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Tax Credits for Individual Health Insurance: Effects on Employer Coverage And Refinements to Improve Overall Coverage Rates

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Executive Summary

Tax credits like those proposed by the Bush Administration could help make individual health insurance affordable for the many uninsured people who do not have access to employment-based health coverage. However, some policy makers believe that tax credits that would be available *only for non-employer coverage* could cause an increasing number of people who now have employment-based coverage to become uninsured. This would principally be the result of some employers choosing to reduce their existing contributions or drop coverage because most of their workers could instead receive the tax credit. Where employers did so, the net out-of-pocket price that a number of workers would face for health insurance would be higher, causing fewer of them to obtain coverage.

Initial estimates indicate that, given what is known about employers' and employees' behavior, such first-order negative effects would be relatively small and would be more than offset by increased coverage of the uninsured. But over the longer term, some experts and policymakers are concerned that there is a risk of much larger erosions in coverage if employers were to react in certain ways to a changed environment. For example, initial effects could cascade as other employers respond to their competitors' decisions to drop coverage. Or individual tax credits could precipitate a shift in the expectation that employers will offer coverage and cause a decline in the demand for employer-financed coverage, destabilizing the funding and coverage source for the vast majority of working-age Americans.

Because tax credits could help many afford coverage, it is sensible to investigate whether tax-credit proposals that allow credits to be used only in the individual market, as is the case with the Administration's proposal, could be modified to minimize the risk that employees and employers might drop existing coverage. Certain employers are more likely to drop coverage than others. Dropping coverage is likely to appear attractive if a significant share of a firm's employees could realize a greater tax subsidy or a lower price for coverage in the individual market. It is also likely if so many (lower-cost) workers voluntarily leave the employer's health plan to use the tax credit that the employer no longer views maintaining the plan as

worthwhile because the remaining participants are few in number and relatively expensive to cover. It is likely if the plan otherwise becomes unstable or unattainable—for example, because the plan no longer meets insurers' group-participation requirements. Small firms are much more likely than large firms to have the workforce characteristics and "critical mass" issues that would cause them to drop coverage.

The workers most likely to shift voluntarily out of group coverage are those who are young (and thus generally could obtain inexpensive individual coverage) and whose modest family income both qualifies them for the maximum tax credit and makes the existing tax exclusion for employer-paid coverage less valuable (because their marginal tax rates are low). Also, certain married workers who have relatively high wages—and are therefore far more likely to have employer coverage and far less likely to be uninsured—could be eligible for a significant tax credit that could induce them to shift out of employer coverage. This situation could occur when the high-wage worker has a spouse with low or no earnings. (For example, as proposed in the Bush reform, the credit is based on family income, not on individual earnings, and is available up to $60,000 when both spouses are covered. Childless couples are eligible at by far the highest income relative to the poverty level, and would qualify for a 50 percent credit even at 340 percent of poverty.)

From the groups that drop coverage, the workers who are most likely to remain uninsured are those who would not qualify for a sizeable tax credit (for example, under the Administration's proposal a single younger full-time worker earning $11 per hour—$22,880 per year—or more would qualify for a credit of less than $400) or modest-income workers who are older or less healthy and would therefore face much more expensive prices for individual coverage.

To minimize such erosion of coverage, tax-credit proposals that provide credits for only non-employer-group coverage could be modified to reduce the incentives that could cause some employers and employees to drop coverage. Three potential modifications are suggested for consideration:

· *Adjust the tax credits for age* to partially offset associated price differences for individual health insurance. This would involve reducing the credit for younger people and increasing it for older workers, relative to the average credit. This change would reduce incentives for young workers with employer coverage to leave the group and would help low-income, otherwise-uninsured older workers to afford individual coverage. We suggest only partial age adjustment—that is, an adjustment to the credit amount that would not fully reflect the actual differences in premiums by age in the individual market. Such an approach would be less costly and more likely to optimize coverage per dollar spent on subsidies than would full age adjustment.

· *Reduce the tax credit for eligible childless couples when one spouse has relatively high individual earnings.* While it would make administration of the credit more difficult, this modification would have two desirable effects. First, it would reduce the credit amount for higher-wage workers, who are much more likely to have employer coverage, and thereby reduce their incentive to drop that coverage. By doing so, it would more effectively target the tax credit on those lower-wage workers who are more likely to be uninsured and need assistance. Second, it would generate savings to fund larger (age-adjusted) credits for older workers with low earnings. (At the $1,000-per-adult tax-credit ceiling in the Bush proposal, linking the credit to individual workers' earnings may not be critically important. But at higher credit amounts, such a linkage could become important in preventing erosion of employment-based coverage.)

· *Allow firms the option to convert their entire employer group from current income-tax preferences for employer coverage to an arrangement where workers can receive the tax credit but the employer contribution is not exempt from income tax (but is exempt from FICA taxes).* Providing firms with this option is intended to encourage continued coverage and contributions by those employer groups most likely to be induced to drop coverage. It is expected to be attractive primarily to small firms in which a sizeable majority of workers qualify for substantial tax credits; therefore, the additional budgetary cost, if any, should be modest. The "entire-group" requirement should minimize any reporting difficulties.

These modifications, while making the tax credit approach somewhat more complex to administer, would reduce and might eliminate any real danger that the tax credit would cause a cascading erosion of employer coverage. And even for those who do not believe that a danger of such erosion exists, these modifications might be attractive as ways to enhance net "first-order" coverage expansions.

While we believe our suggested changes have substantial merit, there could be better or more cost-effective modifications to achieve these objectives. The most important purpose of this paper is to help point toward a constructive middle ground for achievable effective policies to cover the uninsured.

Tax Credits for Individual Health Insurance: Effects on Employer Coverage and Refinements to Improve Overall Coverage Rates

Introduction

As policy makers consider how to cover uninsured Americans, considerable controversy has centered around the interplay between private employer coverage and individual tax credits or public program expansions.

Careful consideration of this potential interplay is warranted since most workers and their dependents have coverage through employer groups. The participation rate in employer coverage is high because employer contributions, which are encouraged by their exclusion from payroll and personal income taxes, substantially reduce the net price workers pay for coverage.[1] In 2001, the average employer paid 85 percent of the cost of worker-only coverage and 73 percent of the cost of full family coverage.[2] To the extent that public policy changes cause employers to reduce their contributions or drop coverage entirely—even if they use the savings to increase workers' wages—net health insurance prices for their workers will rise, and more workers will choose to forego coverage.[3]

Those most in need of government assistance in order to afford health insurance are low-income adults and children. The population with income below 200 percent of the federal poverty level—the core target population both for the Bush Administration's proposed tax credit (roughly speaking) and for many public-program-expansion proposals—comprises almost two-thirds of the (nonelderly) uninsured.[4] The concern about the potential interaction with employment-based health insurance arises because, particularly among those from 100 percent to 200 percent of poverty, more low-income adults and children have employment-based coverage than are uninsured or on Medicaid.[5] (See Figure 1.) Looked at another way, more than one out of six people now covered by an employment-based plan have incomes below 200 percent of poverty.[6]

Figure 1: Health insurance coverage of the nonelderly, 2000

		Percent Distribution by Coverage Type			
Income as Percent of Poverty Level	Nonelderly Population (millions)	Employer Coverage	Medicaid	Other	Uninsured
<100%	38.1	17.8%	37.1%	9.3%	35.8%
100-199%	**41.3**	**46.6%**	**17.2%**	**9.9%**	**26.3%**
200-299%	40.4	70.8%	5.3%	7.8%	16.0%
300% +	122.9	87.1%	1.6%	5.3%	6.0%
Total	**242.8**	**66.6%**	**10.4%**	**7.1%**	**15.8%**

Notes: "Other" includes private non-group and other public insurance (mostly Medicare and military related). Medicaid includes SCHIP. People who held *both* Medicaid and employer coverage during the year are classified as having Medicaid coverage.

