The President’s Proposed Standard Deduction for Health Insurance: Evaluation and Recommendations

Abstract - The President’s proposal to replace the current exclusion of employer–paid health insurance premiums with a standard deduction for qualifying health insurance would level the playing field for employment–based coverage and private plans but would risk the loss of insurance for many workers, threaten existing risk–sharing pools, and unfairly favor the wealthy. This paper evaluates the President’s plan, suggests changes that would improve it, and assesses alternatives that would address the plan’s shortcomings and improve its likelihood of expanding coverage to many families who now lack insurance.

INTRODUCTION

P resident Bush’s FY 2008 budget proposed 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 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 new standard deduction is not biased towards the provision of favored forms of insurance over others. However, the President’s Budget also proposes to continue and even expand tax sub-
sidies for health savings accounts tied to high–deductible health insurance plans. It would, thus, favor such plans over other forms of insurance that could reduce spending (e.g., managed care or plans with higher copayments).

The *de facto* voucher in the President’s plan shares a peculiar feature with the subsidies for health insurance under current law: it is worth more to high–income people than for those with lower incomes, and worth virtually nothing to low–income households with no income tax liability. This is an issue not just for equity (low–income families need more help purchasing insurance) but also for efficiency (the subsidy could be too large for high–income families who would have purchased insurance already and too low for low–income families who might be more responsive to a somewhat larger incentive).

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 (ESI) and insurance purchased in the individual market. But in the process it would also eliminate a method for reducing the market failure associated with adverse selection. 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,\(^1\) 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.

Obvious improvements could be made to the proposal to increase the chances that it would expand coverage for those most at risk. First, the deduction should be converted to a refundable tax credit or a voucher. That way, the subsidy could be targeted to those with lower incomes who are least likely to be able to afford health insurance. Second, the problems in the nongroup market should be addressed directly by conditioning eligibility for the subsidy on states’ setting up effective pooling mechanisms in the nongroup market. For example, states could require that nongroup insurance be sold through pools similar to the Federal Employees’ Health Benefits Program (FEHBP), which covers federal employees without regard to health status.

Replacing the ESI exclusion with a progressive refundable credit would create many winners and losers. Those with higher incomes and more generous employer–sponsored health insurance would pay more taxes and those with lower incomes or who purchase their insurance outside of work would gain. Although only about one–quarter of tax units would pay higher taxes under such a plan, they could be expected to raise political hurdles to bar such a dramatic reform. For that reason, we also consider

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\(^1\) Individual or nongroup health insurance consists of private market plans available to individuals. Such insurance is generally more expensive than employer–sponsored insurance (ESI) because of higher administrative costs and adverse selection (people with health problems are more likely to enroll in private plans, driving up premiums).
incremental options that involve capping the subsidy for ESI at the average level for premiums and then allowing the cap to grow at only the rate of overall price inflation. That option would raise tax revenues by about $680 billion over ten years. The revenue raised could be used to expand public programs that help lower-income households and those with especially high health costs, or for refundable tax credits or vouchers. We show that such tax credits, if targeted at those with lower incomes, could become significant over time, although the targeted credits would markedly shift tax burdens over time.

This paper summarizes the President’s proposal and its likely effects on the health insurance market and the level and distribution of tax burdens. We consider some alternative approaches that would also restrict or eliminate the tax preference for employer-provided insurance but do so as part of a plan that would increase the affordability of health insurance and reduce the ranks of the uninsured without collateral costs for vulnerable workers.

THE PRESIDENT’S PROPOSAL

The President’s plan would replace most existing tax subsidies for health insurance with a new standard deduction for health insurance of $15,000 for family coverage or $7,500 for single coverage.\(^2\) 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 amount would be pro-rated and would be indexed for inflation. The value of health insurance premiums paid by employers or through cafeteria plans would be included in taxable compensation. The standard deduction would also reduce earnings subject to Social Security and Medicare payroll taxes. The proposal would take effect on January 1, 2009.

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).

