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THE TAX CODE AND HEALTH INSURANCE COVERAGE

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, OCTOBER 18, 2007

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THE TAX CODE AND HEALTH INSURANCE COVERAGE

THURSDAY, OCTOBER 18, 2007

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 10:02 a.m. in room 210, Cannon House Office Building, Hon. John Spratt [chairman of the committee] presiding.

Present: Representatives Spratt, Cooper, Schwartz, Becerra, Doggett, Berry, Boyd, McGovern, Hooley, Baird, Moore of Kansas, Moore of Wisconsin, Ryan, Bonner, Hensarling, Lungren, Conaway and Smith.

Chairman SPRATT. Good morning again and welcome to the Budget Committee's hearing on The Tax Code and Health Insurance Coverage. We have two excellent and provocative witnesses to testify before us today, Leonard Burman of the Urban Institute and Grace-Marie Turner of the Galen Institute.

Let me say from the outset that this hearing has been requested by—suggested by, requested and sought by the ranking member, Mr. Ryan. I agreed to hold the hearing at his bequest but also because this is an extremely important issue for the country and not just for the budget and Federal government, but for the entire country.

Our Tax Code plays a pivotal role in making health coverage accessible to millions of Americans. The tax treatment of health insurance has significant budget implications. For example, current law excludes employer contributions for health care from the employee's compensation for income and payroll tax purposes; and this tax expenditure has a substantial impact on the budget, up to $200 billion in foregone revenues.

Employers are a vital source of coverage, however, for 7 out of 10 American workers, especially important to workers with health problems who are unlikely to afford or find affordable coverage on the individual market. Employment-based coverage offers advantages over individually covered, no question about that, in terms of lower administrative costs, greater bargaining power with the insurance companies and medical providers and, to some extent, the ability to pool risk.

At the same time, the number of Americans without health insurance has risen steadily since the year 2000 and currently stands at 47 million Americans, including 9 to 10 million children. People who are young, people who have low incomes, people who work for small firms are more likely to be uninsured because insurance is

not available to them partly because of this and the employer-sponsored nature of our insurance system. The declining availability of employer-sponsored insurance has also been an important factor in the growth of the uninsured population.

As we look for ways to improve health insurance coverage in our Nation, today's hearing will give us an opportunity to examine the question from the standpoint of tax subsidies for health care. We will want to explore, for example, questions such as whether the Tax Code should favor employer-provided insurance over individually purchased insurance and whether tax breaks should be structured to target more assistance for low-income and moderate-income Americans. There may be changes to the tax treatment of health insurance that are worth exploring on the grounds of both efficiency and equity.

But before we start tinkering with a system that is working well for lots of people, we had better be sure we do not make more problems than we solve. Indeed, we should keep in mind research from various outside institutes such as the Urban Institute, which shows that tax subsidies may not necessarily be the most effective and efficient way of expanding coverage.

The SCHIP bill being considered today, on the other hand, has merits and aspects to it that warrant our appreciation as we look through the Tax Code and ask ourselves how we make evolutionary change so that we gradually step by step close the gap that now encompasses 47 million Americans who do not have health insurance.

As I said, Mr. Ryan has sought this hearing; and we are pleased to accommodate him because this is an important subject. So let me turn to him for his statement before we turn to our witnesses.

Mr. RYAN. Thank you, Mr. Chairman.

First I want to thank you for honoring this request, number one; and, number two, you have been a very fair chairman on this committee and I thank you for that.

I just got an e-mail from the floor which shows we are going to have votes between 10:20 and 10:30 and then another vote at 12:30, so we will have a nice gap in between there. But it is a 15-minute vote in about—so we ought to get to our testimony and come back for questions. Is that your intention?

Chairman SPRATT. I hope so. I was going to invite both witnesses, since we only have a panel of two this morning, to take their time in plowing their way through their testimonies.

Mr. RYAN. So we ought to have another half hour?

Chairman SPRATT. I think so.

Mr. RYAN. First, I don't think this hearing could have been better timed. Later today or in a couple of hours we are going to have another vote on the proposed SCHIP expansion that has been so vigorously debated over the past few months.

To be clear, those of us who will vote to sustain the President's veto won't be doing so because we don't like children. It won't be simply because the bill is too expensive, and it won't be because we are somehow trying to punish people who are already in the program. We will vote this way because we have a fundamentally different vision of how best to reform health care for the entire country. Our vision for reform is based on personal ownership, indi-

vidual control of health coverage for everyone. We also believe the reforms we make today need to be sustainable for the next generation.

Unfortunately, the SCHIP vote we are about to have today will take us in exactly the opposite direction. It is an incremental step towards greater dependency on government and will further expand Federal health care entitlement spending that every Member of Congress knows today is unsustainable.

If you could bring up chart one, please. As you can see from this chart, the SCHIP bill spends $35 billion over 5 years to remove 3.8 million people from the uninsured population, leaving 43 million still uninsured. In order to cover the rest of the uninsured population under this plan in this method, the Federal government would have to spend an additional $400 billion over the same 5-year period. This adds at least $8 trillion to the unfunded liability to the Federal government entitlement programs over the next 75 years. $8 trillion ought to be a familiar number. That is the number that people criticize Part D as adding. This adds that and then some.

In short, the SCHIP bill, as currently designed, is going to lure and trap a whole lot of people into a promise that the Federal government, according to nearly every budget expert out there, simply cannot keep in the long run.

We believe there is a better way. There is an alternative path that can fulfill the mission of health security without smothering the economy in expanding, unsustainable levels of dependency.

Here are the fundamental components of the approach we envision. I will say it quickly so we can get to our witnesses.

Reform needs to be comprehensive. To get anywhere in the industry, we have to start looking at the whole picture—health care, Medicare and the Tax Code—which is what we are doing today.

It has got to provide security. Obviously, we want to ensure that everyone has access to coverage; and that includes low-income families, middle-income families, children and people with medical conditions who get branded as uninsurable.

Third, it must enhance our economic competitiveness in this era of globalization. Health care reform has to ease, not add to the unsustainable upward pressure of medical costs; and it must do so without rationing services.

Fourth—and this is the point of today's hearing—the critical role of ownership is essential. The principle of ownership has long been a central component of America's prosperity, and it should apply to health care as it does in other areas. After all, we wouldn't let someone else choose our cars, our refrigerators or what we are going to have for dinner tonight. And yet with something as vital and personal as health care coverage that is exactly what many Americans do. They effectively let employers or the government decide what kind of health coverage they should have.

The problem is that our Tax Code creates an immense bias in favor of third-party ownership of health care. CBO estimates that this bias to personal income tax exclusion for employer-provided health insurance consumes around $3.5 trillion over 10 years. I don't think there is any argument to be made that this is a wise or remotely equitable way to distribute this money. Letting individ-

uals own their own health care coverage would put them back in control of their health care. It would lead to vastly more choices of the kinds of coverage available, and it would relieve the insecurity that comes from having your health insurance tied to your job. Also, if done properly, it could mean that no matter what your income level you would not have to rely on the government dole and all the stigmas that come along with that to get health care coverage.

We are not here to endorse any particular health tax benefit today. We are here to discuss how best to adjust the Tax Code so that all individuals can have access to health insurance that is affordable, that they can own and control for themselves.

I thank you for holding this hearing, Mr. Chairman; and hopefully this is the beginning of a discussion that is two-sided between two different visions of health care. Thank you.

Chairman SPRATT. Thank you, Mr. Ryan.

Now let us turn to our two witnesses; and let me say further what I said earlier, namely, that we have your pre-filed testimony. By unanimous consent, we will make it part of the record. But we invite you to plow through it at length to cover your analysis of the choices before us, because I think both of them are provocative pieces of work and a good analysis of the issues that are confronting us. So thank you for coming. Thank you for your testimony.

Let me ask unanimous consent also that our members be allowed to submit an opening statement for the record at this point in the record. So ordered.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF HON. ADRIAN SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Good Morning. I would like to thank Chairman Spratt for holding today's hearing on this issue of concern to Americans.

Our goal in this committee today is to address access and affordability of health care while looking for solutions that promote both fiscal and individual responsibility. Throughout the nation people are concerned about having access to health care; in my home state of Nebraska 11.1 percent of people go without health insurance.

Today this Congress is grappling with the issue of providing health insurance to needy children. We must not lose sight, however, of the need for public policy that will reduce the number of Americans who are uninsured while continuing to foster a system that provides consumers with choice and competition. Choice and competition in health care promotes efficiency and innovation that works to keep the costs of health care under control.

I look forward to hearing the testimony of the witnesses today.

Mr. Chairman, I thank you for your leadership in holding this hearing.

Chairman SPRATT. Ms. Turner, why don't we begin with you, if that is okay.

STATEMENT OF GRACE–MARIE TURNER, PRESIDENT, GALEN INSTITUTE

Ms. TURNER. Thank you, Chairman Spratt. Thank you, Ranking Member Ryan and members of the committee.

Can you hear okay? Is the microphone on? No, it doesn't seem to be. A little closer? There we go.

Thank you, Mr. Chairman. Thank you, Mr. Ryan and members of the committee. I really appreciate your holding this hearing

today to address the Tax Code and health insurance, and I particularly appreciate the opportunity to testify.

I founded the Galen Institute 12 years ago because I felt it was really important to address this fundamental issue about what I believe is a driving force in the way our health sector is organized. While the favored tax treatment of employment-based health insurance has provided a stable source of coverage for hundreds of millions of Americans over the last half century or more, it is also clear that it is leading to many of the problems that our health sector is facing today and I believe that really makes this issue well worth addressing.

There are a number of provisions in the Internal Revenue Code that address health care and that I have described in my testimony. Economist John Shields, as you mentioned, Mr. Chairman, estimates that the favorable tax treatment of health insurance was worth, in 2004, $189 billion a year in savings to individuals and families. If you think about it, that makes it the third-largest health care program in the Federal government after Medicare and Medicaid, the way that we support employment-based health insurance. This is a sizeable investment by any measure, and it seems appropriate to ask if we are getting our money's worth.

The biggest of these tax expenditures, as John Shields describes them, is the one that I would like to address today and that is the employee exclusion for job-based health insurance which the chairman first mentioned.

Section 106 of the Internal Revenue Code gives employees a generous yet invisible tax preference for health insurance that they receive through the workplace. I will argue that employers should continue to be allowed to deduct the cost of health insurance as a legitimate business expense but that employees should not continue to receive an exemption for an unlimited amount of health insurance that they receive through the workplace. Further, I will argue that there are better ways to use the Tax Code to support health insurance to better align with our 21st century economy.

The Federal tax policy that began in World War II in response to wage and price controls has grown over 65 years to really shape our private health sector. In my written testimony, I detailed the history and impact of this powerful law and explained how it works and how it distorts the health care marketplace.

Briefly, if someone gets their health insurance at work, that part of their compensation package that they receive in the form of health coverage is not taxed. While that seems sort of like a small and invisible thing early on, over time it has grown to become the single-largest tax break allowed by Federal law. Today, that specific provision is worth $160 billion. By comparison, the popular mortgage interest deduction is worth about $88 billion to American taxpayers.

It is unlikely we would have created a subsidy system like this deliberately. Our progressive income tax system works against workers who most need help in purchasing health insurance. An employee earning $10,000 to $20,000 a year gets about $292 a year in value from this tax break. Yet somebody that is making $100,000 a year gets $2,780 in value a year through—in tax forgiveness for the value of their health insurance policy, nearly 10

times more. So, clearly, the regressivity is not something that we would have designed into Federal law.

In addition, with four in ten workers changing jobs every year, tying health insurance to the workplace is leaving millions of Americans behind. People lose their health insurance when they lose or change their jobs, and many work for employers who simply can't afford to offer health insurance coverage. These workers receive little or no tax benefit from this regressive, rich and yet hidden tax preference—most people don't even know they get it—for employment-based health insurance; and it is no surprise that these are the ones that are most likely to be uninsured.

But the revision causes problems even for those who have job-based health insurance. Because the full cost of their health insurance is also invisible to them, they demand richer and richer benefits without realizing that this may be shrinking their take-home pay. If employees saw health insurance as the part of their compensation package that it is, they likely would make different decisions about how they are going to organize this part of their budget.

Many Members of Congress on both sides of the aisle have offered proposals that would move public policy forward on rewriting the tax treatment of health insurance. Congressman Ryan, for example, is working on a proposal that would provide a universal tax credit for health insurance. President Bush has offered a proposal that would replace the current tax exclusion with a generous universal tax deduction with a credit for payroll taxes. Others have offered proposals for income-adjusted refundable tax credits, and some are considering a combination of the tax deduction and a credit for those at the lower end of the income scale.

Senator Hillary Clinton in her recent health proposal recommends capping the amount of income that higher-income individuals can exclude from taxes through health insurance.

The most important thing I think here is that we are beginning to have a conversation over this important issue. Whatever we do to address the problems in our health sector, though, as the chairman indicated, we know from experience that trying to make too many changes too fast will create a backlash of opposition. Millions of people rely on the current system for their health insurance. Making any rapid change needs to be done very carefully and with clear attention to any transitions and to making sure that we are helping people, not hurting them with any changes in policy.

Even though the tax exclusion for job-based health insurance contributes to many distortions in our health sector, the changes will need to be gradual and give employees and employers and individuals options and time to adjust. But with so many people, 47 million, left out of the current system, it is crucial that we begin to build a new system that does not tie health insurance so tightly to the workplace for everyone. That is just not working.

The National Restaurant Association said, how are we going to do this when we have employees that may only work for us for 3 days? So, clearly, individually owned, affordable health insurance is really crucial. Policy changes could allow us to move forward to a system that allows health insurance to be portable from job to job, that allows people to make their own decisions about the

health insurance that suits them and their families and that makes the subsidies for health insurance fairer and more equitable.

Consumers can make decisions for themselves about many, many purchases they make in the economy. Because of the paternalism of our health care system over the last 60 years, they really haven't been asked to make those questions. But new resources are becoming available, really facilitated by the Internet and the information economy.

They are beginning to learn about which physicians and which hospitals are best at which procedures and treatments, what are the costs of certain treatments. Some new consumer-directed kinds of account-based health plans allow people to make decisions, particularly about routine health care expenditures and how they can best allocate those resources.

Policies that were suited to this paternalistic industrialized world are no longer suited to a much more mobile economy. An in-depth survey asking what women want is certainly just as relevant today as in the year 2000 when it was first conducted. The survey found that a large majority of women, 72 percent, would like their health insurance to be independent of employment. This wasn't even one of the issues that those taking the survey had intended to ask about, but it came up so often in the early focus group testing before the poll that they felt they had to include it.

I believe that we are at a turning point in our health sector and that the outcome of the 2008 Presidential elections will largely determine what path we will take. The question is this: Will we slide toward greater and greater government control over our health sector or will we move toward a properly functioning private market?

We certainly need a lot of work in the private market for this to work to provide health insurance that gives people more choice and more control over their coverage. In poll after poll, people clearly stated a preference for private health insurance over government control of the health sector.

If people are going to have the option for viable private insurance, we need to realign the financial incentives that support insurance. Addressing the tax treatment of health insurance is the first crucial step toward that goal. This would allow greater portability of coverage, as Mr. Ryan mentioned, and would minimize the risk that people would lose their health insurance when they lose or change their jobs.

Do we need to—1 more minute, and then I am done.

Chairman SPRATT. We have 4 minutes. So why don't you take the last 3 minutes.

Ms. TURNER. I am almost done.

This would enable greater visibility over the cost of health insurance and health care, providing an incentive for consumers to demand coverage that offers the best care.

We don't have a properly functioning market in the health sector because consumers are not engaged in really bargaining for better value in their health insurance. Which doesn't mean they are going to be negotiating over whether they get an MRI or a CAT scan if they are wheeled into an emergency room after an accident, but they can decide what kind of insurance coverage they want if that were to happen.

It would also facilitate competition among insurers who want to enroll millions of these uninsured people and give the insurance companies an incentive to compete on price and value.

Consumers would have many more choices. And with health care representing one-sixth of our economy, it will certainly take a long time to make any changes. But the first step is for the government to encourage people to buy health insurance that would be able to create some kind of new allowances.

Maybe it is targeted at the uninsured. Maybe it is a reform of the system. That is a hearing for another day. It could be direct subsidies to individuals, refundable credits, tax deductions or a combination. But incentives work and markets work.

What we need to do is engage the power of consumers to transform our health sector to become more efficient, more responsive to consumer needs, more affordable. Making changes to tax policy will offer more options and I believe would be a giant leap to transform the health sector around a 21st century market economy that allows health insurance to be portable, that forces the markets to realign around consumers, to provide them options, that gives individuals ownership of that health insurance so that if they don't like the insurance they can change to another policy or they have contract rights to make sure that they can enforce that contract if the insurer is not abiding by the terms of the contract.

Thank you for the opportunity, Mr. Chairman, to testify today; and I look forward to the opportunity to work with you and members of the committee and the Congress to continue to educate the public about this important issue. Thank you.

Chairman SPRATT. Thank you very much for your testimony.

[The prepared statement of Grace-Marie Turner follows:]

PREPARED STATEMENT OF GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE

Chairman Spratt, Ranking Member Ryan, and members of the committee, I sincerely thank you for calling this hearing today to address the crucial issue of the tax code and health insurance, and I particularly appreciate the opportunity to testify before you today.

I founded the Galen Institute 12 years ago primarily because I wanted to highlight this issue and promote an informed debate over what I believe is a central driving policy in our health sector. While the favored tax treatment of health insurance has provided a stable source of health coverage for hundreds of millions of American workers over the last half century or more, it also is clear that it is leading to many of the problems that our health sector faces today. This issue is well worth addressing today.

There are a number of provisions in the Internal Revenue Code that address health care. For example:

- That part of an employee's compensation package that he or she receives at work in the form of employer-sponsored health insurance is excluded from income and payroll taxes.
- Employers can deduct as a business expense the amount they pay for health insurance for their workers.
- Workers whose employers offer Section 125 cafeteria plans, called flexible spending accounts, can put aside a portion of their income on a pre-tax basis to pay for allowed expenses, including their share of health insurance premiums, copayments, and other allowed medical expenses. Any amount that is unspent at the end of the year reverts back to the employer.
- A 2002 IRS ruling interprets existing law to give companies the opportunity to make deposits to Health Reimbursement Arrangement spending accounts that are tax-free to their employees.
- The self-employed can deduct the cost of health insurance from their income.
- Individuals can deduct medical expenses on itemized returns if their expenses exceed 7.5% of their adjusted gross income.

• Individuals or workers who have high-deductible health insurance policies can put money aside in Health Savings Accounts on a tax-free basis to pay for medical expenses today or in the future. The HSA deposit is tax free, the inside buildup or interest is tax free, the money stays tax free as long as it is spent on allowed health expenses, and the HSA money rolls over from year to year.

THE COST

Economist John Sheils estimates that the favorable tax treatment of these health expenses was worth $188.5 billion in federal tax savings to individuals and companies in 2004.[1] The amount of these tax benefits grows each year without a vote by Congress. Sheils estimates that when federal and state tax benefits are combined, the total in 2004 was $209.9 billion.

This is a sizeable investment by any measure, and it seems appropriate to ask if we are getting our money's worth.

The biggest "tax expenditure," as Sheils describes it, and the one that I would like to address today, is the employee tax exclusion for job-based health insurance. Section 106 of the Internal Revenue Code gives employees a generous—yet invisible—tax preference for the health insurance that they receive through the workplace. I will argue that employers should continue to be allowed to deduct the cost of health insurance as a legitimate business expense, but that employees should not continue to receive tax exemption for an unlimited amount of health insurance because of the distorting effects this exclusion creates throughout the health sector. Further, I will argue that there are better ways to use the tax code to support health insurance that are more appropriate to a 21st century economy.

THE TAX EXCLUSION: HISTORY AND IMPACT

It is worth noting that the tax exclusion for employment-based health insurance is the single largest tax break allowed by federal law, worth more than $160 billion.[2] (By comparison, the popular home mortgage interest deduction is worth $88 billion to American taxpayers.) The tax exclusion for health insurance provides a huge incentive for employees to receive their health coverage through the workplace. And because of our progressive income tax system, the benefits are heavily skewed toward higher-income workers. According to Sheils, the average employee earning $100,000 a year or more shields $2,780 a year from taxes by getting health insurance through the workplace. But an employee earning $10,000 to $19,999 gets only $292 in value from this tax provision, nearly a 10-fold difference.

It is not surprising that the majority of the uninsured are workers and their dependents in these lower-income categories. The deck is stacked against them: They are less likely to have jobs that provide health insurance, less likely to be able to afford their share of the premiums if their employers do offer insurance, and less likely to get much value from the tax exclusion since they are in lower tax brackets.

I don't believe we would ever intentionally have created a system that would have this result. Rather, it evolved from a simple decision decades ago.

THE HISTORY[3]

Early in the 20th century, the link between health insurance and the workplace began to be established in the United States. During and after World War II, however, employment-based health insurance became more widespread, and the link became stronger.

Factories were pushed to meet wartime production schedules. Competition for good workers was intense but was hampered by wartime wage controls. Employers found they could compete for scarce workers and boost compensation without running afoul of these controls by offering health insurance as a benefit in lieu of cash wages. In 1943, federal officials ruled that employers' contributions to group health insurance would not violate wage controls and would not count as taxable income for employees.

That ruling, later codified by Congress in 1954, in addition to rising tax rates on middle-class incomes and the rising demand for health insurance, all combined to create a strong incentive for health insurance to be obtained through employment-based groups.

The generous tax preference accorded to job-based health insurance is a historical accident that has increased automatically over the decades without legislative authorization or appropriations. It has percolated through the economy for more than 60 years to become the foundation for a system that provides strong financial incentives for more than 177 million Americans to get their health insurance through their employers.[4]

HOW THE TAX PREFERENCE WORKS

Employment-based health insurance is part of the compensation package many employers provide to their employees as a form of non-cash wage. Employers can take a tax deduction for the cost of this health coverage, as they do for most other forms of employee compensation. They write the check for the premiums, and some pay medical bills directly if they self-insure. Businesses deduct these costs from their earnings since they are part of the total compensation package paid to workers and must be deducted to measure net profits correctly.

