

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 16 - I-99

Subject: Tax Credit Simulation Project

Presented by: Eugene Ogrod, MD, Chair

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1 The general principle of the tax credit proposal contained in AMA policy on individually selected  
2 and owned health insurance is to replace the present exemption from employees' taxable income  
3 of employer-based health benefits with a "refundable" tax credit equal to a percentage of total  
4 spending on health expense coverage by individuals and their employers (Policy H-165.920[12],  
5 AMA Policy Compendium). As described in Council on Medical Service Report 9 (A-98), the  
6 Council continues to believe that a tax credit, rather than the current individual tax exemption, is a  
7 more equitable approach to obtaining health insurance.

8  
9 In preparing CMS Report 9 (A-98), the Council developed recommendations that would establish  
10 a basic policy agenda for change that could be advocated by the AMA. The Council specifically  
11 wanted to avoid the development of a detailed "all or nothing" agenda that would be inflexible  
12 and perceived as a return to the massively complicated health system reform proposal debated  
13 and rejected by Congress and the public in 1993. As a result, details of the tax credit proposal,  
14 as well as the sequence for transition to the system outlined in CMS Report 9 (A-98), were left  
15 unspecified. For example, the report did not address guidance on the size of a tax credit or a  
16 specific formula for calculating the tax credit.

17  
18 During the past year, several legislative proposals have been introduced that share conceptual  
19 elements with the AMA's tax credit proposal. As this issue continues to "ripen" and emerge as  
20 significant legislation, in terms of Congressional leadership support or committee recognition, the  
21 Council believes that the AMA will need to be in an optimal position to be an active participant in  
22 directing the debate, and in evaluating the estimated impact of the specific elements in the  
23 proposals under consideration.

24  
25 In cooperation with the Council on Medical Service, the AMA Center for Health Policy Research  
26 has initiated a Tax Credit Simulation Project in order to develop economic modeling and  
27 simulation capabilities for assessing the impact of alternative tax-credit options and proposals.  
28 The key components to be examined in the simulation model include the following:

- 29
- 30 • change the deduction from taxable income for health expense coverage in the current tax  
31 structure to a refundable tax credit which reduces tax liability;
  - 32
  - 33 • provide tax equity between employer-provided and individually purchased health coverage;
  - 34
  - 35 • implement a refundable tax credit with sufficient incentive for consumers to purchase an  
36 adequate level of coverage/benefits, with a defined employer contribution to partially offset  
37 the premium for the chosen plan;

- 1 • target larger health insurance refundable tax credits toward low-wage employees and low-  
2 income families as opposed to the current system that gives the largest health insurance tax  
3 benefits to the highest-income families;  
4
- 5 • implement uniform employer defined contributions across plans, but allow direct contributions  
6 to vary by employee based on the individual's health risk;  
7
- 8 • extend refundable tax credit for all spending on coverage, whether contributed by employee or  
9 employer;  
10
- 11 • maintain the current aggregate compensation levels when employer contributions are  
12 eliminated; and  
13
- 14 • exempt employee and employer contributions from FICA and unemployment taxes.  
15

16 This report, which is presented for the information of the House of Delegates, presents a  
17 preliminary examination of the economic issues in evaluating alternative proposals for providing  
18 individuals with a tax credit for the purchase of health insurance. Specifically, the report  
19 summarizes existing research, outlines an analytical framework for examining alternative tax  
20 credit proposals, describes the current employer-based health insurance system, and presents  
21 estimates from the first stage of the simulation model.  
22

### 23 EXISTING RESEARCH 24

25 Including employer contributions for health insurance coverage in employees' taxable income  
26 changes the after-tax price of health insurance relative to the prices of wage benefits and  
27 retirement benefits, regardless of whether or not the firm contributes to employees' health  
28 insurance coverage as part of total compensation. Increases in the after-tax price of health  
29 insurance coverage tend to reduce the demand for health insurance as workers substitute other  
30 forms of compensation for health insurance. The change in the after-tax price of health insurance  
31 will depend upon the federal and state marginal tax rates and the pay-roll tax rate. Providing  
32 a refundable tax credit for the purchase of insurance creates a counter-balancing effect that  
33 influences the demands for each of the benefits in a worker's compensation package. The  
34 refundable tax credit is much like a tax rebate and is expected to increase the demand for coverage.  
35

