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Tax Reform and Health Insurance

By Robert B. Helms

President George W. Bush's ambitious second-term agenda includes proposals to reform the tax system and, more specifically, to use it to make our increasingly costly health-care system more efficient. After explaining the decisive influence of tax policy in shaping the current system, with its preference for employer-based health insurance, this essay discusses the main options for altering the tax treatment of medical expenses and identifies three measures that could lead the way toward more comprehensive health-care reform.

Since the November 2004 elections there has been much discussion among health policy experts and political analysts about what the health policy agenda might be for the Bush administration and the 109th Congress. The common conclusion seems to be that health policy reform will take a back seat to other pressing foreign and domestic policy issues, especially the war in Iraq, Social Security reform, and tax simplification. Since John Kerry left the election platform there has been relatively little discussion concerning what to do about the uninsured, the rising cost of health care, or how to reform Medicare and Medicaid, the large and growing health entitlement programs.

Despite the importance of other issues, health policy issues cannot be avoided. The major problems posed by the rising cost of health care, the decline of employer-provided health insurance, and the cost of caring for the aging baby-boom generation are fundamental and long lasting. All actors in our economy—employers, employees, health care providers, and taxpayers—have an interest in reducing the waste and inefficiency of our system, while assuring the continued improvement in quality promised by research and new medical knowledge. Since tax policy has played such a dominant role in shaping our current system, the new attention to tax reform presents an opportunity to start us on a path to a more efficient system, one that is less wasteful yet more effective in improving our health.

The Tax Treatment of Health Insurance[1]

World War II was a turning point for both medicine and health policy. The development of penicillin to treat wartime injuries and the improvements in antibiotics in the 1950s made it possible for doctors to more effectively fight infections and thereby perform a host of invasive surgeries. This growth of medicine's potential increased the demand for both medical care and the financial protection against high medical costs provided by insurance.

Another World War II event also increased the demand for health insurance. As a response to the labor shortage and wage and price controls during the war, employers began to offer health insurance and pensions as "fringe benefits." The Internal Revenue Service ruled that these benefits were not subject to the wartime wage controls and that they were not to be included in taxable income. While this policy was established at a time when health insurance was an infant industry, it created a special tax advantage that had

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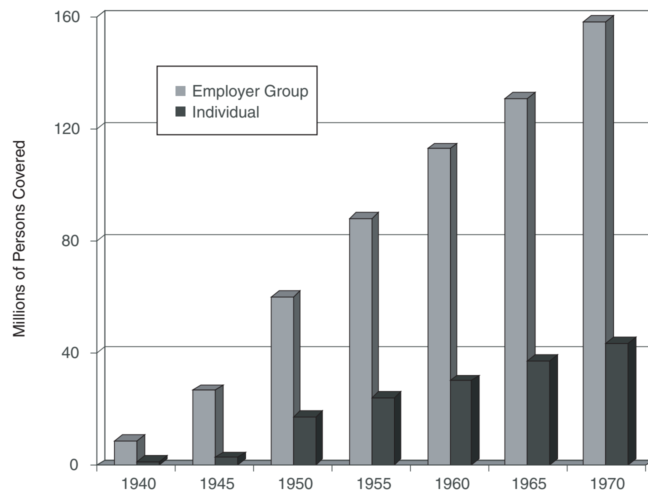
strong effects on the industry's future development.

The growth of health insurance was also affected by a number of economic and demographic changes. Largely as a result of what would later be dubbed "the baby boom," the population of the United States increased from 144.1 million in 1947 to 204.9 million in 1970. During the same period, total civilian employment increased from 57 to 79 million, while per-capita income (in current dollars) grew from $1,327 to $3,945.[2] More people had more money to spend on consumer goods and services, including the financial protection provided by insurance. Meanwhile, advances in medical technology and knowledge made consumers willing to spend more on medical care and insurance.

