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Reforming the Tax Treatment of Health Care: Right Ways and Wrong Ways

Jason Furman
Senior Fellow and Director of The Hamilton Project
The Brookings Institution

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Health care in America faces three fundamental problems. First, according to Census estimates 47 million Americans are uninsured (Census 2007). Second, America spends an enormous amount on health care for the insured while often getting little or no benefit at the margin (e.g., Fisher 2003 and Newhouse and the Insurance Experiment Group 1993). And third, health care is largest source of the long-run fiscal gap (Aaron 2007 and Congressional Budget Office 2007c). An ideal reform proposal would make progress in some or all dimensions simultaneously. A potentially acceptable proposal would make a tradeoff between these three goals. Moving in the wrong direction in some or all dimensions – without any progress in others – should be unacceptable.

The evaluation of reforms is greatly complicated by the enormous complexity and interdependence in the health system which leads to tremendous uncertainty about the impact of reforms. To understand the impact of a health reform proposal requires not just predicting the behavior of individuals, but also of employers, insurance companies, and state insurance regulators – among other important actors in the system. The more a reform departs from historical experience, the less applicable the elasticities and other behavioral assumptions derived from that historical experience become. As a result it is important to evaluate any change, and

especially major changes, not just by the expected outcome but also by the uncertainty that surrounds that outcome. Everything else being equal, it is better to pursue a more certain course.

This paper uses these three criteria to evaluate two reform options that are found wanting. The first is the proposal by John Cogan, Glenn Hubbard, and Daniel Kessler (2005) to make all health expenses tax deductible. The second is the proposal to make all individual market premiums tax deductible. Both of these proposals share the common features that they provide new tax subsidies in the service of reforms that have uncertain benefits and could even be counterproductive. Although there are numerous other health-tax reforms, the shortcomings of these plans provide a cautionary note for many of them. This discussion motivates the considerations in designing a plan to replace the existing tax exclusion with tax credits in a manner that could potentially achieve all three of the above goals simultaneously.

New Tax Incentives to Encourage Less Spending

The tax treatment of healthcare encourages greater spending in a number of ways. The general tax favoritism for health expenditures encourages more of such expenditures. The tax exclusion for employer contributions lowers the after-tax price of insurance and helps underpin an institutional system of employer-sponsored insurance. This leads more people to have insurance and people to have more generous insurance, both of which increase health spending. In addition, the fact that insurance premiums are tax favored and out-of-pocket payments generally are not provides an incentive to purchase plans with higher premiums and lower deductibles and copayments, leading to even more spending.¹

¹ The deductibility of medical expenses in excess of 7.5 percent of Adjusted Gross Income and flexible spending accounts are two exceptions to this general statement.

The aggregate effect of these incentives for spending are quite large. A theoretical paper by William Jack and Louise Sheiner estimates that if agents choose the optimal coinsurance rate, then eliminating the tax subsidy for insurance premiums would raise the coinsurance rate by 65 percent and reduce health spending by 11 percent. This is largely consistent with estimates based on an empirical study by Martin Feldstein and Bernard Friedman (1977) which found that eliminating the tax benefit for employer sponsored insurance would increase the coinsurance rate by 41 percent, which using the RAND Health Insurance Experiment demand elasticity of 0.22, would translate into a 7 percent reduction in spending. If the general equilibrium effects of higher coinsurance rates on spending are larger, as found by Amy Finkelstein (2007), then the impact on spending could easily be three times larger than these estimates suggest. So eliminating the tax exclusion for health insurance would unambiguously reduce health spending.

In contrast, adding new tax incentives has an ambiguous effect on spending. On the one hand, the extra tax incentives reduce the after-tax price of health spending still further encouraging more such spending. On the other hand, to the degree the extra tax incentives encourage more cost sharing they can end up reducing health spending. The net effect of these two factors depends on the specific circumstances.

