Backgrounder

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Health Care Tax Credits: Designing an Alternative to Employer-Based Coverage

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The President's Advisory Panel on Tax Reform, co-chaired by former Senators John Breaux (D–LA) and Connie Mack (R–FL), recently issued a major set of recommendations that the President and Congress can use to reform the federal tax code. This is an important and constructive step in the effort to create a more rational and efficient tax system.

However, a key component of any serious tax reform is changing the tax treatment of health insurance. How President Bush and Members of Congress use this opportunity to address this issue will have profound impact on millions of Americans, especially those who are uninsured.

Today, the tax code creates a significant tax advantage for those with employer-sponsored coverage by exempting the total value of the benefit from a worker's taxable income. This distorts the health insurance market by favoring coverage obtained through the place of work and stifles the advancement of other coverage options. The Advisory Panel's report brings attention to this distortion by suggesting a cap on the current, unlimited tax break found in employer-sponsored coverage.[1]

Regrettably, however, the Panel chose not to recommend redirecting these revenues to help those who are most in need but who receive no assistance under the current health care system, leaving them either to buy private coverage without a comparable tax benefit or simply to go without. Forgoing this opportunity to expand coverage and increase private participation in the health insurance markets would be a major mistake.

Talking Points

- Today's tax code distorts the health insurance market by favoring coverage obtained through the place of work and stifles the advancement of other coverage options.
- To protect against a widening of the number of uninsured Americans, Congress must provide an alternative approach to the current health care system, which is dominated by employer-based coverage and public coverage such as Medicaid and Medicare.
- Health care tax credits offer Americans who do not fit into the current patchwork health care system direct financial assistance in purchasing private health care coverage.
- Individual health care tax credits, in combination with a robust market for insurance products, would offer individuals the opportunity to secure private health care coverage of their own, moving the system closer to a consumer-oriented model that is fairer and more transparent and that empowers individuals to make health care decisions for themselves and their families.

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www.heritage.org/research/healthcare/bg1895.cfm

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The Opportunity

Congress should seize the opportunity offered by the President's Advisory Panel to make fundamental changes in the way the federal tax code treats health care benefits and to establish a system that is more equitable and efficient than the one that exists today. Members of Congress should go beyond the Advisory Panel's recommendations and adopt a system of health care tax credits that offers an alternative for those who are not in the employer-dominated health insurance system.

Ideally, the current employer exclusion should be replaced with a system of universal, individual health care tax credits. Such a system would:

- End the dramatic government discrimination against individuals who do not or cannot get health insurance at the place of work;
- Encourage the retention of insurance coverage in the transition between jobs or during spells of unemployment;
- Promote continuity of care for individuals who have come to rely on a specific set of doctors or medical specialists; and
- Encourage the efficient utilization of scarce resources, particularly federal subsidies, to directly assist those most in need.

Individual health care tax credits are the best single approach to accomplishing these worthy objectives.[2]

To offer health care tax credits to employers, who already receive a tax break for offering health insurance as a cost of doing business, would be to miss the point of this reform. Offering health care tax credits to employers would simply perpetuate the restriction of personal health care choice and the lack of portability in health care coverage, as well as undermine the free-market competition that would otherwise obtain in a robust consumer-driven market.

There are some basic design features that would make an individual tax credit most effective. Most notably, it should be refundable, advanceable, and assignable. There also are various other design choices that Congress should consider to tailor a credit's scope and reach.