FIGURE 1: Private Hospital Insurance Coverage, 1940–1970



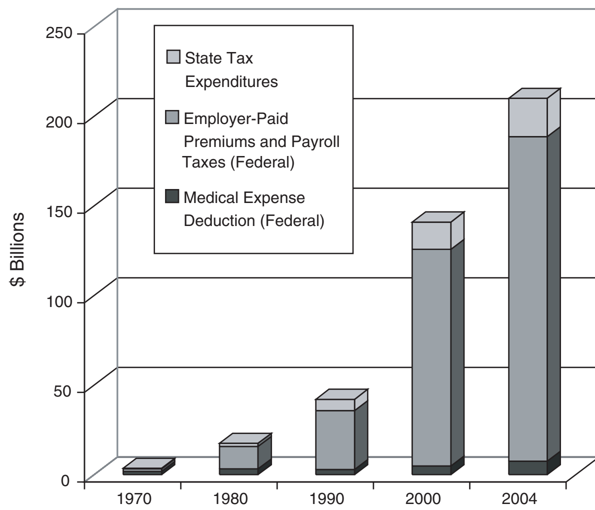
SOURCE: U.S. Census Bureau, *Historical Statistics of the United States*—Colonial Times–1970, Series B 401-412.

Why did employer group coverage become the dominant form of health insurance coverage? There are two major reasons. First, a group of people working for a company provides a convenient and efficient risk pool for insurance. Insurance companies were willing to sell coverage for an employment group at a reasonable rate because they learned that, in most cases, the group could be expected to represent only an average level of medical risk. People go to work for companies for reasons other than health coverage, so insurers did not expect to attract a large proportion of high-cost workers. This was not the case with health insurance policies sold to individuals. Health insurance companies knew already (and still know) that people who expect to have higher-than-average medical costs are more likely to buy insurance coverage. To protect themselves against this adverse selection, companies selling individual insurance priced it at a higher level than equivalent coverage sold to an employer group.

The special tax treatment of employer-based health insurance substantially advantaged this type of insurance over policies sold to individuals. An individual insurance policy must be purchased with after-tax dollars; but, if you get your health insurance through your employer, you do not have to pay taxes on the premiums your employer pays on your behalf. This means that tax policy ends up giving a discount on your insurance coverage that is approximately equal to your marginal tax rate. For most workers who pay both income and payroll taxes, this ranges from about 25 percent to over 50 percent, a substantial discount. This discount is greater for higher-income workers than it is for lower-income workers. The result was that a policy that was put in place to help wartime labor problems had a major effect on the way our health insurance industry developed. This relative growth of employer-based health insurance did not happen in other insurance markets such as automobile and life insurance that are still sold mostly to individuals. Figure 1 illustrates that the number of persons covered by employer-based group hospital insurance grew in the post-war period to about three times the number covered by individual health insurance.[3]

The expansion of private health insurance coverage combined with the creation of Medicare and Medicaid in 1965 brought about a major change in the way we pay for health care. Consumers paid out of pocket for more than half of their health care expenditures in 1960; by 2000, however, they paid directly for less than one-fifth. Payment by third parties covered over four-fifths of such expenditures. The so-called third-party-payment problem describes the tendency of consumers not to worry about costs when someone else is paying the bill. This also affects the incentives of providers—when consumers do not worry about costs, neither do service providers. The result is increases in both the demand and the supply of medical care. We end up spending more for health care than we would in the absence of government policies that encourage this expenditure. That has obvious benefits for most providers and some consumers but also makes it

FIGURE 2: Federal and State Tax Expenditures



SOURCES: Congressional Budget Office, 1970–1990; John Sheils, Lewin Associates, 2000 and 2004.

more expensive for everyone, those who have coverage and those who do not.

One way to quantify the size of the tax subsidy for employer-based health insurance is to look at estimates of tax expenditures, as illustrated in figure 2. Tax expenditures are the amounts that governments do not collect in taxes because of special provisions in the tax code. Health insurance is the largest category of tax expenditures, followed by those for mortgage interest payments and employer-based pensions.