Cogan, Hubbard, and Kessler (2005) have proposed making all out-of-pocket health spending tax deductible. The sign of the effect of such a proposal depends on three factors. First, how much does the coinsurance rate increase? If the coinsurance rate increases enough so that the net, after-tax coinsurance rate rises then spending might fall. Jack and Sheiner (1997) showed that under relatively general conditions this was the theoretical outcome with rational, maximizing agents. But empirical estimates of the actual responsiveness of coinsurance to changes in the tax treatment largely absent and plausible parameters show that the Cogan,

Hubbard and Kessler plan could increase spending by as much as 3.3 percent or reduce it by as much as 6.2 percent (Furman 2006). Second, the incentive to spend more happens the moment the tax changes are enacted but the rising coinsurance rates may take time thus leading the net effect to be for higher spending in the short run. Finally, to the degree that such a plan extends deductibility to out-of-pocket expenses that are not currently covered by insurance, like eyeglasses and over-the-counter medicine, then the net effect from this component of the plan is unambiguously to increase spending.

The effects on coverage of such a proposal would likely be small and would largely be a function of the change in the price of health insurance, although other factors like the impact on employer-sponsored coverage (discussed under the next plan) would also be important.

In contrast to the uncertain benefits, the costs of such a proposal are almost completely certain. The static cost of fully leveling the playing field for both income and payroll taxes would be about \$75 billion in 2008.² To the degree that the proposal resulted in higher or lower health spending the full, dynamic cost would be correspondingly slightly higher or lower. Moreover, this new tax expenditure would likely worsen the after-tax distribution of income both because higher-income households have higher tax rates and because they have higher out-of-pocket health expenditures.

The combination of certain costs with uncertain and potentially nonexistent benefits is a feature of a broader class of proposals to add new tax incentives to remedy the over-spending distortions created by the existing tax incentives. For example, Furman (2006) discusses the President's FY 2007 budget proposal to expand Health Savings Accounts (HSAs) and finds that

² The Center for Medicare & Medicaid Services National Health Expenditure Accounts project \$281 billion in out-of-pocket expenses. Using an average marginal tax rate of 30 percent the cost of full deductibility would be about \$84 billion. Net of the cost existing deductions for out-of-pocket expenses this is about \$75 billion. The proposal would also trigger substantial revenue loss for states that link their tax base to the federal tax base.

the reduced spending by new adopters of HSAs is likely to be outweighed by the incentive the proposal would create for current HSA holders to increase spending. While it is possible to design new tax incentives that would reduce spending (the original HSAs probably had the potential to reduce aggregate spending – see Keeler *et al* 1996), it is hard in practice to be very confident that such measures will achieve this goal. In fact, it is plausible that they will perversely end up increasing spending.

New Tax Incentives to Encourage the Purchase of Health Insurance in the Individual Market

In 2006, 88 percent of privately insured Americans got their coverage through employment-based plans (Census 2007). Employer-sponsored insurance dominates coverage for a number of reasons including the administrative savings from economies of scale, the convenience of employees, and the institutional and cultural path dependence stemming from a series of historical events like wage and price controls in World War II. To the degree these are the most important factors, then employer-sponsored insurance represents a rational choice based on cost, convenience, and tastes. But government policy also encourages people to purchase insurance through their employers through a tax exclusion that effectively provides about a 20 percent discount for the purchase of such insurance by the typical worker.

Critics of the employer exclusion argue that it creates a number of harmful distortions in the market for health insurance and is fundamentally unfair to people who purchase their insurance through the individual market.³ One potential distortion is job lock, the process by

³ To the degree that labor markets tend to adjust before-tax wages to equalize the after-tax wages and benefits in different jobs – taking into account the current tax treatment – then the fairness point is overstated or misleading. This is an example of the broader problems with horizontal equity arguments discussed more broadly in Kaplow (1989).

which workers do not move on to jobs with better matches, reducing productivity, wages, and the overall flexibility of the economy (e.g., Gruber and Madrian 2004). Another potential distortion is a reduction in transparency, choice and competition that could result in inferior choices for workers. Finally, the lack of tax incentives for the purchase of insurance by workers who are not covered by their employers could reduce total coverage.