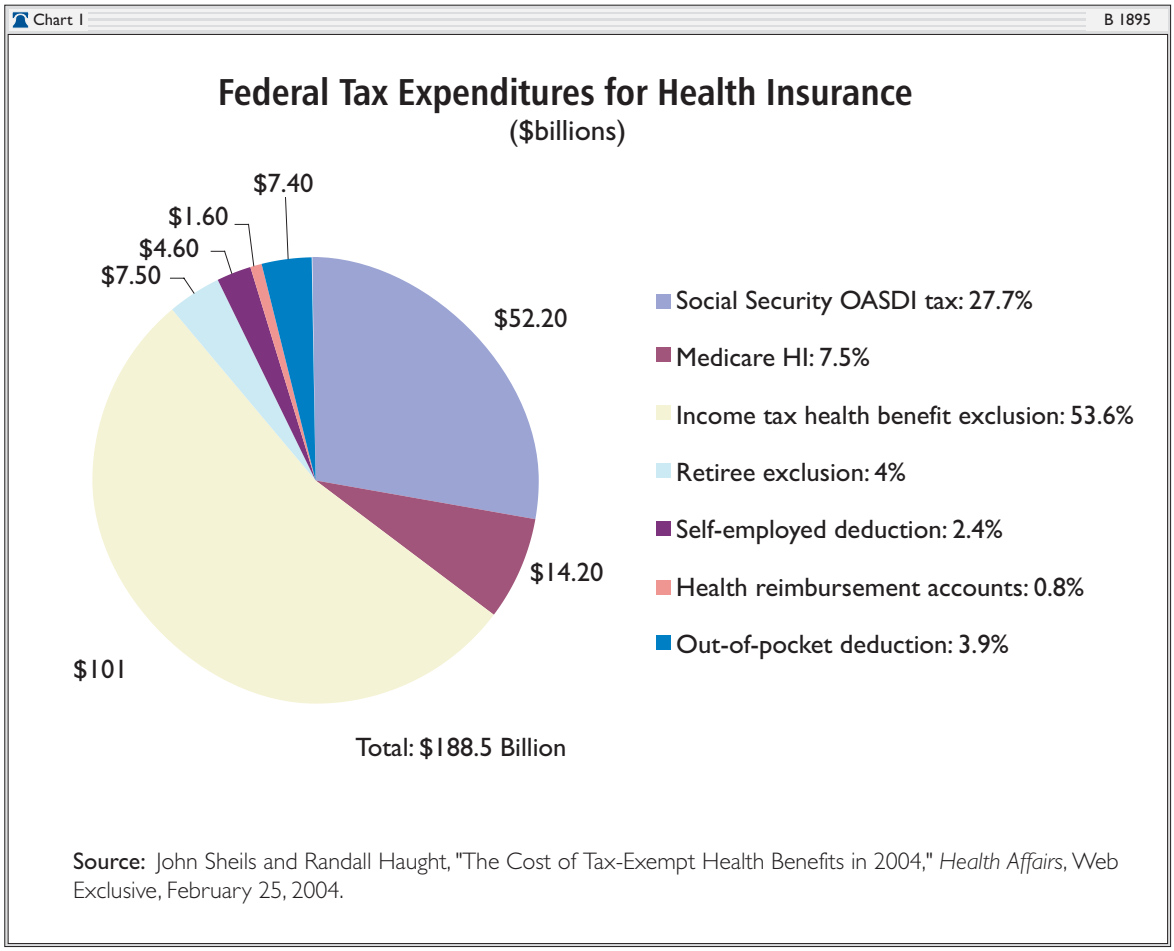
How the Federal Tax Code Works Today

The current federal tax code offers a variety of tax preferences relating to health care. In 2004, these tax benefits—which include employer health care benefits for workers and retirees, deductions of health care premiums for the self-employed, health expenditures through flexible spending accounts, and tax deductions for allowable health expenditures—accounted for $188.5 billion in forgone federal revenue.[3] Of that amount, $122.2 billion was associated with personal income tax exclusions.[4]

By far the largest portion of the personal income tax exclusion ($101 billion) went to the employer exclusion for employee health care benefits.[5] The current employer tax exclusion allows the value of the worker's health care benefit to be excluded from the worker's taxable income. In addition, the exclusion is *unlimited.* This means that there is no cap on the dollar amount; thus, the more generous the health benefit, the greater the amount that is exempt from taxation.

However, it is important to note that these benefits are actually benefits in lieu of wages. As Robert Helms, a resident scholar at the American Enterprise Institute, has explained, the growth of the current employer system began in World War II when, in order to get around the wartime system of

1. See Presidential Advisory Panel on Tax Reform, *Final Report*, November 1, 2005, at *www.taxreformpanel.gov/final-report/*.
2. Analysts at The Heritage Foundation have put forth several proposals based on such an approach as a means to revolutionize the health care system and transform it into one that is both patient centered and consumer based.
3. John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs* Web Exclusive, February 25, 2004, at *http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1* (July 20, 2005).
4. *Ibid.*
5. *Ibid.*