Source: Urban Institute analysis of data from the March 2001 Current Population Survey, as presented in Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2002 Data Update*, February 2002, Table 1.

Both tax credits and public program expansions would provide assistance to the many uninsured who do not have employment-based coverage and are not currently eligible for public programs like Medicaid and the State Children's Health Insurance Program (SCHIP). These include workers whose firms do not offer coverage at all, and part-time, short-term and seasonal workers who are not eligible for the coverage their employer offers to other workers.

But broad availability of public subsidies applicable only to non-work-based health insurance for low-income workers might induce some employers (presumably, those with a significant proportion of subsidy-eligible workers) either to drop coverage they now offer to their workers or to reduce the contributions they make toward that coverage. Others might be *forced* to drop coverage if a number of their younger workers voluntarily left the plan. As a result, private employer contributions dedicated to health insurance could be lost, and some previously insured workers or dependents might become uninsured or less adequately insured.

Moreover, there is a risk—although one very difficult to estimate—that these incentives could erode the market demand or societal expectation that employers will arrange and contribute toward health insurance. As Henry Aaron and others posit,[7] this could lead to a growing increase, rather than a reduction, in the number of uninsured.

It is not our intention in this paper to discuss the relative merits of tax credits versus public program expansions as approaches to subsidizing coverage for low-income Americans. Rather, our primary purpose is to consider constructively how the tax credit approach might interact with employment-based coverage in ways that cause some workers and families to become uninsured, and to identify potential modifications to minimize this risk. Public program expansions, especially those that cover adults above the poverty level, can also cause shifts from employer coverage. While issues surrounding direct public coverage are largely beyond the scope of this paper, we do consider how one modification—taking individual wages into consideration—might mitigate this effect and thus increase the net coverage effect for the uninsured.

A Brief Description of the Administration's Health-Insurance Tax-Credit Proposal

The crowd-out issues we address in this paper apply to tax-credit approaches that do not allow use of the tax credit for the purchase of employer-sponsored coverage. Since the Bush Administration's proposal is the most prominent proposal of this type, we will use it as an example throughout this paper. As proposed by the Bush Administration, health insurance tax credits would not be available to people when they are enrolled in employer coverage or public programs.[8] Beginning with tax year 2003, individuals under age 65 who bought private health insurance (that met specified minimum standards) other than through their employer would be eligible for a refundable credit that would pay up to 90 percent of the health insurance premium, up to a maximum credit of $1,000 per adult and $500 per child for up to two children. Thus, the maximum credit would be $1,000 for a single worker, $2,000 for a childless couple, $1,500 for a single parent with one child, $2,000 for a single parent with two or more children, and $3,000 for a married couple with two or more children. (In subsequent years, these dollar amounts would be indexed to the growth in the Consumer Price Index for all-urban consumers.)

The maximum credit would apply up to $15,000 of (modified) adjusted gross income (AGI) for individuals with no dependents who file a single return, and up to $25,000 of (modified) AGI for all other filers. The subsidy percentage and credit amount would phase down above these income levels. The credit would phase out completely for single filers at $30,000 and for other filers at $60,000 (or $40,000 if the policy covered only one adult). The poverty-level equivalent of these dollar amounts varies, depending on family structure. For example, the maximum tax credit is available up to only 138 percent of poverty for a couple with two children, but up to 209 percent of poverty for a childless couple. Eligibility for a 50 percent credit would extend beyond 200 percent of poverty except for five-person or larger families, and childless couples would still qualify for a 50 percent credit at 340 percent of poverty.[9] (See Figure 2.)

Figure 2: Bush Administration's proposed health insurance tax credit thresholds compared to poverty level

	Maximum Income for Full (90%) Credit		50% Credit Available at (Income)	
Family Type / Filing Status	Dollar Amount	Percent of Poverty	Dollar Amount	Percent of Poverty
Single Childless Adult	$15,000	169% (1)	$20,000	226% (1)
Only One Adult Covered, but not Single Filer	$25,000	(dependent on family size)	$31,667	(dependent on family size)
Childless Couple	$25,000	209% (2)	$40,556	340% (2)
Single Parent with 2 Children	$25,000	166% (3)	$40,556	270% (3)
Couple with 2 Children	$25,000	138% (4)	$40,556	224% (4)

Notes: Numbers in parentheses indicate the family size used to calculate family income as a percentage of the poverty level.

Source: Department of the Treasury, "General Explanations of the Administration 's Fiscal Year 2003 Revenue Proposals," February 2002. Department of Health and Human Services, "2002 HHS Poverty Guidelines." Accessed from http://aspe.hhs.gov/poverty/02poverty.htm.

Significantly, the refundable tax credit could be claimed as part of the normal tax-filing process or could be made available in advance at the time the insurance is purchased. In the latter case, "individuals would reduce their premium payment by the amount of the credit and the health insurer would be reimbursed by the Department of the Treasury for the amount of the advance credit. Eligibility for the advance credit would be based on the individual's prior year tax return."[10]

Characteristics of Currently Covered Workers and Employers Likely to Respond to Changes in Tax Policy

Because of the substantial uncertainty regarding individual and employer reactions to the availability of a tax credit for non-employer coverage, estimates of the effects on employer coverage and the uninsured vary widely. Jonathan Gruber's recent estimate included details about expected effects on employer coverage and predicted that, if the Administration's proposed health-insurance tax credit were implemented, 2.6 million people would switch from employment-based coverage to non-group insurance, while 1.4 million previously insured people would become uninsured due to loss of employer coverage. The drop in employer coverage is estimated to total 4.0 million persons, or about 2.5 percent, while 3.3 million previously uninsured persons would buy individual coverage using the tax credit. Overall, an estimated 10.5 million people would use the credit, and the estimated net reduction in the uninsured population would be 1.9 million persons, or about 4.3 percent.[11]

The Administration recognizes that "a tax credit that is too large may disrupt the ESI [employer-sponsored insurance] market," but argues that capping the maximum credit amount and phasing out the credit as income increases will assure that any disruptions are minimal. The President's Council of Economic Advisers estimates that "6 million or more Americans who would otherwise be uninsured during a year [would] gain coverage."[12]

Expansion of public program coverage to low-income but non-poor adults also seems to result in a reduction in employer coverage. While most studies of public coverage expansions aimed at children have found only modest crowd out of employer coverage, a study of four state expansions that included low-income adults found that, among adults between 100 and 200 percent of poverty, approximately 55 percent of the increase in public program enrollment resulted from a reduction in the number of uninsured, while 45 percent was associated with a decline in private insurance coverage.[13]

While experts disagree about the extent to which tax credits would be likely to "crowd out" existing employer coverage, it should be possible to identify the characteristics of workers and employers who would face the strongest incentives to drop employer coverage. Obviously, workers will not choose to drop employment-based coverage and purchase individual coverage using tax credits or enroll in a public program unless they believe they will be better off by doing so. Nor does it seem likely that many employers would change their health coverage policies unless a significant share of their workers would be better off under the alternative. Before suggesting modifications aimed at reducing the risk that employer coverage will be eroded, therefore, it is first important to identify the characteristics of workers who would be most likely to find the tax credit attractive. That is, we seek to understand:

For what kinds of workers might the tax credit make individual insurance more attractive than their current employer plan?

Other things being equal, workers are more likely to be "better off" choosing tax-credit-eligible individual insurance if they are young and healthy and their income is low enough to qualify them for a significant credit.

A worker's age and health status are important factors for two main reasons. First, in all but a handful of states, premiums for individual insurance can vary with age and gender by as much as 4 to 1.[14] Therefore, a tax credit capped at a fixed dollar amount is most likely to cover a significant proportion of the premium for young, healthy males, who are offered the lowest premiums in the individual market. Second, to keep premiums relatively affordable, individual health insurance tends to impose higher deductibles and other out-of-pocket costs than employer coverage does. Young workers with few health needs are more likely to be willing to accept coverage that is less comprehensive than that offered by their employer.