The proposal was designed to be approximately revenue neutral, although the actual revenue effects are highly uncertain because of the inherent difficulty in projecting medical cost inflation and the effect of the proposal on health insurance coverage. The Department of the Treasury (2007) estimates that the proposal would reduce tax revenues by $32.8 billion (including $37.9 billion in additional refundable tax credits) over the ten-year budget period. The Joint Committee on Taxation (2007) estimates that the proposal would increase tax revenues by $333.6 billion over the same period. Over the long run, estimators at both agencies agree that the proposal would raise increasing amounts of tax revenue (and shore up the Social Security and Medicare trust funds).

Analysis

The proposal would have important effects on both health insurance coverage and the form of health insurance. The

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\(^2\) See Burman, Furman, Leiserson, and Williams (2007) for a much more detailed examination of the President’s proposal.
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.3 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 asks, “Did you have qualified private health insurance?” A “yes” answer means a family could deduct $15,000 from its 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 non-group 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 effect on health care spending could increase the demand for both group and non-group insurance.** If the plan succeeded in reducing the growth of health spending, 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

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3 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.
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 Cogan, Hubbard, and Kessler (2005) 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. (1450) [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.

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,

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 have qualifying insurance coverage 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 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.
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 shortsighted 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 three to five million. Sheils and Haught (2007) estimated that it would cover nine million uninsured and cost proportionately more as well. 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 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

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5 Pooling of risk in large ESI plans holds down premiums by avoiding adverse selection. Low administrative costs and the exclusion of premiums from taxable income make ESI cheaper than nongroup insurance and, thus, encourage healthier workers to participate.
ability to subsidize them. That disparity could leave many families in some states without adequate coverage.\(^6\)

**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 spending 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 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 the recent proposal by Cogan, Hubbard, and Kessler (2005), 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.\(^7\) 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 (Burman, Furman, Leiserson, and Williams, 2007). This runs counter to the basic theme of the proposal to level the playing field and could easily be corrected.

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\(^6\) 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.

\(^7\) U.S. Department of the Treasury (2007, p. 23) explains the administration’s rationale for expanding HSAs: “A health care system that is more market-oriented and consumer driven will help control costs and result in health care that is more affordable and accessible. This goal can be facilitated by making HSAs more flexible and increasing the incentive for individuals to change to HSA-eligible coverage.”
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. (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.)

Figure 1 shows how poorly targeted the current-law exclusion is for employer-sponsored insurance. 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 nine percent for those earning $100,000 to $200,000. But the tax subsidy

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The proposal’s far reaching effects on Social Security—changing both taxes and benefits—warrant further and more-detailed analysis.
has the opposite pattern; it is worth the most to those facing the lowest premium burdens. The tax savings (including payroll taxes) constitute only eight 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 five 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 Earned Income Tax Credit (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 in the figure).

The subsidy rates decline between 2009 and 2017, reflecting the fact that the stan-
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.\(^9\) 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 tax in 2017 (by about 0.6 percent of income) under the proposal than under current law.

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.\(^10\)

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\(^9\) 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).

\(^10\) 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.
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 Consumer Price Index (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 that 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 seven percent would pay lower income taxes and three percent would pay more (primarily because they would lose EITC when employer-paid premiums move them into the phaseout range of income). 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. 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 ten percent of tax units

![Figure 4. Distribution of Tax Change Excluding Social Security, 2009 and 2017](image-url)
with income above $75,000 have no health insurance.

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 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.

BETTER ALTERNATIVES

The President’s proposal is innovative and could possibly increase health insurance coverage while being fiscally responsible over the long run. But it also creates substantial risks, particularly for those with low incomes and chronic health problems who could end up in worse shape if they lost their insurance or were forced into an unregulated, and possibly unworkable, individual non–group market.

Recommendations

Various modifications to the President’s proposal would improve the likelihood that it would meet the critical goals of improving health insurance 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.

Recommendation 1: Replace the deduction with a progressive refundable tax credit or a voucher. This would be more economically efficient and fairer than both the President’s proposal and current law. 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, shifting from an income tax exclusion to an income tax credit would 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.