What makes health insurance different from cash wage or salary compensation, however, is that workers also do not pay taxes on that part of their compensation package they receive in the form of health benefits. That part of their pay is tax free.

Section 106 of the Internal Revenue Code provides that the value of health benefits is not counted as part of the taxable income of employees—i.e., it is excluded from their taxable income as long as the employer writes the check for the coverage. However, workers may receive this tax-favored benefit only if health coverage is provided through an employer. Because it is excluded from their taxable income, the value of the health coverage, the tax benefit, and the costs in forgone cash wages are largely invisible to workers.

HOW THIS DISTORTS THE HEALTH CARE MARKETPLACE

The employee tax exclusion for job-based health insurance distorts the health care marketplace in a number of ways:

- It undermines cost consciousness by hiding the true cost of insurance and medical care from employees.
- Because the full cost of health insurance is not visible to employees, it artificially supports increased demand for covered medical services and more costly insurance. As a result, inefficient health care delivery often is subsidized at the expense of more efficient care and coverage.
- Cash wages are suppressed as health insurance costs rise.
- Many employees with job-based coverage have little choice and control over their health insurance and their access to medical services.
- The tax benefits are skewed to favor higher-income individuals and those who demand the most expensive health coverage and medical treatments.
- Those with equal incomes are taxed unequally.
- Millions of Americans who are unemployed or whose employers do not offer health insurance are discriminated against because they receive much less assistance, if any at all, when they purchase health insurance.

With four in ten workers changing jobs in the U.S. every year,[5] this provision which so generously subsidizes health insurance through the workplace is leaving millions of Americans behind. They lose their health insurance when they lose or change jobs, and many may work for employers who can't afford to offer coverage. These workers receive little or no benefit from this regressive, rich, and hidden tax preference for employment-based health insurance. It is no surprise that they are most likely to be uninsured.

But the provision causes problems even for those who do have job-based coverage. A key element of the problem relates to visibility. Deductions are visible, but exclusions are invisible. When straight tax deductions are taken, as employers do in deducting the cost of health insurance, the full cost of the expenditure is visible because they must first make the payment before taking the deduction. Because employers write the checks for health coverage, they do complain about the high costs of health care.

On the other hand, employees who are demanding expensive health insurance seldom know the full cost of the policy—and the amount of compensation they are forgoing as a result—because its cost is excluded from their income. Few employees are aware that an average of $12,000 a year of their compensation package is going to fund their family health insurance policy.[6] Employees may be receiving smaller pay raises as a result of the rising cost of health insurance, but this is a less visible consequence. If employees saw health insurance as a more visible part of their pay package, they would likely make different choices than they do today about that spending.

So what should we do?

Many members of Congress from both sides of the aisle have offered proposals that would move public policy forward regarding the tax treatment of health insurance. Rep. Ryan, for example, is working on a proposal that would provide a universal tax credit for health insurance. President Bush has offered a proposal to replace the current tax exclusion with a generous universal tax deduction. Others

have offered proposals for income adjusted, refundable tax credits. And some are considering a combination of a tax deduction and credit. Senator Hillary Clinton in her recent health proposal recommends capping the amount of income that higher-income employees can exclude from taxes through health insurance.[7]

The most important thing here is that we are having a conversation about this important issue.

I facilitate a group called the Health Policy Consensus Group that is composed of the leading health policy experts from the market-oriented think tanks. We have long advocated addressing the tax treatment of health insurance, and many of our members support refundable tax credits for health insurance.[8]

President Bush's proposal earlier this year to allow a universal tax deduction brought a new idea to the table in allowing a generous deduction for health insurance combined with a credit against payroll taxes. Because all workers pay payroll taxes, this latter proposal would provide help to those at the lower end of the income scale who may not owe income taxes or are in a very low tax bracket.[9]

Whatever we do to address problems in our health sector, we know from experience that trying to make too many changes too fast will create a backlash of opposition. Even though the tax exclusion for job-based health insurance contributes to many of the distortions in our health sector, any changes will need do be gradual and give employees and employers options and time to adjust. But with so many people left out of the current system of tax subsidies for private insurance, it is crucial that we build a new system that does not tie health insurance so tightly to the workplace. Policy changes would allow us to move toward a system that allows health insurance to be portable from job-to-job, that allows people to make their own decisions about the health insurance that suits them and their families, and that makes the subsidies for health insurance fairer and more equitable.

THE COMING INFORMATION REVOLUTION IN HEALTH CARE

For decades, our health sector has been organized around a paternalistic system in which government agencies or corporate human resources departments have been in charge of making decisions for people about their health benefits. This means that the vast majority of people have little experience or even confidence in making their own decisions involving health care and health insurance, and they have had little information that allows them to seek out the best value in their health spending.

This is beginning to change: New resources are being offered to help consumers learn which physicians and hospitals are more highly rated for certain procedures. The Internet is facilitating a wider dissemination of information about everything from the cost of health procedures, availability of new medical treatments and medicines, and the options for individually-purchased health insurance. Health Savings Accounts and other consumer-centered health care financing arrangements are giving people new incentives to search for options and to seek value in their health spending.

Demands from consumers for greater involvement in their health care decisions is taking root in every developed industrialized country. Policies that were suited to a paternalistic, industrialized world are no longer suited to today's health care economy. An in-depth survey asking "what women want" is certainly just as relevant today as it was in 2000 when it was conducted. The survey found that "a large majority of women—72 percent—would like their health insurance to be independent of their employment. This was not even one of the issues the pollsters had intended to ask about, but it came up repeatedly in the focus groups that preceded the polling."[10]

TAX POLICY IS KEY

I believe we are at a turning point in our health sector, and the outcome of the 2008 presidential election will largely determine which path we take. The question is this: Will we slide toward greater and greater government control over our health sector or will we move toward a properly functioning private market for health insurance that gives people choice and control over their coverage?

In poll after poll, people clearly state a preference for private health insurance over government control of the health sector. If people are to have the option of viable private insurance, we need to realign the financial incentives that support that insurance. Addressing the tax treatment of health insurance is the first crucial step toward that goal.

This would allow greater portability of coverage and would minimize the risk that people would lose their health insurance when they lose their jobs. It would enable greater visibility over the cost of insurance and health care, providing an incentive

for consumers to demand coverage that offers the best value. It would facilitate competition among insurers to enroll millions of new people and would give them an incentive to compete on price and benefit structures. And this would mean consumers would have many more choices than they do today to find the coverage that best suits their needs and pocketbooks. In a world in which individuals have more control over their insurance, they would gain peace of mind by having coverage that they own and that can follow them as they move from job to job and even state to state.

There will need to be new safeguards for consumers in this transformed world of health insurance, but that is the topic for another hearing. Many other 20th century health policies would need to be modernized in this process. For example, states need to do a much better job of allowing individuals more choice by inviting rather than suppressing competition in their health insurance markets. States would need to rethink whether the 1,900 coverage mandates on their collective books are helping or hindering access to affordable coverage. And state monopolies over health insurance could be broken by allowing consumers to purchase health insurance across state lines.

In the process of this transformation, we do not want to make changes so fast that it disrupts the coverage that gives millions of people the security they want and need. If tax policy were relaxed to allow portability of the tax benefits associated with health insurance, some employers would opt to cash out the value of the health insurance they are providing to their workers so they can buy coverage through other sources. I believe that most companies would continue to offer or sponsor health coverage for their workers, just as they do today. But giving people more options in how they arrange the financing of their insurance would get our health care system moving toward 21st century coverage that is more portable, more flexible, and more affordable.

THE CRUCIAL ELEMENT IS CHOICE

With health care representing one-sixth of our economy, it will take a long time to make these changes. But a first step by government to encourage people to buy health insurance would to create new allowances, whether through direct subsidies to individuals, refundable tax credits, tax deductions, or a combination, targeted directly to individuals to assist them in purchasing the health coverage of their choice.

We do need to focus the debate between those who believe that the answer to the problems in the health sector lies in much more government involvement through expansion of public programs, and those who believe that the free market can and does have much more potential to get health insurance costs down and provide people with greater access to coverage and more choices.

In our economy, incentives work and competition works. What we need to do is engage the power of consumers to transform our health sector to become more efficient, more responsive to consumer needs, and more affordable.

We have seen that the tax treatment of health insurance is a powerful force in how the health sector is organized. Making changes to offer more options would be a giant leap to begin to transform our health sector in a way that provides millions of people currently left out of the system with new resources to get coverage; that provides millions of people who are worried they could lose their coverage at work with the security of knowing that they can own their policies; and that provides new incentives to put patients and doctors back in charge of medical decisions.

Thank you for the opportunity to testify today, and I look forward to the opportunity to work with you to advance a more informed conversation about this very important issue.

ENDNOTES

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[2] Office and Management and Budget, "Budget of the United States Government: Fiscal Year 2008," February 5, 2007, at *http://www.whitehouse.gov/omb/budget/fy2008/budget.html.*

[3] Description is drawn from "A Vision Statement for Consumer-Driven Health Care Reform" by the Health Policy Consensus Group. *http://www.org/vision.asp*

[4] U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement, Table HI01. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2006, All Races at *http://pubdb3.census.gov/macro/032007/health/h01—001.htm.*

[5] "Job openings and labor turnover: November 2006," Bureau of Labor Statistics, United States Department of Labor, January 10, 2007. *http://www.bls.gov/news.release/archives/jolts—01102007.pdf*

[6] The Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2007 Annual Survey," September 11, 2007, at *http://www.kff.org/insurance/7672/*.

[7] Hillary Clinton, "American Health Choices Plan," September 2007, at *http://www.hillaryclinton.com/feature/healthcareplan/*.

[8] "Empowering Health Care Consumers Through Tax Reform," Grace-Marie Arnett, Ed., University of Michigan Press, Ann Arbor, September 1999, at *http://www.galen.org/book.asp*.

[9] White House Fact Sheet, "Affordable, Accessible, And Flexible Health Coverage," January 2007, at *http://www.whitehouse.gov/stateoftheunion/2007/initiatives/healthcare.html*.

[10] "In America. Focus on women," Bob Herbert, The New York Times, September 28, 2000.

Chairman SPRATT. Now, if both of you will forebear, we will go vote and come back as quickly as we can. Thank you very much, and we will be back.

The committee will stand in recess subject to the call of the Chair. [Recess.]

Chairman SPRATT. I call the committee back to order; and, Dr. Burman, the floor is yours.

As I said before, you can summarize your testimony as you see fit. But you have got an excellent analytical narrative to go along with your testimony, And we would invite you to take some time to lay out the analysis you have put into your written testimony.

STATEMENT OF LEONARD E. BURMAN, DIRECTOR, TAX POLICY CENTER, SENIOR FELLOW, THE URBAN INSTITUTE

Dr. BURMAN. Thank you very much, Mr. Chairman.

It reminds me a little bit of the old saying, you should be careful what you wish for. Last night, when I was trying to cut my testimony down to a very short bite-sized bit, I said I wish I had more time. Now I am thinking what of the 20 pages of testimony do I want to add in. There are a few points I do want to add in. I hope you will forgive me if at times, it is not entirely polished.

Chairman Spratt, Ranking Member Ryan and members of the committee, thank you for inviting me to discuss the role of the tax system and expanding access to health insurance.

The hearing is extremely timely. About 47 million Americans under age 65, including 9 million children, lack health insurance. As you are acutely aware, Congress and the President are in the midst of a heated disagreement about how best to cover some of those kids; and, of course, the challenges facing adults who cannot attain health insurance are no less daunting.

The current system is far from perfect. The tax subsidy for employer-sponsored insurance—if we could put up the slide with figure one on it. I was told that was possible.

The current subsidy, basically, health insurance you get through your employer is excluded from your income. It is worth the most to you if you are in a high marginal tax bracket and worth little or nothing if you are in a low bracket. Thirty percent of Americans don't owe income taxes and are in the zero income tax bracket. So getting a reduction in their taxable income doesn't really help them at all.

This chart which we did when we analyzed the President's proposal—so it is in 2009 levels—shows that current lost subsidy rates from employer-sponsored insurance—that is the blue line—and it goes from basically zero up to about 30 percent for families with incomes between $100,000 and $200,000. Very high income levels will go up to the 35 percent top bracket.

There is an additional benefit from saving Social Security taxes as well. But that is kind of a mixed blessing, especially if you are a low-income person and you pay less in for Social Security. You are also going to get less benefits when you retire. So that is not included.

The red dash line shows the premium burden for health insurance, which is the after-tax cost of health insurance as a share of income; and what you can see is that for low-income people it is enormous. As Ms. Turner pointed out in her testimony, the average cost of employer-sponsored insurance is about $12,000 for family coverage. Somebody earning twice the poverty level, about $40,000 for a family of four, would be paying more than a quarter of their income for health insurance; and they get virtually no help from the tax system. So there certainly is room for improvement.

I want to point out there are some advantages to tying health insurance to employment. For one thing, it is a natural way to pool health insurance risks. People choose where they work for reasons that are unrelated to their health status and that solves or at least mitigates one of the big problems in the health insurance market, especially for larger firms.

It is also true that for larger firms administrative and marketing costs are much lower. The load factors that the overhead costs for insurance purchased in the individual nongroup market are something like 35 percent of premiums. One-third of the premium dollars goes to pay the costs of marketing and underwriting, determining people's health status. Those costs can largely be saved in the employer setting.

But employer-sponsored insurance is an imperfect pooling mechanism. In small firms, if somebody gets sick, premiums can go through the roof; and that is a big source of uncertainty for employers. I wouldn't want to be in the situation of a small employer who had a sick employee and had to tell her employees either that they are going to pay a lot more for their health insurance or that they were going to have to drop coverage.

And the subsidies for employer-sponsored insurance amplify the advantages that large firms have over small firms. They have the really low costs of providing insurance where small firms have to pay much more for health insurance, and I think that is a problem.

Also, there is this phenomenon called "job lock". The people who become ill stay working for their firms because they don't want to lose their health insurance, and that is clearly inefficient.

But, for all of its imperfections, employer-sponsored insurance covers almost 70 percent of American workers.

If we could see table one on the overhead. It shows some of the statistics about—well it may be better to look in the testimony.

It covers almost 70 percent of American workers. It is 100 million workers and their families that are covered by employer-based insurance. Even in small firms, more than 51 percent of those workers get health insurance through employers. Full-time, full-year workers are much more likely to get insurance than part-time, part-year workers. But even part timers more often than not get health insurance.

Similarly, it is clearly the fact that because the subsidy is worth a lot less for low-income people than for high income people they

are less likely to get health insurance through their employer or through anybody else. But still 45 percent of workers with incomes below $20,000 get health insurance at work. Eighty-six percent of those with incomes over $40,000 get it.

Well, the takeaway from that is that I think there are serious risks to just jettisoning the employer-based system, even if you think that in a perfect world there might be a better alternative. I am put to mind of something Winston Churchill said about democracy, which is that it is the worst system except for all those others that have been tried from time to time.

The nongroup market, which is basically the alternative to providing insurance through employers, doesn't work very well; and some people would argue that the reason is because the tax subsidies keep people out of the nongroup market and because there are a lot of regulations in that market. But there are also some inherent market flaws that would have to be fixed before it would be safe to throw those 100 million workers or even a sizeable fraction of them into the nongroup market. And I want to talk a little bit about the economics because I think some people—I don't think Ms. Turner—but I think some people have oversimplified the challenges we face here.

The basic idea behind putting people into an unregulated nongroup market is that, under some circumstances, markets are economically efficient, meaning you can't do better than the market at allocating resources, allocating goods and services. They drive down prices and get people what they want. But the under certain circumstances part is really important. For markets to work well, there are a number of assumptions that have to be met, and those assumptions and those circumstances are—virtually every one of them fails in the market for health insurance.

Yesterday, it was announced that one of my favorite professors in grad school, Leo Hurwicz, won a Nobel prize in economics for his research on what you do when certain kinds of markets fail. You develop new kinds of mechanisms for getting markets to efficiently establish prices when they fail. Well, he didn't come up with any solution for the nongroup health insurance market, at least not that I know of.

The problem with the nongroup health insurance market—well, there are a number of them. The most important one in terms of the risks it creates for low-income people, especially for people with health problems, is something called adverse selection.

By comparison, if you think about a market that is working, say—when I wrote my testimony, I was thinking about computers. Because I was writing it on a very inexpensive laptop computer that I had delivered to my house, and I thought how wonderful that you can take sand and a whole bunch of people working all over the world and I can get exactly what I wanted for a low price.

When I buy a computer, the seller knows how much it will cost to supply it, and he offers it for cost plus a modest profit, and I buy it if it is worth at least that much to me. Competitive forces keep the computer's cost low, and I have lots of choices.

Well, the health market is just like the computer market, except the seller doesn't actually know how much it will cost to supply the good. The individual, if they really value it, won't be able to buy

it for a reasonable price. And even if you can get it for a reasonable price, say because you are healthy in the short run, over the long term the price can get very high if you really, really need insurance. That is a serious problem.

The health insurance insurers have imperfect information about the health status of their customers. The people who choose to buy insurance tend to be those who value it the most, those that expect to have high health care costs. So an insurer who offered to all comers would have to charge very high premiums to account for the fact that they would get a sicker-than-average pool, this adverse selection problem.

The higher premiums actually discourage more healthy people from buying insurance. A lot of people would value it even if they are not sick. But when the premiums go up, it becomes a worse and worse deal for those who are healthy. That pushes up premiums even further. There is this wonderful term called a "death spiral" that describes this process. And under certain circumstances the market for insurance can fall apart altogether.

Now, it doesn't work out that way in the market for health insurance because the insurers are not passive. What they do is they try to get the healthiest people they can to buy their product. So there is selection on the other side. They can profit if they attract a healthier-than-average workforce and if they can deter those who have, say, preexisting conditions from buying insurance.

But the consequence is that the nongroup health insurance market ironically only works for healthy people. If you are sick and you need insurance and you don't get it at work or through a public program, you are out of luck.

Now, even if you buy affordable insurance when you are healthy, if you develop a chronic illness such as diabetes, your premiums tend to go up over time because you get put into a pool with other people who buy insurance at the same time. And basically there is underwriting at the start so the people in the pool are healthier than average to begin with. Eventually, some people get sick, premiums go up, the healthy people drop out to get a cheaper product somewhere else, and the premiums go up and up for the people who have no other alternative. That is a really serious problem.

Now, I don't think those are insuperable problems, and I have recommendations about what you can do in the nongroup market. But it would be a serious risk to just throw people into the nongroup market without dealing with its inherent flaws.

You could say, well, if you had a tax credit for nongroup health insurance, maybe you could cover some of the 47 million who are uninsured. But the problem is that if all you did was offer a tax credit for nongroup health insurance, a lot of employers would stop offering insurance for a couple of reasons. One is that one powerful incentive for employers to offer insurance now, especially small employers, is that it is the only way for the employer himself or herself to get the tax exclusion. You have to offer it through work. If you had a tax credit for nongroup insurance and you are healthy especially, you could get the tax benefits yourself without offering insurance to your employees.

The other thing is, even if the employer wanted to offer insurance, they would find that the healthy employees would say, well,

I can get a tax credit in a nongroup market. I don't have to pay much for the premium. Don't offer me health insurance. Give me higher wages.

Virtually every model that looks at what would happen if you offered a nongroup tax credit finds that a lot of employers would stop offering insurance. A lot of people would pick up insurance in the nongroup market, but not all of them. The ones who are sick won't be able to find insurance they can afford. Low-income people typically can't afford insurance with the kinds of credits that have been talked about and proposals that have been made.

So the negative message I guess is, without reforms to nongroup markets and substantial subsidies for low-income households, many people who are currently insured are likely to lose their coverage if tax credits were offered for nongroup insurance. Those who lose coverage would tend to be the most vulnerable, those with low incomes and serious health problems, while those who gain coverage would tend to be those who are healthy. In my view, that is a poor trade.

There are other market failures in the health market; and I want to acknowledge right now that, you know, a lot of times when you hear the debate about this, it is like that on one side all they care about is adverse selection and on the other side all they care about is moral hazard. I think both problems are important.

Another problem with the insurance market is that if you have unlimited insurance you really don't care about how much you pay for health care. As Ms. Turner pointed out, that with a big subsidy for health insurance you might not be that interested in shopping for a policy that could constrain costs effectively. That is a serious problem, too. If it pushes up—that actually pushes up the price of health care. If people don't care about what they are paying for the health care because insurance is covering the cost, it pushes up the price. That actually raises premiums, which makes it harder for people to afford to pay for health insurance in the first place. So I think we have to deal with the problems of moral hazard as well.

The President actually had a proposal which—one element of the proposal would have been a good way to deal with this problem of moral hazard. One of the problems with the current subsidy is that you get a larger subsidy the more you pay for health insurance. If you have a $20,000 health insurance policy, your income is reduced by $20,000. You only have to pay a fraction of that cost. The President's proposal said that you get a fixed deduction for having insurance, but if you get a more generous policy, you wouldn't get a bigger deduction; if you got a less generous policy, you wouldn't lose part of your deduction.

Now, having a deduction for health insurance I think shares all the problems of the current system, and he also would allow this in the nongroup market, which would raise some other concerns. It retains the upside down subsidy. But if you turn that deduction into a tax credit and you dealt with the problems of adverse selection in a nongroup market, you conceivably could actually expand coverage and put some downward pressure on prices.

So I have a few recommendations in my written testimony. I will try to go through them very quickly.