Even a young, healthy worker will be unlikely to substitute individual insurance for employer coverage unless he can reduce his net out-of-pocket premium costs by doing so. But it seems likely that many such workers could attain a lower net premium cost under the tax credit, if they were willing to accept less comprehensive individual coverage. In 2001, the average worker had to pay $360 per year for employer coverage.[15] Due to rapidly increasing premiums, average worker contributions will likely increase considerably by 2003 (when the tax credit would go into effect), perhaps to $500 or more. Some workers will have to pay even more. By accepting a higher deductible, a young worker could often obtain individual coverage for $1,200 per year or less, making his net cost after applying the tax credit less than $200 per year. And the incentive to drop employer coverage in favor of individual insurance would be much greater if, by foregoing employer coverage, the worker could convert all or most of the employer's health insurance contribution to other benefits (as, for example, under a cafeteria plan) or to increased pay.

It is also worth noting that, if the tax credit is capped, it will cover a large part of the premium for a larger proportion of workers in geographic areas with less expensive health care than in more expensive areas. (Geographic rating factors used by insurers offering individual coverage can vary by more than 2 or 3 to 1.[16]) Thus, with a capped credit, the incentive to substitute individual insurance for employer coverage will be greater in less expensive regions.

A related question is whether, among those eligible for a health insurance tax credit or enrollment in public coverage, it is possible to identify characteristics of workers who are more likely to have employer coverage and less likely to be uninsured. If so, then policies might be tailored to reduce the incentive for workers with those characteristics to drop employer coverage in favor of tax-subsidized individual insurance or enrollment in a public program.

Among workers in low-income families, what kinds of workers are most likely to have employer coverage and least likely to be uninsured?

The probability that a worker will be offered employment-based health coverage is directly related to that worker's wage or salary level. Higher-wage workers are more likely to have employer coverage and less likely to be uninsured.

· Only one-third of U.S. workers who earned less than $20,000 in 1999 had coverage through their own employer, compared to 68 percent of those who earned between $20,000 and $30,000 and 79 percent of those who earned between $30,000 and $40,000. Only 7 percent of U.S. workers who earned between $30,000 and $40,000 in 1999 were uninsured, compared to 29 percent of those who earned less than $20,000.[17]

· The relationship between wage level and employer coverage persists even if we consider only workers in low-income families who would be likely to qualify for a tax credit or be eligible for public coverage.

· Among full-time full-year workers with family incomes below 200 percent of poverty, 80 percent of those who earned $30,000 to $40,000 had coverage through their own employer, while fewer than 10 percent were uninsured.[18]

This observation is potentially important for program design because there is a subset of low-income workers for whom wages and income are not effectively synonymous. If a worker is married, and his or her spouse has low or no earnings, it is possible for the worker to have relatively high *wages* while still having *family income* low enough to qualify for a significant tax credit or a public program. While a relatively small group, these higher-wage workers are much more likely to have employer coverage than are other low-family-income workers.[19] Therefore, to the extent these workers elect to use the tax credit, more of them will shift from employer coverage and fewer from being uninsured, as compared to tax-credit users who are single or, if married, who both work.

Estimating how many workers who currently have employment-based coverage might be inclined to drop that coverage in order to take advantage of tax credits for individual coverage is difficult and the subject of informed differences of opinion among researchers. But it seems likely that under the Administration's proposal such voluntary shifting—that is, shifting not forced by an employer's decision to drop coverage—would be relatively small. In Jonathan Gruber's one recent estimate, about 1 percent of those with employment-based coverage (and whose employers continue to offer coverage) would switch to non-group insurance under the Administration's tax-credit proposal.[20] Also, the total pool of workers with employment-based coverage who are young and have incomes low enough to qualify for a substantial credit is relatively small. Only about 7 percent of adults with coverage through their own employer are both under age 30 and have family income in the primary tax-credit-eligible range (here estimated as equivalent to under 250 percent of poverty).[21] And only a portion of these currently have to pay a significant amount out of their paycheck in order to enroll in their employers' plan. So the Bush Administration's tax credit alternative would appear to be more attractive than employer-sponsored coverage to only a relatively small number of workers.

What will employers do?

The larger issue is, what will employers choose to do? Faced with rising premiums for health coverage, will employers take the availability of significant tax credits for non-employer coverage as an opportunity to retreat from involvement with health insurance? And would the proportion who do so grow as more employers perceive that their competitors have relieved themselves of this burden?

If credit-eligible workers represent only a small proportion of an employer's workforce, it seems unlikely that the employer would stop offering health insurance or reduce its contribution significantly. But if a majority of an employer's workforce could qualify for a credit, it would be sensible for the employer to consider whether he and his workers would be better off if the employer stopped offering health coverage and, instead, offered higher wages.

Available evidence suggests that the bulk of low-wage (and, therefore, potentially credit-eligible) workers are concentrated in firms with other low-wage workers (where "low-wage" is defined as earning less than $7 per hour or $14,000 per year). In 1997, 58 percent of all low-wage workers worked in low-wage businesses, and 87 percent of all workers in those businesses were low-wage workers. (A "low-wage business" is one in which two-thirds of the employees are "low-wage" workers.) Of all workers employed by low-wage businesses, 31 percent were covered by their own employer's plan.[22]

Thus, there seems to be a subset of employers who both offer health insurance and have a high proportion of potentially tax-credit-eligible workers. Such employers might seriously consider dropping their employer-sponsored health plans if a tax credit proposal like the Administration's were enacted. This might not be a serious problem if all their workers were then able to obtain individual coverage. But at least some workers in these firms would likely be unable to obtain, or to afford, non-group coverage, even with the proposed tax credit. According to one estimate, more workers and dependents in these firms would become uninsured—1.36 million—than would switch to non-group coverage—1.03 million.[23]

Further, some experts and policymakers are concerned that there is a risk of much larger erosions in coverage if employers were to react in certain ways to a changed environment. For example, it is possible that other employers, with fewer tax-credit-eligible workers, could see enactment of a tax credit for individual insurance as an opportunity to drop coverage. Over the longer term, there is concern that modest initial effects could cascade as other employers respond to their competitors' decisions to drop coverage. Or individual tax credits could precipitate a shift in the expectation that employers will offer coverage and cause a decline in the demand for employer-financed coverage, destabilizing the funding and coverage source for the vast majority of working-age Americans.

Possible Modifications of Current Proposals to Reduce the Risk of Displacing Employer Coverage and to Maximize Real Expansion

We have seen that, under the Administration's proposed tax credit for non-employer coverage, some people and some employers would have immediate incentives to drop employer coverage, and others would not. Before proposing modifications to mitigate the risk that workers will become uninsured due to erosion of employer coverage, it may be useful to assess the underlying tension that could cause displacements in coverage. That tension arises from key differences in how tax subsidies for health insurance work at present and how they would work under the Administration's proposal, and in how insurers set premium rates in the individual market versus the group market.

· The tax credit is progressive relative to income, with much higher subsidies for the poor and near poor. The existing tax exclusion of employer-paid premiums for employment-based health coverage is regressive, offering little or no assistance to the poor and near poor, particularly for childless adults.[24]

· The tax credit is capped and the upper limit varies only with the person's income and does not vary with any other personal characteristics, such as age and health status, that insurers use to set premium rates in the individual market in most states. The existing tax exclusion for employer coverage, on the other hand, is open-ended and applies to whatever premium amount is charged. Further, for a given plan and family structure, premiums (or premium-equivalents) and contribution rates rarely vary by characteristics of individual workers within an employer group.