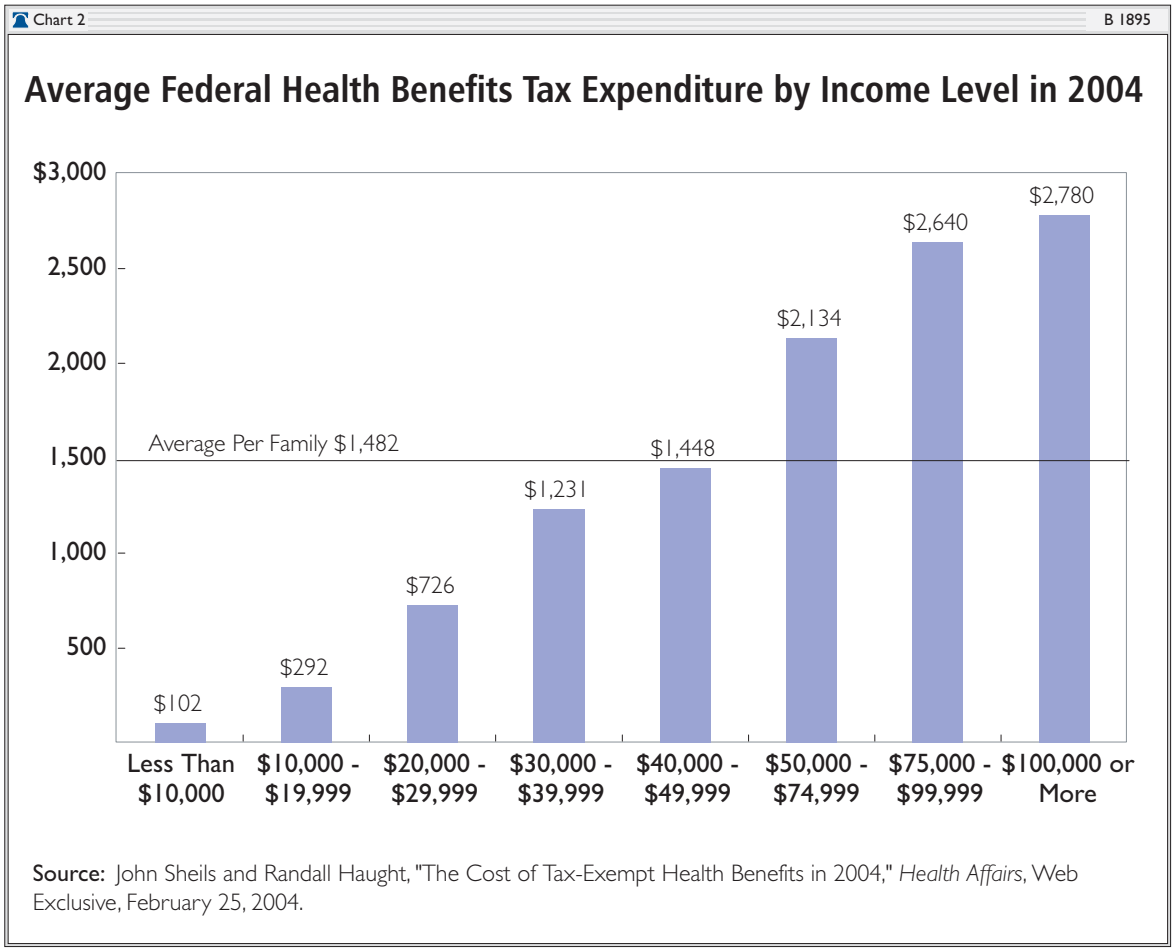


comprehensive wage and price controls, American businesses were allowed to offer "tax free" fringe benefits, such as health insurance, to their employees as a way to compete for scare labor.[6] The wartime economic conditions, including the wage and price control regime, eventually ended, but the basic tax policy governing health insurance has continued largely unaltered and has encouraged the evolution of employer-based coverage.

Winners and Losers. The employer-based tax exclusion for health insurance gives preferential tax advantages only to those individuals who obtain their health care through the place of work. About 60 percent of Americans get their coverage through an employer.[7] However, workers without employer-based coverage do not receive the same tax benefit under the federal tax code and must use after-tax dollars to pay for their health care coverage, as well as any out-of-pocket health care expenses.

Furthermore, the exclusion benefits higher-income workers, who have a higher marginal tax rate, more than it benefits lower-income workers,

6. Robert B. Helms, "The Tax Treatment of Health Insurance: Early History and Evidence, 1940–1970," in Grace-Marie Arnett, ed., *Empowering Health Care Consumers Through Tax Reform* (Ann Arbor: University of Michigan Press, 1999), p. 11. See also Tom Miller, "How the Tax Exclusion Shaped Today's Private Health Insurance Market," Joint Economic Committee, U.S. Congress, December 17, 2003, at *http://jec.senate.gov/_files/HealthTaxExclusion.pdf* (July 21, 2005).
7. Carmen DeNavas-Walt, Bernadette D. Proctor, and Robert J. Mills, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," U.S. Census Bureau, August 2005, p. 16, at *www.census.gov/prod/2004pubs/p60-226.pdf* (July 20, 2005).



who owe less. As noted by health care economists John Sheils and Randall Haught of the Lewin Group, the estimated average tax benefit in 2004 amounted to $2,780 for families with incomes of $100,000 or more but only $102 for families making less than $10,000 per year.[8]

A recent *Washington Post* editorial on the Advisory Panel's recommendations recognizes the inequity and perverse incentives of the exclusion:

> The current tax treatment of health insurance and other medical costs also benefits higher-income taxpayers more than lower-income taxpayers, and it encourages overconsumption. The panel's proposed limits …would begin to level the playing field between those who get health insurance at work and those who do not.[9]

Persistent Problems. While the employer exclusion for employer-sponsored coverage may work for some Americans, there are many other reasons why a health care system dominated by employer-based coverage can be problematic.

First, the federal tax code does little for workers and their families who do not have access to employer-based coverage. Over 80 percent of the uninsured are part of a "working household."[10] Some workers are not offered coverage at the place of work. Nearly 22 million workers are uninsured

8. Sheils and Haught, "The Cost of Tax-Exempt Health Benefits in 2004," pp. W4-109–W4-110.
9. Editorial, "Reshaping the Tax Code," *The Washington Post*, November 4, 2005, p. A22.

because their employer does not offer coverage.[11] This is a growing problem in the small-business sector, where fewer and fewer small employers are providing health care coverage.

Some workers do not qualify for coverage through the place of work, even though their employer may offer coverage. For example, an individual may not work enough hours to qualify for benefits. Others choose not to participate in their employer's coverage because of cost, other options such as coverage through a spouse, or other reasons. Finally, some uninsured Americans do not work and thus do not have access to an employer-based policy.

Second, today's employer-based system limits personal choice. Workers must depend on their employers to select a plan and a plan design to meet their personal health care needs. Employers attempt to offer their employees health plans that will satisfy the diverse needs of their workforce. In large firms, a choice of plans is common practice.

The situation, however, is very different with small firms. Today, 81 percent of small firms—those with from three to 199 employees—offer just one plan.[12] Ultimately, this one-size-fits-all approach does not and cannot accommodate diverse individual needs or preferences for coverage. Employers often do the best they can, but in order to control rising costs, they secure contracts with insurers or managed care companies that micromanage benefits, medical treatments, procedures, or access to specialists. The result: employee dissatisfaction and more labor–management disputes.

The bitter congressional "Patient's Bill of Rights" debate in the late 1990s exposed the high level of patient and physician frustration with managed care arrangements that limited access on the basis of third-party determinations of "medical necessity." Also evident was great dissatisfaction with health plan choices made by employers relative to HMO gatekeepers or restrictive provider networks. Curiously, instead of doing the right thing and taking steps to expand patient choice and ownership of medical plans and procedures, the major congressional bills passed by the House and Senate would have added new avenues of litigation to the health care system, combined with a massive new layer of costly federal regulation of private health plans, driving the costs of health care even higher and pricing even more families out of the health care market.[13]

Beyond the issue of access to medical treatments and procedures, there is the increasingly important issue of the ethical conflict involved in forcing individuals and families to pay for certain medical treatments and procedures that they may consider objectionable. For example, a worker and his family may have a serious moral objection to paying for abortions through their insurance premiums, but the employer's health plan may include abortion in its standard coverage. Conversely, a worker may feel it is his or her right to purchase coverage for abortion or other procedures, but the employer may refuse to cover these procedures. Forcing Americans to pay through premiums for certain procedures they find morally objectionable or unethical is a profound violation of personal choice and conscience.