36 For those with employer-based coverage, the net-effect of treating employer contributions for the  
37 purchase of health insurance as taxable income and providing a refundable tax credit on the  
38 demand for coverage is unclear. For a given level tax credit, higher-income families may receive a  
39 lower tax subsidy than under current law. Lower-income families will see increased benefits or  
40 receive a tax credit. For those currently without coverage, the positive effect of the refundable  
41 tax credit on income is expected to increase the amount of coverage purchased. The amount of  
42 insurance that could be purchased with the credit will vary across small-employer and individual  
43 insurance markets (Chernew, Frick and McLaughlin, 1997; Liu and Christianson, 1996; Feldman,  
44 Dowd, Leitz and Blewett, 1997; and Marquis and Long, 1995).

1 The existing research suggests that changing the tax-favored status of employer contributions for  
2 health insurance and other fringe benefits not only affects household income, but also changes the  
3 incentives employers have to offer benefit coverage and influences the contribution levels, mix of  
4 benefits, and possibly total compensation. Estimates of the impact of a tax credit on employer  
5 costs, however, are mixed. Lewin-VHI (March 1994) estimated that the refundable tax credit  
6 described below would increase employer costs by 4.6%. Woodbury and Huang (1991) estimated  
7 that taxing health insurance contributions would reduce real expenditures on health insurance by  
8 13.9%, during the 1969-1982 time period, and would reduce real expenditures on health insurance  
9 by nearly 9% (annually) under the 1986 tax reform.

10  
11 Woodbury and Huang also account for the substitutions among wages, health benefits and pension  
12 benefits. Real expenditures on wages and retirement benefits also were found to decline when  
13 health insurance contributions are included in taxable income. The trade-off among the  
14 components of total compensation has not been addressed in any other research identified. The  
15 impact of changing the tax provisions of employer contributions for health insurance coverage on  
16 each of these components of compensation will be of primary interest to the stakeholders in the  
17 system. The changes also will play an important part in developing specific elements of the  
18 defined contribution principles outlined in Policy H-165.920.

## 19 20 METHODS

21  
22 The unit of observation in the analysis of health insurance coverage can vary from individual  
23 coverage, family coverage, or some "health insurance unit." The last two units for analysis are  
24 typically composed of the policyholder, his or her spouse, and the children in specified age  
25 categories. Nationally representative samples of the U.S. population are available in the March  
26 Current Population Survey (CPS) and the Medical Expenditure Panel Survey (MEPS). Data from  
27 the CPS and MEPS can be used to identify the populations eligible for the health expense tax  
28 credit, and estimate the number and distribution of persons by health insurance status broken out  
29 by household characteristics (e.g., income category) and employment characteristics.

30  
31 The mathematical representation of the proposed changes in the income tax structure and the  
32 behavioral relationships among the key components of Policy H-165.920 will be developed in  
33 stages. The first stage of the simulation will be performed using data from the CPS and other  
34 sources which have been aggregated to income category or bracket averages. The parameters  
35 measuring the relationships among the variables in the model will be derived from published  
36 sources. The outcome variables from this stage of modeling include changes in the distribution of  
37 tax-credit from employer-based coverage. In the later stages, the simulation project will examine  
38 the relation between benefit levels and the tax liability as influenced by a variety of economic and  
39 demographic variables.

40  
41 By nature, the aggregate level analysis from the first stage of the project does not provide a means  
42 to rigorously identify the economic and demographic characteristics that affect the decision to  
43 obtain health insurance coverage. For example, important factors include wages, family size and  
44 age distribution, health insurance premium, employee share of premium, tax rate, benefit level and  
45 mix, and other employment characteristics. This is the kind of detailed information needed to  
46 develop

1 a specific tax-credit reform proposal with components targeted to corresponding subsets of the  
2 population. From this analysis it is possible to examine various breakouts (e.g., by population  
3 sub-group, state and region, and industry) of the insured and uninsured populations.  
4