One consequence of this set of circumstances is that using the tax credit for individual coverage would result in a relatively low net cost of health insurance for a young, healthy worker, and therefore would also make it attractive for some employers with a number of such workers to drop coverage (or to "outsource" these workers so they are no longer eligible for the employer plan). But, even with the tax credit, older or less healthy workers would face relatively high net costs in the individual market, making it likely that an employer with many such workers would face opposition to dropping coverage in response to availability of the tax credit.

Given this dynamic, modifications to tax-credit proposals like the Bush Administration's can mitigate the risk of coverage loss if they either: (1) reduce the incentives some demographic groups would have to drop employer coverage, or (2) better target the tax credit toward those who are more likely to be uninsured and away from those who are more likely to have employer coverage.

Because the Administration's proposed health insurance tax credit is capped at $1,000 per adult, and because the full credit is available, in most cases, only to workers with incomes under (roughly) 167 percent of poverty, it does not seem likely that en-

actment of the credit as proposed would initially cause significant displacement of those with employment-based insurance. But if a million or so currently covered workers are likely to become uninsured in the short run (as Gruber estimates), some might view this as a significant problem. And, even if these initial effects are not viewed as significant, or are assumed to be smaller, there is justifiable apprehension that the number could escalate over time, as second-order effects ripple out to other employers and workers. It therefore seems to us worth exploring whether some adjustments to the credit as proposed could substantially ameliorate incentives for such a result—that is, stop the "first domino" from falling. We assume that such modifications should be designed to achieve this objective without increasing the cost of the credit or leading to other consequences key policy makers might find unacceptable.

The modifications proposed here are offered in an effort to identify workable and effective changes and, at a minimum, to stimulate creative thinking on this important issue.

Fine-Tuning the Incentives Faced by Individual Workers (and Why Doing So Is Important for Employers' Behavior)

As discussed earlier, under the Administration's health insurance credit proposal as currently drafted, some workers have more incentive than others to leave employment-based coverage, and some workers eligible for the credit are much more likely than others to have employment-based coverage in the first place.

· As to the first point, the tax credit option is much more attractive for younger and healthier workers than for older or less healthy workers, because the maximum credit amount does not vary with age (or by health status), while premiums for individual insurance do vary with age (in almost all states) and by health status (in many states).

· And, as to the second point, other things being equal, a worker with a spouse who has low or no earnings will qualify for a credit at a higher wage level than a worker who is single or whose spouse earns about the same amount. And these higher-wage workers are much more likely to have employer coverage that the tax credit might induce them to drop and are much less likely to be uninsured.

Where it is simply a question of certain workers being better off using tax credits to buy non-employer-group coverage, it would at first glance seem reasonable enough to allow them to leave their employer plans to do so. But the problem with creating incentives for younger, healthier workers to drop coverage is the potential impact on the remaining members of the employer group—the risk, particularly for small-employer groups, that the departure of younger, healthier workers could lead to termination of the group plan entirely, even where such workers are in the minority. If termination occurred, older, less healthy workers could be left uninsured.

Termination could occur in either of two ways. First, the employer plan might no longer meet the carrier's group-participation requirements. For example, if the minimum required participation rate were 75 percent, and a small-employer group currently had 9 out of 12 eligible employees participating, the loss of one currently participating worker would drop the participation rate to 73 percent (8 out of 11). Second, where loss of younger and healthier participants resulted in substantial premium increases, some employers might choose to drop coverage who would not have done so otherwise. In either event, the number of uninsured would increase.

One could attempt to preclude workers from dropping employer coverage by simply making them ineligible for a tax credit if they declined their employer's offer of coverage. But doing so could encourage more employers to terminate their health plans entirely, or constrain eligibility for them, and probably would not be acceptable to many tax-credit proponents who actively want workers to be able to choose options other than their employer's plan. Therefore, we take an alternative approach and propose modest modifications to the tax-credit structure so that all workers face more constructive incentives in assessing the value of the tax credit relative to their current employer coverage.

Again, the modifications proposed here are offered in part as an effort to stimulate constructive, creative thinking on this important issue. In making them, we recognize that different policy makers may have

different objectives in mind for tax credits. For example, the fact that the tax credits as proposed would cover a greater share of the premium for young, healthy workers is clearly intended by the Administration. They observe that such workers need stronger incentives in order to encourage them to purchase coverage that many young adults believe will provide little benefit. And the proposal places a priority on maximizing the number of uninsured who can be covered within proposed expenditure (revenue-loss) levels. Other policy makers express greater concern about providing financial help in a commensurate way to those for whom coverage is more expensive—the older and less healthy. Both objectives are valid.

Balancing these conflicting objectives within the scope of the current proposal is a difficult charge, and we do not presume that they can be fully reconciled. Nevertheless, we believe that that modifications to the tax credit can simultaneously reduce incentives that could cause some covered workers and families to become uninsured and increase assistance for those with low earnings who face higher prices due to their higher cost profile.

Age-Adjusted Credit

Depending on design, adding an age adjustment to the proposed health insurance credit can be relatively straightforward.[25] The Administration's proposal establishes a maximum countable premium for credit purposes.[26] As proposed, there are two different maximum premium amounts: $1,111 for adults and $556 for children. Multiplying the maximum countable premium by the maximum percentage credit (90 percent) yields the maximum credit amounts of $1,000 per adult and $500 per child. One way to incorporate an age adjustment would be simply to establish several additional maximum countable premium amounts for adults that would increase with the adult's age. (There is already precedent for such age adjustment in the tax code: The maximum allowable deduction for premiums for long-term care insurance varies according to the age of the covered person.[27])

We do not propose fully adjusting the credit for age because doing so would almost certainly reduce take-up by uninsured young adults and thus dramatically increase the cost of the proposal per uninsured person covered.[28] Full age adjustment, which would give much larger credits to older people, could also create strong incentives for many older workers to shift out of employer coverage. Instead, we suggest a partial age adjustment that would serve to temper, but not eliminate, both the incentives for young workers to leave employer coverage and the financial inadequacy of the current proposal for older workers (but not by so much that the latter have incentives to drop employer coverage). Assuming the average credit amount stayed about the same, full age adjustment would lead to a dramatic reduction in the credit amount for young individuals and therefore to much lower take-up by uninsured young adults, because they are less risk averse and generally less willing to buy insurance unless the net price to them is low. Thus, a much higher proportion of tax-credit spending would go towards older persons who were already insured or who would become insured even with a smaller credit (that is, less age adjustment), and the cost of the credit per uninsured person covered would increase significantly.[29]

As a very simple illustration of the suggested approach, one might establish three age ranges for adults—for example, under 30, 30-44 and 45-64.[30] Maximum allowable premiums for these age ranges might be set at $889, $1,222 and $1,556,[31] yielding maximum credit amounts of $800, $1,100 and $1,400. (See Figure 3.) The income-based phase-out schedules would remain unchanged, but would be applied to the revised credit amounts.

If this alternative cost more than the original proposal, as seems likely, adjustments to other parts of the design might have to be made to reduce the cost. We suggest one possible adjustment in the next section.

Obviously, having different maximum credits for different age groups will make tax credits somewhat more complex to administer than having just two maximum credit amounts (one for adults and one for children). But it seems to us that the additional complexity would be minimal, easily handled, and well worthwhile in light of the potential advantages of age adjustment.

Figure 3: Age-adjusting the health insurance tax credit—an illustrative alternative

	Age of Covered Adult	Maximum Allowable Premium	Maximum Credit Amount
President's Proposal	All Adults	$1,111	$1,000
Illustrative Alternative	Under 30	$889	$800
	30-44	$1,222	$1,100
	45-64	$1,556	$1,400
Note: (compare to 4 to 1 range for individual i n-surance premiums)	Ratio of largest maximum credit to smallest maximum credit	1.75 to 1	1.75 to 1

There are two primary advantages of partially age-adjusting the credit: giving greater help to those facing higher health insurance premiums, and reducing the risk that the departure of young, healthy workers will cause other workers to become uninsured due to the termination of existing employer-coverage groups.