10. "The Uninsured and Their Access to Health Care," Kaiser Family Foundation *Fact Sheet*, November 2004, at *www.kff.org/uninsured/upload/The-Uninsured-and-Their-Access-to-Health-Care-November-2004-Fact-Sheet.pdf*.
11. Sara R. Collins, Karen Davis, and Alice Ho, "A Shared Responsibility: U.S. Employers and the Provision of Health Insurance to Employees," Commonwealth Fund, *In the Literature* Publication No. 839, June 2005, at *www.cmwf.org/usr_doc/Shared_responsibility_Inquiry_Spring_2005.pdf* (July 20, 2005).
12. Kaiser Family Foundation and the Health Research and Educational Trust, "Distribution of Firms Providing a Choice of Health Plans, by Firm Size, 2005," *Employer Health Benefits 2005 Annual Survey*, Exhibit 4.2, at *www.kff.org/insurance/7315/sections/ehbs05-4-2.cfm*.
13. For an account of the Patient's Bill of Rights legislation, its consequences, and the rational alternatives, see John S. Hoff, "The Patient's Bill of Rights: A Prescription for Massive Health Regulation," Heritage Foundation *Backgrounder* No. 1350, February 29, 2000, at *www.heritage.org/Research/HealthCare/BG1350.cfm*.

With advances in biomedical research, such as the growth of medical treatments based on embryonic stem cell research, reproductive cloning, or genetic manipulation, Americans' ethical and moral dilemmas will only become more pronounced as health coverage based on the fruits of this rapidly advancing research for medical treatments expands.[14]

Third, employer-based coverage lacks portability. It is no longer typical, as it was when employer-sponsored coverage began, for an individual to get a job and health coverage at age 18 with a local manufacturer and remain with that employer until retirement. Today's workforce is far more mobile and does not fit well with a static employer-based health care system. Every time a worker leaves a job, he or she must leave coverage behind.[15] Workers at all income levels risk losing coverage when they change jobs, are laid off, take a temporary leave of absence from the workforce, or retire early.

This loss or change in health care coverage also disrupts continuity in care. Each time a person changes jobs, and thus coverage, the person's access to the existing network of doctors, specialists, and other medical providers is placed at risk. This is bad health policy.

Moreover, there is little incentive for employers—especially those in the small-business sector, where workers often change jobs for reasons as simple as a higher wage—to invest limited resources in treatments and preventive measures for a temporary workforce, especially if these investments do not result in immediate savings to the company's bottom line.

Why Congress Must Offer an Alternative

The tax exclusion also leads to other consequences. As Urban Institute scholar Eugene Steuerle argues, the existing exclusion encourages the purchase of more expensive health care policies, which increases the overall costs of health insurance, thereby making coverage too expensive and contributing directly to uninsurance.[16] Recent trends among small businesses illustrate the dilemma. In 2005, only 59 percent of small businesses (three to 199 workers) offered coverage, compared to 68 percent in 2000.[17]

The U.S. Census estimates that 45.8 million individuals, or 15.7 percent of the population, were uninsured during 2004.[18] This problem, more than any other, reveals the inequity of the current patchwork health care system, which

14. For a discussion of this emerging issue in greater depth, see Phyllis Berry Myers, Richard Swenson, M.D., Michael O'Dea, and Robert E. Moffit, "Why It's Time for Faith-Based Health Plans," Heritage Foundation *Lecture* No. 850, August 24, 2004, at *www.heritage.org/Research/HealthCare/hl850.cfm* (July 20, 2005); see also Robert E. Moffit, "The Economic and Ethical Dimensions of Health Policy," *The Journal of Contemporary Health Law and Policy*, Vol. 18 (2002), pp. 663–672.
15. Even efforts to promote the adoption of Health Savings Accounts (HSAs) create account portability, not portability of insurance.
16. C. Eugene Steuerle, Senior Fellow, Urban Institute, "Tax Reform: Prospects and Possibilities," statement before the Committee on the Budget, U.S. House of Representatives, October 6, 2004, p. 2, at *www.house.gov/budget/hearings/steuerlestmnt100604.pdf*.
17. Kaiser Family Foundation and the Health Research and Educational Trust, "Percentage of Firms Offering Health Benefits, by Firm Size, 1996–2005," *Employer Health Benefits 2005 Annual Survey*, Exhibit 2.2, at *www.kff.org/insurance/7315/sections/ehbs05-2-2.cfm*.
18. DeNavas-Walt *et al.*, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," p. 16. This Census number represents just one way of capturing the number of uninsured and is not the most precise. The Congressional Budget Office points out that the number can vary, depending upon how the uninsured are counted, and the length of time that Americans are uninsured can also vary. See "How Many People Lack Health Insurance and for How Long?" Congressional Budget Office, May 2003, at *www.cbo.gov.* On the small number of uninsured Americans who are uninsured for a long time, see also Kirk A. Johnson, Ph.D., "The Data on Poverty and Health Insurance You're Not Reading," Heritage Foundation *WebMemo* No. 556, August 27, 2004, at *www.heritage.org/Research/Welfare/wm556.cfm*. Curiously, a growing number of uninsured are higher-income individuals. See Devon Herrick, "Uninsured by Choice: Update," National Center for Policy Analysis *Brief Analysis* No. 460, October 7, 2003, at *www.ncpa.org/pub/ba/ba460* (July 20, 2005).

consists of public coverage, such as Medicare and Medicaid, and private coverage, dominated by the conventional, employer-based, third-party payment system. The recent Census numbers also showed a decline in traditional employer-based coverage, while public programs, particularly Medicaid, grew. The continued replacement of private coverage with the expansion of already overstretched and unsustainable public programs highlights the need for an alternative, parallel system that individuals can use to purchase and own their health care coverage.