One is, I think that replacing the ESI exclusion with a progressive, refundable tax credit would be a big improvement over current law. It would be a way to turn that upside down subsidy right. So a refundable tax credit would benefit people who don't have income tax liability. You could target the subsidy to the people who most need help and a subsidy that is available in the employer group would retain the advantages of ESI as a pool—employer-sponsored insurance as a pooling mechanism. It would encourage more healthy people to buy insurance as they tend to have lower incomes, but they would get a larger subsidy under this alternative, and that would tend to lower average premiums.

If a credit is offered for nongroup insurance, the nongroup market must be reformed. One approach would be to set up a pool of insurers that promises to take all comers in exchange for being able to sell insurance that qualifies for the credit. Actually, most of you get insurance through such a pool. The Federal Employees Health Benefits Program contracts with a number of individual insurers who have an incentive to try to keep their premiums relatively low, and you choose the option you like the most, and you can get it irregardless of your health status. There is still the potential for adverse selection if the tax credit is small.

One of the things that makes the FEHBP program work so well is that the government pays 70 percent of the cost. But if you had a credit that was large enough so low-income people could afford to buy in, you could get a lot of healthy people to buy insurance, and that would tend to keep the overall premiums low.

Another improvement would be to require insurers who wish to sell nongroup insurance that qualifies for the tax credit to offer insurance that is fully renewable and portable. Individuals who maintain continuous coverage either through an employer-sponsored insurance or through qualifying nongroup insurance would be guaranteed that they could purchase insurance from any participating insurer at the lowest rates available.

This would solve the problem that when you get sick your premiums start to go up. It would give you an incentive to buy insurance when you are healthy, because it would guarantee that you would get a low premium when you become ill and it would mesh well with the employer-based system which I think for a lot of workers would still be the best option.

There are a number of issues that would need to be addressed if the tax credit is to help poor families gain insurance.

First, the credit would need to be much larger than has so far been proposed. As I noted, the premium for employer-sponsored insurance in 2007 for families is almost $12,000 or 25 percent of the pretax income for a family of four. Experience with the health care tax credit that was enacted in, I think, 2003 to help workers who lost their jobs is that only 11 percent of people took out that credit, and that was I think a 65 percent credit. That experience suggests that for low-income people, for vulnerable people you might need to pay a much larger portion of the premium costs.

I should note that if money is an issue, and particularly if it is difficult to cut back on the current employer exclusion for employer-sponsored insurance, the most cost-effective approach might be to expand existing public programs. I understand there are po-

litical issues involved there. But the evidence is that, say, expanding coverage through SCHIP covers more new people than, say—I didn't say this very well. The SCHIP expansion that is being considered, according to CBO, it would cover something like two new people for every one person that already has insurance who would be getting coverage through SCHIP.

Virtually all of the tax credit proposals that I have looked at—and John Gruber and I did some simulations to examine this—involved a lot of buying up the base. Most of the people who would get a tax credit already have insurance currently, and that adds to the cost of the program.

The bottom line is that there are many ways to improve on the current system, But tax credits for insurance purchase in an unregulated private market would surely make things worse. It would be truly ironic if those who claim to favor market-based solutions messed up the health insurance market so much that middle-class people and small employers demanded a government takeover of the whole system; and, in my view, I think that is a distinct possibility.

With that said, a well-thought-out tax credit program that was integrated with the current employer-sponsored system could make things much better; and I applaud the chairman, ranking member and other members of this committee for taking on this very difficult and very important issue.

Thank you.

[The prepared statement of Leonard E. Burman follows:]

PREPARED STATEMENT OF LEONARD E. BURMAN, DIRECTOR, TAX POLICY CENTER, SENIOR FELLOW, THE URBAN INSTITUTE

Chairman Spratt, Ranking Member Ryan, and members of the committee: Thank you for inviting me to discuss the role of the tax system in expanding access to health insurance. This hearing is extremely timely. About 47 million Americans under age 65, including 9 million children, lack health insurance. They are less likely to get important preventive screenings while healthy, and they receive lower-quality care when sick.[1] And, the public ultimately shoulders the burden of paying for the medical treatment of those lacking insurance, through higher taxes or higher health care costs.

The recent debate over the State Children's Health Insurance Program (S-CHIP) has focused on the best way to cover uninsured children, and many, including the president, have suggested that the tax system is the answer. I'd like to focus on the potential and limitations of using tax credits to expand coverage, as that is the only feasible way to use the tax system to help lower-income households obtain health insurance. Mr. Ryan has cosponsored a bill, H.R. 914, to provide a refundable credit up to $4,000 per year to help lower-income households purchase insurance in the individual nongroup market, similar to an earlier proposal from President Bush.

In considering such options, it is best to keep in mind Hippocrates' dictum: "Do no harm." A carefully designed program of health insurance tax credits combined with effective reforms of the market for nongroup health insurance could significantly expand health insurance coverage, although potentially at very high cost per newly insured person. And proposals to subsidize nongroup insurance alone with no meaningful provisions to fix the inherent failings in the nongroup health-insurance market would cause millions of Americans to lose their health insurance coverage. Those who suffer from chronic health conditions or have low incomes would be most vulnerable.

My testimony briefly summarizes the current tax treatment of health insurance, the effects of tax subsidies on coverage and health care costs, discusses ways that tax credits might affect health care coverage, and concludes with some recommendations.

TAX SUBSIDIES FOR HEALTH INSURANCE

Because the tax system heavily subsidizes employer-sponsored insurance (ESI), most nonelderly Americans get their health insurance at work. Employer contributions to employee health insurance are treated as nontaxable fringe benefits and are not considered part of total compensation for income or payroll tax purposes. The tax subsidies for ESI reduced income and payroll tax receipts by as much as $200 billion in fiscal year 2007.

Section 125 of the Internal Revenue Code allows employers to set up so-called cafeteria plans for administering certain employee benefits. A cafeteria plan allows employees to choose to receive part of their compensation either as cash wages or as one or more nontaxable fringe benefits, including health insurance. Flexible spending accounts (FSAs) are similar to cafeteria plans. They allow employees to set aside a fixed dollar amount of annual compensation to pay for out-of-pocket expenses for medical and dental services, prescription drugs and eyeglasses, and the employee's share of the cost of employer-sponsored health insurance. An FSA is financed through regular salary reductions. Any amount unspent at the end of the year is forfeited to the employer.[2] Employees pay no income or payroll taxes on the medical-related benefits paid through a cafeteria plan or FSA. As a result, employees with access to such plans may pay for all or most of their medical costs with pretax dollars.

Employers may purchase insurance for their employees or provide insurance themselves (i.e., self-insure—typically, in a plan managed by a third-party administrator). Section 105 of the Internal Revenue Code sets out nondiscrimination rules for benefits provided by self-insured plans. These rules aim to prevent highly compensated managers from providing generous tax-free benefits for themselves that are not available to the rank-and-file workers.[3] The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandates and health insurance premium taxes that apply to third-party insurers.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended ERISA to require employers with 20 or more employees who provide health insurance (whether self-insured or not) to allow participants and other beneficiaries (i.e., family members) to purchase continuing coverage for at least 18 months after it would otherwise cease for any reason, including termination, death, or divorce. Employers can charge covered employees their premium cost plus 2 percent for continuation of coverage. Workers who become disabled may retain coverage beyond the 18-month period by paying a premium up to 150 percent of the employer's average cost.

The Trade Adjustment Assistance Reform Act of 2003 created a 65-percent refundable tax credit for health insurance purchased by workers certified by the Department of Labor as having lost their jobs due to foreign competition. Workers covered by a pension taken over by the Pension Benefit Guaranty Corporation also qualify.

Most individuals who purchase their own insurance directly, whether through COBRA or not, cannot deduct the cost. However, individuals may deduct the portion of premiums they pay for health insurance plus other medical expenses that exceed 7.5 percent of adjusted gross income (AGI).[4] In addition, the self-employed may deduct their health insurance premiums from income tax (though not payroll tax) if they do not have access to ESI.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a four-year pilot program to make Medical Savings Accounts (MSAs) available to a limited number of people who are self-employed or work for small firms. The Medicare Prescription Drug Improvement and Modernization Act of 2003 renamed MSAs Health Savings Accounts (HSAs) and made them available to workers regardless of firm size. The Tax Relief and Health Care Act of 2006 modified the rules on annual contributions that could be made to an HSA. To qualify, individuals must be under age 65 and covered by a high-deductible health insurance plan, either offered at work or purchased in the nongroup market. The deductible must be at least $1,100 for single coverage and $2,200 for family coverage. The out-of-pocket maximums are limited to $5,500 and $11,000 for single and family coverage, respectively. The individual may contribute up to $2,850 for single coverage and $5,650 for family coverage into the HSA, regardless of the deductible.[5] Employer contributions to an employee's HSA up to those limits minus any employee contribution are excluded from taxable income for both income and payroll tax purposes—just as contributions to ESI are. Individuals' contributions to an HSA are deductible for income tax purposes.[6] Individuals age 55 to 64 may make additional "catch-up" contributions of up to $800 in 2007.[7] Balances in an HSA may be withdrawn to pay for qualifying medical expenses without penalty; nonmedical withdrawals are subject to

income tax, and withdrawals made before age 65 are subject to an additional 10 percent penalty. Unspent balances in an HSA accumulate tax-free.

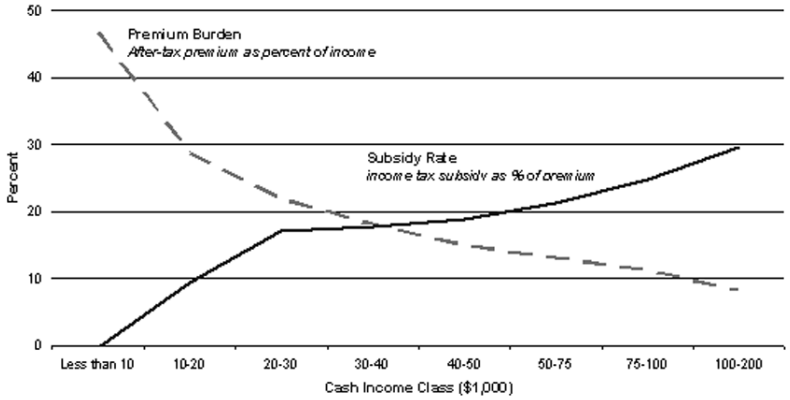
These supplemental tax subsidies for health insurance are small compared with the exclusion for employment-based health insurance. They reduced income tax revenues by an estimated $13 billion in fiscal year 2007. In contrast, the employer exclusion reduced income tax revenues by between $106 and $141 billion in the same year.[8] Including payroll taxes, the total revenue loss could exceed $200 billion per year.[9]

EFFECTS OF TAX SUBSIDIES ON HEALTH INSURANCE COVERAGE

The tax subsidy for ESI has produced mixed results. Although it has undoubtedly allowed millions of Americans to get insurance, it is a flawed subsidy mechanism. On one hand, excluding employer contributions toward health insurance is administratively quite simple. Employers do not need to measure and allocate premiums to include in employees' income.

On the other hand, the ESI exclusion is an upside-down subsidy. The largest subsidies go to high-income taxpayers who would be most likely to obtain insurance under almost any system. Those with low incomes get little or nothing. The subsidy for ESI depends on the marginal income tax rate, which increases with income. Taxpayers in the highest income tax bracket (35 percent) save 35 cents in income taxes for every dollar of earnings received in the form of health insurance. The roughly 30 percent of low-income households in the zero tax bracket, in contrast, receive no income tax benefit. (They might save payroll taxes, but that is a mixed blessing since their reduced payroll contributions to Social Security produce a commensurate drop in retirement benefits.) The result is a system in which households that face the highest premium burden as a share of income receive the smallest subsidy rate (figure 1).

Figure 1. An Upside Down Subsidy: Projected Tax Subsidy Rate Versus Premium Burden for Families with ESI, by Income, 2009



Note: Subsidy includes income tax and Medicare payroll tax savings. See Burman et al (2007) for discussion.

There are also advantages and disadvantages to tying health insurance to employment. The main advantage of subsidizing ESI is that employment is a natural way to pool health insurance risks since people choose employment for many reasons other than their expected use of health care. Employment pooling works best for large firms, but Pauly and Herring (1999) claim that even relatively small groups can effectively pool most risks. But Cutler (1994) found evidence of large year-to-year variation in average health expenditures in small groups, which creates a substantial risk of large premium increases in small firms.

Another advantage with large groups is that administrative and marketing costs are lower (Monheit, Nichols, and Selden 1995). Collecting premiums as a part of payroll processing is less expensive than direct billing. Collecting insurance premiums, either explicitly or implicitly as a part of payroll processing, may also be an especially effective way to encourage participation because individuals like to

break up large expenses into small, automatically collected pieces (Thaler 1992). Also, participation rates are higher if the choice workers face is framed in terms of opting out rather than opting into an insurance plan. Large groups also have bargaining power to lower costs when dealing with insurers and providers. And, to the extent that workers can count on long-term employment with an established firm, ESI may provide more protection against premium increases than does the individual market.

But ESI has drawbacks as well. It is an imperfect pooling mechanism. In a small firm, if one person gets sick, average costs can jump. Also, ESI provides limited renewability at best. People can lose their jobs or employers can decide to drop coverage—for example, because of unacceptably large premium increases.[10] Although no better mechanism for pooling or renewability currently exists in the individual market, such a mechanism might have arisen were it not for the large tax subsidy for ESI. For example, if professional associations, unions, or religious institutions were subsidized, they might also offer group health insurance policies to their members, much as they do with life insurance (Pauly and Herring 2001).

Finally, the subsidy for ESI amplifies the advantage of large firms over small ones as payers for health insurance. To see why, imagine a world without a tax exclusion for ESI. Many large firms might still offer health insurance even without a tax subsidy because of their advantages in pooling and lower administrative costs. Few, if any, small firms would. Now, after a tax exclusion is introduced, taxes fall for employees of firms that offer health insurance, but not for employees of other firms. Firms that do not offer health insurance now would face pressure from their employees to offer this valuable tax-free fringe benefit, and many would do so, but their compensation costs would increase relative to the large firms because, for a given package or benefits, health insurance is more expensive for small firms. The higher benefit costs place smaller firms at a competitive disadvantage. Effectively, the tax exclusion for ESI is a differential labor subsidy that is most valuable to large firms. It distorts the allocation of labor in favor of large firms and reduces production efficiency because workers who might be more productive at small firms are induced to shift to large firms by the tax subsidy.

The subsidy for ESI also creates other inefficiencies. It gives employers an incentive to outsource low-income and younger workers (who would not value the insurance as much) and distorts workers' decisions about work and retirement (CBO 1994).

For all its imperfections, however, ESI covers almost 70 percent of American workers (table 1). Not surprisingly, higher-income workers are much more likely to be covered by ESI than those with lower incomes. About 45 percent of workers with incomes under $20,000 were covered by ESI, compared with 86 percent of workers with incomes over $40,000. Full-time, full-year workers were much more likely to get ESI than part-time or part-year workers. And workers at large firms were much more likely to be covered by ESI than those working for small firms. Nonetheless, more than half of employees at small firms (fewer than 25 employees) were covered by their own or their spouse's ESI. More than 30 percent were covered by their own employer (not shown in table). This raises important concerns about policies that would cause more small employers to stop offering coverage.

Table 1. Primary Source of Health Insurance for Workers Age 18 to 64, by Demographic Category, 2006

	Workers (millions)	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other	
Total—Workers	147.1	69.8	5.7	4.6	1.1	18.8
Age						
18–34	53.7	59.0	6.7	7.0	1.0	26.3
35–54	71.7	75.4	4.7	3.5	0.9	15.5
55–64	21.7	77.6	6.4	2.6	2.3	11.1
Worker's Annual Income						
<$20,000	41.3	45.2	8.1	19.4	1.7	34.6
$20,000–$39,999	46.7	70.5	4.9	3.8	1.1	19.7
$40,000+	59.1	86.3	4.6	1.3	0.8	7.0
Family Poverty Level						
<100%	12.8	20.8	9.4	18.5	1.4	49.8
100–199%	23.3	41.6	7.0	9.7	1.5	40.2
200–299%	24.3	66.2	5.9	3.9	1.5	22.5
300–399%	20.5	79.0	5.4	2.1	1.0	12.5
400%+	66.2	87.6	4.5	1.2	0.9	5.8
Work Status						
Full-time/Full-year	104.0	76.1	4.3	2.8	0.8	16.0
Full-time/Part-year	18.6	55.0	6.2	8.7	1.5	28.7
Part-time/Full-year	12.9	57.2	11.2	7.4	1.5	22.3
Part-time/Part-year	11.6	50.5	10.9	12.0	2.9	23.6
Business Size (# Workers)						
Self-employed	13.5	47.9	18.9	4.1	1.5	27.6
<25	29.6	51.8	7.8	6.3	1.2	33.0
25–99	17.8	68.3	4.7	4.9	1.1	21.1
100–499	17.3	75.0	3.3	4.4	0.7	16.6
500–999	6.6	79.2	2.7	4.8	0.6	12.7
1,000+	41.0	78.1	3.3	4.5	1.0	13.0
Public sector	21.0	86.9	2.5	2.9	1.6	6.2

Source: Health Coverage in America: 2006 Data Update. October 2007. The Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/uninsured/7451.cfm.

Although some analysts believe that a better mechanism would arise if there were no ESI, there is a risk that major tax changes could significantly reduce insurance coverage. Removing or reducing employers' incentives to sponsor health insurance would have mixed effects on coverage. While some young, healthy people might be induced to acquire coverage in the individual nongroup market under a different set of incentives, the loss of ESI could be particularly devastating to old and unhealthy workers who would face prohibitively high health insurance premiums in the private nongroup market in the vast majority of states.

TAX CREDITS FOR NONGROUP HEALTH INSURANCE

Although ESI and public programs cover most Americans, 47 million Americans lack health insurance. Subsidizing the purchase of private nongroup insurance for those who cannot obtain it at work seems a natural remedy, but it might actually do more harm than good.

The appeal of tax credits for nongroup health insurance is obvious. It seems unfair to limit tax subsidies to those who get insurance at work. And most uninsured people do not have access to employment-based health insurance, so the only effective way to subsidize them would seem to be through the nongroup market, a public program such as S-CHIP or Medicaid, or new state- or federally subsidized purchasing pools.

Health credit advocates also believe that moving more consumers into the nongroup market would unleash competitive forces that would constrain health care

costs. Insurers, competing for business, would find new and innovative ways to limit health spending while providing a product that people value. Health care consumers, for their part, when faced with more responsibility for health care costs, would put pressure on providers to avoid unnecessary tests, therapies, and drugs.

On its face, I'm very attracted to these arguments. As an economist, I live in awe of well-functioning markets. It is a marvel that a completely decentralized process whereby agents all over the world, acting completely in their own self-interests, could turn sand and other raw materials into just the perfect computer, delivered right to my door, ready for producing testimony.

But economists also know that there are circumstances in which the magic of the marketplace breaks down. Almost every one of those circumstances applies in the markets for health care and health insurance. That doesn't mean that we shouldn't try to unleash market forces to control costs. It does mean, however, that an unregulated insurance market will fail to provide insurance for many millions of Americans, including those who are most vulnerable. If there is a role for government in any market, there is a role here.

The Achilles' heel of the health insurance market is adverse selection. When I buy a computer, the seller knows how much it will cost to supply it. The seller offers it for cost plus a modest profit and I buy it if it is worth at least that much to me.

For health insurance, the situation is completely different. Most people would like to have insurance if they can get it at a reasonable price because it protects them from a major financial risk. But, because of adverse selection, those who most value health insurance will have trouble finding affordable insurance in the nongroup market.

Insurers have imperfect information about the health status of their customers. And the voluntary nature of health insurance complicates the market further. The people who choose to buy insurance will tend to be those who expect to have the highest health care costs. An insurer that offered insurance to all comers (something that most states do not require insurers to do) would have to charge higher premiums to account for the greater likelihood of attracting high-cost enrollees. The higher premiums, in turn, would dissuade additional healthy people from buying insurance. As the health status of the pool of covered people eroded, premiums would get higher and higher, making it even less attractive to relatively healthy people. In the extreme, this "death spiral" could cause the insurance market to self-destruct altogether (Rothschild and Stiglitz 1976).

In fact, it doesn't work out this way because insurers are not passive in this process. They profit most if they can attract a healthier-than-average customer base. Newhouse (1996) documented how insurers exclude preexisting conditions and use other methods to attract the healthiest individuals. The consequence is that the nongroup health insurance market, ironically, only works for healthy people. If you are sick and need health insurance and you don't get it at work or through a public program, you are out of luck.

One might think that purchasing insurance when healthy and maintaining continuous coverage would guarantee affordable insurance when the insured person becomes ill, but it doesn't work that way in practice, despite the guarantee of renewability. The problem is the way insurers set premiums in the nongroup market. Those who purchase a nongroup policy are included in a pool with other policyholders who purchase the same product at the same time. The original premium is low because underwriting guarantees that the original pool is healthier than average. Future premiums depend on the experience of people in the group. Eventually, some people in the group become ill and the premiums start to rise. Healthy people in the group discover that they can pay a lower premium if they buy into a new, healthier group. (Sometimes their own insurer will offer them a lower premium for a new policy.) As healthy people drop out of the group, premiums start to rise very fast for those who have no other alternative—like a person who has developed diabetes. The consequence is that those who get sick either end up paying very high premiums or find insurance unaffordable and drop coverage altogether (Hall 2000).

I should note that insurers are not doing anything different from other businesses. They are simply seeking to maximize profits. Indeed, an insurer that decided to "do the right thing" and offer affordable insurance to people with serious health problems would go bankrupt. The premiums would not come close to covering the health care costs.

When the market works, as in the market for my laptop computer, many producers compete to sell a product that will be most appealing to consumers. The people who value computers most can find exactly what they are looking for at a fair price.

The private nongroup health insurance market does not, and cannot, produce this wonderful result. The decentralized system of firms trying to make a profit and con-

sumers trying to get a good deal results in very little insurance being sold, and mostly to the people who need it least. Less than 6 percent of workers are covered by nongroup health insurance (table 1). More than three times as many (19 percent) are uninsured. People who most need health insurance often cannot find insurance they can afford.