Figure 2 presents estimates of state and federal health-related tax expenditures and illustrates two important points. First, the value of the tax exclusion for health insurance has grown substantially since 1970, with major growth in the 1990s and early 2000s. This large increase reflects the growth of health care and health insurance costs that accompanied the growth in the economy, as well as rising incomes bumping more people into higher tax brackets.

Second, excluding employer-paid premiums and payroll taxes from taxable income accounts for the great majority of health-related tax preferences. The medical expense deduction (bottom) is relatively small compared to the effect of the exclusion.

The tax subsidy is regressive, offering more benefits to those with higher incomes. John Sheils and Randall Haught of the Lewin Group estimate that those with family incomes over $50,000 got 71.5 percent of the value of the total 2004 federal tax expenditure of $188.5 billion. Those in families with income below $20,000 got only 3.4 percent.[4] This distribution also helps to explain the political popularity of the tax exclusion. The policy gives more to those who have higher incomes and who work for firms that offer health insurance—a powerful bloc of voters.

Tax policy was not the only force behind these historical developments, but it worked to intensify the effects of income, population, and medical technology in ways that both improved and hindered the efficiency of our system. Under a system dominated by employer-based insurance, employees and their unions had strong incentives to bargain for the expansion of untaxed health benefits relative to taxable wages. Employers had little incentive to resist these demands since they could deduct both wages and benefits as a business expense. A more generous health benefit as part of the overall compensation package became a popular way for employers to attract and hold workers.

While health insurance began before World War II as a way to cover hospital expenses, it gradually expanded in the postwar period to cover outpatient and physician office visits, and increasingly mental health services, dental care, and prescription drugs. Another gradual trend was to reduce the amount of cost sharing (deductibles and co-payments) paid directly by the consumer.

The tax preferences for employment-based health insurance produced a higher level of costs, prices, and expenditures than we would have had otherwise. This created winners (and political supporters) among the majority of workers who received additional coverage and the providers who supplied the care. On the other hand, these policies have raised costs for everyone, including the uninsured.

Options for Reforming the Tax Treatment of Health Care

Changes in the tax treatment of health care have been written into several health care reform proposals over the last several years, including the Kerry and Bush proposals during the 2004 presidential campaign. Typically, these changes were part of a broader set of proposals to expand health coverage. The following discussion will

concentrate on only the principal ways that have been suggested to use tax policy as a tool for achieving expanded coverage or improved incentives.

Reduce the Tax Exclusion. Changing the effects of the present tax exclusion can take two forms: eliminating the tax exclusion, or placing a limit on what can be excluded from the employee's taxable income.[5] Most proposals are of the latter type, commonly referred to as a tax cap. For example, if the cap were placed at $6,000 per year, an employer providing a policy costing $8,000 would have to report $2,000 as taxable income for the employee. The higher the cap, the less binding it would be and the less effect it would have on the design and cost of group policies. To the extent that firms redesigned their policies to stay under the cap, there would be little additional revenue flowing to the government. A similar cap now exists in the tax law regarding the value of employer-provided life insurance.

The primary rationale for a tax cap is that it would remove the present open-ended incentive for employees, unions, and employers to keep adding tax-free health benefits relative to taxable wages. Primarily, this would give both firms and insurance companies stronger incentives to design more cost-effective policies.

A tax cap proposal was developed at the Department of Health and Human Services during the Reagan administration and was presented as a legislative proposal in fiscal years 1984 and 1985.[6] After a study of what firms were paying for health insurance, the proposed tax cap was set at the upper range of monthly premiums paid by employers. The cap was to have been indexed to general inflation, which would have made the cap more binding over time as the cost of health insurance outpaced the general level of prices.

A variation of the tax cap proposal is to phase in the cap over several years so that there is more time to adjust to the change. Senate Majority Leader Bill Frist (R-Tenn.) has suggested this as an idea worth considering.[7]

Capping the tax exclusion for employer-sponsored health insurance would encourage employers to intensify their efforts to control the costs of their plans, but always keeping in mind the role that health benefits play in their competitive labor markets. They will still have to provide the type of benefits desired by their employees and assure them access to the providers they prefer. While some firms may raise their level of deductibles and improve their catastrophic benefits, others may turn to various kinds of managed care plans that attempt to produce better value through disease management, patient education, and utilization controls.