Recommendation 2: Availability of the voucher or credit in the individual non-group market.
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nongroup market should be made conditional on states establishing effective pooling and/or subsidy mechanisms that guarantee availability of affordable health insurance. 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 or could be subsidized by the federal government. 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 (Burman and Gruber, 2001).

Recommendation 3: Alternatively, or as a complement to tax subsidies, additional funds could be dedicated to programs targeted at high-risk groups. These could include Medicaid and SCHIP, subsidies for employer-sponsored insurance by small businesses, increased carrots or sticks for states to adopt innovative techniques to ensure affordable access for all, and subsidized pooling arrangements like buy-ins to programs modeled on a (possibly less generous version of) the Federal Employees Health Benefit Plan.

Recommendation 4: Repeal special tax breaks for health savings accounts. If the current law bias in favor of high premium and low out-of-pocket health insurance is eliminated, then there would be no rationale for retaining a tax bias in favor of high-deductible plans in the form of HSAs and they should be eliminated. If the current system’s bias for high premium and low out-of-pocket health insurance is reduced, then HSA subsidies should be reduced in tandem.

Recommendation 5: In acknowledgement of political reality, these changes might be phased in over time.

ILLUSTRATIVE OPTIONS

We consider four illustrative options. The goals are: (1) to remove the link between the tax subsidy for health insurance and the amount spent on insurance in order to encourage cost consciousness; (2) to provide a subsidy for insurance even if purchased outside of employment, subject to the availability of adequate pooling mechanisms in the nongroup market; (3) to minimize disruption to employment-based health insurance in cases where it is working well; and (4) to target subsidies at those who most need help paying for health insurance.

Option 1: Replace current subsidies with a flat credit. The base option would eliminate the exclusion from income tax of employer-sponsored health insurance as well as the income tax deduction for health insurance purchased by self-employed people and tax breaks for health savings accounts and cafeteria plans and replace them with a flat refundable tax credit of $900 per covered adult and $450 for each covered dependent starting in 2009. A policy covering a family of four would, thus, qualify for a tax credit of $2,700. In addition, families would get an additional incentive to purchase health insurance through the continuation of the payroll tax exclusion. The credit would increase at the rate of overall premium growth. As under the President’s proposal, qualifying health insurance policies would have to meet minimum standards set by the Treasury Department. The credit would be available for insurance sponsored by employers as well as insurance purchased in the nongroup market through FEHBP–like pools to be established by the states.
The proposal is designed to be roughly revenue neutral over the budget period (counting the refundable portion of the credit as reduced revenues; see Table 1). It would be much more progressive than either the current law subsidies or the President’s proposal. Most taxpayers with health insurance would pay lower taxes. About 40 percent of all tax units would pay lower taxes while 24 percent would pay more in 2009 (see the left panel of Table 2). The bottom four quintiles would face lower average taxes. For the bottom quintile, the new refundable credits would exceed three percent of income. Tax changes as a share of income would decline as income increases and most people in the top quintile would pay higher taxes. Even so, their income would fall an average of only 0.4 percent. Even though tax increase would be highest for very high income families, those increases constitute an insignificant share of income, averaging just 0.1 percent of income for the top one percent and even less for those at higher income levels.

By 2017, the flat credit switches from being a modest tax cut on average to a modest tax increase. (Expiration of the Bush tax cuts at the end of 2010 and the resulting higher marginal tax rates make an income exclusion more valuable.) By 2017, the top two quintiles would experience higher taxes on average under the proposal, but the bottom three quintiles would face lower average taxes with the largest gains as a percentage of income accruing at the bottom (see the right panel of Table 2). Overall, slightly more people get a tax cut than face a tax increase.

The proposal would not only be more progressive than either current law or the President’s proposal, but it would also likely encourage more people to acquire insurance. Because the credit is refundable, low-income households would benefit even if they have no income tax liability. Since they also tend to lack health insurance, the subsidy is much more efficient at targeting those who need help. That said, the credit amount is small relative to the price of a typical policy, especially for older families, so many households would still find health insurance to be unaffordable.