Also, administrative loads are higher; information for consumers is highly imperfect (widely varying benefit packages make price comparisons difficult, if not impossible; many buy policies without fully understanding what is covered or excluded), and many states allow insurers to use benefit exclusions to deny coverage on particular body parts and body systems related to preexisting medical conditions. Also, in the nongroup market, insurers view an individual looking for a comprehensive policy typical of those available in the group market as someone signaling an intent to use significant amounts of medical services. As a consequence, comprehensive policies are priced high to account for expected adverse selection, leaving policies with higher deductible and cost-sharing and more limited benefit packages as the only affordable options. But such policies are of little value to those with significant health care needs and to those with lower incomes, who often cannot afford the cost-sharing requirements.

POORLY DESIGNED TAX CREDITS MAY UNDERMINE ESI AND REDUCE INSURANCE COVERAGE

Of course, despite the nongroup market's flaws, covering several million more people in that market would seem to be a step in the right direction, even if most of the 47 million uninsured remain uncovered. The problem is that a poorly designed tax credit could cause millions of those with ESI to lose coverage and some of them, especially those in poor health or with low incomes, will not be able to afford coverage in the nongroup market.

Subsidizing private nongroup insurance makes employment-based insurance relatively less attractive. Of special concern are proposals that only make the credit available in the nongroup market, such as President Bush's early tax credit proposals and H.R. 914. This could cause many employers to stop offering coverage, because their employees could only benefit from the credit if they don't get ESI. But even a neutral credit that applied equally to ESI and nongroup insurance would tend to undermine employer-based health insurance, especially at small firms, since it would eliminate the relative tax advantage for ESI.

Due to higher administrative loads and higher year-to-year variability in group medical expenses, smaller employers often face higher health insurance premiums than do large employers—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 sacrifice much in wages in exchange for insurance. If tax credits are available for nongroup insurance, business owners would no longer have to offer insurance to their employees to qualify for a tax break on their own health insurance. The owners could simply purchase insurance in the nongroup market. Healthy employees are also likely to prefer that their employers stop offering insurance under these circumstances, because they would be able to get a better deal in the nongroup market, where healthy people face very low premiums, and still qualify for a tax subsidy. In response to these new incentives, some employers who currently offer health insurance would "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 using the new tax credit to offset part of the premium. 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. Many individuals likely sign up for coverage because it is easy and almost automatic when administered through their employers. Put them in the individual market where search costs for an appropriate policy are relatively high, underwriting requires a medical exam, and payments are not automatically deducted from payroll, and many might make the short-sighted choice to forgo insurance (and potentially impose costs on others who pay the cost of uncompensated care through higher premiums or taxes).

The bottom line is that without reforms to the nongroup market and substantial subsidies for low-income households, many people currently insured would likely lose their coverage if tax credits are offered for nongroup insurance. Those who lose coverage would tend to be the most vulnerable—those with low incomes and serious

health problems—while those who gain coverage will tend to be those who are healthy. In my view, that would be a poor trade.

HEALTH INSURANCE SUBSIDIES AND HEALTH CARE COSTS

Expanding coverage is not the only motivation of health market reformers. There is also an urgent need to rein in the growth of health care costs, which have been continually growing much faster than incomes. Indeed, health cost inflation and health insurance coverage are linked. Rising health care costs translate into higher health insurance premiums, which prices health insurance out of the reach of more and more workers.

Insurance gives individuals an incentive to use too much health care because they have to pay only a fraction of the cost (the deductible and coinsurance). They will thus be willing to undergo medical procedures or take expensive prescription drugs even if they are of little value because the insured persons out-of-pocket cost is very low or even zero. To counteract this tendency, many insurers rely on managed care schemes that limit unnecessary medical expenditures.

But how much of the cost of medical care is due to this moral hazard that arises from the low net-of-insurance price of insured care? Newhouse (1992) argues that the lion's share of growth of health expenditures stems from advances in medical technology, not moral hazard. He concludes that overzealous efforts to limit moral hazard could do more harm than good if they reduced the incentive for medical innovation.

Nonetheless, the tax exclusion for ESI clearly creates an incentive to acquire overly generous health insurance coverage as it lowers the after-tax cost of health insurance by as much as 35 percent for taxpayers in the top income tax bracket (and even more when savings in payroll taxes and state income taxes are considered). At the discounted price, consumers may demand more comprehensive insurance with lower copayments and deductibles, and less aggressively managed care.

Several policy responses have been put forward to offset this incentive to purchase overly generous care. The generous tax subsidies for HSAs are one such approach, intended to encourage the purchase of health insurance plans with high deductibles. However, the high-deductible health plans (HDHPs) may not be the best way to control costs. For one thing, they encourage the risk segmentation of the market, as they are most attractive to healthier-than-average people, for whom the high deductibles are a good bet. If employers offer both HDHPs and traditional insurance, adverse selection will tend to make premiums for traditional insurance higher and higher over time.[11]

But if HDHPs supplant insurance with lower deductibles, they could ultimately reduce coverage, especially for those with low incomes or chronically poor health. The $2,200 deductible for family coverage in 2007, for example, would represent a significant financial risk for a low-income household. If that were its only insurance option, the family might opt to refuse health insurance coverage altogether. It would also represent a substantial hardship for someone with a chronic illness who knows that he or she will exceed the deductible every year.

What's more, HDHPs might not even be a particularly effective means of controlling health care spending. Most health care spending is done by a small number of very sick people. Berk and Monheit (2001) reported that 70 percent of health care spending is attributable to only 10 percent of individuals. Blumberg (2007b) calculated that 97 percent of health care costs are incurred by individuals who spend more than the deductibles in HDHPs. Once individuals reach the deductible, insurance pays all additional costs and they have no more incentive to economize than anyone else with insurance. As a result, HDHPs and HSAs are unlikely to have a substantial effect on overall medical spending.

The president's proposed standard deduction for health insurance represented an innovative approach to balancing adverse selection and moral hazard. The proposal would provide a fixed subsidy solely for acquiring insurance that met minimum standards. More expensive insurance would not qualify for a larger subsidy. This approach would encourage individuals and families to get insurance while preserving a strong incentive to shop for a low-cost plan. The deduction is problematic since it retains the upside-down subsidy structure discussed above, but if the deduction were converted to a refundable credit and the individual nongroup market reformed as discussed below, this proposal could encourage consumers to get insurance without encouraging excessive consumption. What's more, if HSAs were eliminated, this option would remove the bias in favor of HDHPs over other possibly more effective means of controlling costs, such as managed care.

RECOMMENDATIONS

Replacing the ESI exclusion with a progressive refundable tax credit would be an improvement over current tax law. Such a credit could turn the upside-down subsidy right side up. It could be designed to provide the largest subsidy to low-income households who most need help, even if they do not owe income taxes. That would encourage more low-income employees to take up employers' offers of insurance, and would encourage more employers—especially small firms—to offer insurance. Since young, healthy people are more likely to have relatively low incomes, a refundable credit would also encourage more healthy people to take up their employers' offers of insurance, lowering average premiums.

It would also be a good idea, as the president proposed in his State of the Union address in January 2007, to make the subsidy amount depend only on having qualifying insurance, not on the amount of the insurance premium. This would encourage households to gain insurance coverage while retaining an incentive for cost-containment, whether through high deductibles, aggressively managed care, or some other means.

A credit for nongroup insurance alone, as in H.R. 914 and the president's earlier tax credit proposals, would likely do more harm than good. It would cause some employers, especially small ones, to stop offering health insurance, and would likely cause many people with health problems or low incomes to lose their health insurance coverage.

A credit for ESI and nongroup insurance could represent an improvement if the inherent problems in the nongroup market can be solved (Blumberg 2007a). There are several possible approaches to doing this. One would be to set up, either at the national level or within each state, a pool of insurers that promises to take all comers in exchange for being able to sell insurance that qualifies for the tax credit. An example of such an arrangement is the Federal Employees' Health Benefits Program, which includes a set of insurers that offer insurance that meets minimum actuarial standards and charges a community-rated premium in each market to any federal employee who chooses their product.[12] There is still the potential that adverse selection would drive up premiums in the purchasing pool if the credit is small. However, if the credit is large enough, then even healthy people would want to buy into the publicly sponsored pool, which would help keep premiums affordable.

Alternatively, or as a complement to state efforts, insurers who wished to sell nongroup insurance that qualifies for the tax credit could be required to offer insurance that is fully renewable and portable (Burman and Gruber 2001). Individuals who maintained continuous coverage through employer-sponsored insurance or qualifying insurance offered in the nongroup market would be guaranteed that they could purchase insurance from any participating insurer at the lowest rates available, even if their health status worsens. This option would give healthy people a strong incentive to purchase insurance, because they would be guaranteed that they could get affordable insurance when they got sick and they would qualify for a tax subsidy. This strong incentive for healthy people to participate would help keep premiums for qualifying insurance relatively low, as they are in large employer groups. Insurers might try to undermine the pooling arrangement by attempting to cherry-pick healthy individuals, but that might be deterred by federal or state regulation of qualifying insurance.

Some issues would need to be addressed if a tax credit is to help many poor families gain insurance. First, the credit would need to be much larger than has so far been proposed. The premium for employer-sponsored family coverage in 2007 averages almost $12,000. That is over 25 percent of pretax income for a family of four earning 200 percent of the federal poverty level.[13] It is likely that for such families, the credit would need to equal 75 percent or more of the premium to induce substantial participation. The Health Coverage Tax Credit, which covers displaced workers who lose their health insurance, covers 65 percent of premiums, and only 11 percent of qualifying individuals take the credit.[14]

A second issue is getting the credit to workers when they need the money. Almost all tax credits are claimed after the end of the calendar year, when a household files its tax return.[15] For a major expense, such as the cost of family health insurance coverage, a lower-income household would have great difficulty advancing the premium, even if it knows that most of the cost would be refunded at tax time. To deal with this problem, the HCTC is paid directly to health insurers. If the credit is available for both ESI and nongroup insurance (as I recommend), it should also be payable in advance to employers who sponsor health insurance.

A further complication arises if the credit amount is based on income. Current annual income is difficult to predict in advance, especially for low-income families whose attachment to the labor force may be erratic. For that reason, President

Bush's proposals have allowed households to elect to claim eligibility for an advance credit based on a prior year's income. This approach may still result in a mismatch between eligibility and subsidy levels for a family whose income is very volatile. When they have great need, for example, because of a job loss, they might not be eligible because prior year's income was too high. It also raises administrative issues for the IRS.

Also, transferable tax credits may be very costly for the IRS to administer. Dorn (2007b) estimates that in FY 2007, only 66 percent of the cost of the HCTC went to pay for health care. The rest went to the IRS (21 percent) and the cost of health plan administration (13 percent).

Finally, if tax credits are an add-on to current subsidies rather than a replacement for the ESI exclusion (as President Bush's proposals were), they could prove to be a very costly way to expand coverage. Burman and Gruber (2005) estimated that a tax credit for both ESI and nongroup coverage could cost $6.50 for every dollar of new insurance purchased, largely because so much of the cost would go to buying up the base—that is, covering people who already have either ESI or nongroup insurance. And those estimates do not include administrative costs.

The most cost-effective approach to expanding health insurance coverage may not be a tax subsidy at all, but expansion of an existing public program, such as Medicaid, S-CHIP, or Medicare. For example, CBO (2007) concluded that most of the children who gain insurance under S-CHIP would otherwise be uninsured. In contrast, Burman and Gruber (2005) estimated that most of those who would qualify for tax credits (whether for ESI, nongroup, or both) would have had insurance even without the tax credit.

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NOTES

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[1] Hadley (2003) estimates that mortality declines by 4.5 to 7.0 percent for people when they gain health insurance.

[2] Treasury Notice 2005-86 allows employees a grace period of up to two and a half months beyond the end of the calendar year to submit charges for reimbursement under a health FSA if the employer permits.

[3] In contrast, no nondiscrimination rules apply to the provisions of commercially purchased health insurance. The Tax Reform Act of 1986 included a new Section 89, which set out nondiscrimination rules for employee health and welfare benefits, but the new restrictions raised a firestorm of protest among business interests and others and were repealed in 1989.

[4] The threshold is 10 percent for taxpayers subject to the individual alternative minimum tax.

[5] All of the thresholds are indexed for inflation.

[6] If the individual contributions are made through a cafeteria plan, they are also excluded from income for payroll tax purposes.

[7] The catch-up contribution limit phases up to $1,000 by 2009. The concept of a catch-up contribution was implemented for individual retirement accounts and defined contribution plans in the Economic Growth and Taxpayer Relief and Reconciliation Act of 2001 based on the logic that women had to make additional contributions to catch up for the time spent out of the labor force. This is a dubious justification for a provision that mostly benefits men, and its application to HSAs is truly puzzling since their ostensible purpose is to offset unusually high medical expenses, not provide another retirement savings vehicle.

[8] The official government estimates are done for Congress by the Joint Committee of Taxation (JCT) and for the administration by Treasury's Office of Tax Analysis (OTA). Their estimates for the deduction for medical expenses and for health insurance premiums of the self-employed are similar, but their estimates for the exclusion from income tax of ESI diverge markedly. OTA estimates that the latter provision will reduce revenues by $141 billion in fiscal year 2007; JCT estimates a $106 billion revenue loss. The JCT estimates are smaller because they assume that, absent the tax exclusion, individuals who itemize deductions would be able to deduct the part of their health insurance premiums that, combined with other medical expenditures, exceeds 7.5 percent of AGI. OTA does not account for this offsetting deduction because it would logically require an increase in the tax expenditure estimate for the itemized deduction for health expenditures. Note that tax expenditure estimates differ from revenue estimates because, by convention, they do not take into account most behavioral responses or interactions with other tax expenditures. See Office of Management and Budget (2007) and JCT (2007).

[9] Payroll tax revenue losses are more than half of the income tax revenue cost. (See Burman et al. 2003). Thus, conservatively, the payroll tax expenditure would be at least $70 billion, based on Treasury numbers, or $53 billion, based on JCT's estimates. This yields a range of $159 to $211 billion or more for the combined revenue loss.

[10] HIPAA requires insurers to offer insurance to terminated employees who have exhausted their COBRA coverage, but insurers can and do charge much higher rates for HIPAA customers. For example, CareFirst (Blue Cross-Blue Shield) charges a markup of about 80 percent for

HIPAA coverage in Virginia compared with otherwise identical underwritten policies (*http://www.carefirst.com,* October 8, 2006).

[11] To see why, consider the story of Blue Cross high option health insurance. For years, federal employees had a choice of "high option" Blue Cross health insurance and a standard option with a slightly lower deductible and a few other limitations. For the typical federal employee, the high option was worth a little more, and initially premiums were slightly higher. Young, healthy employees risked having to pay the higher deductible in exchange for the small premium difference. Older, sicker employees preferred the high option. But the premium difference grew larger over time as more healthy people shunned the high option. When last offered in 2001, the Blue Cross high-option family premium was $1,500 more than standard option. In 2002, the high option was discontinued.

[12] The minimum actuarial standard is necessary to prevent insurers from cherry-picking—designing policies that are most attractive to healthier-than-average employees. The advent of high-deductible plans that qualify for HSAs may have undermined this policy, although it is too early to tell.

[13] The average premium for family coverage offered through employers is an estimated $11,790 in 2007. The federal poverty level for a family of four in 2007 is $20,650.

[14] There are other issues with HCTC, as discussed in Dorn (2007a).

[15] The EITC allows advance payments through employers, but almost nobody takes advantage of this option (GAO 2007). The HCTC provides payments directly to health insurance providers, although there is a delay before payments begin (Dorn 2007a).

Chairman SPRATT. Thank you very much, both of you. Dr. Burman and Ms. Turner, I thank you very much for your excellent testimony.

But, Dr. Burman, you leave us with sort of an elliptical paragraph there at the end. You say the most cost-effective approach to expanding health insurance coverage may not be a tax subsidy at all, after spending about six or seven pages discussing the tax credit, but expansion of an existing public program such as Medicare, Medicaid or SCHIP. I would like for you to elaborate on that.

Before you do, let me just make a statement.

Ms. Turner, you were talking about turning much more of this type of coverage over to consumers, individual consumers and the individual market and allowing them to amass their consumer influence and get something that they wanted, as opposed to having paternalistic employers provide it for them. Bear in mind that today 46 percent, according to MedPAC, of the health care paid for or provided in this country is paid for or provided by the Federal Government through Medicaid, Medicare, FEHB, Tricare Prime, Tricare for life, Veterans Administration and SCHIP; and I find it hard to believe that we would turn this battleship around and undo most of that coverage that is institutionally so rooted in everybody's expectations, that to change the system, we have got to change it incrementally, in my opinion.

We have really got two choices. We will take a revolutionary leap to a completely different type of health care delivery and a completely different type of health care compensation or insurance or do we go step by step with incremental change. The early 1990s and the Clinton proposal convinced me we would find it very difficult to do anything revolutionary. It has got to be evolutionary.

If we are going to have a market-based solution, then we, the Members of Congress, have to market it, first of all, to our constituents; and that is awfully hard to do. Most of them are satisfied to have the employee make the decision about their policy. They don't read their policy.

I don't think there is a member sitting here in this room who can tell you that he or she has read his health insurance policy obtained under FEHB. We are generally familiar with the coverage. We know basically what the deductibles and copays are. We would probably find something excluded that we would think was there—

hearing aids, eyeglasses, stuff like that—that we might assume was there until we went and looked and found that it isn't.

I am just saying it is going to be extraordinarily difficult to change anything; and to the extent, the more radical the change, the harder it will be, first of all, to sell to the population, I think.

But, Dr. Burman, going back to my first question to you, you seem to be headed off in a different direction in that last paragraph of your testimony.

Dr. BURMAN. And getting dangerously on the verge of a subject in which I am not an expert. But the problem with the tax credit approach is that almost all the proposals would involve a lot of buying up the base.

Say we had just a tax credit for nongroup health insurance. Nongroup health insurance covers a lot of people already, and all of those people would qualify for a tax credit, and they wouldn't get additional coverage. The estimates that John Gruber and I did suggested that only a fraction of the people who would get the credit would actually be newly insured. By comparison, according to CBO, the SCHIP expansion, something like two-thirds of the people who would get SCHIP under the expansions are currently uninsured.

There is crowd out in both public programs and in tax credits. But I think it is a little bit—it appears to be harder to target tax credits to the people who are currently uninsured than it is to target, say, something like the SCHIP expansion. That might not be true if we had a major expansion in public programs, if we decided we wanted to cover everybody with insurance up to 400 percent of poverty or 500 percent of poverty. Obviously, a lot of those people have insurance now. But for these small, incremental changes—you get 400 million people getting coverage at a relatively modest price, it would be hard to do that through a tax credit program.

There have been proposals saying that you only get the credit if you don't currently have insurance, but there are two problems with that.

One is, it seems unfair. People have been struggling to pay premiums themselves for all these years and they find out that the people who are going to get it are the ones who were opting out of the market. That just doesn't seem right.

The other one is it can create some bad incentives. You can, say, drop your insurance for a year so you can qualify for a credit down the road.

Similarly, there are some subsidies—you only get it if your employer doesn't provide insurance. That provides a very strong incentive for the employers to drop their coverage. Because, basically, by offering insurance at work, you are poisoning the well for all of your employees. If they wanted to get a credit in the nongroup market, you would have to drop it.

So those are the kinds of concerns that I was worried about.

Chairman SPRATT. Ms. Turner?

Ms. TURNER. I think that Dr. Burman, who really describes that whatever we do is going to be complex, and I absolutely agree with him, Mr. Chairman, that whatever we do needs to make sure that we don't rock the boat for people who have stable coverage.

But one of the concerns that many people have right now is even job-based coverage is starting to decline. You know, we see it fall

below 60 percent in the latest Census Bureau numbers. And my concern is, if we don't do something to give people who are left out of the system and who may be left out of the system in this evolving economy other options, that we are going to continue to see that number of uninsured increase to the point that public programs may seem to be the only option. And that is certainly something that I think, considering the current budget deficit and the current budget debt, is just really—is very difficult to envision; and I would like to——

You know, one of the things that I see that is particularly important in changes in the health sector is recognizing that there would be a different market response if the incentives were different. And it is not really just the current individual market, which, by the way, insures about 27 million people but also—it is not just the individual market as we know it now or the employment-based group market as we know it now, but I believe all kinds of new groups would evolve so that people could have the advantages of purchasing group health insurance through other kinds of groups that may be more stable forces in their life than their job—their church group, community, professional, labor trade associations—that gives them continuity of coverage. But allowing people to have the tax break follow them as a person rather than as an employee would allow them to find new kinds of efficient mechanisms to purchase health insurance rather than just the current individual market. So——

Chairman SPRATT. You have more confidence than I do in the ability of individuals to get into the complex insurance market and make comparative decisions about the type of coverage, the cost of coverage that he or she might want to get.

When I was younger, I used to have a life insurance salesman come by my office almost every week trying to sell me whole life insurance; and in all the years that I was in private practice, in business, nobody ever tried to sell me an individual health insurance policy because I had group coverage. But nobody tried to sell me an individual policy even though—an umbrella policy.

Ms. TURNER. I also think that many of the problems that we see currently in the health insurance market could be addressed if people had greater continuity in their ownership of that health insurance policy.

I was in Europe——

Chairman SPRATT. Are we talking about preexisting conditions or renewability?

Ms. TURNER. Yes, absolutely. But I think also if people had a policy that they owned and could keep with them for years—I was in Europe recently talking with a woman from Germany who had the same health plan, sickness fund for 40 years.

Chairman SPRATT. Are you saying that the company, once having to ensure this individual, regardless of his or her health, couldn't adjust upward the premium?