While many of these criticisms of employer-sponsored insurance have merit, they need to be set against the serious market failures that plague health insurance markets as a result of adverse selection stemming from imperfect information about purchasers of health insurance. Employers create large pools of people selected together for reasons that are largely unrelated to health status, providing one, albeit imperfect way of solving the adverse selection problem and pooling longer-term health risks.

Eliminating the differential cost between employer-sponsored insurance and individual market insurance, either by reducing subsidies for employer-sponsored insurance or increasing them for individual market insurance, would lead some employers to drop coverage, especially smaller employers who are more marginal in their current offers and appear more sensitive to the price of health insurance in their offers (see CBO 2007b for a survey of the evidence). There are a number of reasons employers would drop coverage. First, some smaller businesses may offer coverage so that their owners or senior managers can take advantage of the tax preference for employer-sponsored insurance. Under the current non-discrimination, these firms are compelled to offer insurance to all their workers. If the owners and senior managers had another option, then they might drop coverage altogether. Second, if the younger and healthier workers opted out of the firm's plan and bought coverage on their own, then the remaining premiums would rise reducing the attractiveness of offering insurance.

Workers in firms that dropped coverage could potentially buy health insurance in the individual market. But the individual market has a number of limitations. The first is the higher load factors on insurance premiums that result from the failure to take advantage of economies of scale, the larger cost of marketing to individuals, and the cost of underwriting in the individual market. As a result, load factors in the individual market consume 29 percent of the total premium – compared to 9 percent for firms with 100 or more workers (CBO 2007b).

The second problem with the individual market is that it is plagued by adverse selection for new entrants. For people who have been in the individual market before they developed a health condition, insurance works reasonably well. Bradley Herring and Mark Pauly (1999 and 2006) have shown that there is a large amount of risk pooling in the individual market, a fact they attribute to guaranteed renewability rules which require insurance companies to renew policies at the class average rate. But in considering reforms that could potentially lead to large-scale dropping from employer-sponsored insurance the relevant question is how the individual market works for new entrants. And in this case guaranteed renewability does nothing, in fact it provides an incentive for insurance companies to be even more selective and charge even higher premiums reflecting the long-term risks associated with entering into an insurance contract.

Adverse selection can manifest itself as a separating equilibrium where low-risk types end up purchasing less insurance than they would want, a theoretical prediction that finds some evidence in the individual market (Rothschild and Stiglitz 1976 and Browne 1992). The more troubling consequence of adverse selection is that individuals are denied coverage, only can get very expensive coverage, or get coverage that excludes their pre-existing conditions.⁴ The most

⁴ Strictly speaking if someone gets actuarially fair insurance, plus a load factor, it is not adverse selection. In the case of someone with a pre-existing condition such insurance might be very expensive. In practice, however, it is useful to consider insurance from the perspective of the person before they developed the pre-existing condition. In

vivid evidence for the pervasiveness of this phenomenon comes from work conducted by Karen Pollitz and others on behalf of the Kaiser Family Foundation (2001). They invented seven individuals or families with pre-existing conditions ranging from hay fever to being HIV-positive and sent insurance applications to 420 different insurance applications to a variety of states and insurers. Only 10 percent of the applications came back with a clean offer. The most common offer, in 40 percent of cases, included benefit limitations to exclude the pre-existing conditions. In 35 percent of cases the application was rejected outright. The Pollitz *et al* hypothetical examples are very relevant for considering the potential of tax benefits for the individual market to help the uninsured because “almost half of all uninsured nonelderly adults have a chronic condition,” a rate that is higher than for the insured population (Kaiser Family Foundation 2007).

