions are deductible and earnings and withdrawals are tax-free as long as the money is used to pay for health care. That provision would make HDHPs and HSAs more favored than 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. This could increase 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.

(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 larger incentive to get coverage while higher-income families would likely still retain their coverage.

(2) Eligibility for the voucher or credit in the individual nongroup market could be made conditional on insurers offering community-rated premiums (possibly adjusted by age) or some other mechanism that guarantees that people who are continually insured can purchase insurance at the same low rate as everyone else, even if they develop chronic health conditions. Alternatively, insurance premiums on qualifying nongroup insurance could be subject to a tax, the proceeds of which would be transferred to a state fund designed to make affordable insurance available to those with low incomes and those with 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) Make the mandate for coverage more explicit. Massachusetts has adopted a mandate and Governor Schwarzenegger has proposed one in California. Both states would implement the mandates by denying tax benefits to households that go without coverage. The administration's proposal could be interpreted in a similar way: all families get an extra $15,000 tax deduction and then families that do not purchase insurance get penalized by losing it. Making that choice more explicit could increase coverage, reduce adverse selection, and make more explicit the nature of the social bargain—everyone has to get health insurance and the government has to ensure that it is affordable.

(5) Tax subsidies for health savings accounts, which would be retained under the proposal, 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.

(6) One advantage of the proposal is that it would improve the long-run fiscal outlook ending unlimited increases in tax subsidies for health insurance, growing the subsidy with the CPI rather than overall health spending. 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. Alternatively, the voucher or credit could be indexed to the health CPI or even the rate of growth of overall health spending. An intermediate proposal would start with a higher deduction or credit to ensure minimal disruption to existing arrangements and then let it grow more slowly than overall health spending for a period of time. Indexing would resume at health CPI or overall health spending once a target value is reached.

Conclusion

Despite its limitations, the proposal marks an encouraging departure from current policies that underprovide incentives to purchase insurance and encourage families to be over-insured and underpaid. 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.