The proposal would also maintain a small tax advantage for ESI by continuing the exclusion of employer contributions from payroll tax. This helps limit the competition of nongroup insurance for ESI. It is also much, much simpler than the President’s proposal.

Finally, like the President’s plan, the proposal would encourage people to find less-expensive health insurance policies because the credit would not vary with the size of health insurance premiums. On the margin, the cost of health insurance would be paid with after-tax, not pre-tax, dollars, providing a strong incentive to economize. In addition, including employers’ premium contributions in taxable income would improve the transparency of health insurance financing, potentially leading to even larger effects as individuals are better able to make tradeoffs between spending on health insurance versus spending on all other goods and services.

Option 2: Cap the ESI income tax exclusion and expand public programs. This option would cap the exclusion for employer-sponsored health insurance at the average 2007 premium level with

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11 Table 1 assumes that all existing nongroup insurance qualifies for the tax credit and that no employers decide to offer or drop coverage. These assumptions are surely wrong and our estimates will, thus, underestimate the cost of the new credit if many people gain coverage as a result of the proposal (and will overstate the cost if many employers drop coverage). The Tax Policy Center is currently developing a model that will be able to produce dynamic estimates of the effects of the health insurance market to changing tax (and other incentives). We will use that model to evaluate a variety of health insurance options in subsequent work.
### Table 1
Options to Reform Tax Incentives for Health Insurance
Static Impact on Individual Income Tax Liability and Revenue ($ Billions), 2008–17

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<tbody>
<tr>
<td>repeal exclusion for employer–provided health insurance and self-employed health insurance deduction, allow refundable credit of $900 per covered adult, $450 per covered dependent (beginning in 2009)¹</td>
<td>0.0</td>
<td>-16.4</td>
<td>-20.7</td>
<td>-11.6</td>
<td>-7.4</td>
<td>-5.5</td>
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<td>-0.3</td>
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<td>7.0</td>
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<td>22.4</td>
<td>34.2</td>
<td>40.2</td>
<td>48.6</td>
<td>57.1</td>
<td>66.2</td>
<td>76.3</td>
<td>87.4</td>
<td>99.7</td>
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<td>645.6</td>
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<td>27.0</td>
<td>-7.8</td>
<td>-20.7</td>
<td>-15.6</td>
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<td>-6.9</td>
<td>-1.7</td>
<td>4.3</td>
<td>11.2</td>
<td>19.3</td>
<td>-2.1</td>
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<tr>
<td>+ repeal medical expense deduction (2008), allow refundable credit of $1200/$600 with phaseout above $30,000 (2009)³</td>
<td>27.0</td>
<td>-8.9</td>
<td>-22.1</td>
<td>-16.8</td>
<td>-12.4</td>
<td>-7.9</td>
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<td>3.9</td>
<td>11.1</td>
<td>19.7</td>
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<tr>
<td>repeal exclusion for employer–provided health insurance and self-employed health insurance deduction, allow refundable credit of $900 per covered adult, $450 per covered dependent (beginning in 2009)</td>
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<td>-21.9</td>
<td>-20.3</td>
<td>-8.8</td>
<td>-7.0</td>
<td>-5.0</td>
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<td>0.5</td>
<td>3.8</td>
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<td>-53.1</td>
</tr>
<tr>
<td>cap exclusion for employer–provided health insurance at inflation–adjusted mean value in 2007 (beginning in 2008)⁶</td>
<td>29.9</td>
<td>35.6</td>
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<td>50.9</td>
<td>59.2</td>
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<td>102.9</td>
<td>117.1</td>
<td>674.9</td>
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<td>-5.7</td>
<td>-0.4</td>
<td>5.8</td>
<td>13.0</td>
<td>21.4</td>
<td>3.2</td>
</tr>
<tr>
<td>+ repeal medical expense deduction (2008), allow refundable credit of $1200/$600 with phaseout above $30,000 (2009)³</td>
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<td>-21.6</td>
<td>-15.2</td>
<td>-11.4</td>
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<td>5.5</td>
<td>13.0</td>
<td>21.9</td>
<td>-3.4</td>
</tr>
</tbody>
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(1) Baseline is current law. Estimates are static and do not account for any potential microeconomic behavioral response. Official estimates from the Joint Committee on Taxation would likely show a somewhat different effect on revenue.

