



Benefits with Risks — Bush's Tax-Based Health Care Proposals

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In his State of the Union address in January, President George W. Bush announced a major two-part health initiative that would create a new uniform tax deduction for all those obtaining health

insurance and provide assistance to states that make basic private health insurance available to residents (see box). The first and primary proposal addresses the tax code's perverse and inequitable treatment of health care expenditures, seeking thereby to reduce the ranks of the uninsured.¹ If adopted as proposed (a highly unlikely prospect), the initiative would take half a step toward a more equitable system, but it would have an uncertain effect on the expansion of coverage and could expose insured Americans to some significant risks.

Currently, neither compensation in the form of employer-paid health insurance premiums nor health expenses and premiums paid by workers through cafete-

ria plans are subject to income or payroll taxes. In addition, U.S. taxpayers who itemize their deductions may take an income-tax deduction for out-of-pocket health care spending exceeding 7.5% of their income. These provisions create an open-ended subsidy for certain types of health care spending that has encouraged the purchase of generous employment-based insurance and excessive spending. In the face of spiraling health care costs, such encouragement seems perverse.

The provisions are also inequitable. Because the value of the tax benefit depends not just on the amount spent on insurance and health care but also on a taxpayer's marginal tax rate, the benefit is worth more for upper-income

than lower-income taxpayers. When a firm contributes \$10,000 toward its employees' insurance, workers in the 15% tax bracket receive a \$1,500 income-tax subsidy, whereas those in the 35% bracket get a \$3,500 subsidy. The fact that the benefit is available only to people with employer-sponsored policies results in an additional inequity: those whose employers do not offer health plans get no subsidy — they must buy their coverage with after-tax dollars.

Under Bush's proposal, these subsidies would be scrapped starting in 2009, and employers would be required to include the amounts they contribute toward health insurance premiums in their workers' taxable compensation. However, everyone enrolled in a "qualified" health plan, whether obtained through an employer or purchased independently, would be given a new standard deduction for health insurance — \$15,000 for a family and

President Bush's Health Insurance Proposals

1. To reform the tax code with a standard deduction for health insurance:
 - Families with health insurance, whether provided through an employer or purchased independently, would not pay income or payroll taxes on the first \$15,000 in compensation; singles would not pay income or payroll taxes on the first \$7,500.
 - Health insurance from an employer would be considered taxable income.
2. To provide assistance to states for making basic private health insurance available and assistance to individuals who cannot afford insurance or who have persistently high medical expenses:
 - The Affordable Choices Initiative would redirect federal grants to states to help poor and hard-to-insure residents pay for private insurance.
 - The Department of Health and Human Services could allow states to redirect their Medicaid disproportionate-share payments from institutions to needy individuals to help them purchase private health insurance.

\$7,500 for an individual — that would reduce the portion of their income that is subject to both income and payroll taxes.

The arrangement would decouple the value of the tax benefit from the amount spent on health insurance premiums and out-of-pocket costs, instead providing a tax break simply for having insurance that met minimum standards. Thus, the existing incentive to spend more would be eliminated, as would one of the inequities of the current system: the deduction would be available to everyone with qualified insurance, not just those with an employer-sponsored plan. The benefit to those in the higher tax bracket would persist, however, because the value of the new deduction would increase with the taxpayer's marginal tax rate. The income-tax break would be worth \$5,250 for a family in the 35% tax bracket but only \$1,500 for a family in the 10% bracket.

Under this proposal, all taxpayers whose insurance premiums plus other tax-favored health care spending add up to an amount that is less than the new deduction would get a larger tax benefit than under the current policy. Estimates for 2009 from the Tax Policy Center suggest that some 48% of tax filers would see their tax benefit

increase, whereas 17% would be worse off.² Over time, however, fewer and fewer taxpayers would be winners, because health insurance premiums and other health care costs are likely to increase at a faster rate than the Consumer Price Index (CPI), which would be used each year to adjust the size of the new deduction.

The Bush administration has estimated that if adopted, the proposal would increase the number of insured people by 3 million to 5 million. Certainly, people in the middle- and upper-income levels whose employers did not offer insurance would have a strong new incentive to obtain it in the nongroup market. Some people in the lower-middle income range might also be motivated to purchase basic policies if the premiums approximated the value of the new tax benefit available to the 57% of tax filers with a 10% or 15% marginal tax rate. However, employers' responses to the tax change could offset some or all of these gains in coverage. Some firms, particularly smaller ones, that now offer insurance might drop their coverage if their employees became entitled to insurance-related tax benefits that did not depend on having an employer-sponsored plan. New firms would certainly

be less likely to offer insurance. If these responses were substantial, the policy might even swell the ranks of the uninsured.