Ms. TURNER. I think we need to look at what the rules would be. If people have a contract that says if you stay with us for 5 years or 10 years, we are going to cover you no matter what, and we are going to negotiate what that premium would be so that you have something that is affordable for you.

But I believe that if people saw an incentive to have a longer-term relationship—nobody really wants to go renegotiate their health insurance policy every year, and I believe if they have that continuity that it would work on both sides. Not only would insurers have more of an incentive——

Chairman SPRATT. Realistically, whom do you know who has ever sat down individually and negotiated health insurance policies?

Ms. TURNER. That is why I think these new kinds of groups would help people to aggregate so they have some trusted agent that would help do that for them. The individual market may not work. It may work for a few people. But I think new kinds of groups and new kinds of mechanisms for people to be able to aggregate together to get a better deal, to have more longevity in their coverage would actually provide many new options than we see in today's market.

Chairman SPRATT. Thank you.

Dr. Burman.

Dr. BURMAN. I definitely think it is possible that if we had a different set of incentives that there would be institutions that would set up in the individual market that would solve some of the problems.

But the inherent problem of adverse selection is really difficult. For example, if the church offered health insurance to people who would be most likely to want to sign on, it would be the people who have high health costs and the church doesn't have any way of requiring or even providing much of an inducement for all of their members to join in.

One thing employers can do is say, well, I am going to pay 70 percent of the premium; you can take it or not. But given that that money is already on the table, it is a very strong incentive for most people to buy into the plan. It is possible and almost—it is likely that the market would come up with some innovations that it hasn't if it got a lot larger, and certainly if more people were buying insurance in the nongroup market that by itself would help some with the adverse selection problem. But I think it would be a tremendous gamble to just assume that those institutions would arise and solve these seemingly very serious problems without some kinds of other restrictions.

I was glad to hear Ms. Turner say that we need to change the way we deal with long-term contracts with insurers. I think a really fundamental problem is that when you buy term life insurance or whole life insurance that your insurer doesn't come back to you 10 years later and say, well, you have gotten—it looks like you are really healthy. You have started riding your bike. You are going to live forever. Therefore, I will cut your premium—or I guess it is the other way around. You started smoking, so I am going to raise your premium, or you developed heart problems.

You have got to have some way that if you keep continuous coverage for health insurance you can get the lowest premium, and there needs to be a way to keep insurers from cherry-picking. There is a very strong incentive for insurers to find ways to get the healthiest people to sign up and to discourage the people who are unhealthy from being in the pool. I mean, it is just—competitive

pressures actually force them to do that. It is not because they are especially evil. It is just that if you decide to be the good guy and take sick people, you will go bankrupt.

There is an example I heard of—it is probably apocryphal—but there was somebody selling Medigap coverage for a really low price and all you had to do was walk up to the second story to get it. Insurers are very creative at finding ways to select the healthy risks.

Mr. RYAN. Is that a true story?

Okay. This is a great hearing. Let me just ask both of you these questions as I go on.

When we have these conversations, we keep seeming to think that the market is the way it is and it is always going to be the way it is; and we need to challenge that conventional wisdom. You mentioned it is $12,000, on average, for a family to buy health insurance on the individual market, and that is just too much, and there is nothing we can do about it. I would like to challenge the fact that there probably is something we can do about it. So my questions go to, you know, how do we find that sustainable equilibrium, that sweet spot between moral hazard and adverse selection? Where is it so that you are not careening between the two?

And the question is, basically, if you take a look at the underwriting guidelines of insurers today, their interests are directly opposed to the interests of their clients or their consumers. Where else is it good economic sense to get a pool together, to get a bunch of clients and then run it for 5 years and then just cancel the whole thing? So you made your spread and start over again and get rid of these clients. That is basically what they do. That is what the economics—that is good business practice.

So how do we reform the market without having a government takeover of this market? But how do we reform this so that the underwriting guidelines and the interests underpinning those more clearly align with those of us as consumers? That is question number one.

Question number two is, as you look at that and you model this, don't you agree with the premise that if we find a way to do that, whether it is reinsurance or, you know, connectors or good high-risk pools that work that address the moral hazard issue, isn't it axiomatic that the rest of the cost of insurance for everybody else will go down? If we find a good mechanism that gets people with two co-morbidities, the high-risk people, insured at an affordable rate and we just subsidize that, which is probably the easiest, most rational way to do it, isn't it axiomatic that the average cost won't be $12,000 for a family plan for relatively healthy people, that it would go down?

And the final question here, and I will actually have a follow-up with my time, I think, you know, if we don't address the root cause of health inflation, we are all in trouble. So we have got to—we have got a need in our economy—in our society that 16 percent of GDP is growing at two—in some years three—times the rate of ordinary inflation. More government programs doesn't address that. The same kind of tax policy we have doesn't address that. It is clearly that something that changes the market structure and in-

centives has to be done to address the root cause of health inflation.

Because, as we see in this committee, we are in a completely unsustainable course with—and it is basically health care. If you take health care out of the equation with our entitlements, we really don't have a problem. But because of health care—and, more importantly, if you look at Peter Orszag studies and all of these other, health inflation is more than demographics, the problem we are facing with these entitlements. So if you could get into those, I would very much appreciate it.

Dr. BURMAN. Those are great questions.

The first was how you could reform the system to align incentives. One thing that is important to point out is that the current system doesn't actually work for insurers even, at least in the aggregate, because the adverse selection means that many fewer people have insurance than would have it if the market somehow could be made to work. Insurers would like to sell insurance to everybody who wants to buy it, but they are trying to figure out a way to do it and still make money.

If you had a system where there were substantial subsidies, especially for low-income people so they could afford to buy it; if you had incentives for people to retain continuous coverage; if you were able to prevent the kind of cherrypicking, which is an incentive for every individual insurer but not an incentive of the whole market; so by setting up these purchasing pools or by requiring to take all comers so long as they have maintained continuous coverage, insurers could sell a lot more insurance.

It would lower average premiums, because you would have more healthy people in the pool, and people, when they got sick, would still be served, either through employers or through reforms in the nongroup market.

Mr. RYAN. When you say that, are you just suggesting, you know, just, sort of, mandates like guaranteed issue or community rating? Is that what you are suggesting when you say that? Or are there other——

Dr. BURMAN. The problem with community rating, just by itself—I mean, there are sort of simplistic solutions that have been put forward on both sides. Community rating, by itself, creates—that actually leads to the death spiral, if you don't have other incentives. Because if the insurers have to take everybody and the people who want to buy insurance most are the ones who are sick, premiums are high, healthy people drop out, premiums get even higher.

So it is a combination of—basically, my view, particularly if you are going to offer tax credits, tax credits ought to pay for something—something the market is not doing now—and not just provide a subsidy to people who are buying insurance in a dysfunctional market.

And what I suggest, and I actually wrote a paper a while ago with a different Gruber, Amelia Gruber, who was my RA back in the late 1990s. It was called something like "Health Insurance with a Purpose." Basically it said that the insurers would have to come up with a way to guarantee that you could continue to get insurance at the lowest premium from any provider, basically guaran-

teed issue, but the requirement on the other side was that you have to maintain continuous coverage.

And, obviously, you are going to need to do things to take care of people who lose their jobs, who can't afford to pay for the premiums, people who fall upon hard times. But you don't want people basically saying, "I am only going to buy insurance when I really need it," because that is just a recipe for disaster. And you don't want the insurers to be able to turn down everybody but the healthy people.

Mr. RYAN. So guaranteed issued with the mandate, basically.

Dr. BURMAN. Not quite. It is softer than a—obviously, a mandate would work, too. And if you wanted to make subsidies large enough so that actually everybody could afford to pay for health insurance, which means pretty big subsidies at the low end, that is a way you could get universal coverage in a decentralized system.

What I am suggesting is something less radical than that, which is just that if you keep continuous coverage, either through an employer or by purchasing in the nongroup market, all insurers have to take you, and they have to take you at the lowest premium, and they can't raise your premiums over time if you get sick.

You asked about what would happen if you covered high-risk people through some kind of high-risk pool. And it is certainly true that it would lower premiums in the rest of the market. I don't know that that, by itself, does anything to the overall problem of what we are spending on health care. It just means you are kind of segmenting the market into a high-risk pool that gets subsidized insurance through States or some other mechanism and then a relatively healthy pool, which might include employers as well as—right now, basically, we have a healthy pool anyway. So insurers are mostly covering people who are healthier than average. And this would just make that even, sort of—have that be an explicit policy. But I am not sure it would do anything about overall health spending. It would just change who was paying which parts of it.

I think there also might be some problems in terms of risk adjustment, although I am not an expert on that, so I will defer to others on that issue.

On the issue of health cost inflation, I think you are exactly right. If we don't deal with the problem of rising health-care costs, the Government is going to go bankrupt. And basically no one in this room will have a situation they like. We will have Government spending 30 to 40 percent GDP, mostly on health care for the elderly. There won't be any money left for other programs we care about, like roads, safety net for low-income people, and everything else. And we will need really high taxes, as well. Solving that problem is the biggest challenge you are facing, going forward.

Peter Orszag, when he talks about it, has focused a lot on information, finding ways to automate processes in hospitals and among medical providers to reduce—you know, one big problem is there is a lot of just duplication of care. I heard stories about—my colleague, Howard Gleckman, followed some people around in a hospital, and really sick people, and discovered that a patient was getting prescribed the same MRI by two or three different doctors, because they didn't have any way of figuring out what other doctors had prescribed. Doctors prescribe medicines without even knowing

what other medicines people are taking, which sometimes makes people even sicker. So, obviously, there is some potential there.

I do think we do need to deal with the problem of moral hazard. And I like the idea behind the President's proposal of having the subsidy for health insurance depend on purchasing an adequate health policy but not have the subsidy be larger if you purchase a policy that is even more comprehensive and more expensive.

That said, you need to pay attention to problems of adverse selection. One approach that has been put forward to control costs is health savings accounts and high deductibles. And it is certainly true that if you are paying your own money for medical care, rather than having the insurer reimburse it, you are going to pay more attention to the cost. But the problem is that, if people have a choice between high-deductible plans and other plans, the people who are going to like the high-deductable plans are the ones who are healthy. It is a good bet for them. And maybe it is okay for everybody to be in high-deductible plans, except, if you do that, you have to acknowledge the fact that a $2,200 deductible might be no problem for people in this room but it will be an insuperable barrier to somebody with relatively modest income. Again, you could end up having the most vulnerable people thrown out of the system because of this sort of selection process.

Ms. TURNER. In an attempt to be efficient with out time, I may have not made it clear that the $12,000 cost of a family policy is in the job-based market. And actually, when you look at the individual market, it is less than half that for a family policy. And one of the reasons is—one of the reasons—is because people who are purchasing their own health insurance are more likely to choose to have a higher-deductible policy in order to be able to really have the policy cover them for major expenses.

Then we get into a pricing issue. What about lower-income people who can't afford the higher deductible? Well, that is a pricing issue. That is a subsidy issue. And if we were to have a system in which the subsidies were risk-adjusted, if we provide additional subsidies, as Leonard said, for people at the lower end of the income scale to help them purchase that coverage, they can buy that lower-deductible policy because they have more resources to do that.

So it is really a pricing issue that I think could be solved in order to be able to make this market work well even for people at the lower end of the income scale.

And to your question about incentives, that is really it. Right now, insurance companies are selling to big employers, small employers. They talk about people as covered lives. They don't even talk about them as individuals, instead of as customers, instead of as consumers.

And if we had a market in which consumers had more control over those resources, then I believe the market would have a much greater incentive than it does now to make those policies something that people want to buy; to make them be long-term contracts, long-term stable pricing of those contracts, to make sure that people know they have guaranteed coverage.

And part of the problem is the market we have now, of the 47 million, 45 percent or so are just moving through the employment-

based market. They are likely to have health insurance again in 4 to 5 months. They are just—they have fallen off the cliff and getting coverage again. So we need to break this down and figure out who really needs subsidies, in addition to a tax credit, a refundable tax credit, or a tax deduction, however those subsidies are organized, in order to be able to help them get into the system.

And you are absolutely right that the rising costs of health coverage are not only unsustainable for the Federal budget, but they are really unsustainable for businesses. We hear so much talk—look at General Motors, deciding that it is going to officially cash out the value of its health benefits to employees to their labor union so that they can begin to get some stability with those costs. And I think that is really an important issue.

How do we give both individuals an incentive to shop for better value than they do in this current invisible market for health insurance, give employers an opportunity to know what their costs are going to be? And Mr. Cooper, I know, has proposed legislation that says employers need to tell employees what the value of your health insurance policy is, and then provide incentives for the market to do a better job than it is now of providing something that people actually want to buy.

Mr. RYAN. I have so many other questions. But I want to——

Chairman SPRATT. We will come back around.

Mr. RYAN. Thank you, Mr. Chairman.

Chairman SPRATT. Mr. Cooper?

Mr. COOPER. Thank you, Mr. Chairman.

After decades of stalemate in health reform, I hope that at least on this issue we can have a truce or perhaps, with lower expectations, at least a temporary cease-fire.

I appreciate Ms. Turner mentioning my bill—I was going to bring that up anyway, as you might expect—H.R. 847, which is a remarkably simple and hopefully bipartisan approach that would just require that, on the employer's W-2 form, they also list what the employer is sponsoring, in terms of the health benefit.

Because this key piece of information is completely missing from anyone's paperwork. Now, nothing prevents an employer today from telling the employee what they are paying. But some folks don't believe their employer, especially with these astronomical health-care costs.

Mr. RYAN. Will you yield just for a second?

Mr. COOPER. I would be delighted to yield.

Mr. RYAN. Would you put me on as a cosponsor? And now you can call it bipartisan.

Mr. COOPER. Thank you. Good man. I am proud to have you, Paul.

I think it is a particularly key issue, because this puts information at the fingertips of the worker right when they are doing their taxes, and they can see how much they paid in for Social Security and Medicare and 401(k) and things like that. It is my understanding that this change actually could be done administratively today, but the White House needs some encouragement in that direction. They liked the proposal, but they haven't been willing to go ahead and do it.

But at least we, as members, could put this key piece of information in the marketplace. Because the most important point to me is this: The money that goes to pay for the health benefit is not the boss's money. It is really the worker's money. Most economists agree on this. It is foregone wage increases. And that is the tragedy, that the employee today is prevented, by a cumbersome bureaucratic system, by even seeing what he or she is being forced to pay for health coverage. That is a truly amazing situation, and we can cure that with this one simple, one-page bill.

There are deeper questions I wanted to get into. I worry that we have underestimated the coming-together that has already occurred, the lessening of hostilities. It is amazing, the first President to mention fundamental tax change, that I have ever remembered, and what President Bush did in the State of the Union, that was a brave move, although probably a lot of people missed it.

Second, to have Andy Stern of the SEIU join together with AT&T, Intel, Wal-Mart and others to recommend a shift away from the employer-based system is amazing. Ron Wyden's bill in the Senate is an amazing thing. Brian Baird, I know, is going to talk about that in a few minutes. That is a remarkable and fundamental reform that most of our presidential candidates can't talk about.

The CED, the thinktank, just came out with a bold new report recently that is amazing and actually steps away from their prior thinking on this issue, by recommending that we move away from the employer-based system.

So there are great signs of hope right now, even in the partisan atmosphere in Washington.

I think the best way to preserve peace on this issue is to avoid misconceptions. And the way I see it is no one in either party wants to push people into the so-called individual market today, because that is full of so many problems. It has got to be reformed. So that is kind of a strawman that is sometimes put up. It is not all bad, but it has some real problems.

Likewise, on the other side, another strawman is that a tax credit is just a delightful answer to these problems. As Len points out in his testimony on page 13, one type of tax credit would cost $6.50 for every dollar of new insurance purchased. I have seen some other studies from Len and Jon Gruber that indicate some of these credits are so inefficient you might be spending $15 or $18 for every dollar of new coverage. Surely, no one is for that.

So hopefully we can get away from these straw figures and focus on the real thing, because I don't think any Democrat alive today would vote in favor of a tax subsidy system that is so horribly expensive and that favors employees of large companies who are the highest-paid. Now, we love high-paid people, but, you know, those are the folks that need the subsidy the least. And yet, as your graph pointed out, Len, they are getting most of the money. It is a crazy, upside-down system that our forebears may have ratified in 1954, the year I was born, but it should not be allowed to continue.

So this is a very encouraging hearing. I appreciate the Chair holding it. These are fundamental but invisible issues, and they

have got to be dealt with, because you can't have a $200 billion market distortion and have the system work.

I am sorry for the statement more than a question.

Ms. TURNER. Mr. Cooper, you have really been a leader on this issue for as long as I have been following it. At least 15 years, you have been trying to get attention. And thank you for coming back to Congress to continue this battle.

I do think that the climate is much more fertile now to consider this issue, because we do see bipartisan support to say the current system is not working; we have got to do something different. And you have really provided wonderful leadership on this. Thank you.

Chairman SPRATT. Mr. Conaway?

Mr. CONAWAY. Thank you, Mr. Chairman.

And thank you all for being here.

You need to start the clock. Being a CPA, I am a slave to the rules. Thank you, sir.

Insurance is not a panacea; it is a risk-management tool. And when I hear both of you make comments about restricting growth in premiums because somebody got sicker, those costs still have to be paid for. I mean, insurance is not the—you know, whatever it is going to cost, the premiums, whether paid by the Federal Government or the employer or the individual, still have to cover the cost of the care, overhead and some profit, unless it is the Government, to the insurer. And to the extent you both make comments about not allowing that mechanism to happen, I question how that mechanically can work.

The Chairman talked about revolutionary change. There is not enough pain in the system to support that right now. My little brother needs a knee replacement, and he has for 20 years. And the trigger on that was when he got in so much pain that he was willing to do it, and he will have the surgery on November the 5th.

Well, the analogy is there is not enough pain—there is plenty of pain in the payment system now, as you testified to, we all pontificate about. But, quite frankly, there is not enough pain in the system for us to be willing to give up all the things that we think work and go to a blank sheet of paper and start over.

We all cling to things that are currently working in pieces and try to figure out the Band-Aids and the props and the other kinds of things that will continue to cobble along this current system that we knew. And whether it is the baby boomers not being able to find doctors to take them under Medicare or whether it is employers significantly dropping the number of people off of employer-sponsored plans, whatever those triggers or tipping points are going to be, we are headed for a spot where, one of the these days, the will of the people will say, "Mr. President, Congress, Senate, fix this problem." But I don't think we are there, at this point.

Ms. Turner, you mentioned new groups that you want to see formed up. What are the barriers, Ms. Turner, that you see are in place to prevent that from happening right now?

Ms. TURNER. Well, the portability of the tax treatment of health insurance, really. Because, right now, you can only get this generous tax benefit worth—what was it—collectively $189 billion if your employer writes the check for your insurance.

So, in order to be able to have health insurance be portable and for people to have other group options than just the employer group, that insurance tax deduction or tax break, tax exclusion, tax credit, would need to be portable and follow the person as an individual rather than as an employee.

Mr. CONAWAY. All right.

Speaking of individuals and personal responsibility, we passed, maybe last term or this term, a law that allows employers to automatically sign up people in 401(k) plans, because participation levels are greater if you are automatically in and have to opt out.

So, speak to us about the personal-responsibility elements of both of your proposals, in that people choose to make bad decisions. Particularly low-income people, if we were to say, "All right, you are going to get the extra 12,000 a year that the employer is paying for your health insurance," I am reticent to think that all of those people will automatically turn around and buy health insurance to cover their families, because they are living paycheck to paycheck as it is.

So how do we avoid the paternal issue that you spoke of earlier, which I agree with? Do we have the coldness of heart to tell folks, "Well, you know, we have now gone to a system where you are personally responsible for your health insurance; you chose not to get health insurance because you weren't sick at the time; you are now sick; you are going to have to die"? That doesn't seem to be an America that most of us would want to live in.

Ms. TURNER. No. And I think there are a lot of ways that you could address this in a new world.

First of all, employers could easily make it contingent, that we are not going to cash out the value of your—the amount——

Mr. CONAWAY. Well, that is a different—my colleague Mr. Cooper has left. If we just keeping adding additional mandates to employers, somebody has to comply with it.

Ms. TURNER. Well——

Mr. CONAWAY. Somebody has to figure out how much the cost of—they both left—of putting that number on your W-2. You continue to make it more difficult for employers to do what they are doing by splitting it up.

Ms. TURNER. Well, but if individuals can't get the tax break, if they don't buy the insurance, then they are going to be—in fact, you could even make a credit assignable, so that that person is eligible for that credit. And if they don't buy health insurance, then they get bought in, you know, they become part of a pool of insurers. Then they rotate through that pool of insurers who agreed to participate in the pool.

Mr. CONAWAY. Well, how does that insurer force the premium up? When you tell me that the sickest folks are going to be doing this, how do you make sure that you have insurers making a profit on that program?

Ms. TURNER. You know, I really think that people—people really want health insurance. Even young people want health insurance. They just don't want to pay $12,000 a year for it. So what you need is the incentive for the market to begin to provide more incentives to provide coverage that is affordable that people want to buy, and, if they are in those lower income categories, to be able to provide

them with resources to help them purchase that coverage. And employers can be great facilitators for access to coverage, maybe not necessarily totally responsible like they are today.

But I think that it is really a reformed market in which people have many more choices, new incentives to purchase coverage. That coverage is more affordable because consumers are really demanding better value in their health insurance, and they see the whole price of that coverage. That really is going to move us in a different direction than we currently are, toward more and more health insurance coverage that is more and more expensive, more and more invisible, more and more subsidies for people at the higher end of the income scale, and Government programs becoming ever more of a safety net for those people for whom that system is not working.

Mr. CONAWAY. It is going to get ever more expensive. I mean, so far nothing that you have talked about has pulled the expense piece out of that mechanism.