5 Future stages of the Tax Credit Simulation Project will focus on developing empirical economic  
6 models of individual and family health insurance coverage decisions. The results of the modeling  
7 procedures will be used to simulate the impact of alternative tax credit reforms on insurance  
8 coverage and the other outcome variables (e.g., tax revenues, and fringe benefit compensation  
9 shares). The AMA Center for Health Policy Research is working with a consulting firm to  
10 construct a database from the CPS for estimating these models. The database will be expanded by  
11 linking the CPS database to health care expenditure and health insurance premium data from  
12 MEPS and other sources.  
13

#### 14 EMPLOYMENT-BASED HEALTH INSURANCE COVERAGE

15  
16 Table 1 presents the distribution of nonelderly persons covered by employer-based health  
17 insurance, the percentage of persons in each income category with employer-based coverage, and  
18 the average premium for health insurance by family income, in 1997. The percentage of  
19 nonelderly in each category covered by employer-based coverage increases with income. While  
20 12% of individuals in families with income no greater than \$10,000 have coverage, 90% of  
21 individuals in families with income of \$200,000 or more have coverage from employers. The  
22 health insurance premium also rises with income. For families with income of \$10,000 or less, the  
23 average premium is \$1,861. The average premium for employer-based coverage is over \$7,000 for  
24 families with income of \$200,000 or more.  
25

#### 26 SUBSIDY FROM EMPLOYMENT-BASED HEALTH INSURANCE COVERAGE

27  
28 Exempting health benefits (i.e., premiums, flexible spending accounts, out-of-pocket expenditures  
29 in excess of 7.5% of adjusted gross income, etc.) from taxes has been estimated to cost the federal  
30 government as much as \$111.2 billion (Sheils and Hogan, 1999). The portion of that federal  
31 revenue foregone or “tax subsidy” from employer-based health insurance is determined by the  
32 effective average tax rate (CBO, 1998a), the premium for health insurance, and the share of the  
33 premium paid by the employer (Rice, et. al., 1998). Multiplying the average value for each of the  
34 variables in an income category would give the average subsidy per family in that income  
35 category.  
36

37 Table 2 presents the distribution of the federal tax subsidy from employer-based health insurance  
38 coverage, by family income. Under current law the tax subsidy rises with income (see Exhibit 1).  
39 The subsidy rises from \$169 per family with income of \$10,000 or less, to \$2,024 for families in  
40 the \$200,000 or more income category. This is because tax rates, premiums and employer  
41 contributions are generally higher among higher income families. The largest share of the total tax  
42 subsidy, 25% or over \$16 billion, is received by families with incomes between \$50,000 and  
43 \$75,000 (see Exhibit 2).

1 EMPLOYMENT-BASED HEALTH INSURANCE TAX CREDIT REFORMS

2  
 3 Several reform schemes to treat employer contributions to health insurance as taxable income  
 4 and provide a tax credit for the purchase of health insurance have been proposed. There is little  
 5 agreement, however, on the rule or formula for calculating the dollar value of the tax credit. One  
 6 approach would be to propose a level or flat credit. For example, the value of the credit could be  
 7 set at the average tax subsidy received by those currently with employer-based coverage. The  
 8 National Center for Policy Analysis estimates this to be \$500 per person (National Center for  
 9 Policy Analysis, 1997.) Alternative credits, \$800 per person, have been proposed by the Council  
 10 for Affordable Health Insurance. The formula also could be specified so that the credit varies  
 11 inversely with gross income. For example, if health coverage expenses were either below 10%  
 12 of gross income, between 10% and 20% of gross income, or over 20% of gross income, the  
 13 percent reimbursed or credited would be 25%, 50%, and 75%, respectively (Lewin-VHI, 1994).  
 14 A means test based on family income as a percentage of the poverty guidelines also could be used  
 15 (CBO, 1998b).

