Backgrounder

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# The Tax Equity and Affordability Act: A Solution for the Uninsured

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Congress can no longer afford to ignore the changing dynamics in health care coverage. The latest Census Bureau report shows that the number of uninsured increased from 45.3 million in 2004 to 46.6 million in 2005.[1] Moreover, the percent of people with employer coverage is still declining, dropping from 59.8 percent in 2004 to 59.5 percent in 2005.[2]

Failure to address these changing dynamics reinforces the status quo, which ultimately leads the uninsured to depend on an inefficient and disjointed system of uncompensated care and creates political pressure to expand government-run health care programs—both at the expense of U.S. taxpayers.

Lawmakers—especially those interested in preventing the incremental expansion of government control over the personal lives of American citizens—need to create an innovative alternative to the status quo. The new policy should be based on the free-market principles of consumer choice and competition, which leverage the enormous potential of private health insurance.

The Tax Equity and Affordability Act (TEA Act, S. 3754), introduced by Senator Mel Martinez (R–FL), offers just such a solution. Specifically, the bill would:

- **Establish a new system of income-based health care tax credits for individuals and families without employer-based health insurance.** Lower-income individuals would be eligible for a credit worth up to $2,000 annually. Lower-income families would be eligible for a credit

## Talking Points

- New census numbers confirm that the number of uninsured Americans has increased and that the percentage of Americans with employer-based coverage continues to decrease.
- Policymakers need to recognize that contentment with the status quo adds to the already overburdened and costly system of uncompensated care that treats the uninsured. Moreover, it fuels efforts by those whose solution for the uninsured is to expand government-run health programs for working-class Americans.
- The Tax Equity and Affordability Act (S. 3754) would create an alternative tax mechanism that would enable individuals and families who do not fit into today's employer-based health care system to secure private health insurance. The TEA Act is based on free-market principles and promotes fairness, choice, and personal ownership.

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worth up to $4,000 annually. Individuals earning above $30,000 would receive an annual tax credit worth $1,250; families earning above $60,000 would receive an annual tax credit worth $2,500.

- **Cap the existing, open-ended employment-based tax exclusion for health benefits.** The bill would set an $11,500 cap for family coverage and a $5,000 cap for self-only coverage on the total amount of health care benefits that can be excluded from a worker's taxable annual income. Under current law, non-taxable compensation of health care benefits is unlimited—no matter how generous the value of the benefit or how high the person's income. The bill would preserve the tax preference up to the cap, but benefits above that amount would be taxable.

The bill would establish a new federal tax mechanism for working families without employer-based coverage that is far more equitable than the existing system. It would also create the conditions for a more effective and efficient health insurance market. Specifically, it would promote personal choice and ownership of health insurance policies, which automatically establishes portability of coverage, regardless of job or job status. Based on recent research in the professional literature, real portability of health insurance alone would significantly reduce the number of uninsured.[3]

## A Declining Employer-Based System

The employer-based health insurance system, a relic of World War II policy that accelerated insurance coverage in the 1940s and 1950s, has functioned very well for the vast majority of Americans for many years. However, the economic conditions of postwar America have changed dramatically, while government tax and regulatory policy has remained virtually unchanged. Today, the old employer-based system clearly has several weaknesses.

*First,* the number of individuals with employer-based health care coverage has declined in recent years. According to current census data, the percent of individuals with employer-based coverage dropped from an estimated 64 percent in 2000 to 59.5 percent in 2005.[4] Moreover, fewer small businesses are offering coverage to their workers. The Employer Health Benefits 2005 Annual Survey found that only 47 percent of firms with fewer than 10 workers offered health care coverage in 2005, compared to 58 percent in 2002.[5]

*Second,* having a job does not guarantee that a person has employer-based coverage. Eighty percent of the uninsured are part of a working household. Some workers may not be offered coverage by their employer. Others decline coverage because of cost, while others, such as part-time or contract workers, may not qualify because of their work status. Paul Fronstin of the Employee Benefit Research Institute, a prominent think tank specializing in employee compensation, found that in 2002 54 percent of uninsured workers were without coverage because their employer did not offer coverage, 64 percent of uninsured workers found their employer plans too costly, and over 44 percent were ineligible for coverage because of their part-time status.[6]

1. Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, "Income, Poverty, and Health Insurance Coverage in the United States: 2005," U.S. Census Bureau *Current Population Reports: Consumer Income*, August 2006, p. 20, at *www.census.gov/prod/2006pubs/p60-231.pdf* (August 29, 2006).
2. *Ibid*, p. 21.
3. Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, Vol. 22, No. 6 (November/December 2003), pp. 247–249. See also Pamela Farley Short, Deborah R. Graefe, and Cathy Schoen, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," Commonwealth Fund *Issue Brief*, November 2003, p. 10, at *www.cmwf.org/usr_doc/Short_churn_688.pdf* (July 12, 2006).
4. DeNavas-Walt *et al.*, "Income, Poverty, and Health Insurance Coverage in the United States," p. 60.
5. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*, September 14, 2005, p. 35, at *www.kff.org/insurance/7315/upload/7315.pdf* (August 28, 2006).