If the total cost of the proposal is to remain in the same order of magnitude, allowing a greater credit for older adults would be offset by reducing the maximum credit for younger adults (and possibly by other changes in the design as well). While a smaller credit for younger adults could reduce displacement of existing employer coverage, it will also inevitably mean that somewhat fewer of the uninsured among them will decide to buy individual insurance and will thus become insured.

A sophisticated modeling effort would be necessary to analyze the likely cost and coverage effects of alternative age-adjustment strategies.

Earnings-Related Credit

We propose another modification to the structure of the Administration's proposed tax credit that would accomplish two purposes. First, it would generate savings that could be used to increase the credit amount for those in greater need, and, second, it would reduce the incentives for workers with higher earnings (who, as discussed earlier, are far more likely to have employer coverage than those with lower earnings) to shift out of employer coverage. Under the proposed modification, the tax-credit structure would take account of *individual* worker's earnings in addition to adjusted gross income for the family, when two adults and no children in the filing unit are covered.[32]

Many policymakers understandably view federal poverty guidelines and other standards based on *family* income as the most equitable measure of need. But a policy that based public subsidies on individual earnings could reduce crowd out and save money because of the strong relationship between employer coverage and workers' wage levels discussed earlier. Although neither means-tested public programs nor other income-tax-related provisions typically use individual earnings, doing so would not be without precedent. A number of other well-established public programs—from Social Security to Medicare to workers' compensation programs—base contributions on individual earnings.

Structuring the tax credit to decrease as wages increase (or, for public programs, requiring a premium contribution that increases as wages increase) would make it less likely that those people most likely to have employer coverage would drop it or switch jobs to qualify for publicly financed coverage while gaining increased wages. Thus, government would less often differentially subsidize those in the target income range who leave employer coverage over those who do not. Also, government would less often extend a competitive advantage to employers

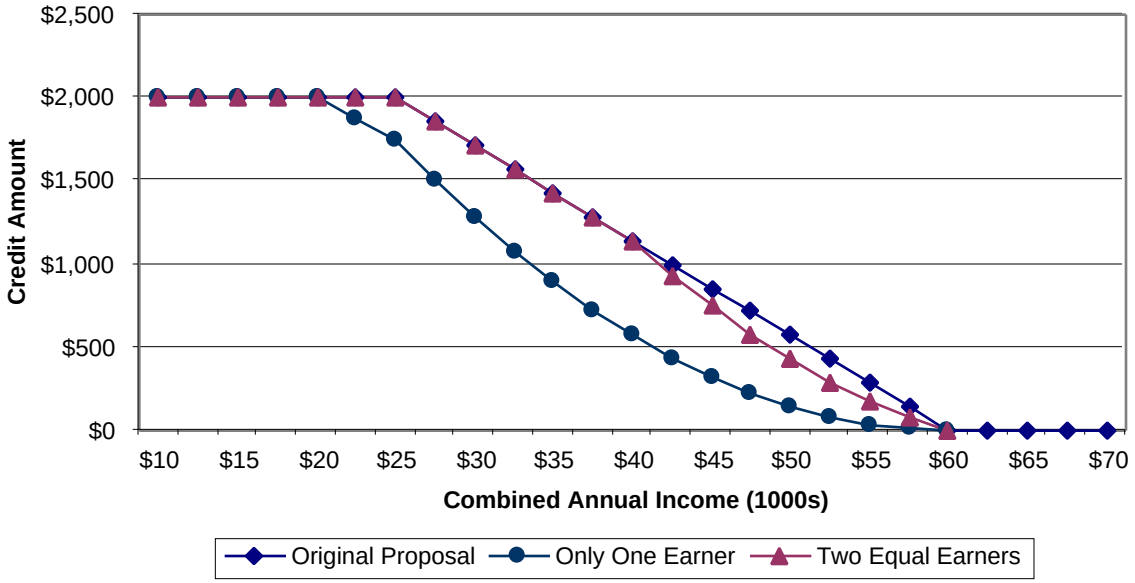
who do not pay for health insurance over those who do.[33]

The strong relationship between employer coverage and a worker's wage level holds whether or not the worker has children. Thus, an argument can be made that the proposed modification should be applied to all married couples, whether or not they have minor children. We suggest limiting the adjustment to couples without children for two reasons. First, preventive and primary care services are particularly important for children. Insurance that covers these services costs considerably more than the maximum $3,000 credit for family coverage under the Administration's proposal. Second, in the Administration's proposal, only childless couples remain eligible for a significant credit amount at incomes far above 300 percent of poverty. For example, a childless couple still qualifies for a 50 percent credit at an income that equals 340 percent of poverty, while the credit percentage for a couple with two children falls to 50 percent at an income that equals 224 percent of poverty (see Figure 2), and phases out entirely at 331 percent of poverty. And childless workers are actually more likely than working parents to have coverage through their own employer at equivalent annual-earnings levels (as opposed to poverty levels). However, they were less likely to be covered as a dependent (being less often married).[34]

The Administration's credit is based on the family's adjusted gross income and phases out between $25,000 and $60,000. Under our modification, the credit would be reduced if either spouse's earnings exceeded $20,000.[35] The reduction would be calculated as a percentage of the credit otherwise payable. The reduction would be zero percent of the initial credit amount at $20,000 and would rise, on a straight-line basis, to 100 percent of the initial credit amount at the upper income limit of $60,000.

The effects of this reduction are compared to the Administration's original proposal in Figure 4. Two polar cases are shown: one in which only one of the spouses has earnings, and one in which both spouses earn the same amount. (For purposes of these simple illustrations, families are assumed to have no income other than earned income.)

Figure 4: Health insurance tax credit amount by total family income for a childless couple: under the Bush Administration's original proposal and under an alternative approach linking the tax credit amount to individual earnings*



*As noted in the text, the primary motivation for this proposal is the fact that higher earners are much more likely to have employment-based coverage and much less likely to be uninsured.

This modification would make the credit more complicated to calculate and could require significant IRS systems changes to administer.[36] But it would reduce the credit more rapidly in earnings ranges where existing employer coverage is very likely and would generate savings that can be used to fund other proposed tax-credit modifications.

At the tax-credit levels in the Administration's proposal, linking the credit to individual workers' earnings as suggested here will have at most a modest effect on the incentives facing the overall population of workers with employer coverage and may not be worth pursuing unless the potential administrative difficulties can be readily resolved. But, at higher credit amounts, such a linkage could become very important in preventing erosion of employment-based coverage.

As noted, one reason for suggesting better targeting of the tax credit through an individual earnings adjustment is to generate some savings to help fund larger credits for older earners. Figures 5a and 5b show the combined effect of, and the trade-offs involved in, both proposed modifications—the partial age adjustment and relating the credit to individual workers' earnings. Figure 5a shows how the credit amount would differ from the Administration's original proposal when both spouses work and earn the same amount, and Figure 5b illustrates the situation when both spouses are in the same age range and only one spouse works. In each case, we illustrate the effects for persons under age 30 and over age 45.