(2) Fiscal–year revenue numbers assume a 75–25 split. The actual effect on receipts could differ.

(3) Credit values are presented in 2009 dollars and grow at the rate of growth of health insurance premiums.

(4) Also caps self–employed health insurance deduction at the same value.

(5) The progressive credit phases out at a 10 percent rate for each dollar of adjusted gross income in excess of $30,000 for joint tax units and $15,000 for single, head–of–household, and separate tax units.
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<td>With Tax Cut</td>
<td>With Tax Increase</td>
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<tr>
<td>Lowest Quintile</td>
<td>19.6</td>
<td>0.5</td>
</tr>
<tr>
<td>Second Quintile</td>
<td>36.7</td>
<td>8.2</td>
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<tr>
<td>Middle Quintile</td>
<td>51.3</td>
<td>16.1</td>
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<tr>
<td>Fourth Quintile</td>
<td>54.1</td>
<td>30.5</td>
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<tr>
<td>Top Quintile</td>
<td>36.0</td>
<td>56.3</td>
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<tr>
<td>All</td>
<td>39.5</td>
<td>22.3</td>
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<tr>
<td>Addendum</td>
<td>30.7</td>
<td>63.0</td>
</tr>
<tr>
<td>Top 10 Percent</td>
<td>26.3</td>
<td>66.9</td>
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<tr>
<td>Top 5 Percent</td>
<td>30.1</td>
<td>62.1</td>
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<tr>
<td>Top 1 Percent</td>
<td>25.8</td>
<td>65.5</td>
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<tr>
<td>Top 0.5 Percent</td>
<td>24.5</td>
<td>65.6</td>
</tr>
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</table>


Percentile breaks are at $15,758; 30,093; 52,361; 93,024; 137,004; 192,737; 459,038; 712,376; 2,032,183 of cash income in 2009. For 2017, the breaks occur at $21,998; 40,237; 68,797; 123,895; 184,262; 257,882; 624,423; 970,802; 2,769,352.(1) Calendar year. Baseline is current law. Proposal repeals the exclusion for employer–provided health insurance and the self-employed health insurance deduction and allows a flat refundable credit of $900 (about $1,200 in 2017) for each covered adult and $450 (about $600 in 2017) for each covered dependent. Credit values are presented in 2009 dollars and grow at the rate of growth of health insurance premiums.

(2) Tax units with negative cash income are excluded from the lowest income class but are included in the totals. For a description of cash income, see http://www.taxpolicycenter.org/TaxModel/income.cfm.

(3) For the income levels at each quintile and the top income percentiles used in this table, see http://www.taxpolicycenter.org/TaxModel/percentiles.cfm.

(4) Includes both filing and non–filing units but excludes those that are dependents of other tax units.

(5) After–tax income is cash income plus employer–paid insurance premiums less: individual income tax net of refundable credits; corporate income tax; payroll taxes; and estate tax.

(6) Average federal tax (includes individual and corporate income tax, payroll taxes for Social Security and Medicare, and the estate tax) as a percentage of average cash income.
adjustment for overall price inflation starting in 2008. By our estimates, this option would raise over $680 billion over the ten–year budget period, with growing annual gains in later years (see Table 1). In 2017, the cap would increase income tax revenues by $118 billion. This would put strong pressure on employers to control the cost of health insurance premiums, because employees would—on the margin—pay those premiums out of after–tax income.

The $680 billion gained could be used to expand SCHIP, a state–run but mostly federally financed program that provides free health care to low–income children from families with incomes as high as 300 percent of poverty in a few states (200 percent is more typical). The 300–percent threshold could be made universal. Expanding this program to lower–income parents, improving the take–up rate for currently eligible children, and raising income limits would all be relatively inexpensive and high–value ways to expand health insurance coverage.