The Cost of Uncompensated Care. There is a distinction between health insurance coverage and the provision of health care. A person may be without health care coverage, but that does not mean that he or she does not have access to health care. Most uninsured individuals receive care but in a very inefficient and disjointed way. Under current federal law, no person who enters a hospital emergency room may be denied medical treatment merely because of financial incapacity to pay for that care.[19] Thus, payment for uncompensated care for the uninsured is left to taxpayers.

Jack Hadley and John Holahan, researchers with the Urban Institute, concluded that in 2001, an estimated $35 billion in uncompensated care was delivered to the uninsured and that over $30 billion of this amount was financed by the government.[20] In Maryland, it is estimated that these uncompensated costs will cause employer-based health premiums to rise by an estimated $948 for family coverage and $322 for individual coverage in 2005.[21]

Growing Consensus. The growing agreement within the health care policy community regarding the dimensions of this problem is reflected in a growing congressional consensus on how to help the uninsured, especially low-income workers and their families. Over the years, individual health care tax credits have gained wider interest and broader support from a bipartisan group of policy leaders.

For example, in 2000, Representatives Jim McCrery (R–LA) and Jim McDermott (D–WA), both members of the House Committee on Ways and Means, discussed ways to find common ground on the provision of tax subsidies for health care.[22] In 2001, then- House Majority Leader Richard Armey (R–TX) and Representative William Lipinski (D–IL) sponsored "Fair Care," a broadly supported bipartisan health care tax credit proposal.[23] In the most recent presidential election, refundable health care tax credits were key components of both President George W. Bush's and Senator John Kerry's health care proposals.[24]

Thus, there is wide and growing recognition that individual health care tax credits are a legitimate vehicle for progress in reducing the number of the uninsured. As Jonathan Gruber of the Massachusetts Institute of Technology and Leonard Burman of the Urban Institute acknowledge, "tax subsidies

19. EMTALA, the Emergency Medical Treatment and Active Labor Act (42 USC 1395dd), enacted under the Consolidated Omnibus Budget and Reconciliation Act of 1985.

20. Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs* Web Exclusive, February 12, 2003, p. W3-78, at *http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.66v1* (July 20, 2005).

21. "Short Term and Long Term Strategies to Ensure the Viability of the CSHBP and the Small Group Market," Presentation to Maryland Health Care Commission, September 15, 2005.

22. See Matthew Miller, "Health Care: A Bolt of Civic Hope," *Atlantic Monthly*, Vol. 286, Issue 4 (October 1, 2000).

23. See James Frogue, "Recent Survey Points to Affordable Individual Health Insurance," Heritage Foundation *Executive Memorandum* No. 740, April 17, 2001, at *www.heritage.org/Research/HealthCare/EM740.cfm*.

24. See Robert E. Moffit and Nina Owcharenko, "An Examination of the Bush Health Care Agenda," Heritage Foundation *Backgrounder* No. 1804, October 12, 2004, at *www.heritage.org/Research/HealthCare/bg1804.cfm* (July 20, 2005), and Robert E. Moffit, Nina Owcharenko, and Edmund F. Haislmaier, "Details Matter: A Closer Look at Senator Kerry's Health Care Plan," Heritage Foundation *Backgrounder* No. 1805, October 12, 2004, at *www.heritage.org/Research/HealthCare/bg1805.cfm* (July 20, 2005).

appear [to be] the only game in town for expanding the federal role in the provision of health insurance."[25] The remaining obstacle is technical and programmatic: agreement on their design.

How Congress Can Design an Effective Health Care Tax Credit

Congress can address the distortions in the health care system and chip away at the number of uninsured by reforming the tax treatment of health insurance. Ideally, the current tax structure, especially the exclusion for employer-based health insurance, should be replaced with a more unified universal tax credit system.[26]

Short of comprehensive reform, Congress could at least create an alternative to the current system by designing an individual health care tax credit to assist lower-income workers and their families, who do not benefit from the current tax treatment of health coverage, to purchase private health insurance coverage. This, in effect, would create a tax policy parallel to the existing one and establish some equity in today's system. In essence, it would level the playing field by offering a comparable tax break for those who do not fit into today's current employment-based structure but take it upon themselves to purchase health insurance of their own.

Basic Design Features. Three basic features are universally accepted, as well as programmatically desirable and policy consistent, in the design of an individual health care tax credit. Specifically, a credit should be:

- **Refundable.** A refundable health care tax credit would ensure that an individual, even one that owed little or nothing in taxes, would be eligible to receive the credit—in effect a direct subsidy for the purchase of health care coverage. While some in Congress may object to the creation of yet another low-income subsidy, it should be recognized that an individual refundable tax credit could replace the current employer exclusion. In fact, The Heritage Foundation has proposed such an approach.[27]

  At a minimum, Congress could replace the existing set of billions of dollars in taxpayer subsidies for health care provided through public programs and uncompensated care for the uninsured. It would be a far more efficient, effective, and transparent subsidy than the disjointed and costly taxpayer mandates that exist today.