Figure 5a: Illustration of the combined effect of partial age adjustment and individual-earnings adjustment: health insurance tax credit amount for two same-age adults with no (covered) children by total family income and for two age ranges (under age 30 and age 45 or older): under the Bush Administration's original proposal and under an alternative approach linking the tax credit amount to both individual earnings and age, where both spouses work and have the same earnings

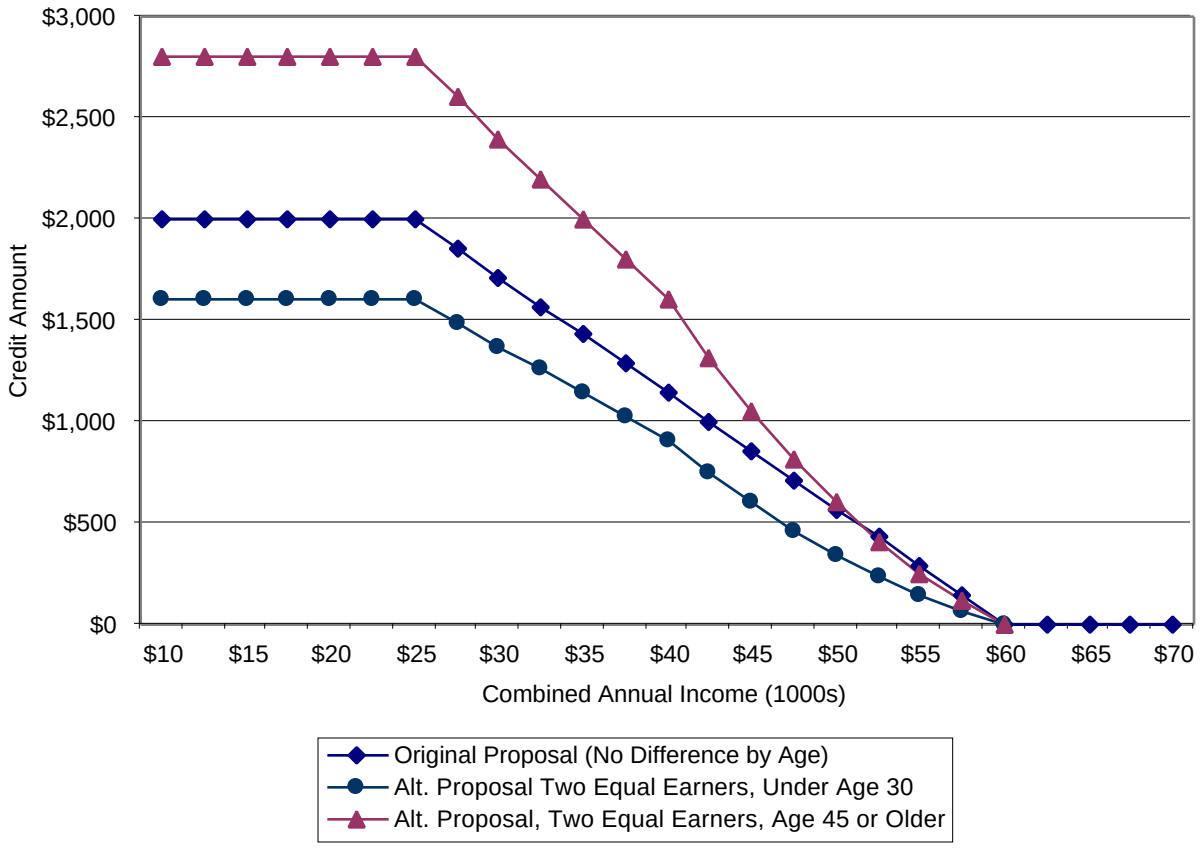
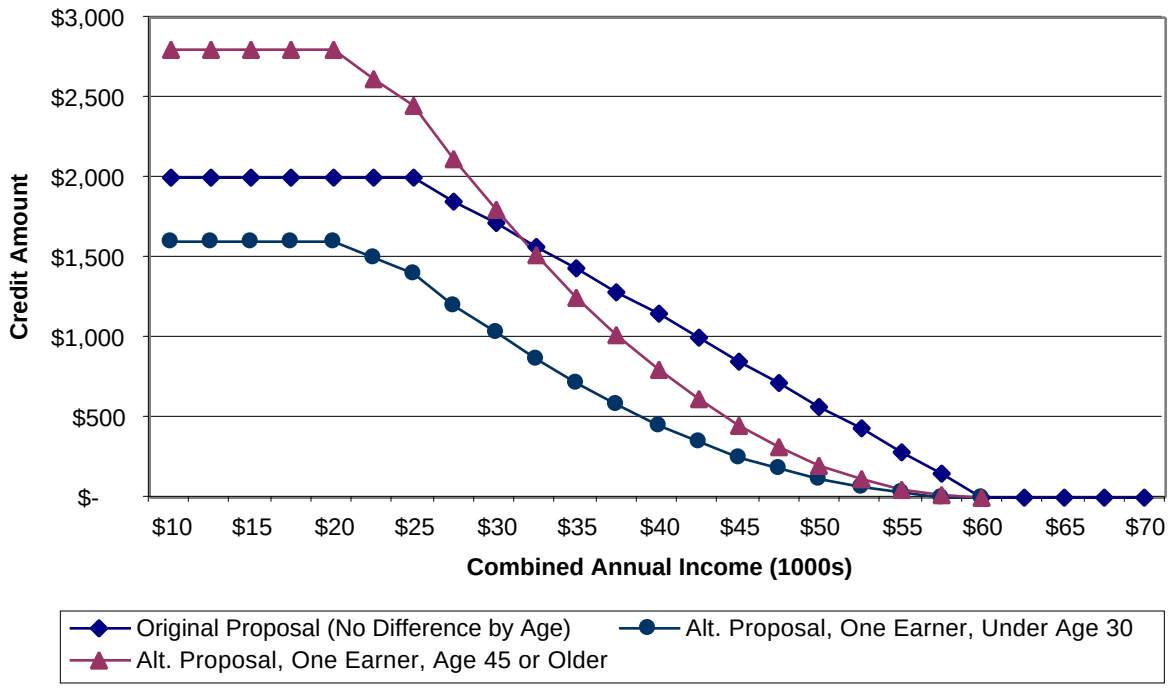


Figure 5b: Illustration of the combined effect of partial age adjustment and individual-earnings adjustment: health insurance tax credit amount for two same-age adults with no (covered) children by total family income and for two age ranges (under age 30 and age 45 or older): under the Bush Administration's original proposal and under an alternative approach linking the tax credit amount to both individual earnings and age, where one spouse has all the couple's earnings



Because the adjustment for high individual earnings has only a very small effect on the credit amount when both spouses earn the same amount, Figure 5a illustrates primarily the effects of the proposed partial age adjustment. Note that, if the spouses were in different age brackets, the credit amount would fall somewhere within the range shown in the figure. In Figure 5b, because one spouse has all the earnings, the impact of the high-earnings adjustment is more prominent. Above $30,000, even the older couple would receive a smaller credit than under the Administration's original proposal. But, as discussed earlier, more than 80 percent of workers earning $30,000 or more already have coverage through their own employer. The savings gained by reducing the credit for high individual earners and for younger workers would be used to fund larger credits for older, lower-income people who face much higher premiums for individual insurance than do younger adults.

Modifications to Reduce Incentives for Employers to Drop Coverage

Workers and dependents who voluntarily leave employer plans and use the tax credit to buy individual insurance obviously do not become uninsured. But the availability of the tax credit could cause employers to terminate their group plans or significantly reduce their premium contributions, either immediately or over time. Then some of their currently covered workers and dependents could lose group coverage and find themselves unable to afford individual coverage, even with the tax credit.

Those most at risk of becoming uninsured would be workers whose employers dropped coverage and who, because they are older or less healthy, would face higher net out-of-pocket costs to obtain individual insurance, even after applying any tax credit for which they are eligible.

Employer Option to Switch to Tax Credits for Employment-Based Coverage

In this section, we explore one possible way of encouraging employers with many tax-credit-eligible workers to maintain their employment-based group plans. We propose to allow employ*ers*, under certain restrictive conditions, to choose between two subsidy options for their employees: employees can continue to take advantage of the fact that employer premium contributions are not taxed as personal income, or they can use the tax credit. They cannot do both, however. The restrictions are as follows:

· An entire employer group, and only an entire employer group, can convert from the current income-tax-treatment of employer-sponsored health insurance to the tax credit. To do so:

− Any employer contribution toward health insurance must be reported as taxable income for income-tax purposes for *all* employees, not just those who qualify for the credit. However, in order to encourage employers to continue contributing toward health insurance, any employer contribution would continue to be exempt from FICA taxes, for both employer and worker.

