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Obamacare and Health Subsidies: Expanding Perverse Incentives for Employers and Employees

Brian Blase and Paul L. Winfree

The Patient Protection and Affordable Care Act (PPACA)[1] offers subsidies for most individuals who purchase insurance in the newly created health insurance exchanges—a premium assistance subsidy and a cost-sharing subsidy. These subsidies are the most expensive component of the overhaul, costing over $460 billion by 2019. Perhaps even more problematic, they will cause significant and harmful disruptions far outside the health care system by discouraging work and further complicating the tax treatment of health insurance. The subsidies reinforce current tax code inequities and create new ones.

Summary. Section 1401 of PPACA[2] amended the Internal Revenue Code of 1986 by inserting Section 36B, "Refundable Credit for Coverage Under a Qualified Health Plan." This section establishes a tax credit for qualified households below 400 percent of the federal poverty level (FPL)—nearly $95,000 for a family of four in 2014—who purchase coverage in an exchange.[3]

Section 1001 of the reconciliation component (H.R. 4872) of the final health care legislation sets the premium credit at an amount that limits the percentage of income that qualified households pay for health insurance with an actuarial value of 70 percent, equivalently a "silver" plan in the exchanges.[4] According to Section 1412 of PPACA, the credit will be paid directly to the insurer.

The tax credits for premium assistance are based on a sliding scale in which the credit declines as household income rises. Households at 133 percent of the FPL cannot spend more than 3 percent of their income on out-of-pocket premium contributions toward a silver plan, and households between 300 percent and 400 percent of the FPL cannot spend more than 9.5 percent.[5] The credit is also linked to age.[6]

For example, a family of four at 200 percent of the FPL (about $50,000 in 2016) cannot pay more than 6.3 percent of its income for silver plan coverage. The Congressional Budget Office (CBO) estimates that the average price in 2016 of the second-lowest-cost silver plan for a family policy will be $14,100. Therefore, the family at 200 percent FPL would receive a refundable tax credit of nearly $11,000 to purchase insurance in 2016, leaving approximately $3,100 (or 6.3 percent of its income) to be paid out of pocket. If the family buys a more expensive plan, it would be responsible for the additional premium. If the family buys a cheaper plan, it would keep the difference by paying less for the policy.

If premiums grow faster than income or if the tax credits exceed a specified amount, the out-of-pocket contribution toward the premium will increase, according to the reconciliation bill. Specif-

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ically, the dollar amount that an individual must pay toward the premium (calculated as a percentage of income) will increase at a rate of premium growth over income growth. Moreover, if the total amount of the tax credits exceeds 0.504 percent of gross domestic product, households' responsibility for their premiums will increase further by the rate of premium growth over inflation as measured by the Consumer Price Index.

Section 1402 of PPACA creates another subsidy, which reduces the amount that qualified individuals pay for out-of-pocket health care services.[7] This is achieved in two ways. First, the maximum amount people pay out of pocket is capped for households with incomes below 400 percent of the FPL.[8] Second, households below 250 percent of the FPL will receive subsidies to purchase plans with fewer cost-sharing requirements. The insurer is paid directly to reduce co-payments and deductibles,[9] which will effectively raise the plan's actuarial value.[10]

Impact. The cost of the subsidies harms the nation's long-term fiscal health. Furthermore, the subsidies will encourage employers to drop coverage, perpetuate an already inequitable tax code, and discourage work and upward mobility.

Encourages Employers to Drop Coverage. Former CBO Director Douglas Holtz-Eakin has warned that more people will likely drop employer-sponsored insurance (ESI) than the CBO expects.[11]

1. Congress cannot build sound market-based health care reform on the foundation of a flawed health care law. Therefore, the health care law must be repealed in its entirety.

   The House of Representatives has taken a major step towards full repeal of the Patient Protection and Affordable Care Act (PPACA—otherwise known as "Obamacare"). Until full repeal occurs, Congress must continue to focus on the core failures and consequences of PPACA and block its implementation to allow time to achieve repeal and lay the groundwork for a new market-based direction for health care reform.
2. Patient Protection and Affordable Care Act of 2010, Public Law 111–148, and Health Care and Education Reconciliation Act of 2010, Public Law 111–152.
3. A household qualifies for subsidies unless it is eligible for Medicare or Medicaid or is offered "affordable" coverage by an employer. "Unaffordable" coverage covers less than 60 percent of the cost of benefits or has a premium that exceeds 9.5 percent of income.
4. A plan with an actuarial value of 70 percent means that for all enrollees in a typical population, the plan will pay for 70 percent of expenses in total for covered benefits, with enrollees responsible for the rest.
5. Individuals in household below 133 percent of the FPL cannot pay more than 2 percent of their income in personal premium contributions. The applicable percentage for individuals in households between 300 percent and 400 percent of the FPL is 9.5 percent. Those percentages for individuals between 133 percent and 300 percent of the FPL are based on a sliding scale with a linear interpolation for individuals in the middle of five FPL levels. The applicable percentages are 3 percent for individuals at 133 percent of the FPL, 4 percent for individuals at 150 percent of the FPL, 6.3 percent for individuals at 200 percent of the FPL, 8.05 percent for individuals at 250 percent of the FPL, and 9.5 percent for individuals at 300 percent of FPL.
6. The law also puts in place age rating bands. This interaction with the subsidy scheme will result in older individuals qualifying for larger credits.
7. This provision was modified by the reconciliation bill (H.R. 4872).
8. The standard out-of-pocket maximum limits ($5,950 for individuals and $11,900 for families) would be reduced by one-third for those at 100–200 percent of the FPL, one-half for those at 200–300 percent of the FPL, and two-thirds for those at 300–400 percent of the FPL.
9. Under PPACA, every insurer will have to offer the same basic package of benefits, although they may differ in how those benefits are obtained and the degrees of cost-sharing.
10. For individuals in households with incomes between 133 and 150 percent of the FPL, the actuarial value of coverage is raised to 94 percent. For individuals between 150 and 200 percent of the FPL, the actuarial value is raised to 87 percent, and the actuarial value is raised to 73 percent for individuals between 200 and 250 percent of the FPL.
11. Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform: New Results," American Action Forum, May 2010, at *http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10.pdf* (July 6, 2010).