In addition, some of the money could also be used to expand Medicaid eligibility to more households with high health costs relative to their incomes, either because their incomes are especially low or because chronic conditions lead insurers to consider them high–risk. That expansion could include childless adults, whom the current system helps least. Funds could also help subsidize coverage through a state–run pool similar to FEHBP. And some might be used to help small employers offer health insurance coverage to their workers.

From a tax policy perspective, a uniform credit dominates a fixed cap for three reasons. First, a fixed cap retains a marginal subsidy for the purchase of health insurance below the cap. Second, proposals with a fixed cap provide a smaller incentive for going from no insurance to some insurance than proposals providing a flat benefit not linked the generosity of the insurance. Finally, a fixed cap is still regressive—in a way that is both unfair and inefficient.

One other common criticism of a fixed cap may have less merit: that it could disproportionately hurt taxpayers in areas with especially high health care costs. (This criticism was leveled against the President’s tax reform panel, which proposed a similar cap with no regional variation.) To the extent that regional variation in health costs is related to differences in uncontrollable cost factors, such as higher rents and salaries, the concern may have some merit (although it would apply not just to the health system but to taxes more generally). In a country with perfect mobility, however, the higher cost of living in some areas should reflect greater perceived benefits of living there. Moreover, perfect mobility would mean that higher property values—and, thus, rents—would offset any attempts to mitigate the higher costs of living in the tax–favored areas. Moreover, to the extent that differences in health care costs simply reflect differences in treatment patterns, reducing the tolerance of consumers in high–cost areas for more expensive treatments would be a good thing.12

**Option 3:** Cap the ESI exclusion and use the revenue gained to provide a flat refundable tax credit of $300 per covered adult and $150 per dependent. The maximum contribution to HSAs would be set at 2007 levels and fixed in nominal terms (so it would decline in real terms over time). A credit would be offered to small employers that offered health

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12 Extensive research has found no correlation between spending on health care and health outcomes. See, for example, Dartmouth Atlas Project (2006).
insurance for the first time between 2008 and 2010.\footnote{This credit would be similar in nature to previous proposals. For example, President Clinton’s 2001 budget proposed the creation of health insurance purchasing coalitions and tax credits to encourage small businesses that did not provide health insurance coverage for their workers to use the coalitions to obtain such coverage. Along similar lines, President Bush proposed in his 2006 budget to create refundable credits for small businesses that contribute to health savings accounts for their workers.} This proposal combines the tax part of option 2 with a scaled back option 1. The credit amounts would be much smaller than under option 1, because a cap generates much less tax revenue than repeal. For example, the credits for a family of four would total just $900 in 2009. Even so, this proposal would cut taxes for more than three-quarters of families with health insurance. About 48 percent of all tax units would pay lower taxes in 2009, while less than 15 percent would pay more tax (see the left panel of Table 3). The bottom four quintiles would pay lower taxes on average, and even within the top quintile, the average tax increase would be just 0.1 percent of income. The dollar values of the tax changes are also quite modest—averaging $95 for the lowest quintile (reflecting the fact that most low-income workers lack health insurance) and $221 for the third and fourth quintiles. The modest tax changes would grow over time after the Bush tax cuts expire and the tax cap binds more. By 2017, the top quintile would face an average tax increase of close to $1,000. Nonetheless, most tax units would pay lower taxes (see the right panel of Table 3).

The combination of the ESI cap and the credit for health insurance coverage that does not vary with premium would reduce the incentive to overconsume health care and underconsume other goods and services. Removing inflation adjustments from the maximum contribution to HSAs would reduce the bias in favor of high-deductible health plans over time, as the tighter and tighter cap would reduce the bias under the ESI exclusion in favor of more-generous health insurance. And, by tilting tax benefits in favor of lower-income households, the proposal would target assistance at those most in need. However, the amount of the credit is likely to be too small to induce many low-income families to purchase coverage.