While the effects of the exclusion of employer-based health insurance are well understood by health policy experts, they are not generally understood by the general public or most politicians. This has led to much skepticism about the political feasibility of such a change. The situation is summed up nicely by Clark Havighurst, a longtime student of health policy:

> [A] tax subsidy is insidious precisely because, in addition to being an off-budget public expenditure, it can misallocate huge amounts of society's resources, yet be entirely painless at the level of individual producers and consumers. Since the affected interests simply adjust their behavior to the incentives created, they have no occasion to complain or to call for political attention. Thus, in the abstract, capping the tax subsidy is a notion that only a policy wonk could love, a meritorious policy idea with no natural political constituency.[8]

Since the tax exclusion has now been in effect for over sixty years and has created strong constituencies who oppose any change, most political analysts give its elimination little chance of success. This situation has led to a number of alternative proposals designed to remove more gradually the distortionary effects of the present policy and make them more appealing to a wider array of political interests.

TAX POLICY TERMINOLOGY

Tax Exclusion: the exclusion of employer-provided health insurance from the taxable income of the employee.

Business Tax Deduction: the inclusion of the cost of providing health insurance as a business expense when computing the net income of the firm.

Personal Tax Deduction: the ability of individual taxpayers to deduct out-of-pocket medical expenses that are greater than 7.5 percent of their adjusted gross income.

Reduce the Business Tax Deduction. Under present practice, firms are able to treat the cost of health insurance premiums they pay in the same way as any other legitimate business expense, such as the cost of wages, taxes, and raw material inputs. That policy could be changed by eliminating or capping the amount of premium payments that firms could deduct as a business expense. Such a policy would not affect firms that did not offer health insurance but would give firms that did strong incentives to drop that coverage to avoid higher taxes. It would also competitively disadvantage firms offering health insurance compared to those not offering insurance. The incidence of the change in policy would depend on the marginal tax rates of the business firms offering insurance, so that the burden would fall more heavily on the more profitable firms. This policy would likely increase tax revenues for the federal government but would also increase the number of Americans without health insurance as firms dropped their coverage in favor of paying wages that could still be deducted.

Despite the perverse health system effects of such a policy, it has political appeal for those who favor taxing businesses rather than individuals. The rationale is that taxing business firms can raise revenue without directly affecting a large group of voters. The *Washington Post* has reported that a type of tax cap on business deductions for health insurance may be under consideration by the Bush administration.[9] This has not been confirmed, so it is impossible to know if such a deduction cap is really being considered or if this is yet another example of confusion in the press between the terms "tax exclusion" and "tax deduction."

Expand the Deductibility of Personal Health Expenditures. This tax policy change is the core idea behind a new health reform proposal by John Cogan, R. Glenn Hubbard, and Daniel Kessler.[10] They argue that the present system of giving a tax subsidy only to premiums paid by an employer leads to excessive benefits and low-deductible policies that raise health care costs and increase the number of people without coverage. They propose to overcome this distortion by making *all* health expenditures paid directly by individuals—out-of-pocket expenses, premiums for individually purchased insurance, and employee contributions to employer-provided insurance—deductible to each individual taxpayer. They would require the taxpayer to have at least a catastrophic health insurance policy and make the deduction available to all taxpayers, those who itemize deductions and those who do not.

In addition to promoting tax fairness across all taxpayers, they argue that their policy would have reduced health care spending by approximately 6 percent ($40 billion) in 2004. This would have been achieved primarily by inducing people to buy more cost-effective health insurance policies and giving people an incentive to pay directly for health care rather than rely on insurance. They estimate that their proposal would also reduce the number of the uninsured by 2 to 6 million people.