  The inescapable consequence of *not* mainstreaming low-income Americans into private coverage through this sort of direct subsidy is continued growth in the number of the uninsured and increased taxpayer funding of an inefficient system of uncompensated care and public programs.
- **Advanceable.** An advanceable tax credit would allow individual credit recipients to claim the credit up front when insurance premiums are due rather than wait until the end of the year for reimbursement. This would ensure that the subsidy is available for application in a timely fashion—a particularly desirable feature for low-income individuals who may have limited disposable resources, which the credit is intended to relieve.
- **Assignable.** An assignable tax credit would be forwarded directly and automatically to the insurer of the tax credit recipient's choice, leav-

25. Leonard E. Burman and Jonathan Gruber, "Tax Credits for Health Insurance," Urban–Brookings Tax Policy Center, *Tax Policy Issues and Options* No. 11, June 23, 2005, p. 1, at *www.urban.org/UploadedPDF/311189_IssuesOptions_11.pdf* (July 20, 2005).
26. Many professional economists and a wide range of analysts from the American Enterprise Institute, the Galen Institute, The Heritage Foundation, the National Center for Policy Analysis, and the Progressive Policy Institute have all proposed such an approach, with various modifications. See Health Policy Consensus Group, *A Vision for Consumer-Driven Health Care Reform: A Statement of Principles and Recommendations by Leading Health Care Economists and Health Policy Analysts to Guide Health Care Reform* (Alexandria, Va.: Galen Institute, 1999), at *http://www.galen.org/vision.asp*.
27. The Heritage Foundation has put forth several iterations of a universal tax credit. For the most recent version, see Stuart M. Butler, "Reforming the Tax Treatment of Health Care to Achieve Universal Coverage," in *Covering America: Real Remedies for the Uninsured*, Vol. 1 (Washington, D.C.: Economic and Social Research Institute, June 2001), pp. 21–42, at *www.esresearch.org/RWJ11PDF/full_document.pdf* (July 20, 2005).

ing only the balance, if any, to be billed to the recipient.[28] This is a key feature advanced by the Bush Administration in its health care tax credit proposal.

Congress might wish to add another feature to encourage a stronger participation rate: a system of automatic enrollment through the place of work, or through some other entity, to qualify individuals for the credit. This could also facilitate the provision of plan information from a menu of available coverage options.[29]

It is imperative that the basic design features make the process of applying and receiving that tax credit as simple as possible. In a recent analysis of an existing tax credit, the Trade Adjustment Assistance (TAA) tax credit, Economic and Social Research Institute policy analyst Stan Dorn and his co-authors conclude, among other things, that the tax credit process must have effective outreach and be consumer friendly.[30]

Remaining Design Options and Recommendations

There are many other design features that Congress must consider when structuring an individual health care tax credit. Moreover, within each feature, there can be multiple variants. The various policy choices and trade-offs will affect the size, scope, cost, and effectiveness of the health care tax credit proposal.

Option #1: Universal vs. Targeted. The initial—and unavoidable—policy question for Congress focuses on the extent of change in the health care system that Members wish to design for the American people. If policymakers want a comprehensive approach to unravel decades of outdated health care policy, they could do so by instituting a universal credit that replaces the currently complex health tax policy with a system of individually based tax credits. Individuals would receive a tax credit that would be used to pay for private health insurance premiums and other medical expenses.[31]

If policymakers choose incremental change and focus on the problem of the uninsured, a tax credit targeted to a specific group or population could be designed. Such a targeted tax credit could be designed broadly to be available to individuals who purchase private health care coverage on their own, or it could be designed more narrowly to target subgroups, such as low-income individuals or those working for small businesses. Nonetheless, policymakers should be aware that the more targeted the credit, the more complexity it brings to the tax code, thereby engendering a new set of administrative issues.

The most common tax credit proposals target credits to lower-income individuals who lack employer-sponsored coverage. The Bush Administration has proposed such a credit, and variations of this approach have been proposed in Congress.[32] However, credits have been even more narrowly designed. In 2002, the President signed into law the Trade Act of 2002, which provides a health care tax credit to TAA workers who lose their jobs due to expanded international trade and

28. This system has already been developed through the existing TAA health care tax credit, described below.

29. There are also several ways that one could administer a tax credit efficiently and effectively, and also increase the employee take-up rate for coverage, by relying on the existing employer withholding system. For a more detailed discussion of how this can be done, see Lyn Etheredge, "How to Administer Health Insurance Tax Credits for Working Families," Heritage Foundation *Backgrounder* No. 1516, January 31, 2002, at *www.heritage.org/Research/HealthCare/BG1516.cfm*.

30. Stan Dorn, Janet Varon, and Fouad Pervez, "Limited Take-Up of Health Coverage Tax Credits: A Challenge to Future Tax Credit Design," Commonwealth Fund *Issue Brief*, October 2005, p. 10, at *www.cmwf.org/usr_doc/Dorn_limited_take-up_tax_credits_869_ib.pdf*.