16  
 17 To illustrate the impact of changing the tax-exempt status of employer contributions to health  
 18 insurance, two simple tax-credit proposals can be compared. Both would treat employer  
 19 contributions for health insurance as taxable income and provide a level credit (i.e., the credit  
 20 does not vary with income). The first proposal provides a \$750 credit for the policyholder and  
 21 an additional \$250 credit for each dependent. A second proposal would provide a \$250 tax credit  
 22 per covered person. Table 3 presents the average tax subsidy, the change in tax subsidy and the  
 23 change in federal tax revenues under the two proposals. Compared to current law, the \$750/\$250  
 24 credit proposal increases the tax subsidy \$89 per family on average, and reduces federal tax  
 25 revenues by \$5.6 billion. This \$89 represents an increase in after tax income for the average  
 26 family. The \$250 credit proposal decreases the tax subsidy \$411 per family on average, and  
 27 increases federal revenues by more than \$25.5 billion.

28  
 29 The tax subsidies from the two tax-credit proposals also are presented in Exhibit 3. The  
 30 distribution of the subsidy from either proposal is more uniform than under current law as  
 31 presented in Exhibit 1. As illustrated in Exhibit 4, the largest increases in subsidies come at the  
 32 low end of the income distribution and the largest decreases in subsidies come at the high end of  
 33 the income distribution. Relative to current law, families in the lower income categories would  
 34 receive larger subsidies, while families in the higher income categories would see their subsidies  
 35 fall. In fact, families with income of \$75,000 or greater would have their after-tax income fall if  
 36 the \$750/\$250 tax credit proposal became law. Under the \$250 credit proposal, after-tax income  
 37 would fall for all families with income of at least \$20,000.

38  
 39 EXPANDING TAX CREDIT TO UNINSURED

40  
 41 The tax credits for the purchase of health insurance outlined also would be available to those  
 42 without health insurance coverage. Table 4 presents the number of uninsured persons, by percent  
 43 of federal poverty level, potentially impacted by tax credit legislation. The last two columns of  
 44 Table 4 contain estimates of the impact on federal tax revenues of implementing the \$750/\$250  
 45 tax credit and the \$250 tax credit proposals, respectively. If all households currently without  
 46 coverage were to purchase insurance, the \$750/\$250 proposal would result in a revenue loss or  
 47 cost of \$22.8 billion. Combined with the \$5.6 billion subsidy to the insured, the cost of the

1 \$750/\$250 proposal would total \$28.4 billion. In contrast, expanding the \$250 tax credit would  
2 cost \$10.7 billion, but the additional \$25.7 billion taxes paid by those with employer-based  
3 coverage under that proposal would more than offset the cost of expanding the tax credit to the  
4 uninsured. On net, the \$250 tax credit proposal would increase federal tax revenue \$15 billion  
5 (\$25.7 billion in additional revenue minus \$10.7 billion to cover the uninsured).  
6

7 One means to assess the ability of the uninsured to pay for health insurance, even when the  
8 purchase is subsidized with a tax credit, is to examine the share of income needed to purchase a  
9 typical plan. For simplicity, it could be assumed that a “typical” plan has a \$1,800 premium for a  
10 single individual and a \$4,800 premium for family coverage. The tax credit proposal considered  
11 has eligibility tied to household income relative to the federal poverty level, and is similar to that  
12 offered in the bill sponsored by Sen. Jim Jeffords (R-VT). It allows those without employer-based  
13 coverage to purchase health insurance and receive a tax credit of \$1,200 per adult and \$600 for  
14 children. Because the tax credit and health insurance premiums differ significantly between single  
15 individuals and joint and head-of-households, the two categories of tax filers are compared.  
16

17 Income levels and the after-tax premiums as a share of income, by percent of federal poverty level,  
18 under this type of proposal are presented in Table 5. The last two columns show the percentage of  
19 income a single filer, and a joint or head-of-household filer, respectively, would have to allocate to  
20 the purchase of health insurance. For single filers, the after-tax premium would represent between  
21 4% and 7% of income. The after-tax premium for joint and head-of-household filers would be  
22 between 12% and 28% of income. Existing research suggests that people generally do not  
23 purchase health insurance if the premium is more than 5% to 8% of income. Thus, tax credits of  
24 \$1,200 per policy holder and \$600 per dependent may not reduce the after-tax premium enough or  
25 create a large enough incentive to get substantial numbers of low-income families currently  
26 without health insurance to buy coverage.  
27