This policy proposal has attracted strong criticism from proponents of other tax policy proposals.[11] Some charge that making more health expenditures deductible will not make the tax code more fair because the value of a deduction is directly related to one's marginal tax rate. For a given expenditure, a higher-income person will receive a more valuable tax subsidy than would a person of lower income. Another criticism is that giving additional subsidies to health expenditures may encourage even more health expenditure and counteract the restraining effect of higher cost sharing and other cost-saving policies now being adopted by employers.

Cogan, Hubbard, and Kessler may be correct that there are some short-term efficiency gains from making more health expenditures deductible, but it will also create new constituencies for the tax deduction that may make it more difficult to reform the bigger distortion caused by the tax exclusion when the Congress is forced to act in future years.

Establish a New Deduction for HSA Policy Premiums. President George W. Bush recently proposed that Congress establish a new tax deduction for the premiums individuals pay for the purchase of a high-deductible health plan attached to a Health Savings Account (HSA). Under the legislation establishing the new HSAs, an individual can make tax-free contributions into a special savings account as long as that person is covered by a high deductible policy. HSA policies can be paid for tax-free by an employer, but only to employees of that firm. Self-employed individuals can also deduct the cost of an HSA policy, but the plan leaves others who purchase non-group insurance with no way to get a tax subsidy. Under current policy, the premiums paid by an individual for an HSA policy must be paid with after-tax income.

The rationale for HSAs is that they promote more efficient health care consumption by giving individuals strong incentives to spend their own money carefully.

Contrary to the incentives to be wasteful when consumers pay no more than minimal co-payments, HSAs enable their owners to accumulate money in these accounts if they use fewer health services. The rationale for a new tax deduction for the cost of premiums for HSA policies is that this will encourage the extended use of these more efficient forms of insurance by giving a new class of consumers a tax break. There is substantial interest among employers and insurance companies in these new policies, but it is too early to know the extent to which they will attract new enrollees.

In addition to the more general criticisms of HSAs, the president's proposal has also been criticized for singling out a specific kind of health insurance policy for subsidies before it has proven itself in the marketplace. The behavioral changes brought about by HSAs may lead to more efficient health care, but it is now impossible to know if this would be more efficient than some alternative policy.

Expand the Use of Tax Credits. Tax credits for specific purposes are popular in a number of policy areas because they allow tax subsidies to be targeted more effectively to a specific group than tax deductions.[12] While a tax deduction can only be an advantage to a taxpayer who owes taxes, tax credits can be designed as a way of giving subsidies to taxpayers who do not owe any taxes. This makes it possible to use the tax system as a means of giving a subsidy to low-income persons without setting up a new bureaucracy to determine eligibility and transfer cash payments as we do with other welfare programs.

To understand health tax credit proposals, it is important to understand their distributional effects as compared to those of tax deductions. If a taxpayer is allowed to *deduct* the cost of a yearly health insurance premium ($2,000) from his yearly income ($20,000), then he pays a tax ($2,700), which is determined by multiplying his tax rate (15 percent) by his taxable income ($20,000 – $2,000 = $18,000). This means that a given health insurance premium will produce a tax subsidy that increases with one's marginal tax rate. Treating the same premium ($2,000) as a *tax credit* produces a different effect because the tax credit is subtracted from one's tax liability after the tax has been determined. In this example, a person with an income of $20,000 would pay taxes of only $1,000 ($20,000 x .15 = $3,000; $3,000 – $2,000 = $1,000). All other things being equal, a tax credit targets the tax subsidy more to the low-income taxpayer than does a tax deduction. A refundable tax credit would pay the taxpayer (or provide him with a voucher for the purchase of health insurance) if the amount of the credit ($2,000) exceeded his tax obligation. (If a person had an income of $10,000, and fell in the zero tax bracket, he would receive a refund of $2,000 since he would not owe any taxes.)