A third and less studied problem with the individual market is that it does not have any institutional or behavioral mechanism to encourage households to purchase insurance coverage. One lesson of the behavioral literature on savings is that defaults matter a lot. Automatic enrollment in 401(k)s increases participation rates, with particularly dramatic increases for workers who are the least likely to participate in opt-in savings (Madrian and Shea 2001). In most firms health insurance is a more like an “active decision” where the employer essentially requires the employee to decide yes or no, a mechanism that in the savings context is closer to automatic enrollment than it is to opt-in (Choi *et al* 2005). In addition, the employer contribution dramatically lowers the marginal cost of purchasing insurance through one’s firm.⁵ As a result, 82 percent of workers eligible for insurance take it up and many of the remaining are covered

this case, they are in effect trying to insure not just against unexpected events in any given year but also against developing a chronic condition.

⁵ Note that ignoring the higher load factors, the total cost of purchasing insurance through the individual market is not higher. Most labor market models have the feature that firms that drop coverage will ultimately pay their workers more, money they could put towards purchasing insurance in the individual market. If workers are fully rational then they would be better off with the combination of higher income and bearing the full marginal cost of insurance. In practice, however, substantial evidence from the savings literature casts doubt on the premise that people make rational inter-temporal choices.

through a spouse (Kaiser Family Foundation and Health, Research and Education Trust 2007). The fact that the takeup rate for employer-sponsored insurance is substantially higher than for Medicaid and SCHIP, which have similar or even more generous subsidies but do not share the same semi-automatic enrollment administrative mechanism, suggests that much of this high enrollment is driven by institutional factors. In contrast, in the individual market it is much more likely that people will be inattentive and not go through the time and effort to identify and purchase a complicated product. This inattentiveness may be compounded by myopia, possibly due to hyperbolic discounting, that makes people reluctant to pay money today in exchange for future benefits.

Taken together, these three factors imply that not everyone dropped from their employers' coverage will be willing or able to gain coverage in the individual market. The health policy concern has traditionally been that people with lower incomes and more pre-existing conditions are most likely to be unable to gain coverage in the new system. But the general rise in price combined with the behavioral considerations suggest that the effects may go well beyond these groups.

As a result, this effect can offset some of the benefits of extending new tax incentives for coverage. In the worst case, the new tax incentives could potentially even increase the number of people without coverage. For example, Jonathan Gruber (2006a) estimates that fully leveling the playing field for high-deductible insurance through a payroll tax credit and income tax deduction for purchases in the individual market would increase the net number of uninsured by 1.5 million. In gross terms 2.4 million of the previously uninsured would use the new tax benefits to purchase insurance in the individual market, but this would be more than offset by 3.9 million people who lost employer coverage and did not purchase coverage in the individual market. If

the new tax benefit were not limited to high-deductible policies it is likely that the outcome would have been even worse.

Adding new tax incentives for the individual market is in many ways analogous to adding new tax incentives to encourage reduced spending discussed in the previous section. It has a certain cost in terms of increasing the long-run budget challenge. But the effects in terms of coverage are of uncertain sign and magnitude. On the one hand, the subsidies provide more of an incentive to get covered through the individual market. On the other hand, the subsidies encourage dropping by employers. Well-designed policies can maximize the chances that the new tax incentives enhance coverage, but cannot eliminate the partially offsetting effects of dropping and the uncertainty about the benefits.

Replacing the Tax Exclusion with a Tax Credit – Together With Other Reforms

The most promising way to move forward in all three dimensions – coverage, cost, and long-run fiscal situation – is to replace the employer exclusion with a tax credit, a step that has been proposed many times before (e.g., Butler 1991 and Pauly and Hoff 2002). Firms would still be allowed to deduct the cost of their contributions to employee premiums, just as they can deduct wages and other expenses today for the purpose of calculating taxable income. But workers would now have to include employer contributions to health insurance in their earnings for the purpose of calculating taxes (precisely which taxes is discussed below). In exchange for, workers who purchased qualifying insurance would get a refundable tax credit. Qualifying insurance would be along the lines proposed by the President in his standard deduction for health insurance, including limits on out-of-pocket payments, coverage of a general range of medical care, and guaranteed renewability by the provider (Treasury 2008).