− Workers pay any income tax due on the sum of their regular salary plus their employer's contribution toward their health insurance, but they are entitled to the new tax credit based on the *total* premium for the coverage they enroll in through their employer.

Tax treatment of health insurance for self-employed proprietors would not change.

Note that this narrowly drawn proposal differs considerably from simply allowing the tax credit to be "used for employer coverage," which some legislative proposals would permit.[37] The all-or-none requirement of this proposal would assure that employers would elect this option only when a substantial majority of their employees would qualify for a substantial tax credit,[38] and should lessen any income-tax reporting problems.[39] But, by allowing continued exclusion of any employer contribution from FICA taxes in those cases, it would provide an incentive for the employer to maintain contributions for the group plan, thereby lessening the risk that some of the currently covered workers would become uninsured.

The impact of this modification on the cost of the tax-credit proposal is difficult to assess. Presumably, there will be some additional cost because employers will not choose this option unless it affords their workers greater tax savings than the current tax system does. But the all-or-none requirement should limit use of the tax credit by entire employment-based groups to a relatively small number and thus limit any risk that the additional cost would be excessive. If desired, this option could be permitted only for firms with fewer than a specified number of workers, perhaps 50 or 25.[40] Such a restriction would provide additional assurance that the potential cost of the option would be limited.

The Issue of Choice

Some supporters of individual tax credits see them primarily as a means of assuring recipients choice of health plans. Therefore, some policy makers might oppose this proposed modification because of a concern that many employers do not offer workers choice among competing health plans.

To address this concern, employers could be given the option to use the tax-credit alternative for their workers only if they used a coverage venue that affords such choice. Such a requirement could be framed to allow use of one or more of the following: a private consumer-choice purchasing-group structure similar to PacAdvantage in California, a clearinghouse for health plans with functions similar to those described by Lynn Etheredge,[41] or access to plans serving federal employees through an enrollment-broker function.

Summary

We have explored the risk that providing tax credits for non-work-based health insurance for low-income workers might cause some previously insured workers or dependents to become uninsured or less adequately insured due to loss of existing employer coverage. Although relatively few workers would be likely to lose coverage at the outset, the longer-term risk that these first-order

effects could precipitate a cascading erosion of the societal expectation that employers will arrange and contribute toward health insurance should not be underestimated. To counteract any such tendency, we suggest some minor modifications to the Administration's (or similar) tax-credit proposals that focus on remedying the immediate incentives that could cause some covered workers and families to become uninsured. Our suggestions also increase assistance for those with low earnings who face higher prices due to their higher cost profile. In making these suggestions, we have tried to stay within the scope—the overall budgetary magnitude—of the Administration's proposal as originally presented. Our suggestions are offered in an effort to stimulate constructive, creative thinking on this important issue. Obviously, considerable additional cost- and impact-analysis of our, or other, suggestions would be necessary before converting our suggestions into fully formed proposals.

This paper was prepared for the *Covering America* project and the Economic and Social Research Institute by the Institute for Health Policy Solutions with additional support under an ongoing IHPS project funded by The David and Lucile Packard Foundation. *Covering America* promotes serious consideration of a diverse range of comprehensive proposals to provide affordable health coverage for millions of uninsured Americans. The *Covering America* project is coordinated by the Economic and Social Research Institute, a nonprofit, nonpartisan institute in Washington, D.C., and is made possible by a grant from the Robert Wood Johnson Foundation, Princeton, New Jersey.

Notes

[1] Economists agree that workers pay for some portion of employee benefits such as health coverage through reduced wages (although they argue over how large that portion is under what circumstances). Our point here is that, once the level of benefits has been determined for a particular firm, the individual worker generally cannot convert benefits to wages. If he or she does not enroll in the employer's health coverage, for example, the employer's contribution toward that coverage is simply lost. Thus, the "price" that the worker faces for employer-sponsored health insurance is not the total premium. Instead, it is the (much smaller) amount (if any) that the worker is required to pay in order to enroll in the coverage.

[2] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2001 Annual Survey*. The average annual total premium for workers covered by employment-based insurance in 2001 was $2,650 for worker-only coverage and $7,053 for full family coverage.

[3] In addition to the effect on average net price of insurance, many analysts worry that the advantages of risk spreading for older or less healthy workers within employer groups would be lost. Because a combination of rating rules or coverage venues might theoretically achieve similar risk spreading in the non-group market, and because of differences of opinion among experts and policy makers on these matters, we treat these issues as beyond the scope of this paper.

[4] Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2002 Data Update*, February 2002. Table 7. (Based on analysis of data from the March 2001 Current Population Survey by the Urban Institute.)

[5] *Ibid*. Table 4.

[6] Authors' calculations based on Kaiser Commission on Medicaid and the Uninsured, *op.cit.*, Table 1, and unpublished Institute for Health Policy Solutions analysis of the March 2000 Current Population Survey.

[7] See *Individual Tax Credits and Employer Coverage: Assessing and Avoiding the Downside Risks*, Summary of an Institute for Health Policy Solutions Round-Table held April 19, 2002. Washington, D.C.: Institute for Health Policy Solutions, 2002.

[8] Apparently, people who are offered coverage by their employer but decline it would be eligible to use the credit for other coverage. The Administration's explanation of its proposal states only that "Individuals *participating* in public or employer-provided health plans would generally not be eligible for the tax credit." See Department of the Treasury, "General Explanations of the Administration 's Fiscal Year 2003 Revenue Proposals," February 2002. (As of July 2002, the proposal had not been put into legislative language.)

[9] Poverty-level equivalents calculated using 2002 federal poverty guidelines from Department of Health and Human Services, "2002 HHS Poverty Guidelines." Accessed from http://aspe.hhs.gov/poverty/02poverty.htm.

[10] Department of the Treasury, "General Explanations of the Administration's Fiscal Year 2003 Revenue Proposals," February 2002.

[11] [Written] testimony of Jonathan Gruber, Ph.D., before the House Ways and Means Subcommittee on Health, Hearing on Health Insurance Tax Credits, February 13, 2002, Table 1. Electronic copy provided by Dr. Gruber. While we report estimates from Dr. Gruber's model, it is not our intent to portray his estimates as more "correct" than others. Rather, they serve simply to illustrate the possibility that shifts in coverage could lead to loss of coverage by some currently covered workers and dependents.

[12] Council of Economic Advisers, "Health Insurance Credits," February 14, 2002.

[13] Richard Kronick and Todd Gilmer, "Insuring Low-Income Adults: Does Public Coverage Crowd Out Private?" *Health Affairs* 21:1 (January / February 2002), pp. 225-239. Similarly, in research pending publication, Susan Marquis and Stephen Long of RAND report findings suggesting a significant substitution of public insurance for private insurance across the seven states that expanded coverage for a broad spectrum of their low-income populations in the mid-1990s. In contrast, most studies of Medicaid's expansion of coverage to children (only) up to 133 percent of poverty and pregnant women to 185 percent of poverty during the late 1980s and early 1990s found only relatively modest crowd-out of employer coverage. For a review of this work, see Lisa Dubay, *Expansion in public health insurance and crowd out: What the evidence says.* The Henry J. Kaiser Family Foundation, October 1999. While not conclusive, the evidence available so far also suggests that there has been little crowd out with respect to children in the SCHIP program. See Amy Westpfahl Lutzky and Ian Hill, "Has the Jury Reached a Verdict? States' Early Experiences with Crowd Out under SCHIP." *Occasional Paper* Number 47. The Urban Institute, June 2001.

[14] Personal communication from Mutual of Omaha.