Tax credits for health insurance can be set at a fixed dollar amount ($2,000) for each family or as a percent of the cost of insurance. For a given budget outlay, a fixed-dollar tax credit would provide a subsidy to more people than a proportional tax credit. A proportional tax credit would not cover as many people but would provide greater subsidies to those with more serious health conditions who have to pay higher premiums to buy insurance.[13]

Expand tax credits to small employers. Tax credits can be targeted to specific populations. A majority of the 45 million Americans without health insurance are in families where at least one member works for a small business. Since most small businesses do not offer health insurance, a popular proposal is to provide a tax credit to small employers for the purchase of health insurance. A tax credit to employers was one common feature included in both the Kerry and Bush health plans during the 2004 election, although there were important differences between their proposals.[14] The tax credit goes to the employer and reduces the net cost of buying a group policy for all the workers in the firm. The objective is to reduce the number of the uninsured by inducing more small firms to offer health insurance to their employees. Typically, such proposals are restricted to firms of a certain size (for example, fifty employees or less) and may contain income or other restrictions designed to prevent the subsidies going to small firms with high-income employees, such as law firms and physicians' offices.

Tax credits to small employers would encourage more firms to offer health insurance, but this type of tax credit may exacerbate the present inefficiencies in the group market and give employees less choice of plans. Group policies are available from a wide variety of competitive health insurance companies, so they allow the employer to select one or more plans with the features preferred by the employer. Since it is cheaper to sell to and administer a group policy than individual policies, the cost of insuring a given number of employees and their dependents is lower than if the insurance is purchased in the individual market. On the other hand, the expansion of group policies forces more employees to accept the choices made by

their employer rather than having the freedom to purchase the level and type of health insurance they may personally prefer. In addition, expanding the number of people in group policies makes the cost problem greater since it gives more firms incentives to keep expanding the scope of benefits.

Expand tax credits to the uninsured. Several tax credit schemes, including those proposed by President Bush and the tax credits now being implemented under the Trade Adjustment Assistance Reform Act of 2002 (TAA), provide tax credits to low-income individuals who do not have health insurance.[15] The Bush proposal would provide a tax credit of 90 percent of the cost of a non-group policy with an upper limit of $1,000 for a single adult and $3,000 for a family.[16] The 90-percent tax credit would be phased down to zero for individuals with incomes between $15,000 and $30,000; the phase down for families would occur between incomes of $25,000 and $60,000. The Bush proposal would allow the tax credit to be used for the purchase of an individual health insurance policy but would not be available to any person covered under a public program or presently covered by an employer.

A contentious debate has developed among health policy analysts regarding the effectiveness of tax credits. The pessimists argue that the level of tax credits offered in most plans, especially the Bush plan, are just too small to induce many people to buy health insurance. They point out that the uninsured are predominantly low income and that the average cost of health insurance exceeds $9,000 per year for a family policy.[17] In addition, in what is referred to as the "crowd-out" argument, they say that tax credits to low-income workers would induce many employers to drop coverage for their workers, thereby shifting the cost of health insurance from the private to the public sector while having little effect on the number of people insured.[18]

Supporters of tax credits have a different view. They point out that the high cost of inefficient policies now on the market is one of the major reasons why we have so many uninsured people. They envision that tax credits and changing market conditions will induce insurance companies to offer more efficient and cheaper health insurance. These options will be more attractive to all buyers, including those buying with the aid of a tax credit, thereby increasing the level of coverage. They also argue that the pessimists' fears of crowd-out are exaggerated since broader labor market conditions determine when firms offer health insurance, and these conditions will not be fundamentally changed by the tax credits.[19] While economists Mark V. Pauly and Bradley Herring have agreed that relatively low tax credits may not have much effect since they are targeted to a class of workers who have already chosen not to have health insurance, their model projections suggest that higher levels of tax credits can be very effective in increasing the level of coverage.[20]

Starting the Transition to a Better Market

While I admire those who call for a complete restructuring of our complicated and inefficient tax system, it is highly unlikely that we are going to eliminate the present tax exclusion for employer-provided health insurance. This change would be the quickest way to more efficient reform, but the economic interests that are now invested in the present system are too great to allow it. Meanwhile, if we are going to have any debate about tax policy, there are several policy changes that could start us on the road to a more efficient health care system.