Many businesses and their employees—especially lower-income employees—will find that replacing ESI plans with subsidized coverage on the exchanges is mutually beneficial. Employers would no longer offer health insurance but would offer wage increases as wages and benefits are substitutes in an employee's net compensation. At the same time, these workers will still have access to coverage through the exchanges with the subsidies or through Medicaid.

Massive Taxpayer Burden. The CBO estimates that by 2018 some 19 million individuals covered by a policy purchased through the exchanges will receive a subsidy. The estimated total cost between 2014 (when the subsidies begin) and 2019 top $450 billion in new government spending.[12] Approximately 38 million Americans with ESI live in households below 250 percent of the FPL.[13] Most employees in households below 250 percent of the FPL would be better off dropping ESI coverage, according to Holtz-Eakin's analysis. CBO estimates that fewer than 8 million individuals would lose ESI coverage in response to the subsidized exchanges. However, if CBO has underestimated the number of people who will lose ESI and receive subsidized coverage in an exchange, spending will likely increase substantially over initial projections.

As mentioned, PPACA provided some protection against substantial increases in the federal cost of the tax credits if premiums grow excessively or if the cumulative subsidy cost exceeds a specified amount. However, political pressure to increase the subsidy amount if premiums greatly increase will likely follow. If Congress acquiesces, the taxpayer burden of the subsidy will increase further.

Increased Tax Inequity. One advantage of buying insurance through the workplace is that employees do not pay taxes on health insurance premiums paid by their employers as compensation. Individuals who do not buy insurance through work lack this tax advantage. Instead of remedying this inequity, PPACA creates new ones. Lower-income individuals with ESI receive less favorable tax treatment than wealthier individuals without ESI. For example, a family of four with ESI headed by a 50-year-old at 150 percent of the FPL stands to benefit by about $3,600 because of the tax exclusion. However, a family of four at 300 percent of the FPL would receive a tax credit worth roughly $10,200 if it did not have access to ESI, treatment nearly three times as generous as that received by the poorer family.

A Disincentive to Work. The subsidies will discourage work by individuals eligible for the subsidy and for other taxpayers who will likely be forced to pay higher taxes in order to finance the subsidies.[14] There is an enormous "cliff effect" at 400 percent of the FPL, where earning additional income results in a total loss of the subsidy. A family of four headed by a 60-year-old would lose more than $15,000 worth of tax credits as household income passes 400 percent of the FPL.[15] The subsidy will also encourage individuals to retire early and to change the way they report income. This subsidy structure also penalizes upward income mobility and marriage.[16]

A New Direction. The subsidies in the health care law have a large price tag. They will disrupt existing employer-based coverage and create new distortions in the health insurance market. The subsidies further complicate an already complex tax code while establishing new inequities. Moreover,

12. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to Nancy Pelosi, Speaker, U.S. House of Representatives, March 20, 2010, at *http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf* (June 22, 2010).
13. These estimates come from the 2009 Current Population Survey.
14. The health care law largely pays for the subsidies by cutting Medicare spending. If those cuts never materialize or when Medicare cost growth causes spending to exceed tax revenue set aside for Medicare over time, the federal government will be forced to increase taxes on households to finance the subsidies.
15. Calculations obtained from the Kaiser Family Foundation's Health Reform Subsidy Calculator, at *http://healthreform.kff.org/SubsidyCalculator.aspx#incomeAgeTables* (January 13, 2011).
16. Katherine Bradley and Robert Rector, "The New Federal Wedding Tax: How Obamacare Would Dramatically Penalize Marriage," Heritage Foundation *WebMemo* No. 2767, January 20, 2010, at *http://www.heritage.org/research/reports/2010/01/the-new-federal-wedding-tax-how-obamacare-would-dramatically-penalize-marriage.*

the subsidy structure creates incentives for individuals to engage in unproductive activities, such as working less and retiring early.

Positive health policy reform should level the playing field between those who get their coverage at work and those who do not. In particular, a fairer and more equitable tax structure should replace the current tax treatment of health insurance and redirect existing health care spending to help families and individuals purchase private health insurance. This structure would promote personal ownership, portability of insurance, and cost transparency.

*—**Brian Blase** is a Policy Analyst in the Center for Health Policy Studies and a Doctoral Candidate in Economics at George Mason University and **Paul L. Winfree** is a Senior Policy Analyst in the Center for Data Analysis at The Heritage Foundation.*