The impact on health spending

The impact of such a proposal on health spending by the insured is largely independent of the details. Requiring workers to include employer contributions to premiums would reduce health spending by the insured for two reasons. First, it would eliminate any subsidy at the margin to purchase more generous health insurance. This would encourage people to purchase more non-health consumption goods and spend less on health insurance. And unlike HSAs, this change would be neutral about how exactly individuals reduce their premiums. Individuals would be free to spend less by engaging in more cost sharing, but they would also be able to spend less by choosing health plans that have more managed care features that reduce utilization.

Second, at the margin the plan would level the playing field between premiums and out-of-pocket expenses by eliminating the tax subsidy for both sets of purchases. This would be expected to give individuals an incentive to purchase plans with higher cost sharing. As discussed above, this would reduce aggregate health spending by at least 7 percent taking into account the partial equilibrium effects of higher coinsurance on individual spending decisions. Using the Cogan, Hubbard and Kessler parameter assumptions spending would be reduced by 26 percent – four times the spending reductions they claim under their plan. Note that the Congressional Budget Office (CBO) estimates that the President’s proposal would result in spending reductions of 15 percent in 2010.

In addition, the proposal would potentially have general equilibrium effects that would gradually reduce spending by even more, potentially even reducing the long-run growth rate of health expenditures. Although technology is the primary driver of health spending, the development and adoption of technologies are endogenous. With less generous insurance, there

would be less incentive to develop expensive technologies and more incentive to develop cost-saving technologies, potentially bending the curve of health spending.

The impact on coverage

Virtually any way of replacing the health exclusion with tax credits or tax deductions is likely to increase coverage. The current exclusion provides an incentive to go from no insurance to some insurance and from some insurance to more insurance. A reformed system would eliminate the incentive to go from some insurance to more insurance, and put much or all of those dollars into increasing the incentive to go from no insurance to some insurance. The direct effects of the tax incentive would be reinforced by the indirect effects on health spending. Over time, these effects on health spending could be quite large – lowering premiums and further increasing the demand for health insurance.

For example, the President's proposal to replace the exclusion with a \$15,000 tax deduction for family coverage would provide the same incentive as current law to purchase an average health insurance policy. But for an uninsured person considering buying an inexpensive health insurance plan it would provide substantially more of an incentive than current law because any qualifying plan would receive the full \$15,000 tax deduction regardless of its cost. Given the large variance in premiums, this could essentially double the incentive to purchase minimally acceptable insurance.⁶

Three estimates have shown that this proposal would meaningfully expand coverage. CBO estimated that it would increase coverage by 7 million in 2010 (CBO 2007a).⁷ CBO also estimated that there would be little adverse change in the composition of the insured: 1.5 million

⁶ For more on the President's proposal see Burman *et al* 2007,

⁷ The

people would lose their employment-based coverage and become uninsured, but more than 8 million people would go from being uninsured to being insured, mostly in the individual market but also 1.3 million of the uninsured would gain employer-sponsored insurance. The Lewin Group estimated that the proposal would increase coverage by 9 million in 2009, with 2.3 million people going from employment-based coverage to the ranks of the uninsured (Sheils and Haught 2007). Treasury estimates that the proposal would increase the number of insured by 8 million, but does not specify the year or the composition effects (Treasury 2008).

The standard deduction for health insurance, however, is poorly designed to serve the goal of expanding coverage. The exclusion is replaced by a deduction that has no value for low-income households and rises in value as income rises. As a result, the majority of the uninsured have little or no incentive to purchase coverage.⁸ In addition, the proposal does nothing to minimize employer dropping and adds essentially no new regulations to make the individual market work better.⁹ As a lower bound for coverage effects, estimates in the range of 7 to 9 million are very promising.

Several measures could improve on it, increasing the expected increase in coverage and also minimizing the downside risks associated with these highly uncertain projections. In the limit, these measures could achieve essentially universal coverage of the 47 million uninsured.