First, *efficient reform requires some form of a tax cap as an upper limit on the tax exclusion*. For political reasons, this could be set at a relatively high level and moderately indexed so that it becomes more binding over time. While this may be modest in its initial effect, it would send a strong signal to employees, employers, and insurance companies that it is time to get serious about redesigning health insurance coverage and cost-containment policies. Health insurers and employers are beginning to move in this direction by exploring new information systems and new forms of disease management, but a stronger effort by a larger number of employers would speed the process of reform. This kind of reform cannot be done through direct regulation and so must be done through market experimentation to determine the most effective strategies.

Second, *a new program of refundable tax credits could be used to promote the twin objectives of increasing coverage for low-income workers and promoting the growth of market-based insurance*. Allowing the credits to be used for the purchase of individual insurance is a necessary condition for efficient market reform. Allowing low-income individuals to use the credits to buy into an employer's group plan, while raising the cost to the federal government, would help to control crowd-out and promote the growth of coverage among the small firms that presently do not offer health coverage. Allowing the credits to be used for a variety of health insurance plans would help

to promote a more efficient market than mandating that they be used for HSAs alone.

Third, *despite my concerns about singling out HSAs as the only type of health policy worth encouraging, I do believe they have the potential to exert a strong influence on consumers and providers alike to seek both better quality and more cost-effective care.* Given the interest they are receiving in the marketplace, they are a target of opportunity. Giving them more favorable treatment among individuals and employers would speed their rate of adoption and their influence on basic incentives. This movement would be even more effective if combined with tax credits to low-income individuals and a limitation on the tax exclusion.

A complete discussion of health reform must consider how to reform Medicare and Medicaid, our large and growing public entitlement programs. But since these programs have been modeled on the private sector, their reform must now be led by examples of more efficient systems in the private sector. The attention to tax reform may give us a new chance to improve private sector health policy in the next few years. Changing the 1943 policy on the exclusion of employer-provided health insurance from taxable income may not be popular, but the sooner we bite that bullet, the sooner we begin the journey toward a more efficient health care system. Meanwhile, making some small changes in the right direction might actually start us down that road.

Notes

1. For a more complete history, see Robert B. Helms, "The Tax Treatment of Health Insurance," in Grace-Marie Arnett, ed., *Empowering Health Care Consumers through Tax Reform* (Ann Arbor: University of Michigan Press, 1999), 1–25; Melissa A. Thomasson, "The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance," *American Economic Review* 93, no. 4 (September 2003): 1373–1384; and U.S. Congress Joint Economic Committee, "How the Tax Exclusion Shaped Today's Private Health Insurance Market," December 17, 2003 (available at jec.senate.gov/_files/HealthTaxExclusion.pdf).

2. U.S. Census Bureau, *Historical Statistics of the United States–Colonial Times to 1970*, Series A 6-8, Series D 11-25, and Series F 17-30.

3. Figure 1 shows the number of persons covered for hospital stays, the type of insurance that was most common in the early years of the health insurance industry. Typical medical insurance policies gradually increased their coverage to various non-hospital types of care in later years.

4. John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs*—Web Exclusive, February 25, 2004, Exhibit 3 (abstract available at content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.106).

5. The elimination of the tax exclusion was included as part of the "reformed income tax option," one of five tax reform options included in an internal Treasury Department analysis of tax reform. See "Memorandum for Secretary O'Neill," from Pamela F. Olson, assistant secretary for tax policy, Department of the Treasury, November 7, 2002.

6. Executive Office of the President, *Special Analysis, Budget of the United States Government, Fiscal Year 1984*, G-29; and *Fiscal Year 1985*, G-34.

7. William H. Frist, "Health Care in the 21st Century," *New England Journal of Medicine* 352, no. 3 (January 20, 2005): 267–272. For another congressional view of the role of tax policy, see Bill Thomas, "Vision for Health Care," National Center for Policy Analysis, February 12, 2004 (available at www.ncpa.org/ prs/tst/20040331bttst.htm).