*Third,* the data show that many lower-income workers are heavily disadvantaged in the employer-based system. The employer-based tax exclusion for health insurance benefits allows workers who obtain coverage through the workplace to exclude the value of such compensation from their taxable income. Since lower-income workers pay lower taxes, their tax benefit is relatively small, whereas higher-income workers who pay higher taxes benefit most from this tax preference. According to the Lewin Group, a nationally prominent econometrics firm, families with incomes above $100,000 received an average annual tax benefit of $2,680 from the employer exclusion in 2004, while families with incomes less than $10,000 received an average of $102 in tax relief from the exclusion.[7] Thus, those workers who need the most help get the smallest tax benefit.

## More Affordable Coverage Options

The open-ended nature of the employer exclusion contributes to overall rising health care costs. The Lewin analysis estimated that the total tax benefit for the employer exclusion topped $101 billion in 2004, making it the largest of all federal tax-exempt health benefits.[8] Since most workers are isolated from the true cost of their health care coverage, the incentives of the existing system increase the demand for more generous benefits.

However, employers, who face perpetual annual premium increases, struggle to sustain such trends. In 2005, premiums for employer-sponsored coverage rose an average of 9 percent.[9] Albeit slower than previous years, this is still a substantial increase. The Employer Health Benefits Annual Survey estimates that the average annual premium in 2005 was $10,880 for a family employer-based policy and $4,024 for an individual employer-based policy.[10] In response, some employers have adopted consumer-directed health insurance products, such as health savings accounts, which engage workers in helping to moderate health care spending.

There are, of course, more affordable alternatives to standard employer-based health insurance coverage, which is often cited as the routine cost of coverage. An America's Health Insurance Plans survey found that the average annual premium in the individual market was $4,424 for a family policy and $2,268 for a single policy.[11] These are dramatic differences in cost. Given the opportunity to buy coverage for themselves, especially with the direct assistance of a federal health care tax credit, individuals and families could shop for plans and choose policies that best met their needs in terms of price and value.

## Crowding Out Private Coverage

On the left, many health care policy analysts often promote the role that government health care programs can play in absorbing individuals who have lost employment-based coverage, arguing that expanding government-run health care programs protects more individuals from joining the ranks of the uninsured. Often overlooked in these policy recommendations, however, is that public program expansions often supplant or "crowd out" private coverage, particularly among lower-income work-

6. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey," Employee Benefit Research Institute *Issue Brief* No. 287, November 2005, pp. 15 and 17, at *www.ebri.org/pdf/briefspdf/EBRI_IB_11-20051.pdf* (August 28, 2006).
7. John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs Web Exclusive*, February 25, 2004, pp. W4-109–W4-110, at *http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.pdf* (August 28, 2006).
8. Federal and state tax expenditures for health care totaled $210 billion in 2004. Sheils and Haught, "The Cost of Tax-Exempt Health Benefits in 2004," p. W4-110.
9. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*, p. 17.
10. *Ibid.*, p. 16.
11. America's Health Insurance Plans, Center for Policy and Research, "Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits," August 2005, p. 1, at *www.ahipresearch.org/pdfs/Individual_Insurance_Survey_Report8-26-2005.pdf* (August 28, 2006).

ing families. Outside of a narrow ideological preference for government-run health care, it is hard to imagine why responsible lawmakers would passively watch taxpayer-funded public coverage expand at the expense of privately financed health insurance.

Over the years, dependence on public coverage, specifically Medicaid and the State Children's Health Insurance Program (SCHIP), has increased. According to census estimates, almost 13 percent of people were dependent on Medicaid or SCHIP coverage in 2005, compared to 9.7 percent in 1990.[12] However, greater dependence on government-run public health programs such as Medicaid and SCHIP to solve the deficiencies in the current health system is a poor solution. These public programs have expanded beyond their original intent, are fiscally unsustainable, and often deliver poor-quality care.[13]

Instead of following the model of welfare reform, which was designed to move people from public welfare programs into the private economy, many states address the growing number of uninsured by expanding eligibility for these public health programs. This is especially evident among children. Twelve states have Medicaid or SCHIP eligibility of children above 200 percent of the federal poverty level. Of those, six set eligibility at or above 300 percent of the poverty level.[14] Moreover, these government-run health care programs are not immune to rising health care costs. Spending grew by 7.9 percent in 2004, totaling $292 billion in federal and state expenditures, and is projected to reach $320 billion by 2006 and $670 billion by 2015.[15]

Fiscally responsible lawmakers, regardless of political party, should be worried about these trends, which are a result of the health care status quo. Such trends not only expand government control over a larger number of working American families, but also jeopardize care for the very poorest Americans—precisely those whom these government programs were intended to serve.