These measures include:

⁸ Low-income workers would have their payroll taxes reduced by the proposal. But they would also have their taxable earnings and thus future Social Security benefits reduced as well. In present value terms they would get little benefit and might even lose money. In terms of behavioral effects, however, they would likely place more weight on the immediate payroll tax reduction and thus would purchase more coverage.

⁹ The tax benefit is limited to insurance plans that have guaranteed renewability, that is an enrollee can automatically renew the plan with premium growth equal to average premium growth for his or her cohort. Most individual market insurance plans already have this feature due to state regulations or consumer demand. As a result, it would make very little difference for coverage.

(1) Progressive tax credits. With a deduction the after-tax price of health insurance is lower for high-income households. This may result in a price that is too high for low-income households to purchase health insurance but higher than it needs to be to encourage high-income households to purchase such insurance. In the absence of evidence that the elasticities are higher for high-income households, the optimal policy in the face of an externality (or to serve a social goal) is to use a uniform, refundable credit (Batchelder, Goldberg and Orszag 2006). In the more plausible case, the elasticity is larger for lower-income households and thus progressive tax credits that decline with income are warranted.

(2) Mandatory coverage or other institutional mechanisms to increase participation.

Insurance coverage depends on both financial incentives and institutional structures. An effective mandate combines both, giving people a negative financial incentive to get coverage (by avoiding a penalty) and also creating a self-reinforcing culture of compliance (Glied, Hartz and Giorgi 2007). Combining a mandate with positive incentives can increase the bang-for-the buck of tax incentives. Gruber (2008) compares the impact of a set of tax subsidies with and without a mandate. Without a mandate the subsidies would cover 23 million people at a cost of \$99 billion. With a mandate the coverage nearly doubles to 45 million while the cost only rises by about one-quarter to \$124 billion.

As an alternative to mandates, automatic enrollment together with other institutional mechanisms may result in similar effects as a mandate while avoiding the problem of making some people feel worse off.

(3) New pooling mechanisms. The biggest risk in eliminating the exclusion is that it undermines the pooling through the employer-sponsored system. One option would be simply to limit any tax credits to employer-provided insurance. But this is likely to be politically infeasible and also does not address some of the genuine problems with the employer market discussed above. An alternative is to limit the tax credits to the employer-sponsored market or new pools. These pools could be modeled on the Federal Employees Health Benefit (FEHB) or the closely related Connector in Massachusetts. One option to make pooling more affordable would be to mandate that companies participating in the pool provide an income-related cost sharing plan (Furman 2007). In addition, some of the downside risk for low-income and vulnerable families could be mitigated by expanding public programs like Medicaid.

(4) Reducing adverse selection in existing pooling mechanisms. Finally, additional mechanisms could be considered to reduce adverse selection in order to ensure that the pool was successful. These could include catastrophic reinsurance, risk-adjusted payments to plans, and high-risk pools. Possibly these could be done on a state-by-state basis so that a variety of state-level experiments could help determine the right mixture for policy.

The fiscal impact

Such a plan could be designed to be revenue neutral or even revenue increasing, in contrast to the revenue losing plans discussed earlier. Moreover, the tax exclusion for employer-sponsored insurance has a fiscal advantage over most other ways of paying for insurance in that its value grows with the cost of health insurance. In contrast other offsets, like increasing

income tax rates, generally only grow with nominal GDP and thus if they are designed to pay for health subsidies in the short run they will generally fall short in the long run.