8. Clark C. Havighurst, *Health Care Choices* (Washington, D.C.: AEI Press, 1994), 102–103.

9. For example, see "Bush Plans Tax Code Overhaul," *Washington Post*, November 18, 2004; and "Theoretically, Tax Reform Should Fly," *Washington Post*, December 3, 2004.

10. John F. Cogan, R. Glenn Hubbard and Daniel P. Kessler, "Brilliant Deduction," *Wall Street Journal*, December 8, 2004 (available at www.aei.org/news21664). Senate Majority Leader Bill Frist has also proposed that premiums for the purchase of individual health insurance policies be allowed as a tax deduction.

11. See Grace-Marie Turner, "No Silver Bullet," *Galen Reports*, The Galen Institute (December 10, 2004); and Tom Miller, "How Elastic Is Bad Health Care Theory?" December 5, 2004 (available at voxbaby.blogspot.com/2004/12/tax-treatment-of-health-insurance.html).

12. For examples of support for tax credits, see Mark V. Pauly and John S. Hoff, *Responsible Tax Credits for Health Insurance* (Washington, D.C.: AEI Press, 2002); and Health Policy Consensus Group, "A Vision for Consumer-Driven Health Care Reform," The Galen Institute (available at www.galen.org/vision.asp). Jonathan Gruber, however, argues that expanding public programs such as Medicaid allows the subsidies to be targeted more effectively to the low income than by using tax credits. See Jonathan Gruber, "Tax Policy for Health Insurance" NBER Working Paper 10977, December 2004 (available at www.nber.org/papers/w10977).

13. For a sample of the extensive literature on tax credits, see Pauly and Hoff, *Responsible Tax Credits*; Mark V. Pauly and Bradley Herring, *Cutting Taxes for Insuring: Options and Effects of*

Tax Credits for Health Insurance (Washington, D.C.: AEI Press, 2002, full text and other information available at www.aei.org/publications/book45); Jack A. Meyer, Sharon Silow-Carroll, and Elliot K. Wicks, *Tax Reform to Expand Health Coverage: Administrative Issues and Challenges* (Economic and Social Research Institute, January 2000); and Gruber, "Tax Policy for Health Insurance."

14. Joseph Antos, et al., "Analyzing the Kerry and Bush Health Proposals," AEI, September 13, 2004 (available at www.aei.org/publication21166). For the latest version of the Bush proposal, see www.whitehouse.gov/infocus/healthcare.

15. Stan Dorn and Todd Kutyla, *Health Coverage Tax Credits under the Trade Act of 2002: A Preliminary Analysis of Program Operation*, Economic and Social Research Institute, April 2004 (available at www.cmwf.org/usr_doc/dorn_725_ trade_act.pdf). The TAA tax credits pay 65 percent of the cost of health insurance but are available only to persons receiving a trade adjustment payment or to individuals between the ages of 55 and 64 who are receiving pension benefits from the Pension Benefit Guaranty Corporation. While the credits can be used to pay for COBRA policies or a state health insurance plan, using this subsidy to buy an individual policy is highly restricted.

16. U.S. Treasury, "General Explanations of the Administration's Fiscal Year 2005 Revenue Proposals," February 2004, 21–23. The president released a new set of health reform proposals on September 2, 2004, that included tax credits to both small employers and individuals to help them set up HSA accounts. The original tax credits were retained for those choosing to buy a traditional health insurance policy rather than an HSA.

17. *Employer Health Benefits*, 2004 Annual Survey, The Kaiser Family Foundation and Health Research & Educational Trust, publication number 7150, chart 4 (available at www.kff.org/insurance/7148/upload/46206_1.pdf). Average annual premiums in 2004 were $9,950 for family policies and $3,695 for single policies.

18. Gruber, "Tax Policy for Health Insurance."

19. Pauly and Herring, *Cutting Taxes for Insuring*.

20. Pauly and Herring, *Cutting Taxes for Insuring*, Chapter 3 and Table 3.