**Option 4: Cap the ESI exclusion and use the revenue gained to provide a progressive refundable tax credit with a maximum value of $1,200 per covered adult and $600 per dependent.** The proposal is similar to option 3, except that the credit would phase out at a ten percent rate on adjusted gross income (AGI) above $30,000 for joint tax returns and $15,000 for other filing statuses. Thus, for example, a family of four would continue to receive a partial credit until their income reached $66,000. (The maximum credit of $3,600 would phase out over a $36,000 income range.) In addition, employer contributions to health insurance would remain excludable from payroll taxes. By design, this credit is targeted at lower-income tax units. The average tax unit in the bottom quintile would receive a tax credit of $374—more than four percent of income in 2009 (see the left panel of Table 4). The second quintile would see an average tax savings of $700, about three percent of income. However, under this option, slightly more tax units would face higher taxes than lower taxes: almost 26 percent would pay higher taxes, while less than 24 percent would receive a tax cut. By 2017, most tax units with health insurance would face higher taxes than they would under current law (see the right panel of Table 4).

Because the credit is so targeted at households that are less likely to
### TABLE 3

CAP EMPLOYER EXCLUSION, SELF-EMPLOYED DEDUCTION; ALLOW FLAT REFUNDABLE CREDIT

DISTRIBUTION OF FEDERAL TAX CHANGE BY CASH INCOME PERCENTILE, 2009 AND 2017

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<tbody>
<tr>
<td></td>
<td>Percent of Tax Units²</td>
<td>Percent Change in After–Tax Income³</td>
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<tr>
<td>Lowest Quintile</td>
<td>With Tax Cut 19.5</td>
<td>0.4</td>
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<tr>
<td></td>
<td>With Tax Increase 38.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Second Quintile</td>
<td>With Tax Cut 55.8</td>
<td>10.8</td>
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<tr>
<td></td>
<td>With Tax Increase 63.9</td>
<td>18.7</td>
</tr>
<tr>
<td>Middle Quintile</td>
<td>With Tax Cut 62.0</td>
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</tr>
<tr>
<td>Fourth Quintile</td>
<td>With Tax Cut 48.1</td>
<td>12.7</td>
</tr>
<tr>
<td>Top Quintile</td>
<td>With Tax Cut 58.9</td>
<td>32.7</td>
</tr>
<tr>
<td>All</td>
<td>With Tax Cut 53.9</td>
<td>36.6</td>
</tr>
<tr>
<td></td>
<td>With Tax Increase 49.7</td>
<td>38.1</td>
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<tr>
<td></td>
<td>With Tax Increase 46.8</td>
<td>39.9</td>
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<tr>
<td></td>
<td>With Tax Increase 43.9</td>
<td>41.1</td>
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Addendum

Top 10 Percent    58.9 | 32.7 | -0.1 | 166 | 36.8 | 55.3 | -0.4 | 1,241 |
Top 5 Percent      53.9 | 36.6 | -0.1 | 346 | 32.8 | 58.8 | -0.3 | 1,545 |
Top 1 Percent      49.7 | 38.1 | -0.1 | 454 | 27.1 | 61.8 | -0.2 | 1,811 |
Top 0.5 Percent    46.8 | 39.9 | 0.0 | 552 | 25.9 | 62.2 | -0.1 | 1,882 |
Top 0.1 Percent    43.9 | 41.1 | 0.0 | 587 | 24.1 | 62.4 | 0.0 | 1,877 |


Percentile breaks are at $15,758; 30,993; 52,361; 93,024; 137,004; 192,737; 459,038; 712,376; 2,032,183 of cash income in 2009. For 2017, the breaks occur at $21,998; 40,237; 68,797; 123,895; 184,262; 257,882; 346,423; 970,802; 2,769,352.

(1) Calendar year. Baseline is current law. Proposal caps the exclusion for employer–provided health insurance and the self–employed health insurance deduction at the CPI inflation–adjusted mean value for 2007 and allows a flat refundable credit of $300 (about $400 in 2017) for each covered adult and $150 (about $200 in 2017) for each covered dependent. Credit values are presented in 2009 dollars and grow at the rate of growth of health insurance premiums.