## 28 CONCLUSION

29

30 The Council on Medical Service continues to believe that the AMA’s proposal to reform the health  
31 insurance system by replacing the present exemption from employees’ taxable income of  
32 employment-based health benefits with a refundable tax credit, and shifting toward individually  
33 selected and owned health insurance, is in the best interests of all Americans. As the information  
34 in this report indicates, however, additional study and policy refinements will be needed to provide  
35 policymakers with the necessary guidance to turn this proposal into reality.  
36

37 The aggregate level estimates presented in this report provide benchmarks for beginning to  
38 evaluate the impact of alternative proposals to reform the tax treatment of employer contributions  
39 for the purchase of health insurance. There is a need, however, to develop individual level models  
40 of the policyholder and family decision to obtain health insurance coverage. Those models are  
41 well suited to account for the offer or access to health insurance, as well as household and labor  
42 market characteristics. For example, offer rates and take-up rates have been found to vary by wage  
43 rates and firm size (Cooper and Schone, 1997; and Rice, et. al., 1998) and are important factors to  
44 be accounted for in the individual level simulation models. In addition, the cost and coverage  
45 impacts of specific characteristics of households as they relate to eligibility (e.g., state and small  
46 group reform initiatives, CHIP eligibility, Medicaid eligibility and expansion, and federal poverty  
47 level eligibility triggers) can only be accurately assessed using more micro level analysis.

1 The Council will continue to work with the AMA Center for Health Policy Research on the Tax  
2 Credit Simulation Project. It is the Council's intent to present a follow-up report to the House of  
3 Delegates at the 2000 Annual Meeting that contains "guiding" policy principles to better evaluate  
4 emerging legislative tax credit proposals.

References and a description of the data sources used in this report are available from the AMA  
Division of Health Policy Studies

**Table 1.** Employment-Based Health Insurance Coverage<sup>a</sup> and Health Insurance Premiums<sup>b</sup>, 1997

Family Income (\$)	Nonelderly Persons with Employment- based Coverage (Millions)	Share with Employment- based Coverage	Average Health Insurance Premium
0 to 10,000	2.9	12%	\$1,861
10,000 to 20,000	9.0	31%	\$2,410
20,000 to 30,000	15.6	54%	\$3,132
30,000 to 40,000	19.4	69%	\$3,712
40,000 to 50,000	19.3	75%	\$4,444
50,000 to 75,000	41.4	82%	\$5,166
75,000 to 100,000	21.6	87%	\$6,112
100,000 to 200,000	17.1	88%	\$6,519
200,000 or More	4.7	90%	\$7,013
<b>All Incomes</b>	<b>151.0</b>		<b>\$4,383</b>

Source: <sup>a</sup>Fronstin, 1998; <sup>b</sup> derived from CBO 1994 and Various KPMG Peat Marwick surveys, see Rice, et. al., 1998.

**Table 2.** Employment-Based Health Insurance Tax Subsidy

Family Income (\$)	Average Tax Subsidy	Average Tax Subsidy per Family Member	Total Tax Subsidy (Millions)	Share of Total Tax Subsidy
0 to 10,000	\$169	\$72	\$209	0.3%
10,000 to 20,000	\$399	\$276	\$2,488	4%
20,000 to 30,000	\$710	\$429	\$6,686	11%
30,000 to 40,000	\$798	\$418	\$8,103	13%
40,000 to 50,000	\$967	\$437	\$8,431	13%
50,000 to 75,000	\$1,171	\$389	\$16,134	25%
75,000 to 100,000	\$1,543	\$470	\$10,139	16%
100,000 to 200,000	\$1,694	\$503	\$8,594	14%
200,000 or More	\$2,024	\$564	\$2,630	4%
<b>All Incomes</b>	<b>\$1,015</b>	<b>\$420</b>	<b>\$63,414</b>	

Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.