## Key Components of the TEA Act

The federal tax code sharply discriminates against those who are without employer-based coverage. The Tax Equity and Affordability Act would rectify this inequity by creating a new tax mechanism for the individual purchase of health insurance. The TEA Act would establish a universal system of refundable, advanceable tax credits for working Americans without employer-based coverage, enabling them to purchase their own private health care coverage.[16] This new tax system would also deter the incremental expansion (and growing tax burdens) of government health care programs.

Individuals earning between $15,000 and $30,000 would receive a $2,000 tax credit. Families earning between $30,000 and $60,000 would receive a $4,000 tax credit. Individuals and families earning above these income levels would receive a smaller tax credit that would mimic the current value of the employer exclusion. Individuals earning above $30,000 would receive a $1,250 tax credit, and families earning above $60,000 would receive a $2,500 tax credit.[17]

Finally, the legislation caps the employer exclusion for family coverage at $11,500 and $5,000

12. DeNavas-Walt *et al.*, "Income, Poverty, and Health Insurance Coverage in the United States," p. 60.
13. See Nina Owcharenko, "A Road Map for Medicaid Reform," Heritage Foundation *WebMemo* No. 1863, June 21, 2005, at *www.heritage.org/Research/HealthCare/wm355.cfm.*
14. See Kaiser Family Foundation, "State Health Facts," at *www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&welcome=1&category=Medicaid+%26+SCHIP* (August 28, 2006).
15. Christine Borger, Sheila Smith, Christopher Truffer, Sean Keehan, Andrea Sisko, John Poisal, and M. Kent Clemens, "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs*, Vol. 25, No. 2 (2006), p. w67, at *http://content.healthaffairs.org/cgi/reprint/25/2/w61* (August 28, 2006).
16. "Refundable" means that individuals would receive the full credit regardless of their tax liability. "Advanceable" means that individuals receiving the credit would receive it up front, when insurance premiums were due, instead of waiting until the end of the year for a refund.

for self-only employer coverage. This is an important provision that helps to offset the revenue impact of the new health care tax credits, targeting those who need it most, and encourage stability and control over the rising cost of employer-sponsored coverage.[18]

## Key Benefits of the TEA Act

The TEA Act accomplishes more than just providing a tax subsidy for individuals to purchase their own health insurance. It achieves several important policy goals that will begin to transform the health care system into a consumer-based system in which individuals can regain control of their health care needs.

- **Fairness.** The TEA Act would level the playing field between those with the generous employer-based tax treatment and those without it. First, it would give workers without employer-based coverage a comparable tax benefit to buy their own coverage. Second, it focuses more assistance on lower-income workers, who need it most and—more important—are most at risk of being folded into government-run health care programs such as Medicaid and SCHIP.
- **Choice.** Unlike other health care proposals, the TEA Act does not dictate the types of coverage that individuals can purchase with their tax credits, enabling them to buy the plans that best suit their needs. The same products that are currently available to individuals to purchase without the tax credit would be available with the credit. Moreover, those individuals who purchase a more economical HSA-qualified high-deductible health plan would be able to transfer any remaining tax credit funds into their health savings accounts. For a real market to flourish, consumers must be able to select the products that they deem appropriate, and insurers must be able to design innovative products that meet consumer demand based on price and benefits.
- **Ownership and Portability.** This tax credit option would also allow individuals to own the health care policies that they purchase. Ownership automatically creates a new dynamic in the health care system. Individuals would have a direct impact on the products, services, and delivery of care that are made available to them. After they secure access to health insurance, they would also be able to keep it regardless of any changes in their work status. This would reduce the heavy churning in the existing health insurance system that directly contributes to uninsurance. In other words, personal ownership of health policies would largely resolve the major problems of gaps in health care coverage and the absence of portability. Insurers and providers would also be held accountable for their performance by the patients themselves, not by employers or government bureaucrats.

## Conclusion

Congress has done virtually nothing to address the persistent problem of the uninsured or the pernicious dynamics of the distorted health care market, which frustrates consumer choice and open competition. Current tax and regulatory policies are outdated and growing less relevant to the everyday lives of Americans. Labor markets are increasingly fluid, with millions of Americans changing jobs and even careers, and the older system of employer-based health coverage is declining.

Meanwhile, uninsured individuals and families must often secure medical services through the costly and inefficient system of uncompensated care. Preserving the status quo does nothing to help the uninsured and fuels efforts to expand government-run health care programs, thus increasing government control over the personal health care decisions of Americans.

17. The full credit amounts would gradually be phased down from $2,000 to $1,250 for individuals earning between $15,000 and $30,000 and from $4,000 to $2,500 for families earning between $30,000 and $60,000.
18. The President's Tax Reform Panel also suggested capping the employer exclusion. See President's Advisory Panel on Federal Tax Reform, *Final Report*, November 1, 2005, p. 81, at *www.taxreformpanel.gov/final-report*.

Members of Congress should seize the opportunity to provide individuals with the ability to control their own health care decisions. The TEA Act gives individuals who do not fit into the current health care system an alternative way to secure private health care coverage. The bill embodies sound public policy and is based on free-market principles that promote fairness, choice, and personal ownership.

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