31. As discussed, The Heritage Foundation has proposed such an approach. In a 1999 analysis of the Heritage plan, the Lewin Group estimated that 210 million Americans would qualify for the credit, which would cost $55 billion (in 2000 dollars). For a full description of this plan, see Robert E. Moffit, "Do We Need a National Healthcare Policy?" in Howard Jacob Karger, James Midgley, and C. Brene Brown, eds., *Controversial Issues in Social Policy*, 2nd Edition (Boston, Mass.: Allyn and Bacon, 2003), p. 139.

to Pension Benefit Guaranty Corporation beneficiaries.[33] Others have suggested extending such credits to all unemployed workers.[34]

Tax credits could also focus on workers in the small-business sector that do not have coverage.[35] This is certainly a promising option since roughly eight out of 10 of the nation's uninsured are found in working families and are disproportionately concentrated in small firms.

Recommendation. Ideally, a universal tax credit such as The Heritage Foundation has proposed would revolutionize the U.S. health care system by establishing a patient-centered system grounded in consumer choice and competition. However, as concluded during the debate over the Clinton health plan, a radical departure from the current health care system may be too politically difficult.

Thus, at the very least, policymakers should create a parallel alternative through the adoption of health care tax credits for those individuals who do not fit into today's patchwork system. Further narrowing, such as focusing tax credits on lower-income individuals or exclusively on workers in small businesses, could be an effective incremental approach aimed at reducing a specific group of the uninsured.

Option #2: Insured vs. Uninsured. Another consideration for congressional policymakers is whether the credits should be directed solely to those who are currently uninsured or whether they should also be available to those who are currently insured but not receiving any tax advantage for purchasing coverage on their own. It is important to note the difference between those who purchase coverage on their own and those who have coverage through the place of work. As noted, while the employer-based system is not the most efficient or effective, a worker does receive a tax break for signing up for coverage through the place of work.

It is certainly reasonable to argue that in the current fiscal situation, it is most urgent to help the currently uninsured. Not only do these individuals have no consistent medical protection, whether from catastrophic health emergencies or other problems, but they also are a drain on existing taxpayer-funded, uncompensated care.

However, it can also be argued that a tax credit focused only on the uninsured is unfair and raises serious unintended consequences and equity issues. Limiting a credit only to the currently uninsured ignores those similarly situated individuals who take responsibility and purchase coverage on their own without preferential tax treatment. Furthermore, it also could encourage those with existing coverage to drop it, creating a gap in coverage, in order to qualify for the credit.

Recommendation. It is far more preferable to treat all individuals equitably and not further segment eligibility based on existing coverage. Such an approach would avoid the conflict of penalizing individuals who sacrifice to obtain coverage while rewarding those who do not. Finally, focusing solely on the uninsured does not address the core failures of the current health care system; all it does is provide a stopgap to those who fall through the cracks.

Option #3: Fixed vs. Percentage. There are two basic approaches to determine the value of a health care tax credit. A tax credit can be designed to provide a fixed dollar amount toward a health care premium or a percentage amount of a health care

32. The Bush Administration has proposed such a tax credit, which would be available for those who did not have employer-based coverage. See Moffit and Owcharenko, "An Examination of the Bush Health Care Agenda." Members of Congress have also put forth variations of this approach. See H.R. 765, introduced by Representative Mark Kennedy (R–MN); H.R. 2089, introduced by Representative Kay Granger (R–TX); and H.R. 1872/S. 978, introduced by Representative Sam Johnson (R–TX) and Senator Rick Santorum (R–PA).

33. See Public Law 107–210 at *http://thomas.loc.gov.*

34. See Jeff Lemieux, "Expanding the Health Care Tax Credit," Centrists Policy Network, October 6, 2003, at *www.centristpolicynetwork.org/archives/000039.html*.

35. See Stuart M. Butler, "Reducing Uninsurance by Reforming Health Insurance in the Small Business Sector," Heritage Foundation *Backgrounder* No. 1769, June 17, 2004, at *www.heritage.org/Research/HealthCare/bg1769.cfm*.

premium, or a combination of both approaches. Both approaches have merit; thus, much depends on the goals that Congress wants to accomplish.

A fixed tax credit offers a flat dollar amount to be applied to a health care premium. For example, a credit could be worth $1,000. Such an approach creates a defined and predictable amount that would be easier to administer and can, depending on the size of the plan deductible, reduce the number of uninsured by up to 85 percent.[36] It would also make recipients more sensitive to the price of the policies they purchase, encouraging them to choose a plan based on value.

A percentage credit provides an individual with a credit that is worth a percentage of the individual's health care premium. For example, a credit could be worth 65 percent of an individual premium.[37] While a percentage credit may be more complicated to administer and more costly, it would better reflect individual needs by taking into account such variations as age and health status.

Recommendation. As a way to achieve both fiscal predictability and individual premium variability, Congress could combine the premium sensitivity advantages of a percentage credit with the fiscal stability of a fixed credit. Variants of both could be adopted to make the credit as effective and efficient as possible so that individuals receive a credit in proportion to their actual premium while taxpayers are protected from an open-ended subsidy.

President Bush's health care tax credit proposal provides a percentage credit with a fixed dollar cap.[38] Another option could be a sliding scale tax credit based on total health care expenses and household income, thus better reflecting the variations between individual incomes and health status.[39]

Option #4: Full or Limited Coverage Options. A tax credit can be applicable to a broad range of health care coverage options, or it can be limited to a specific set of coverage options. Under a broad application, a tax credit could be used to purchase any coverage option that is currently available to an individual but for which that individual does not currently receive a tax benefit. The credit could also be designed to apply not just to premiums, but also to any qualified medical expense as defined by the Internal Revenue Code.