[15] Kaiser Family Foundation and Health Research and Educational Trust, *op.cit.* Exhibit 7.1.

[16] Personal communication from Mutual of Omaha.

[17] IHPS analysis of the March 2000 Current Population Survey. These figures include adults who worked less than full time or for less than a full year. Note that the data used in the following reference differs slightly because it is based only on full-time, full-year workers.

[18] For further discussion of the strong association between annual earnings and coverage through the worker's own employer, see Ed Neuschler and Rick Curtis, *Individual Workers' Wage Levels, Total Family Income Relative to Poverty, and Prevalence of Employer Coverage* (Issue Brief), Institute for Health Policy Solutions, August 2001 (prepared with funding from the California Healthcare Foundation). Available at www.ihps.org.

[19] In 1999, about 4 percent of full-time full-year wage-and-salary workers in families with incomes below 200 percent of poverty had individual earnings of $30,000 or more, and about 19 percent had individual earnings of $20,000 or more. As noted, 80 percent of the former group had coverage through their own employer, as did about 68 percent of those with earnings between $20,000 and $30,000. Institute for Health Policy Solutions analysis of the March 2000 Current Population Survey. See also Neuschler and Curtis, *op.cit.*

[20] Gruber, *op.cit.*

[21] IHPS analysis of the March 2000 Current Population Survey.

[22] Stephen H. Long and M. Susan Marquis, "Low-Wage Workers and Health Insurance Coverage: Can Policymakers Target Them through Their Employers?" *Inquiry* 38:331-337 (Fall 2001). Unfortunately, coverage rates specific to low-wage workers cannot be calculated from their data, so it is not possible to estimate what percent of *covered* low-wage workers work for low-wage employers.

[23] Gruber, *op.cit.*

[24] For low-income parents who avail themselves of the earned income tax credit, the existing tax exclusions can be of substantially higher value than for low-income childless adults.

[25] By contrast, a health-status adjustment, which theoretically could also be desirable, would be unworkable, in our view.

[26] If people pay more for their coverage, the credit will be based on the maximum countable amount, rather than on the actual premium paid.

[27] See Department of the Treasury, Internal Revenue Service, Publication 502, "Medical and Dental Expenses" (for use in preparing 2001 Returns), page 8. For this purpose, 5 age categories are used.

[28] In making this statement, we assume that younger workers are more price sensitive than older workers, which seems a reasonable assumption. Even though there is a lack of research about the relative price elasticity of demand for health insurance among younger and older workers, it is well documented that younger workers are more likely to be uninsured and to decline employer coverage when it is offered.

[29] A different conclusion might be reached by policy makers whose goal is to maximize the *value* of new coverage gained, rather than the *number* of persons gaining coverage. If the credit were fully adjusted for age—or even overadjusted for age—older persons would receive a much larger credit. Fewer persons would gain coverage, but those who do would, arguably, value it more. But full age adjustment would still, in our view, lead to greater crowd out of employer coverage.

[30] Obviously, more age breaks could be used, but a manageable number is desirable for administrative simplicity.

[31] In its February 2002 paper on Health Insurance Credits, the Council of Economic Advisers cites an average premium for an "older male" (that is, a 55-year-old single male) that is 2.8 times the average premium it cites for a "younger male" (that is, a 25-year-old single male).

[32] The Administration's proposal already provides for a faster phase-out of the subsidy when the non-group policy covers only one adult (and no children) but the tax filing status is other than "single."

[33] Consider a married worker earning $18 per hour ($37,440 per year) with an employer health insurance contribution of $4,200 ($350 per month) toward family coverage and a non-working spouse. Labor economists generally agree that workers pay for some portion of health and other employer-paid benefits through reduced wages (although they argue over how large that portion is under what circumstances). Thus, our $18-per-hour worker could generally expect to earn up to $3,900 more per year ($4,200 less the employer's share of FICA taxes) in a comparable job that did not offer health benefits. In the first job, the fact that the employer's $4,200 contribution is excluded from FICA and income taxes saves the worker about $950. In the second job, the worker would pay an additional $883 in income and FICA taxes on his higher earnings but would qualify, under the Administration's proposal, for a tax credit of $1,067 toward health insurance for himself and his spouse, or $1,600 if he covered two children in addition to his spouse. Which choice is actually more beneficial to the worker will depend on the worker's health insurance preferences and the net cost of coverage to him after the tax effects. But in cases like this, under the Administration's proposal, the government subsidy will be larger for the worker who opts for non-employer-sponsored health insurance, and therefore, employers may not need to offer the full equivalent of the typical employer contribution as increased wages in order to induce workers to take jobs that do not offer health benefits.

[34] Ed Neuschler and Rick Curtis, *Family (Parental) Status and Prevalence of Employer Coverage by Family Income and Individual Earnings* (Issue Brief), Institute for Health Policy Solutions, September 2001 (prepared with funding from the California Healthcare Foundation). Available at www.ihps.org. See especially Figure 3a.

[35] The $20,000 figure was selected as a compromise between $15,000 (the highest income at which a single filer would be eligible for the maximum credit under the Administration's proposal) and $25,000. Data from the March 2000 Current Population Survey show that more than half (55 percent) of workers who earned between $15,000 and $20,000 during 1999 had employer coverage in their own name. Thus, beginning to phase down the credit at $20,000 seemed consistent with the goal of reducing incentives to leave employer coverage.

[36] To implement this concept, particularly in conjunction with advance payment of the tax credit, the Internal Revenue Service will need to have ready access to each filer's individual earned income, in addition to total adjusted gross income for the (joint) filing unit. This, in turn, will require either more timely coordination of earnings data between federal agencies (employers report individual earnings data to the Social Security Administration, not to the IRS) or the addition of a field to the tax forms for joint filers. (Although both earners in a couple are required to file copies of their W-2 earnings reports with their income taxes, it appears that that information is not now captured electronically, because the current 1040 tax form does not include separate fields for individual earnings.)

[37] One such proposal is S. 590, sponsored by Senators Jeffords, Breaux *et al*. Under it, workers who enrolled in an employer-sponsored plan could qualify for a credit equal to 40 percent of the credit that would be available if they purchased insurance on their own.

[38] Note that higher-income workers (though not the self-employed proprietor/owner) would lose all tax advantages with respect to employer-sponsored health coverage except the exclusion of the employer's contribution from FICA taxes. The employer's contribution would be taxable for income-tax purposes, and such workers would not be able to use section 125 flexible spending accounts to tax-shelter any portion of their premium. Thus, firms with any covered higher-income workers (presumably, non-owner managers) would be unlikely to elect this option. The proposal could be modified further to allow some tax preferences for such workers, but doing so would increase the cost of the proposal by greatly increasing the number of firms likely to take advantage of the option.

[39] Because employers electing this option would have to include their contribution toward health coverage when reporting earnings for income tax purposes for *all* employees, there should not be any great confusion or lack of clarity about what is required. By contrast, if individual workers were allowed to choose whether to take the tax credit or use the current tax preferences, the potential for confusion among employers and workers would be very high.

[40] Arguably, making this option available could lead employers to attempt to game the system by splitting into separate companies in order to meet an arbitrary size restriction or, more generally, to create units in which few or no employees would be hurt by switching to the tax credit. But, in our view, the major incentive for employers to do so would be created by any tax credit for non-employer coverage. Allowing the credit to then be used for employer coverage, as we propose, would at most enhance the underlying incentive by a relatively small amount.

[41] Lynn Etheredge, "How to Administer Health Insurance Tax Credits for Working Families," Heritage Foundation Backgrounder No. 1516, January 31, 2002. We believe the broader application of an employer-based clearinghouse approach for tax-credit recipients, without incentives or requirements for employer contributions, could lead to increased "crowd-out" of employer contributions. But, if the clearinghouse concept were combined with the requirements we propose here, we believe the risk of crowd-out would be mitigated.