Ms. TURNER. Well, when you look at the fact that a job-based health insurance policy, which has gotten usually a lot richer and much lower deductibles, costs $12,000, but the policy that people are buying on their own in aggregate costs $4,000 to $5,000 on average——

Mr. CONAWAY. They still have to cover the cost of care.

Ms. TURNER. But the insurance companies are selling those policies. They must be making——

Mr. CONAWAY. Thank you, Mr. Chairman.

Chairman SPRATT. Mr. Doggett?

Mr. DOGGETT. Thank you, Mr. Chairman.

And I thank our witnesses.

Ms. Turner, you used the term, in describing the way we deal with the employer-provided tax system now, that it is a tax expenditure. And I certainly agree with you. I think it is an expenditure just as real as if we wrote an appropriations bill and paid that money out.

And your comment causes me to reflect on a recent hearing that this committee had with Peter Orszag and others on the importance of performance evaluation applying to tax expenditures also. I raised that issue with Mr. Ryan when we met with Secretary Paulson the other day.

Given the fact that the current Treasury Department favors your perspective, to a significant degree anyway, I hope you will join us in encouraging the Treasury Department to begin a process of evaluating each of these tax expenditures. They could do it without our passing any legislation. We need that kind of evaluation just as we need careful performance evaluations of all of our appropriations, our direct appropriations.

That is an area we agree on. I think I disagree with your conclusions.

First, you mentioned in your testimony, Dr. Burman, about the difficulty of targeting tax credits to the uninsured. And it does seem to me that all of our tax credits, all of our tax expenditures, are rather blunt instruments to accomplish their purpose.

To some extent, I think what we need is a cost-benefit analysis on these tax credits. If we are really concerned—and you have

talked about the challenges that we have in providing health care to seniors through the current system. And we are talking about, on something like children's health insurance today, what is the most cost-effective way to reach the largest number of uninsured children today or uninsured adults on some other day?

I just have great difficulty in seeing that the tax credits would be the most cost-effective way to cover children and that a direct Government program relying on private insurance, in many cases, for children's health insurance is a more cost-efficient way for the taxpayer, for the Treasury to reach more of our children.

Would you react to that, Dr. Burman?

Dr. BURMAN. Based on the evidence that I have seen, that certainly seems to be right.

And I completely agree with you that we should do tax expenditure analysis. One of the ironic things in the U.S. is that we actually invented the notion of tax expenditures. It was Stanley Surrey, who was a Treasury Assistant Secretary in the 1960s, who invented the whole notion. This has been embraced by countries all over the world.

I went to Mauritius to talk to them about—this little island country in the Indian Ocean—to talk to them about evaluating their tax expenditures and comparing them to direct spending programs. Everywhere else they do that, and the tax subsidies and the direct spending programs are all on the table. In the United States, we pretend that there is this big difference.

David Bradford, who is a Princeton professor, once said that he could run the military with tax credits, and it wouldn't look like a spending program anymore. It would be a dumb thing to do, but it would be a tax cut instead of new spending, so it would look like it was an improvement.

The fact is you would have to raise taxes to pay for, not only the tax credits, but all the inefficiency that they created as well. So I completely agree.

Mr. DOGGETT. You feel that using tax credits would not be a very effective, a very cost-efficient way of insuring more uninsured children?

Dr. BURMAN. I can't think of a tax credit program that would be anywhere near as cheap as expanding SCHIP. I mean, you could reform the whole system, and you could certainly do better than we are with current subsidies, as Ms. Turner said, but for an incremental expansion, the President has said that he thinks tax incentives are the answer, but the tax subsidies that he proposed in his budget would only cover a tiny fraction of the cost of health insurance for these low-income children, according to an analysis my colleague Linda Blumberg did.

Mr. DOGGETT. I think her presentation, which is in our written materials—and are you making that a part of our record, I suppose, Mr. Chairman, or should I ask unanimous consent to do that, the Blumberg study?

Chairman SPRATT. Sure.

Mr. DOGGETT. I would ask unanimous consent——

Chairman SPRATT. You want to enter it in the record?

Mr. DOGGETT. Yes. I think it is a valuable study, and it prompted my question.

And then I would just close by saying, not on the tax credit issue, but on the question of the advantages of personal choice, which we are all for, when you apply that into the practicalities, as you said in one of your observations earlier, of having everyone dealing with insurance sales people on this issue, we have something of a demonstration project under way right now. It is called Medicare Advantage.

And I just came from a hearing in our Health Subcommittee this week about the tremendous number of marketing abuses to our seniors under this attempt to privatize Medicare and let it wither on the vine, as our former Speaker said.

And there are plenty of practical problems in turning over seniors, particularly poor seniors, to these private insurance companies. It has been very costly to the taxpayer. And, if anything, it is the demonstration project and the example that simply privatizing this entire area may not be the best way to go.

Chairman SPRATT. Do you have a copy of the Blumberg article?

Mr. DOGGETT. I do. I believe it is here in our packet that each member has, but I will formally tender it to the committee for the record.

Chairman SPRATT. Without objection, it will be made part of the record.

[The information follows:]

Can the President's Health Care Tax Proposal Serve as an Effective Substitute for SCHIP Expansion?

Timely Analysis of Immediate Health Policy Issues
October 2007

By: Linda J. Blumberg

Summary

The Bush administration has proposed using the tax system to subsidize the purchase of health insurance, suggesting that offering parents tax deductions to offset the costs of insurance—rather than expanding the State Children's Health Insurance Program (SCHIP)—would be an effective way to extend coverage to more children. This brief compares the financial burden that parents would incur in obtaining coverage for their children under the president's tax-deduction proposal against that associated with SCHIP. It finds that the financial burdens for families between 150 and 300 percent of the federal poverty level (FPL) would be much higher under the tax-deduction approach than under SCHIP. Even after receiving the proposed tax subsidies under the president's proposal, a two-parent family with two children earning approximately $32,000 per year would pay 39 percent of their income to obtain private nongroup coverage for their children with comparable benefits to that provided through SCHIP at no cost to the family. Under the president's proposal, a two-parent/two-child family earning approximately $54,000 per year would still spend more than a fifth of their income on private nongroup health insurance to obtain comparable benefits to what they could obtain for their children under SCHIP for 1 percent of their income. The financial burden for single-parent families with one child are even greater under the tax proposal. Therefore, the potential to decrease the number of uninsured children would be substantially greater under an SCHIP expansion than under proposed tax deductions.

Background

Congress and the Bush administration are currently at odds over the reauthorization of the State Children's Health Insurance Program (SCHIP). In early October, the president vetoed the bill Congress passed that would have provided sufficient funding to maintain current levels of public coverage for children, cover more uninsured children who are currently eligible for Medicaid and SCHIP but are not yet enrolled, and cover additional children who would become eligible for coverage as a result of eligibility expansions.[1]

Last February, the Bush administration proposed using the tax system to subsidize the purchase of health insurance. The administration has suggested that this approach is preferable to expanding coverage for children through SCHIP, preferring to preserve public programs for only the lowest-income children.[2] The president's tax proposal would eliminate the current tax exemption for employer contributions to health insurance and replace it with a new standard deduction for individuals and families purchasing health insurance. The approach would eliminate the current tax preference for employer-based insurance, since the deduction would apply regardless of whether coverage was purchased through an employer or directly through the nongroup insurance market. The deduction would also decrease any current incentives to purchase overly comprehensive insurance policies, as the value of the deduction would not vary with the premium. The deduction would be set at $15,000 for family policies, and that amount would grow with the consumer price index. As is the case with the current tax exemption, the tax savings associated with this deduction increases the higher the family's income and marginal tax rate.[3] An inherent difficulty in relying upon the president's proposal for expanding health insurance coverage specifically for children is that it was not designed to subsidize the purchase of coverage for children only. As a consequence, to obtain new coverage for children, a tax-paying adult in the family must also obtain coverage, thereby increasing the implicit cost associated with insuring children.[4]

In contrast, SCHIP uses a combination of state and federal funding to provide health insurance specifically to children, most of whom live in families with incomes below 200 percent of the Federal Poverty Level (FPL).[5] The vast majority of SCHIP enrollees receive coverage through private health insurance plans that contract to provide such services with the state in which the child resides.[6] While the federal government does not require a particular benefit package be offered, benefits must be consistent with designated benchmarks within the state, and these benchmarks are made up of comprehensive employer-based plans.[7] However, cost-sharing requirements under SCHIP are lower than under typical employer-based plans. SCHIP provides a number of limits on cost-sharing that can be imposed, including that cost-sharing may not exceed 5 percent of a family's income. Additional protections are in place to reduce the

Urban Institute

chance a child might be disenrolled from the program due to premium nonpayment.[8]

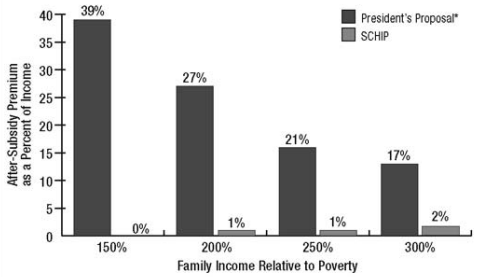
The purpose of this brief is to compare the family financial burdens associated with covering children and to assess the potential for expanding health insurance coverage for children between 150 and 300 percent of the FPL under the president's proposal and under SCHIP.[9]

Data and Methods

We compare the typical price of health insurance coverage relative to family income for children in the 150 to 300 percent of the FPL income range under the president's health insurance tax deduction proposal and under SCHIP. We focus on this income group because it contains a large share of uninsured children and because many SCHIP enrollees are in this income group. However, 92 percent of children currently enrolled in SCHIP are in families with income below 200 percent of the FPL,[10] and 75 percent of the uninsured children who are eligible for SCHIP but not enrolled fall into this low-income group as well.[11] It is also critical to remember that the majority of children who are currently uninsured but eligible for public insurance are eligible for Medicaid, not SCHIP,[12] and these children come from families with even lower incomes than the children analyzed here. While the congressional bill includes funding and policy changes aimed at increasing enrollment of these children in Medicaid at little or no cost to the families, families in this income bracket would receive little to no subsidy from the administration's tax-based approach.

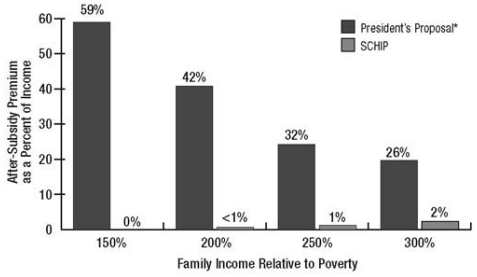
We analyze the family's cost of obtaining insurance coverage for their uninsured children under each policy option for two prototypical families—a single parent with one child and two parents with two children—at four different income levels relative to poverty (150, 200, 250, and 300 percent). We calculate the costs under the administration's proposal in two ways: first, assuming the family buys coverage through the private nongroup market, and second, assuming the coverage comes through the

FIGURE 1: Financial Burden of Providing Nongroup Health Insurance to Children Under the Bush Tax Plan and Under SCHIP: Prototypical Two-Parent/Two-Child Families, 2009



*Note: 80% of uninsured children in this income range have no parent with employer-based coverage, making the nongroup market their most likely insurance source under the president's plan. Estimates reflect the cost of obtaining family coverage, since the proposal is not designed to subsidize the purchase of coverage for children only.
Source: Author's calculations based upon current and proposed tax law and source material based upon Kenney, Hadley, Blavin 2007.

FIGURE 2: Financial Burden of Providing Nongroup Health Insurance to Children Under the Bush Tax Plan and Under SCHIP: Prototypical One-Parent/One-Child Families, 2009



*Note: 80% of uninsured children in this income range have no parent with employer-based coverage, making the nongroup market their most likely insurance source under the president's plan. Estimates reflect the cost of obtaining family coverage, since the proposal is not designed to subsidize the purchase of coverage for children only.
Source: Author's calculations based upon current and proposed tax law and source material based upon Kenney, Hadley, Blavin 2007.

employer. We then calculate the family cost associated with covering children under the SCHIP program.

Because 79 percent of uninsured children between 150 and 300 percent of the FPL do not have even one parent with private health insurance coverage,[13] providing coverage to children under the administration's proposal would usually require the purchase of a new family policy, not merely a change from adult-only coverage to family coverage. Coverage for all family members comes with the higher costs of purchasing a private family policy under the administration's proposal, whereas SCHIP coverage would typically only insure the children, thereby keeping the cost down for insuring them specifically.

In the private nongroup market case, we assume that family members are of average age and health status, such that they would be able to purchase coverage consistent with a typical employer-based policy at an average price in the small employer group market. We rely on national average premiums in the small group market[14] to provide a basis for a consistent comparison with the benefit packages provided under SCHIP, which are based on typical employer-based insurance policies in the state. To analyze the proposals in 2009 dollars, average premiums obtained from the 2005 Medical Expenditure Panel Survey Insurance Component (MEPS-IC) are increased by the predicted rate of growth in private health insurance premiums.[15]

Consequently, in this simple analysis, we do not address the difficulties inherent in the private nongroup insurance markets of most states, where people with current or past health problems may be unable to purchase a policy at any price, or may face premiums much higher than those used in this analysis, or may only be offered benefit packages that permanently exclude services for particular health care needs. We also have not increased premiums relative to employer averages to account for the higher administrative loads implicit in nongroup premiums relative to those in the small group market. Lack of guaranteed access to adequate coverage through the current nongroup market is, however, a critical issue that should be considered when evaluating the president's proposal. Additionally, equalizing the tax subsidy for health insurance in the group and nongroup markets decreases incentives for employers to offer health insurance to their workers. This change may lead some employers to drop their coverage, leaving more families to purchase coverage in the nongroup market, a situation that could make many currently insured people worse off, particularly those with high health care needs. Again, this brief does not account for such an impact.

In the group market case, we again use national average employer premiums (from the 2005 MEPS-IC) increased by the predicted rate of growth in private health insurance premiums to 2009 levels. Unlike the situation with nongroup insurance, the current tax code already provides a subsidy for the purchase of employer-based insurance. For uninsured families with access to employer insurance, the current subsidy is an insufficient incentive to enroll. Consequently, when analyzing the president's proposal and its potential for increasing the coverage of children in the group market, the measure of key interest is the *difference* between the current and proposed tax subsidies. If the proposed subsidy is significantly larger relative to family income or relative to the full premium than the current subsidy, it might be expected to have a significant impact on coverage decisions. But if the difference is small, one would not expect it to induce a significant change in coverage decisions.

The individual income tax liability for each prototypical family is determined using a simplified tax calculator that assumes wages are the only source of income; the family takes only the standard deduction and the proposed standard deduction for health insurance; children are eligible for both the child tax credit (CTC) and the earned income tax credit (EITC); and the family claims no credits other than the CTC and EITC. The calculator includes the impact of the alternative minimum tax (AMT) and assumes the only AMT preference items are the standard deduction and personal exemptions. The values of parameters used to calculate taxes in 2009 are based on the January 2006 inflation forecast from the Congressional Budget Office.

The reduction in tax liability under the administration's proposal would occur through reductions in income taxes and payroll taxes; at lower incomes, the payroll tax reduction makes up the largest share of the tax savings. As Burman et al note, counting the full amount of the payroll tax reduction as a subsidy would be inappropriate, since such current "savings" would be largely, if not completely, offset by future reductions in social security benefits, particularly for the low-income.[16] In essence, low-income workers would be paying for today's tax subsidy with forgone future social security payments since the less they pay into the system today, the less the system pays out to them upon retirement. Consequently, the results shown here exclude the payroll tax reductions from the subsidy calculations under the administration's proposal as well as in the calculation of the tax liability under current law. (Calculations including the payroll tax reductions are available upon request from the author.)

SCHIP premiums used here for children of different income levels are the medians of the range of premiums that states charged families in 2007.[17] No analysis documents the rate of growth in SCHIP premiums; consequently, we inflated the premiums to 2009 using the projected growth rates in private health insurance premiums. This likely biases future SCHIP premiums upward, as many states have gone several years without changing these premiums.

Findings

Table 1 provides estimates of the impact of the administration's proposed health insurance tax subsidy on the cost of family coverage for two-parent/two-child families and one-parent/one-child families in the private

nongroup market. As the first section of the table shows, even after the tax subsidy is taken into account, purchasing family health insurance coverage that would include insurance for both children would cost a typical two-parent/two-child family at 150 percent of the FPL 39 percent of their family income in 2009, with the subsidy only covering 5 percent of the premium cost. For those at 300 percent of the FPL, with the tax subsidy, the cost of coverage to the family constitutes 17 percent of income, with the subsidy covering 17 percent of the full premium. In later years, the financial burdens would increase for all income groups, as the deduction is not designed to increase at the same rate as health insurance premiums.

For the single-parent families analyzed in the bottom section of Table 1, the financial burden of purchasing coverage for their children is even greater. Purchasing a family insurance policy in the private nongroup market with benefits comparable to those that the child would receive under SCHIP would cost a family at 150 percent of the FPL 59 percent of family income, with the subsidy covering 5 percent of the full premium. For a typical family at 300 percent of the FPL, purchase of the insurance policy would cost 26 percent of income in 2009 (a premium subsidy of 17 percent). Notable across both sections of the table is how the value of the subsidy is lowest for those at the bottom of the income range and increases with income, which runs counter to the purpose of a subsidy designed to provide greatest support to the most economically vulnerable.

Some families might be able to purchase coverage at a lower price if the coverage excluded certain benefits typically considered part of comprehensive insurance policies, or if they chose policies with significantly higher deductibles and/or cost-sharing requirements than are typical under SCHIP. However, the greater the out-of-pocket requirements imposed, the greater the difficulty low-income parents face when attempting to access necessary care for their children and the greater their consequent out-of-pocket spending burdens.[18]

In the past, the administration has proposed using refundable tax credits as opposed to a new standard tax deduction to lower the cost of private nongroup insurance coverage for the

TABLE 1: Impact of President's Health Care Tax Proposal on the Price of Family Health Insurance in the Private Nongroup Market By Family Income Relative to Poverty, 2009

Two-Parent Family with Two Children				
Income as Percent of the Federal Poverty Level	150%	200%	250%	300%
Family Income	32,379	43,137	53,895	64,654
Subsidy for Health Insurance	698	1,569	2,107	2,289
Subsidy as Percent of Premium	5%	12%	16%	17%
After-Subsidy Premium as Percent of Income	39%	27%	21%	17%
Single-Parent Family with One Child				
Income as Percent of the Federal Poverty Level	150%	200%	250%	300%
Family Income	21,412	28,201	35,512	42,824
Subsidy for Health Insurance	611	1,353	1,928	2,250
Subsidy as Percent of Premium	5%	10%	15%	17%
After-Subsidy Premium as Percent of Income	59%	42%	32%	26%

Source: Urban Institute analysis of prototypical families, based upon current and proposed tax law. See data and methods section of text for further detail on income tax calculations.
Notes: Calculations of the subsidies do not include payroll tax reductions under the proposal as these reductions would largely be paid back by future reductions in Social Security benefits. Results including payroll tax reductions can be obtained upon request of the author. The average family premium in 2009 is $13,206.

TABLE 2: Difference Between President's Health Care Tax Proposal and Current Law Tax Subsidies for Family Health Insurance in the Private Employer Group Market By Family Income Relative to Poverty, 2009

Two-Parent Family with Two Children				
Income as Percent of the Federal Poverty Level	150%	200%	250%	300%
Family Income	32,379	43,137	53,895	64,654
Current Subsidy for Health Insurance	3,644	1,981	2,290	3,434
Proposed Subsidy for Health Insurance	1,692	2,230	2,559	3,742
Difference between Current and Proposed	-1,952	249	269	308
Difference as Percent of Premium	-15%	2%	2%	2%
Difference as Percent of Income	-6%	1%	<1%	<1%
Single-Parent Family with One Child				
Income as Percent of the Federal Poverty Level	150%	200%	250%	300%
Family Income	21,412	28,201	35,512	42,824
Current Subsidy for Health Insurance	3,814	3,021	1,981	2,247
Proposed Subsidy for Health Insurance	1,883	2,230	2,250	2,516
Difference between Current and Proposed	-1,931	-791	269	269
Difference as Percent of Premium	-15%	-6%	2%	2%
Difference as Percent of Income	-9%	-3%	1%	1%

Source: Urban Institute analysis of prototypical families, based upon current and proposed tax law. See data and methods section of text for further detail on income tax calculations.
Notes: Calculations of the subsidies do not include payroll tax reductions under the proposal as these reductions would largely be paid back by future reductions in Social Security benefits. Results including payroll tax reductions can be obtained upon request of the author. The average family premium in 2009 is $13,206. Negative differences between current-law and proposed subsidies indicate that the proposed subsidy is smaller than the current law subsidy for a family at the given income level.

low-income population. But even under such an alternative, the administration has not proposed a subsidy greater than $3,000 for a two-adult/two-child family, which would still leave such a family at 150 percent of the FPL with a premium burden of 32 percent of income. In addition, this option would still require that the shortcomings of the nongroup market be addressed in order to ensure access to adequate coverage.

For the roughly 20 percent of uninsured children in families with incomes between 150 and 300 percent of the FPL where a parent has ESI coverage, we compare the current-law tax subsidy for employer-sponsored insurance payments for family coverage with the subsidy under the administration's proposal. Table 2 shows the results for our prototypical families. Here we see that for the families at the low end of the income range, the subsidy provided under the administration's proposal would be smaller than the current-law subsidy provided by exempting employer-sponsored insurance from tax. This implies that such families would be *less* likely to purchase family coverage under the proposal than they are today. For the higher-income families, the administration's proposed subsidy would be larger than the current subsidy, but the difference is very small, amounting to no more than 2 percent of premium or 1 percent of family income. Such a small increase in the subsidy could not be expected to have a significant impact on the likelihood of purchasing coverage relative to current law.