One aspect of the fiscal impact of such proposals that has gotten too little attention in previous proposals is the interaction with the Social Security system. In fiscal year 2008 the total value of the federal tax expenditures for health spending will total about \$250 billion, including \$164 billion in income tax expenditures and roughly \$85 billion in payroll tax expenditures. Policymakers have three choices. (1) Only repeal the exclusion for income taxes but maintain it for Social Security taxes – making \$250 billion available. This is the simplest option but it creates an inconsistency that also undermines some of what the proposal is trying to achieve. (2) Repeal the exclusion for both income and payroll taxes but do not count the additional payroll taxes towards Social Security benefits. This inconsistent treatment would be hard to justify on economic grounds. Moreover, if policymakers use all \$250 billion to pay for refundable credits for health insurance it raises the potentially serious issue of double counting because the added Social Security and Medicare Hospital Insurance revenues are counted both towards the solvency of these programs and also used to pay for tax credits for health care. In effect, this route creates the illusion that more fiscal improvement in Medicare and Social Security has been accomplished than is actually the case. The way to avoid the problem would be to limit the new health tax credits to the \$164 billion generated by repeal of the income tax exclusion and protect the remaining revenues for deficit reduction and solvency. (3) Repeal the exclusion for both income and payroll taxes but count the additional payroll taxes towards Social Security benefits. This is the most logical and consistent treatment. But it raises some of the same problems as option 2. Moreover, the higher taxable earnings would result in higher Social Security benefits, undoing some of the long-run fiscal benefits associated with the proposal.

Once again, the solution is either to limit the health-tax proposals to \$164 billion or to take the politically infeasible step of combining them with future reductions in the Social Security benefit formula intended to leave benefits roughly unchanged.

Conclusion

The American health care system faces a variety of challenges. Tax reform will be insufficient to solve many of them. Comparative effectiveness research, better benefit designs, electronic medical records, disease management, and prevention are all important in ensuring higher levels of quality, greater degrees of affordability, or both,.

But the health-tax system is a well understood part of the problem. It costs more than \$200 billion annually in federal dollars, and even more in state dollars. It is an unfair and inefficient mechanism to expand coverage. And it encourages higher spending.

Proposals that would add new tax breaks risk keeping this entire structure intact. At best, they will help ameliorate some of the problems but at a potentially large budgetary cost that would have to be paid for in other manners. At worst, the extra spending could even risk being counterproductive and worsen the very indicators it is trying to improve, like coverage and health spending. Often, the level of uncertainty is such that it is not clear which of these cases prevails.

Instead, a better approach is to replace the existing income tax exclusion itself. By itself such a policy risks disrupting employer-sponsored insurance, making some people worse off, and not achieving significant gains. But structured in the right way, including progressive tax credits, a mandate or other institutional mechanisms, new pooling systems, and other techniques to

reduce adverse selection, it could be a relatively low-risk and no cost way to reduce health spending and expand coverage – potentially to all Americans.

References

- Aaron, Henry. 2007. "Budget Crisis, Entitlement Crisis, Health Care Financing Problem—Which Is It?" *Health Affairs* Volume 26, No. 6 (November/December), pp. 1,622-1,633.
- Batchelder, Lily, Fred Goldberg, and Peter Orszag. 2006. "Efficiency and Tax Incentives: The Case for Refundable Tax Credits," *Stanford Law Review* 59, no. 23: 23-76.
- Browne, Mark. 1992. "Evidence of Adverse Selection in the Individual Health Insurance Market," *Journal of Risk and Insurance*: 13–33.
- Burman, Leonard, Jason Furman, Greg Leiserson, and Roberton C. Williams. 2007. "An Evaluation of the President's health insurance proposal." *Tax Notes* 114 (10).
- Butler, Stuart M. 1991. "A tax reform strategy to deal with the uninsured." *Journal of the American Medical Association* 265 (19).
- Cogan, John F., Glenn R. Hubbard, and Daniel P. Kessler. 2005. *Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System*. Washington, DC: AEI Press.
- Census. 2007. *Income, Poverty and Health Insurance Coverage in the United States: 2006* (Washington, D.C.)
- Choi, James, David Laibson, Brigitte C. Madrian, and Andrew Metrick. 2005. "Optimal Defaults and Active Decisions." NBER Working Paper 11074.
- Congressional Budget Office. 2005. *Effective Marginal Tax Rates on Labor Income*.
- Congressional Budget Office. 2007a. *An Analysis of the President's Budgetary Proposals for Fiscal Year 2008* (Washington, D.C.)
- Congressional Budget Office. 2007b. *CBO's Health Insurance Simulation Model: A Technical Description* (Washington, D.C.)
- Congressional Budget Office. 2007c. *The Long-term Budget Outlook* (Washington, D.C.)
- Feldstein, Martin and Bradley Friedman. 2007. "Tax Subsidies and the Rational Demand for Insurance and the Health Care Crisis," *Journal of Public Economics* 7, no. 2 (April): 155-78.
- Finkelstein, Amy. 2007. "The aggregate effects of health insurance: Evidence from the introduction of Medicare." *Quarterly Journal of Economics* 122 (1): 1–37.
- Fisher, Elliott S. 2003. "Medical care: Is more always better?" *New England Journal of Medicine* 349 (17): 1665.