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(3) For the income levels at each quintile and the top income percentiles used in this table, see http://www.taxpolicycenter.org/TaxModel/percentiles.cfm.

(4) Includes both filing and non–filing units but excludes those that are dependents of other tax units.

(5) After–tax income is cash income plus employer–paid insurance premiums less: individual income tax net of refundable credits; corporate income tax; payroll taxes; and estate tax.

(6) Average federal tax (includes individual and corporate income tax, payroll taxes for Social Security and Medicare, and the estate tax) as a percentage of average cash income.
TABLE 4
CAP EMPLOYER EXCLUSION, SELF-EMPLOYED DEDUCTION; ALLOW PROGRESSIVE REFUNDABLE CREDIT DISTRIBUTION OF FEDERAL TAX CHANGE BY CASH INCOME PERCENTILE, 2009 AND 2017

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<tr>
<td></td>
<td>Percent of Tax Units</td>
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<td></td>
<td>With Tax Cut</td>
<td>With Tax Increase</td>
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<td>Lowest Quintile</td>
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<tr>
<td>Fourth Quintile</td>
<td>22.9</td>
<td>35.4</td>
</tr>
<tr>
<td>Top Quintile</td>
<td>1.3</td>
<td>55.7</td>
</tr>
<tr>
<td>All</td>
<td>23.1</td>
<td>22.8</td>
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Addendum

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<th>Projected Effects in 2009</th>
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<td>Percent of Tax Units</td>
<td>Percent Change in After-Tax Income</td>
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<td></td>
<td>With Tax Cut</td>
<td>With Tax Increase</td>
</tr>
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<td>Top 10 Percent</td>
<td>0.8</td>
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<td>Top 5 Percent</td>
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<td>Top 0.5 Percent</td>
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<tr>
<td>Top 0.1 Percent</td>
<td>0.4</td>
<td>61.2</td>
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(1) Calendar year. Baseline is current law. Proposal caps the exclusion for employer–provided health insurance and the self–employed health insurance deduction at the CPI inflation–adjusted mean value for 2007 and allows a progressive refundable credit of $1,200 (about $1,600 in 2017) for each covered adult and $600 (about $800 in 2017) for each covered dependent. The credit phases out at a 10 percent rate for each dollar of adjusted gross income in excess of $30,000 for joint tax units and $15,000 for single, head-of-household, and separate tax units. Credit values are presented in 2009 dollars and grow at the rate of growth of health insurance premiums. Phaseout thresholds are presented in 2009 dollars and grow at the overall rate of inflation.

(2) Tax units with negative cash income are excluded from the lowest income class but are included in the totals. For a description of cash income, see http://www.taxpolicycenter.org/TaxModel/income.cfm.

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(6) Average federal tax (includes individual and corporate income tax, payroll taxes for Social Security and Medicare, and the estate tax) as a percentage of average cash income.
have health insurance, it would be a very efficient way to expand coverage while minimizing interference with employer–sponsored insurance. It would also include the same strong incentives to seek inexpensive insurance as in option 3.

Finally, it is worth noting that this credit could be designed to mitigate the tax increases in 2017. If the tax cuts enacted since 2001 are allowed to expire, which would make the ESI exclusion more valuable, the tax credits for health insurance could be set at higher levels on a revenue–neutral basis. In 2017, the progressive credits could be raised to $2,200 for adults and $1,100 for children on a revenue–neutral basis (compared with the projected credit levels of $1,900 and $950 if they grow at the rate of health insurance premiums overall).

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. Alternative plans that maintain the basic principle of improving the tax treatment of employer–sponsored health insurance but do so in a manner that attends to both the greater efficiency of tax credits and the market failures in the individual market could increase insurance coverage and help stem the rapid rise in American expenditures on health care.

This paper illustrates several promising options. Future work will examine the effect of such reforms on insurance coverage both through employers and in the nongroup market and their effect on vulnerable populations.

Acknowledgments

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.

REFERENCES


APPENDIX: 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). 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.

For additional details on the TRIM database, see Burman, Uccello, Wheaton, and Kobes (2003).