Table 3 shows the predicted financial burdens associated with SCHIP premiums for the same types of families used in analyzing the president's proposal. The after-subsidy cost of obtaining coverage for children in either the two-parent family or the single-parent family ranges from 0 to 2 percent of income, depending on family income. In contrast to the administration's tax proposal, under SCHIP, financial burdens as a percentage of income are lowest for the lower-income families and highest for the families at 300 percent of FPL.

TABLE 3: The Cost to the Family of Children's Health Insurance Under SCHIP By Family Income Relative to Poverty, 2009

Two-Parent Family with Two Children				
Income as Percent of the Federal Poverty Level	150%	200%	250%	300%
Family Income	32,379	43,137	53,895	64,654
After-Subsidy Premium	0	243	617	1,081
After-Subsidy Premium as Percent of Income	0%	1%	1%	2%
Single-Parent Family with One Child				
Income as Percent of the Federal Poverty Level	150%	200%	250%	300%
Family Income	21,412	28,201	35,512	42,824
After-Subsidy Premium	0	128	405	811
After-Subsidy Premium as Percent of Income	0%	<1%	1%	2%

Notes: After-subsidy premiums are equal to the 2007 unweighted median across 50 states, inflated to 2009 using the projected growth in per capita private health insurance expenditures.
Source: Premium data were obtained from a 2007 update of the data used in Kenney G, Hadley J, and Blavin F, 2007.

Conclusion

The financial burden under SCHIP is therefore substantially lower than under the president's tax proposal, as Figures 1 and 2 illustrate. Both experience and the economic literature are clear that the higher the premium, the lower the voluntary enrollment in insurance will be.[19] Consequently, if each program is evaluated solely on its ability to expand health insurance coverage to children, SCHIP's potential far outpaces that of the Bush administration's proposal on price alone. The differential impact on insurance coverage is especially dramatic when one takes into account that 1.7 million children projected to gain insurance coverage under the SCHIP bill would be covered by Medicaid[20]—most of these children have lower incomes than those analyzed here and would receive little to no subsidy under the president's approach. Add to that the complexities, limitations of access, premium variation, and higher cost-sharing requirements in the private nongroup market, and the investment in outreach and enrollment improvements included in Congress's SCHIP reauthorization bill, and the differences between the two approaches are amplified.

[1] G. Kenney, A. Cook, J. Pelletier, "SCHIP Reauthorization: How Will Low-Income Kids Benefit Under House and Senate Bills?" *Timely Analysis of Immediate Health Policy Issues Series* (Washington, DC: The Urban Institute, 2007), http://www.urban.org/publications/411545.html

[2] See for example, 7/17/07 letter from the U.S. Department of Health and Human Services Secretary Leavitt to Senators Baucus and Grassley and 7/26/07 letter from Secretary Leavitt to Congressman Rangel.

[3] In fact, at the lower income levels, the tax deduction provides value only through the payroll tax element, since those at very low income levels have almost no income tax liability to offset. The proposal also includes a reintroduction of the president's proposal to allow federally licensed association health plans to sell insurance to small employers outside of state health insurance regulations. It also includes a proposal that is not well defined to allow states to redirect funds currently received through the Medicaid Disproportionate Share Hospital program to be used to purchase health insurance coverage for low-income individuals and those with chronic medical conditions; however, there is no requirement for states to do so, and no additional federal funding beyond current levels. These latter two dimensions of the proposal are not assessed here.

[4] There is no indication that the administration anticipated the tax deduction being applied to the purchase of coverage for children only, an insurance option not widely available or subscribed to at the current time. Coverage for the adult taxpayer, at a minimum, is presumed under the approach. U.S. Department of Treasury, "General Explanations of the Administration's Fiscal Year 2008 Revenue Proposals (The Blue Book)" (Washington, DC: U.S. Department of the Treasury, 2007), http://www.treas.gov/offices/tax-policy/library/bluebk07.pdf.

[5] C. Peterson and E. Herz, "Estimates of SCHIP Child Enrollees up to 200% of Poverty, above 200% of Poverty, and of SCHIP Adult Enrollees" (Washington, DC: Congressional Research Service, 2007).

[6] J. Solomon, "The False 'Public versus Private' Choice for Children's Health Coverage" (Washington, DC: Center for Budget and Policy Priorities, 2007), http://www.cbpp.org/6-21-07health.htm.

[7] The three benchmark options are a state employee health plan, the Blue Cross Blue Shield standard option plan offered to federal employees, and the HMO plan with the greatest enrollment in the state. See http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp.

[8] http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp.

[9] While the president's proposal has a scope well beyond expanding coverage for children, we do not assess its impacts in other areas. Such comprehensive analyses of the president's proposal have been done by others (see L. Burman, J. Furman, and R. Williams, "The President's Health Insurance Proposal—A First Look" [Washington, DC: Urban Institute–Brookings Institution Tax Policy Center, 2007).

[10] See Peterson and Herz, "Estimates of SCHIP Child Enrollees up to 200% of Poverty, above 200% of Poverty, and of SCHIP Adult Enrollees."

[11] G. Kenney, A. Cook, and J. Pelletier, "SCHIP Reauthorization: How Will Low-Income Kids Benefit under House and Senate Bills?"

[12] Congressional Budget Office, "Cost Estimate for H.R. 976, Children's Health Insurance Program Reauthorization Act of 2007" (Washington, DC: Congressional Budget Office, 2007), available at http://www.cbo.gov.

[13] Urban Institute tabulations of the 2006 ASEC Supplement to the Current Population Survey.

[14] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2005 Medical Expenditure Panel Survey-Insurance Component, Tables I.C.1 and I.D.1.

[15] Centers for Medicare and Medicaid Services (CMS), "NHE Projections 2006–2016, Forecast Summary and Selected Tables," http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage.

[16] See Burman, Furman, and Williams, "The President's Health Insurance Proposal—A First Look."

[17] Premium data were obtained from a 2007 update of the data used in G. Kenney, J. Hadley, and F. Blavin, "The Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," *Inquiry* 43, no. 4 (2007): 345–61.

[18] S. Zuckerman and C. Perry, "Concerns about Parents Dropping Employer Coverage to Enroll in SCHIP Overlook Issues of Affordability" (Washington, DC: The Urban Institute, 2007), http://www.urban.org/url.cfm?ID=411555.

[19] L. J. Blumberg, L. M. Nichols, and J. S. Banthin, "Worker Decisions to Purchase Health Insurance," *International Journal of Health Care Finance and Economics 1*, no. 3–4 (2004): 305–26; M. E. Chernew, K. D. Frick, and C. McLaughlin, "The Demand for Health Insurance Coverage by Low-Income Workers," *Health Services Research* 32, no. 4 (1997): 453–70; G. Kenney, J. Hadley, and F. Blavin, "The Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," J. Hadley, J. Reschovsky, P. Cunningham, G. Kenney, and L. Dubay, "Insurance Premiums and Insurance Coverage of Near-Poor Children," *Inquiry* 43, no. 4 (2007): 362–77.

[20] Congressional Budget Office, "Cost Estimate for H.R. 976."

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Mr. DOGGETT. Thank you both.

Chairman SPRATT. Mr. Lungren?

Mr. LUNGREN. Thank you very much, Mr. Chairman.

I appreciate the witnesses here.

I understand the seriousness with which you talk about, quote/unquote, "tax expenditures." I just have a problem with the ease with which we talk about tax expenditures, because, philosophically, it presumes that all money someone earns, first claim on it is the Government, and if the Government decides to not take it from you, it is an expenditure by the Government. It seems to me that reverses the relationship of who is to serve whom.

Now, I understand how you have to analyze this in terms of budgets and so forth. But I just would like to render at least my

objection to the ease with which we use tax expenditures, which seems to presume that the Government has first call on the money, and if we in Government are nice enough to let you keep it, then we have expended something.

I am also reminded in this debate of a townhall I had recently when someone in the back got up and said, "Congressman, we demand, or we deserve, or we should have the same health care that you have." And I said, "Fine;" I said, "I pay insurance, like everybody else does." "Well, I am not saying that I ought to pay it," she said. And it reminded me of Frederic Bastiat's comment where he said, "The state is the great fictitious entity by which everyone seeks to live at the expense of everyone else."

And what I am trying to figure out in this whole process is, how do we move toward health-care access to the American people in a way which makes transparent the costs involved, so that we can make some logical decisions with respect to this—for any number of reasons, the first of which, the way the system works now, particularly Medicare and Medicaid, it is going to bankrupt us; we just can't keep going that way. But secondly, does that enhance or does that inhibit the ability for us to bring down the rate of increase of cost in medical care?

And the reason I ask that is this: Recently, I went through a procedure dealing with veins in my legs. Now, 25 years ago, you would have done that by stripping it. They would have cut one end of your leg and cut the other end of the leg, put an instrument in there and actually pulled it out. It would have required hospitalization for any number of days. Now they have a system where they put a catheter in with a wire inside that has radio frequency, and they literally, through high-intensity heat, burn the inside of your vein, and it collapses in on itself. And the procedure takes 20 minutes. The actual use of radio frequency is about 7 minutes. No hospitalization. If it all goes well, you go home. You are able to work the next day.

It is not the most comfortable thing, but the difference between that procedure 25 years ago and today, in terms of the cost of hospitalization, in terms of lost work, in terms of your ability to continue with other activities, is tremendous. Now, the procedure isn't cheap, but in terms of probably inflation-adjusted cost, it is cheaper than the procedure 25 years ago.

There is evidence of where the overall cost to the individual or society or whoever pays for it is less; the interruption or opportunity cost lost is less.

Similarly, we now control things by use of medication, where, before, it probably would lead toward surgical intervention or, in some cases, even incapacitation from work.

So, on the one hand, I see tremendous improvements in medical care that actually are expressed in economically beneficial ways. And, on the other hand, I see the continuing costs going up of the overall system that seems to outstrip this benefit.

To what extent, if any, does the way that we operate our health-care system, with insurance primarily sponsored or subsidized by employers, cause the advantages that we see in medical advancements to be overcome by the way we operate?

I know that is kind of a general question, but I am really confused by that as I continue to look at the evidence of improvement here.

Is it because we have such inefficiencies in other parts of it that are unrelated to true care that we have it? Or is it just that the advances I talk about cost so much to get there that, even though maybe in an individual procedure it is more efficient, the overall system that had to create it overwhelms the costs of the system?

Ms. TURNER. I do think that that really shows that—why does the health sector not work like the rest of the economy, where we can figure out ways to get faster, better, cheaper by having these innovations be more widely adopted?

And in the health sector, I do think that a huge part of it is the invisibility of the cost, the third-party payment system. When you ask a doctor or a hospital how much does an MRI cost or how much is this procedure going to cost, they don't know. So how can you have a true market when buyers and sellers don't have the vaguest idea whether or not it is more efficient to do these kind of services?

But I do think that the private marketplace is absolutely going to encourage much more of that kind of innovation than a Government-run system in which the Government is expanding current programs under payment schedules and systems of A, B, C and D are covered. You need to make sure that you have got that vitality and that energy to continue to come up with innovations. And we see so much more of that in this country than you do in other countries that have Government-dominated health-care systems.

So there are a million different things, including utilization of these new technologies, that are driving up costs. As people are able to get more and better medical procedures to address their health-care issues, then they want more of them, including new medicines.

So, are we healthier as a result of increased use of technology? Not always. We have seen that in Florida, for example, with the Medicare program, that Florida residents in a couple of counties spend twice as much as someone living in Minnesota on medical care, and yet they are oftentimes less healthy.

So if consumers are given an incentive to—and especially seniors in Florida, who seem to think of going to the doctor as more of a recreational activity, in many cases, you know, "Should we go to lunch today before or after your doctor's appointment?"—is that really the right kind of incentive? Or do people need to have more price visibility so that they can utilize those services more wisely?

And I also think that if we have a system in which the Government is paying less and less and less, as it is now, for both doctors and hospitals and procedures, then it pushes up the prices of private insurance. So we have got to get to a system in which private insurance is not going up simply because doctors and hospitals have to recoup their costs someplace. And they are not even making ends meet oftentimes if they see Medicaid patients.

We need to find a system in which the payments are more visible and there is more rationality in those pricing systems, and let this sector of our economy have more of the market forces that really direct and organize the rest of the economy. I think that is pri-

marily what is absent in the third-party payment system, both on the public and the private side.

Dr. BURMAN. May I make just a quick comment?

There actually is some evidence specifically on the question that you asked about whether the medical innovation is, on balance, a good thing or a bad thing. There is a study by Harvard economist Joe Newhouse that looked at the relationship between insurance and medical innovation, the thing you benefited from. And he said that, on balance, he thought that it was a good thing, that the fact that people had insurance meant that there were a lot of cost-effective medical innovations that were created. Obviously, not all of them are.

And the concern he raised, actually, was that if there was an overzealous effort to restrain moral hazard, try to really push down pressure on prices, that, in fact, a lot of cost-effective innovations wouldn't be done because it would be harder for companies to invest in new technologies.

Chairman SPRATT. Mr. Baird?

Mr. BAIRD. Thank you, Mr. Chairman.

And I want to thank our witnesses.

As I listen to many of the issues you raise and the concerns, I have to reflect that it seems to me that there is a bill proposed that solves most of them. And the Wyden-Bennett bill in the Senate, Baird-Emerson in the House, does it.

And I will just list a few of them. When you speak about adverse selection, our bill specifically says insurance companies have to take in all takers, so the competition is based on quality of care and price control, not on cherry-picking or adverse selection.

Now, the issue Ms. Turner raised, and I think it is absolutely valid, about health care information, under my bill in the House, we would require that patients be given—we move toward a system where patients be given a priori information about costs, options and what percent they will share. So that if you want to have back surgery versus core-strengthening exercises, yet the empirical data suggests they are similar in outcome, then you pay for the back surgery, the bulk of that, over what it would cost you for core-strengthening exercises.

So many of the things you address—and my friend Mr. Conaway said we are afraid in the Congress to start from scratch. Not Ron Wyden and me. We have started from scratch. We have not said, let's cobble together, you know, SCHIP and Medicaid, et cetera.

We have said, clear it out, it is a simple bill; the model is that you have to buy your own health-care insurance because God didn't say your employer is responsible for your health; you are responsible for your health. The employers don't get the deductions; you don't have that price distortion. And you get large-group purchasing, so that the individual person is in the same boat as the person in the largest corporation. And if you change jobs, you are not locked into your job, because you have your own health policy. And there is an incentive for you to save your health costs because, over time, you can reap the benefits of that by choosing a policy that, by the way, under our bills, have incentives to save costs.

So I am very happy to hear your testimony. I wish I could get more members of Congress to hear it and look seriously at our bill.

I don't think we have to wait until the next messianic President on either side to solve the problem. We are Article I, we are the Legislative Branch, it is our responsibility.

And, by the way, as I have looked at the plans on both sides, both the Republican presidential candidates and many of the Democratic presidential candidates, I don't see a one that I think is superior to the bill that we have put forward in the legislative branch. And so I hope some of my colleagues on both sides of the aisle—we have bipartisan sponsorship now, but I hope others will do it.

One difference between Wyden's bill and my bill is we are calling for credits and Ron would go for a deduction. And I am just interested in your thoughts. I don't necessarily have a big dog in the fight one way or the other. I just want to know what your thoughts are about what would work best in that regard.

And at the risk of even looking toward a third rail, I wonder if you might want to speculate on the feasibility of extending a system like this throughout the lifespan of a person. So, in other words, when they hit 65, they don't necessarily drop off my policy; I could carry my policy.

And if there is a third part to the question, what are your thoughts about if there were a—one of the options that we could pick—you know, Mr. Lungren's constituent said, "I want your plan." That is what prompted Ron to develop his, and I agree with it, except you are right: We have to pay for it. And it would be foolhardy not to pay it, because you don't value and conserve what you don't pay for.

But what if one of the choices in the FEHB-type plan that Ron's bill and mine would offer were a Government-run plan? If you want to put your money on the back of the Government, you can do that. The Government would still bill you for it; it is not free. But you could purchase a Government-provided system.

So those are three questions I would love your thoughts on.

Ms. TURNER. On the question on credits versus deductions, it is such a difficult question, because I think that deductions are much more like the tax exclusions that 160 million people have benefited from through the employment-based system—invisibly, but it is much more like a deduction. So, you know, that could make an argument for the deduction for people who currently have coverage.

But credits are much more valuable to people at the lower end of the income scale. So that a deduction, you know, for all of the reasons that we have discussed, is just not going to help people at the lower end of the income scale, unless you supplement it somehow. And it could be through refundable credits, but it could be through other kinds of payments. But, essentially, people just need more help if they are going to actually purchase——

Mr. BAIRD. Yes, I should say, in our House bill, it is not a full credit for everything you pay. It is a limited amount, so that lower-income people would benefit proportionately more because they will hit that limit, presumably, sooner. And, also, those who buy more conservative policies would, as well.

Dr. BURMAN. The current system is just extremely poorly targeted, and deductions just can't help low-income people. Thirty percent of people are in the zero tax bracket. They don't benefit if

their taxable income is reduced. And, you know, they are the ones who most need help paying for health insurance.

I actually think credit versus deduction is the easiest question.

Ms. TURNER. And regarding the carry-forward to Medicare, we were talking earlier about the State Children's Health Insurance Program. There is no reason that the SCHIP benefit couldn't be basically cashed out to allow people that may be eligible for health benefits through Wal-Mart but just can't afford to make their part of the premium coverage for their dependents couldn't use the value of that to be able to have family coverage through Wal-Mart.

And I think that is sort of the same thing with the Medicare benefit. Why couldn't people have the value, the actuarial value, in a risk-adjusted, age-adjusted I am sure, mechanism, to let people have the opportunity to continue whatever coverage they have selected that provides stability, longevity?

I think the whole question of stability is so important because, both on the individual side and on the—the insurer and on the physician side, that continuity is going to get us to a system where we have better incentives for chronic care management. Rather than just saying, "How long do I have to cover this person before they get sick?", you are thinking, "How can I keep this person healthy as long as possible?"

And we need to realign all the incentives to make that happen. And longevity in the ownership of health insurance and the relationship with the company that provides your care, and therefore the financing that supports it, I think are all really critical elements.

Dr. BURMAN. One thing I think is important about your plans is the idea of mandates and pooling at the insurer level.

One thing that Ms. Turner said a few times that I actually will take issue with is that nongroup insurance is inexpensive. And it is true, the premiums for nongroup insurance in the current market are a lot lower than what they are for typical employer-based coverage. But there are two things. One is that there are huge load factors. Thirty five percent of the premium, by some estimates, is marketing costs and underwriting. And most of those costs are not incurred through large employer groups, and they wouldn't be incurred through a system where insurers had to take all comers and there was pooling on a large scale.

The other thing is the adverse selection; the people who buy insurance in the nongroup market are healthier than average. The sick people can't get in, whereas they are in, at least the larger groups.

The third thing is the kind of insurance sold in the nongroup market tends to have very, very high deductibles and copayments. Again, it works okay for people who are healthy, but, basically, the way the nongroup market works is——

Mr. BAIRD. Mr. Burman, let me just interrupt for a second. I just would point out—I know that we have other questions, and I think we have a vote coming up—our bill obviates all of that.

Dr. BURMAN. Yes.

Ms. TURNER. Right.

Dr. BURMAN. I am agreeing.

Mr. BAIRD. Yes. I think that is part of what the merit is. I think part of what is so impressive.

Any thoughts, finally, about this issue of does it make sense to offer a Government-run program as one of the choices in addition to the private insurance market? Because in Ron's bill and mine, you can buy your policy from the private insurance market, but if the Government wanted to offer one and you believed in the Government, does that make sense?

Ms. TURNER. I believe in choice, so, absolutely.

Dr. BURMAN. It seems like you could do a cost-benefit analysis to see what the cost of running that is versus contracting with private insurers.

Chairman SPRATT. Thank you, Mr. Baird.

Gwen Moore, Mrs. Moore from Wisconsin.

Mrs. MOORE OF WISCONSIN. Well, thank you very much, Mr. Chair.

And thank the witnesses for appearing.

I regret that I wasn't here for the beginning of the meeting, because I feel like I have missed so much. And so, I ask the members and the Chair and ranking member's indulgence if I cover ground that has already been covered or I repeat myself.

I guess I would like to go to the bottom of page 11, Dr. Burman, of your testimony, where you indicate that replacing the ESI exclusion with a regressive refundable tax credit would be an improvement over the current tax law. And then you go on to page 12 to say that it would encourage low-income employees to take up employers' offer of insurance. I am a little bit confused about this, for a variety of reasons.

Number one, you know, I think about the time that I did my daughter's Earned Income Tax Credit when I did her taxes for 5 years in a row. She kept begging me for money, and I finally did her—she had no tax liability, and she was stunned to see how much money she got back.

I am concerned about access of poor people, if they, in fact, get a refundable tax credit. They would have to make the initial expenditures for health care, which might mitigate against them dealing with preventive health care.

You also seemed to indicate, you also seemed to assume, in that one statement, that employers would still have an incentive to offer health care without the exclusion. And I guess I am not quite understanding how this would work.

Dr. BURMAN. Well, there are two issues.

One is there is certainly an issue of timing of tax credits. If we, the middle class, upper-income people, get tax breaks at the end of the year, we can front the money and then we get it back on our tax returns. There is a big problem with timing, that if you have to pay $12,000 for your health insurance and you get even a big credit 16 months later, that will be too late.

Mrs. MOORE OF WISCONSIN. Exactly.

Dr. BURMAN. There have been proposals. Both President Bushes, actually, have proposed transferable credits that could go directly to insurers. I think the first President Bush had a proposal that would have gone to employers in advance. And there are a lot of administrative challenges, but you could at least conceivably design

a credit that could be advanced, and you would get the money when you needed it.

The problem with the current system is it really provides almost no help to low-income households. It doesn't help you to reduce your taxable income if you don't owe taxes anyway. You might even be worse off. If you are on the Earned Income Tax Credit and you are in the phase-in range for the ITC, reducing your income could actually raise your taxes, because you—I am sorry, yeah, reducing your income would raise your taxes, because you would lose some of the Earned Income Tax Credit.