In addition, the policy would create incentives to reduce the generosity and comprehensiveness of insurance plans. Doing so, after all, is one of its objectives. Driven by a desire to maximize the value of their tax benefit, many might opt for low-premium, high-deductible health care plans, which might well leave many low- and moderate-income families underinsured and unable to pay their health care bills.

The extension of the tax benefit to people who purchase their own policies and the likelihood that some employers would stop providing insurance would result in an increase in the population covered through the nongroup market. Unfortunately, that market has significant shortcomings: in many states, carriers can refuse to insure anyone whom they consider to be high-risk, policies can exclude coverage for preexisting conditions, and premiums vary with enrollee health status, making coverage prohibitively expensive for people in poor health.

Critics argue, first, that President Bush's initiative fails to provide poorer families who face low or zero marginal tax rates with an incentive for obtaining insurance. This deficiency might be overcome by offering a refundable tax credit rather than a standard deduction. A refundable credit would eliminate the remaining inequity, because everyone with insurance would receive the same size tax benefit, and it would provide lower-income families with some resources for purchasing basic insurance. But the cost to the Treasury of a credit that did not make many people worse off would also

be substantially higher than the cost of a deduction.

To address the lack of incentives for low-income families, the President has proposed the Affordable Choices Initiative, under which states could use their Medicaid disproportionate-share money and certain federal grants to give low-income and vulnerable populations access to basic private insurance. This initiative represents a weak and uncertain response to a serious challenge.

A second concern is the inadequacy of the state-regulated individual insurance market, to which many more would turn if the new deduction accelerated the erosion of employer-sponsored insurance. To address this concern, states could be required to revise their individual insurance-market regulations to meet some minimum federal standards. Alternatively, those without employer-sponsored coverage could be permitted to buy either Medicare coverage or a plan offered through the Federal Employees Health Benefits Program.

The decision to index the proposed deduction to the CPI, which increases much more slowly than

medical inflation and health insurance premiums, is a third dimension that has troubled critics. The deduction could be indexed to the medical care component of the CPI, although such an adjustment would still fail to accommodate real increases in health care spending. However, indexing the standard deduction at a higher rate would increase the proposal's cost substantially.

Although the President's proposals are unlikely to gain much traction in Congress, they could start a long-overdue discussion of the extent to which tax preferences should be used to encourage the purchase of health insurance and the forms that such encouragement should take. Any effort to make the tax treatment more rational, however, will come up against the entrenched interests of those who stand to lose. It would not, for instance, prove broadly acceptable to limit the tax subsidies granted for very expensive health insurance policies, because not all such policies provide "gold-plated" coverage: insurance premiums and health care spending in general depend on more than the gener-

osity of one's insurance policy. Regional differences in health care prices, practice patterns, and patient preferences all affect the cost of insurance, as do the size, average age, and health risks of the group with which one is pooled. These complexities will make it difficult to move down the path prescribed by the President absent universal access to national plans such as the Federal Employees Health Benefits Program.

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An interview with Congressman Pete Stark (D-CA) and Senator Chuck Grassley (R-IA) can be heard at www.nejm.org.

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Making Motherhood Safe in Developing Countries

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This year marks the 20th anniversary of the Safe Motherhood Conference in Nairobi, an event that launched a global initiative to reduce maternal mortality in developing countries. At that time, maternal and child health programs focused primarily on the health of infants and young children.¹ Providing pregnant women with lifesaving medical care was thought to require high technology at large hospitals, and policymak-

ers thought it more feasible to reduce child mortality with preventive measures such as immunization, oral rehydration, and breast-feeding. The conference spotlighted the number of pregnant women dying each year and issued a call to action. So, how far have we come in the past 20 years?

Tracking changes in maternal mortality in developing countries can be difficult, because the data are unreliable. Vital-registration

systems in rural areas of most developing countries are deficient, and surveys produce estimates with wide margins of uncertainty. By all accounts, however, progress in reducing maternal mortality has been very slow. The vast majority of maternal deaths are due to direct obstetrical complications, including hemorrhage, infection, eclampsia, obstructed labor, and unsafe abortion. An estimated 500,000 or more women still die