- Furman, Jason. 2006. "Two wrongs do not make a right." *National Tax Journal* 59: 491–508.
- Furman, Jason. 2007. "The Promise of Progressive Cost Consciousness in Health-care Reform." Hamilton Project Discussion Paper 2007-05, The Brookings Institution.
- Glied, Sherry, Jacob Hartz, and Genessa Giorgi. 2007. "Consider it Done? The Likely Efficacy of Mandates for Health Insurance," *Health Affairs* 26, no. 6 (November/December): 1612-1621.
- Gruber, Jonathan. 2006a. "The Cost and Coverage Impacts of the President's Health Insurance Budget Proposals," *Center on Budget and Policy Priorities*.
- Gruber, Jonathan. 2006b. "The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond," Kaiser Family Foundation.
- Gruber, Jonathan. 2008. "Covering the Uninsured in the U.S." NBER Working Paper 13758 (January).
- Gruber, Jonathan and Bridgette Madrian. 2004. "Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature," in C. McLaughlin, ed., *Health Policy and the Uninsured* (Washington, D.C.: Urban Institute Press), 97-178.
- Herring, Bradley and Mark Pauly. 1999. *Pooling Health Insurance Risks*. Washington, D.C.: AEI Press.
- Herring, Bradley and Mark Pauly. 2006. "The Effect of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market." NBER Working Paper 12504.
- Jack, William and Louise Sheiner. 1997. "Welfare-Improving Health Expenditure Subsidies," *American Economic Review*, 87, no. 1: 206-21.
- Kaiser Family Foundation. 2007. *The Uninsured: a Primer*.
- Kaiser Family Foundation and Health, Research and Education Trust. 2007. *Employer Health Benefits 2007*.
- Kaplow, Louis. 1989. "Horizontal Equity: Measures in Search of a Principle," *National Tax Journal* 42.
- Keeler, Emmett B., Jesse D. Malkin, Dana P. Goldman, and Joan L. Buchanan. 1996. "Can medical savings accounts for the nonelderly reduce health care costs?" *Journal of the American Medical Association* 275 (21): 1666-1671.
- Madrian, Brigitte and Dennis Shea. 2001. "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior." *Quarterly Journal of Economics* 116, no. 4.

- Newhouse, Joseph P., and the Insurance Experiment Group. 1993. *Free for All? Lessons from the RAND Health Insurance Experiment*. Cambridge, MA: Harvard University Press.
- Pauly, Mark and John Hoff. 2002. *Responsible Tax Credits for Health Insurance*. Washington, D.C.: AEI Press.
- Pollitz, Karen, Richard Sorian and Kathy Thomas. 2001. *How Accessible Is Individual Health Insurance for Consumers in Less-than-Perfect Health?* Kaiser Family Foundation.
- Rothschild, Michael and Joseph Stiglitz. 1976. "Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information." *Quarterly Journal of Economics* 90.4, 630-649.
- Sheils, John and Randy Haught. 2007. "President Bush's Health Care Tax Deduction Proposal: Coverage, Cost and Distributional Impacts," The Lewin Group.
- Treasury. 2008. *General Explanations of the Administration's Fiscal Year 2009 Revenue Proposals*.