But I think those problems, at least conceivably, can be dealt with. And the fact is, a credit is a lot more progressive than a deduction or exclusion.

The second issue you asked is, why would employers still provide health insurance if it wasn't excluded from the income of their employees? I am not talking about eliminating——

Mrs. MOORE OF WISCONSIN. I am talking about the income—not excluded from their employees. The income tax liability, their deduction.

Dr. BURMAN. I should have made clear that the health insurance premiums paid by employers would always be deductible for employers. It is just the legitimate cost of doing business, just like wages are. The proposal is that it would be included in the income of the employees, but they would get a tax credit instead.

So right now, if your employer provides you with $10,000 worth of health insurance, your income for tax purposes is reduced by $10,000. The employer gets to deduct it, as it would wages. But the difference is that, unlike cash compensation, you don't have to pay tax on it as an individual.

The alternative I am suggesting is that you would add that $10,000 back into your income, or the employer would report that on your W-2 form as taxable income, but you would get a tax credit. And maybe the credit would be 40 or 50 percent for a low-income person, or even more. And that would be a much more valuable tax subsidy than the exclusion. You could target it to the people who most need help. And that is the basic idea behind it.

Is that clear?

Mrs. MOORE OF WISCONSIN. Well, it is clear, to some extent. But 70 percent of working people are covered by the current system, and I don't think necessarily that people's health insurance ought to be necessarily tied to work, because, at some point, we all don't work. We are fired, we are retired, we are too sick, we are too young, we are too old. And so, it is a system where, at some point, you won't have health coverage, maybe at a point at which you really need it.

I guess the confusion for me comes in with, you know, with I guess both of you not necessarily proposing some system that is not tied to folks' employment.

Dr. BURMAN. The concern is—I mean, you are right that the employer-based system is not the ideal, and people can lose insurance just because they lose their jobs. Although there are some provisions that allow them to continue coverage, if they can afford it.

The concern is that you might throw a bunch of people in the individual, nongroup market; some would pick up insurance, but oth-

ers wouldn't be able to find it in the system as it is currently formulated.

I think Ms. Turner and I agree that there need to be reforms in the nongroup market. If we have reforms that guarantee that low-income people can afford insurance, that people who are ill can find insurance that is affordable in a nongroup market, you could conceivably significantly expand coverage.

But all of the tax credit proposals that I have seen don't seriously address the fundamental problems. The President had a proposal for the standard deduction for health insurance, which had some very good ideas in it. And he said that there were problems in the nongroup market, but there were no details on how those problems would be solved and no money to help States solve it.

So I think those problems need to be taken very, very seriously. Otherwise, you could end up further unraveling the employer-based system, which, admittedly, already has problems, and not having a good alternative in the nongroup market, and a lot of people would end up losing coverage.

Ms. TURNER. One of the options would be—I absolutely agree that tying health insurance to the workplace—we just need to give other people other options. It is not just working for an increasing number of people.

One option would be to boost the value of the Earned Income Tax Credit, so that if people used the extra amount to buy health insurance, then they get an enhanced Earned Income Tax Credit. And some of the President's proposals would have made the tax credit not only refundable but advanceable, so you could get it in advance; assignable, so it could be assigned to an insurance company right then, so you don't have to wait 16 months; and nonreconcilable, which means that if your income changes during that year and you were advanced money to buy that health insurance, then that is just too bad for the Government. You have had health insurance coverage.

So refundable, advanceable, assignable, nonreconcilable all make the IRS crazy, but there are solutions, I think, to help make that coverage more stable for individuals.

Mrs. MOORE OF WISCONSIN. Thank you so much.

Thank you, Mr. Chairman.

Chairman SPRATT. One last question from me, if I could.

Jose, do you have that map of the United States with the variation in cost?

This map is a little hard to read from your vantage point, but you can see the basics of it, and you have seen it before, I am sure. The variation in cost varies from region to region, as much as $11,352 in certain places like Miami, and as little as $4,272 in other places like, probably, in Minneapolis.

How do you have one certificate, call it what you will, one tax credit, equal across the United States that will respond to each one of those districts, with that spread, from $4,200 to $11,300? How do you deal with that variation?

Ms. TURNER. That is one of the reasons that the President, I think, decided on a deduction, because that is based upon how much you spend. So people that live in Los Angeles or people that

live in Houston would get a bigger credit simply because they are able to spend more on their health insurance.

But I think there are also ways to make the credit adjustable and to make it be—even the credit be contingent upon the percentage that a person spends for their health insurance. So that if you talk about a fixed-dollar credit of $3,000, it is going to be a very different value to somebody living in Idaho than it is to somebody living in south Florida or LA. So a percentage-adjusted credit is also a way to begin to address that.

Dr. BURMAN. Just to clarify, the President's proposal would have been a fixed—it was the same amount regardless.

But, I mean, I think what you raise is an extremely difficult issue. For one thing, you have to determine how much of that difference is due to legitimate differences in costs and how much of it is due to just differences in taste for health insurance. And I think——

Chairman SPRATT. I am told it is largely due to how they practice medicine.

Dr. BURMAN. Yeah. And, actually——

Chairman SPRATT. And in Miami it is a much more diagnostic-intensive, instrument, procedural thing. And in some other part of the country where the cost per patient is lower, it is a more judgmental practice of medicine.

Dr. BURMAN. But, I mean, that would be an argument for not varying the credit by regions and giving people an incentive—having a credit for purchase of insurance but not a credit that is larger if you spend more on insurance, because that would give people an incentive—give people in Miami an incentive to say, "I would like you to practice medicine like they do in Iowa."

But, I mean, that is a lot of theory, too.

Chairman SPRATT. If you accommodate this variation with differential values depending on where you live, you lock in these costs and the cost differential.

Dr. BURMAN. I think there would also be a lot of game-playing, too. A lot of people live near—like, we have three different jurisdictions within 10 miles of each other. Are you going to have different rates for Maryland and for D.C. and for Virginia, and will people take advantage of that?

Chairman SPRATT. Would you both agree, then, that this is a problem that has to be more or less fixed in order for these tax certificates, these tax refunds to be issued on a nationwide scale?

Ms. TURNER. Well, I—yes, absolutely. I think that it is a fundamental issue that is going to have to be addressed.

But I also think that it is important to recognize that the current system is also subsidizing health insurance in an equally and equitable way; it is just invisible. That somebody who lives in Boston and has much higher health-insurance costs through their employer is still getting a much higher value from the tax break than somebody who lives in Iowa, where health insurance costs a lot less, for example, simply because of that differential.

So you have inequities today; it is just that it is not visible. And I do think, though, that it is something that would have to be addressed if you are going to be talking about a uniform new credit,

some sort of subsidy to help people purchase health insurance, especially those currently left out of the system.

Dr. BURMAN. I agree; it is an important issue. But I can't figure out how you would fix it.

This actually comes up in a lot of other contexts, too. I have had people say to me that the standard deduction ought to be higher in New York City than it is in Des Moines, because the cost of living is so much higher. Tax brackets ought to be adjusted for differences in cost of living across regions. I don't think there is any practical way to do that.

Chairman SPRATT. Well, under the existing system, the constant factor is, from place to place, the services provided, the coverage extended is basically the same. There is some variation. In the HMO programs, you might get eye glasses or something, but basically it is the same.

So, as long as you are measuring only whether or not the coverage is the same in Phoenix as it is in Atlanta, it comes out basically the same on the bottom line. But when you start assigning a dollar value to the refundable tax credit, and people from region to region see the differential, I think the issue becomes extremely difficult.

Been around here a long time, you know. These allocation formulas from place to place can be a huge food fight. It is a very difficult matter to handle. It could be that you would force the issue by having stickers like that and eventually come up with some resolution of it. But we have forced the issue before, and, generally speaking, the solutions are pretty jerry-rigged.

Ms. TURNER. And I think it also—the practice pattern variation is something that is really an issue in the medical profession. Why do you need to have so much more diagnoses just because you live in south Florida or in Boston? Is that actually adding value?

And, of course, the same thing is true with the differentiation in Medicare spending, in spending for Medicare and even in Medicaid. You know, New York spends a lot more per capita than other States do.

So I think that beginning to have a serious conversation about this issue is really—because Federal tax dollars and State tax dollars are really at stake—is important not only to figure out how we are going to address the issue of the uninsured but how we make the spending more equitable and more reasonable and more responsible, even for those who do have coverage.

Chairman SPRATT. Thank you once again, both of you, for your excellent testimony. Very provocative and very useful for us. And we appreciate the effort and time you put into coming here and giving your statements.

Ms. TURNER. Thank you, Mr. Chairman, very much for holding this hearing. You have shown, once again, your good bipartisan spirit and really showing that I think this is an issue that both sides agree on. Thank you very much.

Chairman SPRATT. Just a few final housekeeping measures.

I ask unanimous consent that members who didn't have an opportunity to pose questions to the witnesses be given 7 days to submit questions for the record.

[Questions for the record submitted by Mr. Smith follow:]

QUESTION FOR MS. TURNER FROM MR. SMITH OF NEBRASKA

As we look at ways to use the tax code to reduce the number of uninsured, we have seen different proposals including either tax credits or tax deductions to individuals and families for health care. In a general sense, as we look at the differences between credits, deductions, or a combination of the two, which approach will 1) be more fiscally responsible; and 2) do more to reduce the number of uninsured?

RESPONSE FROM GRACE-MARIE TURNER

Thank you for your question, Mr. Smith. As I discussed in my testimony, many members of Congress from both sides of the aisle have offered proposals that would move public policy forward regarding the tax treatment of health insurance. Ranking Member Rep. Paul Ryan, for example, is developing a proposal that would provide a universal tax credit for health insurance. President Bush has offered a proposal to replace the current tax exclusion with a generous universal tax deduction. Others have offered proposals for income adjusted, refundable tax credits. And some are considering a combination of a tax deduction and credit. Senator Hillary Clinton in her recent health proposal recommends capping the amount of income that higher-income employees can exclude from taxes through health insurance. And Sen. Ron Wyden has received a great deal of attention for his proposal to replace the current tax exclusion for job-based health insurance with a direct, income-adjusted subsidy to individuals.

The Health Policy Consensus Group, a group of leading health policy experts from the market-oriented think tanks, has long advocated addressing the tax treatment of health insurance, and many of our members support refundable tax credits for health insurance.

President Bush's proposal in 2007 to allow a universal tax deduction brought a new idea to the table in allowing a generous deduction for health insurance combined with a credit against payroll taxes. Because all workers pay payroll taxes, this latter proposal would provide help to those at the lower end of the income scale who may not owe income taxes or are in lower tax brackets.

There are always going to be constituencies that argue for credits over deductions and vice versa and a case can be made for both. I personally believe that a combination of credits and deductions would be most beneficial and believe that merging them into a single policy initiative might provide the impetus to finally move policy forward on this important issue.

The refundable credit would be more valuable to those at the lower end of the economic scale by providing meaningful help to purchase health insurance. And a deduction would be more like the tax benefit which those with job-based insurance currently receive through the tax exclusion. Alternatively, Congress could cap the tax exclusion for job-based health insurance in order to limit the open-ended tax benefit it provides to those with higher incomes and the most generous health benefits.

If you were to develop a new system of subsidies, the amount could flow from the numbers to determine the amount of the credits and deductions and what the cutoff and trigger points would be. It even may be possible to give people the option to choose between the two.

See below for a discussion in the academic literature about the issue of credits vs deductions for health insurance. I am greatly indebted to my colleague Thomas Miller of the American Enterprise Institute for providing me with the following excerpts and citations from the academic literature.

Thank you again for the opportunity to testify before your committee on this important issue and for this follow-up question. I would be very happy to come in to discuss this research and these options further with you. As you will see, there clearly is much more room for research on this issue.

Thomas Miller, "Expanding Access to Care by Empowering Workers with Better Incentives and New Options," in Covering America: Real Remedies for the Uninsured, Washington, D.C.: Economic and Social Research Institute, November 2002, online at *http://www.cato.org/research/articles/miller-coveringamerica.pdf.*

The primary vehicle for accomplishing various market-strengthening reforms that lower future health care costs and expand access to health care would be a new federal tax credit option. The tax credit would amount to 30 percent of the cost of qualified insurance coverage * * * Essentially, individuals could subtract this portion of their insurance costs directly from their federal income tax liability. The tax credit is an option; it would not eliminate the current tax exclusion that is available for workers insured by employer-sponsored insurance (ESI) plans. (A similar federal income tax deduction also is available on a partial basis—70 percent of the cost of qualified health insurance—for the self-employed, and it will become 100-percent de-

ductible from federal taxable income in 2003.) Instead, it would provide a competitive alternative to the tax exclusion for those workers to opt for in place of the tax exclusion. It would encourage a more gradual transition toward other forms of private insurance coverage. Workers who choose to enroll in an ESI group plan would continue to use the current tax exclusion. Employees who choose to decline ESI coverage and not take advantage of the current tax exclusion could use the tax credit option instead to purchase other forms of health insurance coverage.

From Mark V. Pauly and Bradley Herring, Cutting Taxes for Insuring: Options and Effects of Tax Credits for Health Insurance, Washington, D.C.: AEI Press, 2002, full text and other information available at *http://www.aei.org/books/bookID.45,filter.all/book—detail.asp.*

* * * THE KEY TRADEOFF

Our simulation estimates serve to illustrate numerically a key tradeoff suggested earlier. For a given amount "spent" on credits, there is a tradeoff between the breadth of the reduction in the number of uninsured and the depth of the increase in the coverage they take. There is also an interaction with risk levels. At one extreme, a flat credit that does not specify a minimum policy will cause all of the previously uninsured to obtain some insurance coverage. At very low risk levels, the previously uninsured will probably be able to buy coverage society would regard as "adequate."(There is no objective standard for "adequate coverage. ")

But persons with high risks who are unwilling or unable to pay more of the premium themselves will have to select coverage with deductibles and (especially) upper limits. While the new coverage will provide both more protection against out-of-pocket payments and more encouragement for the use of beneficial care, the protection and encouragement will obviously be smaller than if nominal coverage were more generous.

Under a policy of fixed-dollar credits and a requirement to buy an "adequate" benchmark policy, some of the uninsured will reject the subsidy and remain uninsured. Persons with lower risks and those who place high value on avoiding being a charity or bad debt case will move to coverage which, by definition, is "adequate." Compared to the alternative policy discussed in the previous paragraph, this policy will convert fewer people from uninsured to insured, but among those who are converted we will see a larger effect on their use of and protection by health insurance.

Finally, a policy of proportional credits will move fewer people out of the ranks of the uninsured, but, of those it does cause to become insured, more will come from the higher risk categories. But such a policy may also stimulate (and subsidize) the purchase of coverage in excess of the benchmark level; it could lead to "lavish plans," especially among those who were formerly insured but can become eligible for the credit.

Which of these three alternatives is best? The answer clearly cannot be given with objective certainty; it all depends on how the different patterns of changes are valued. If one invokes the principle that the first few dollars of insurance coverage (like the first few dollars of anything beneficial) are likely to do the most good, a design that places rather light obligations on the comprehensiveness of coverage and uses fixed-dollar credits may make sense. But ultimately the choice itself will require consensus on exactly why "we" want the uninsured to become insured, and what benefits we expect to accrue to all from that change.

Another key issue when choosing tax credit options is how generous the credit is to be. At a given income level, small credits will have little effect on the number of uninsured, whereas large credits will have large effects. If we focus on the large majority of the uninsured who have incomes above the poverty line, our general conclusion is that credits will need to be substantial to make much of a dent in the number of uninsured. For low-income workers (and their dependents) below 300 percent of the poverty line (where the uninsured are disproportionately found), we conclude that substantial reductions in the numbers of uninsured will require credits in the range of approximately half of the individual insurance premiums, with even greater credits needed for families with incomes at the bottom of this range. Thus another important tradeoff occurs between reductions in the number of the uninsured versus tax revenues that could be spent on other public programs.

But note that much of the "cost" of tax credits does not represent a reallocation of real resources away from other uses and toward the health care needs of the previously uninsured. Instead, much of the credit effectively represents a tax reduction for the majority of lower-middle-income people who formerly had obtained health insurance for themselves and their families in some fashion. Limiting eligibility for the credit to a subset of those at the same income level engaging in the same health

insurance purchasing behavior can reduce the "cost," but at the real expense of horizontal inequity and substantial distortion in the labor market.

To make any such judgments rationally, however, one would need more information than just a head count of the formerly uninsured. The missing piece of information is important for the entire policy exercise: How much of an improvement in health is generated by the presence of insurance coverage (compared to its absence) for people at different income and risk levels? It is possible, for example, that insurance coverage for people who are initially low risks may produce more of an improvement in health than coverage for those who are initially high risks. Almost all of the research on the impact of insurance coverage either looks at the uninsured as a group or singles out poor uninsured people, but the most relevant question is the amount of good that health insurance would produce for a lower- middle-income family (compared to their being uninsured). As noted elsewhere by Pauly and Reinhardt (1996), our failure as researchers to produce this information on effectiveness makes it more difficult to persuade our fellow citizens to support tax credits or any other programs to reduce the numbers of the uninsured.

The fiscal design of tax credit programs is not the only influence on the number of uninsured. Most programs envision making everyone who is uninsured (at some income level) eligible for subsidy. This design stands in strong contrast to the Medicaid program, for which only some low-income uninsured are eligible. The universal character of tax credit programs would thus allow the government to direct subsidies or credit vouchers to everyone below a certain income level who is not insured; it would not be necessary for people to apply. In addition, once people at some income level had all been made eligible for credits judged to provide adequate subsidies to permit them to afford insurance, there would be less justification for someone to remain uninsured, and therefore less need to have a permissive charity care or bad debt policy applied to that person. Changes in the financial responsibilities imposed on uninsured people might themselves stimulate people to become insured, although some safety net will need to remain for those who truly fall through the cracks. Finally, rewarding the great majority of lower-middle-income people who do choose to be insured with a substantial tax reduction might both call attention to the social value of being insured and offer the uninsured further incentive to change their status. While it is unlikely that the number of uninsured will ever be literally zero, carefully designed credit programs can both reduce the numbers of uninsured and improve the equity of tax treatment of the insured.

Footnote citation from Lily L. Batchelder, Fred T. Goldberg Jr., and Peter R. Orszag, "Efficiency and Tax Incentives: The Case for Refundable Tax Credits," New York University School of Law, NYC Center for Law and Economics, November, 2006, at *http://ssrn.com/abstract=941582*.

For example, Zelinsky has discussed why tax incentives may enhance economic efficiency by correcting for positive externalities and has applied his analysis to the home mortgage interest deduction and accelerated depreciation. See Edward A. Zelinsky, Efficiency and Income Taxes: The Rehabilitation of Tax Incentives, 64 TEX. L. REV. 973 (1986). However, his article is concerned with the decision of whether to retain or institute a tax incentive and not with what form of tax incentive is most efficient. Id. at 1023. Weiss has proposed converting certain investment tax incentives to credits, but this proposal was based on equity and not efficiency concerns. See Deborah M. Weiss, Tax Incentives Without Inequity, 41 UCLA L. REV. 1949 (1994).

The economics literature has examined the merits of credits relative to deductions only in a few specific examples, such as the deduction for charitable giving and the exclusion for gifts. See, e.g., Louis Kaplow, A Note on Subsidizing Gifts, 58 J. PUB. ECON. 469 (1995) (considering the optimal subsidy for gifts in the presence of externalities and concluding that a tax deduction is not obviously inferior to a credit); Peter Diamond, Optimal Tax Treatment of Private Contributions for Public Goods With and Without Warm Glow Preferences, 90 J. PUB. ECON. 897 (2006) (concluding that the optimal subsidy for private contributions to public goods may rise with earnings but not reaching any policy conclusions about whether the optimal subsidy is a deduction). Rosen provides a brief general discussion of the choice between a deduction and a credit when the purpose of a provision is to encourage certain behavior. See HARVEY ROSEN, PUBLIC FINANCE 377 (7th ed. 2005) ("If the purpose is mainly to encourage certain behavior, it is unclear whether credits or deductions are superior * * * If people differ with respect to their elasticities of demand, it may make sense to present them with different effective prices. "). Gruber also provides a brief general discussion of the choice between deductions and credits but does not discuss the possibility that externalities or elasticities vary by income level. See JONATHAN GRUBER, PUBLIC FINANCE AND PUBLIC POLICY 507 (2005). He also briefly discusses the debate about refundability but only

from an equity and not an efficiency perspective. See id. at 508. Seidman argues for converting some deductions and exclusions into refundable credits but largely on equity grounds. LAURENCE S. SEIDMAN, POURING LIBERAL WINE INTO CONSERVATIVE BOTTLES 20-27 (2006). He also differs in his skepticism of uniform credits, arguing that "a better prescription would simply be [that] * * * each refundable tax credit should utilize a schedule that the citizenry judges to be equitable." Id. at 26.

ADDITIONAL LITERATURE CITATIONS THAT MAY BE USEFUL TO YOU INCLUDE

James D. Reschovsky and Jack Hadley, "The Effect of Tax Credits For Nongroup Insurance on Health Spending By the Uninsured," Health Affairs, February 25, 2004, at *http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.113v1/DC1.*

Mark Pauly and Bradley Herring, "Cutting Taxes for Insuring: Options and Effects of Tax Credits for Health Insurance," University of Pennsylvania, May, 2000, at *http://council.brandeis.edu/pubs/Paulytx.PDF*

Jonathan Gruber, "Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals," Kaiser Family Foundation, March 2004, at *http://www.kff.org/insurance/upload/Coverage-and-Cost-Impacts-of-the-President-s-Health-Insurance-Tax-Credit-and-Tax-Deduction-Proposals.pdf.*

Thank you very much, indeed.

The committee is now adjourned.

[Whereupon, at 12:25 p.m., the committee was adjourned.]

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