Under a limited application, either a tax credit could be used only for specifically designated coverage options or certain coverage options could be excluded from purchase with a tax credit. Under the Trade Adjustment Assistance Act, Congress specified the coverage options to which the tax credits could apply.[40]

Recommendation. It is important for policymakers to ensure that the tax code is neutral in its view of health care, whether an individual chooses to purchase a traditional indemnity plan, a managed care plan, a preferred provider organization plan, or a consumer-directed product such as a

36. Mark Pauly, Bradley Herring, and David Song, "Tax Credits, the Distribution of Subsidized Health Insurance Premiums, and the Uninsured," National Bureau of Economic Research *Working Paper* No. 8457, September 2001, at *www.nber.org/papers/w8457*.
37. The TAA tax credit provided a 65 percent credit (with no maximum) for all qualified individuals.
38. The President's proposal would create a credit worth 90 percent of a premium up to a fixed dollar amount (a $1,000 credit for individuals making less than $15,000 a year and a decreasing credit up to $30,000) and a $3,000 credit for families making less than $25,000 and a decreasing credit up to $60,000.
39. In the most recent version of the plan for *Covering America*, Butler proposes allowing lower-income individuals to select between a fixed credit and a sliding scale credit based on health status and family income. Higher-income individuals would receive the sliding credit. Under the sliding scale credit, individuals with health care costs up to 5 percent of their income would receive a credit worth 25 percent of their costs; individuals with costs between 5 percent and 15 percent of their income would receive a 40 percent credit; and those with health costs above 15 percent of their income would receive a 60 percent credit. For further discussion, see Butler, "Reforming the Tax Treatment of Health Care."
40. The TAA legislation restricts the application of the tax credits to the following options: COBRA coverage; spousal coverage; individual coverage (in a very limited capacity); or a state-designated plan. For more detailed information, see Nina Owcharenko, "Why Congress Should Expand Displaced Trade Workers' Access to Health Care Coverage," Heritage Foundation *WebMemo* No. 290, Jun 12, 2003, at *www.heritage.org/Research/HealthCare/wm290.cfm*.

Health Savings Account. This would ensure that the process is not further complicated with new exceptions and/or limitations.

Tax credits are simply a direct subsidy to individuals to assist them in purchasing coverage, creating an alternative to the existing tax break given through the place of work. Thus, the same policies that individuals purchase without a credit should be available to them with the credit. Credits should apply to health insurance and qualified medical expenses.

However, one appropriate restriction may be related to employer-sponsored coverage. As noted, working individuals already receive an unlimited tax benefit in the form of the tax exclusion where the value of the benefit package is excluded from a worker's taxable income. Thus, Congress could prohibit the use of the tax credit for existing employer-based coverage. Or individuals could choose to forgo the existing exclusion and use the credit to purchase their own coverage or vice versa.[41]

Alternatively, an individual choosing to get coverage through the place of work could receive a smaller, scaled-back credit linked directly to the employee's share of the premium.[42] This could be especially useful for low-income individuals who have access but find it financially difficult to afford their employee share of the premium. It could also discourage employees from dropping their employer coverage in order to qualify for the credit.

Option #5: Ceiling vs. Floor. A federal tax credit can be designed as either a ceiling or a floor for health care subsidies. In other words, a tax credit can be designed as the maximum or minimum federal health subsidy an individual could receive for obtaining coverage and/or health care expenses. As a ceiling, a tax credit would be the maximum subsidy for health insurance or health care expenses for which a person may be eligible. As a floor, a tax credit could be supplemented by other financing mechanisms, public or private.

Recommendation. In principle, there is no reason for policymakers to make the provision of a tax credit a rigid either/or policy proposition. In designing the individual health care tax credit as a floor, policymakers could authorize additional contributions from a variety of sources, including funds currently expended in existing state public health programs. States could use Medicaid and/or State Children's Health Insurance Program (SCHIP) dollars to further enhance the federal contribution. A federal tax credit could also be augmented by other state subsidies, including a state-based health insurance tax credit.

Employers and charitable organizations could also provide additional resources. A voluntary contribution toward their workers' coverage—a defined contribution in lieu of providing a health care benefit package—could be a valuable tool for employers, especially small businesses that struggle to provide traditional health care benefits, and for part-time workers, who may not qualify for an employer's full benefit package.

Conclusion

Today's tax code distorts the health care market and creates inequities in the system. The President's Advisory Panel on Tax Reform was correct to recommend capping the exclusion for employer-based coverage. However, another critical measure is needed to right this wrong and make health care coverage more affordable—health care tax credits.

Congress must act now, building upon the recommendations of the Advisory Panel, to create an alternative to the current system. Health care tax credits can help to "level the playing field" for those—especially lower-income individuals—who do not fit into today's patchwork health care system by giving them a tax subsidy that is at least comparable to that offered to those in the current struc-

41. Representative John Cooksey (R–LA) introduced such a concept in H.R. 4925, the Patient Access, Choice, and Equity Act, during the 106th Congress.

42. Senator Jim Jeffords (I–VT) introduced such a proposal in S. 590, the Relief, Equity, Access and Coverage for Health Act, during the 107th Congress.

ture. However, Members of Congress must be very careful about how they develop and design a tax credit proposal. The impact of the credits, for good or ill, will depend largely on these design details and policy decisions.

Individual health care tax credits, in combination with a robust market for insurance products, would offer individuals the opportunity to secure private health care coverage of their own, moving the system closer to a consumer-oriented model that is fairer and more transparent and that empowers individuals to make health care decisions for themselves and their families.

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