**Table 3.** Average Tax Subsidy and Changes in Tax Subsidy for Alternative Tax Credit Proposals

Family Income (\$)	\$750/\$250 Tax Credit Proposal			\$250 Tax Credit Proposal		
	Average Tax Subsidy	Change in Average Tax Subsidy	Change in Federal Tax Revenues (Millions)	Average Tax Subsidy	Change in Average Tax Subsidy	Change in Federal Tax Revenues (Millions)
0 to 10,000	\$1,085	\$917		\$585	\$417	
10,000 to 20,000	\$861	\$462		\$361	-\$38	
20,000 to 30,000	\$914	\$204		\$414	-\$296	
30,000 to 40,000	\$978	\$180		\$478	-\$320	
40,000 to 50,000	\$1,053	\$87		\$553	-\$413	
50,000 to 75,000	\$1,252	\$81		\$752	-\$419	
75,000 to 100,000	\$1,321	-\$222		\$821	-\$722	
100,000 to 200,000	\$1,341	-\$353		\$841	-\$853	
200,000 or More	\$1,397	-\$627		\$897	-\$1,127	
All Incomes	\$1,104	\$89	-\$5,572	\$604	-\$411	\$25,675

Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.

**Table 4.** Expanding the Tax Credit to the Uninsured

Income as a Percent of Poverty	Uninsured Nonelderly Population (Millions)	Uninsured Children (Millions)	Uninsured Nonelderly, Single Filers (Millions)	Uninsured Nonelderly, Joint and H-of-H Filers (Millions)	Cost to Expand \$750/\$250 Tax Credit Proposal (Millions)	Cost to Expand \$250 Tax Credit Proposal (Millions)
< 150%	19.1	5.3	9.1	10.0	\$10,893	\$4,775
150% - 199%	7.7	1.9	3.0	4.7	\$4,172	\$1,925
200% - 399%	16.2	2.7	4.3	11.9	\$7,743	\$4,049
> 399%	0.4	0.8	0.0	0.4	\$169	\$101
Total	43.4	10.7	16.3	27.1	\$22,808	\$10,749

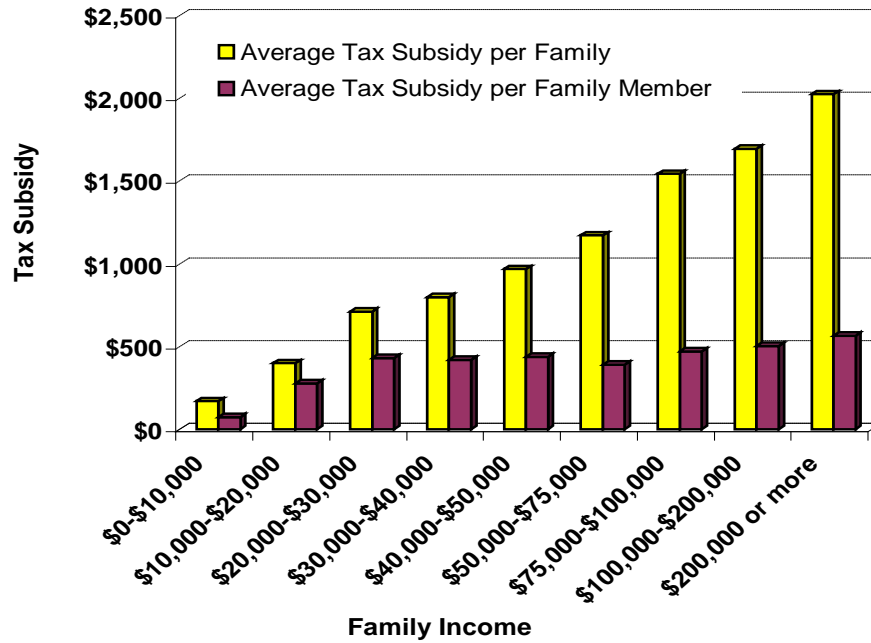
Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999; estimates of the number of uninsured are derived from Government Accounting Office, 1998, and Thorpe 1999.

**Table 5.** Expanding Coverage - After Tax Premium Income Shares

Income as a Percent of Poverty	Income - Single Filer	Income – Joint and Head of Household Filers	Jeffords-like Proposal	
			After Tax Premium as Share of Income – Single Filer	After Tax Premium as Share of Income - Joint and Head of Household Filers
100%	\$8,240	\$10,827	7%	28%
150%	\$12,360	\$17,164	5%	17%
200%	\$16,480	\$23,845	4%	12%

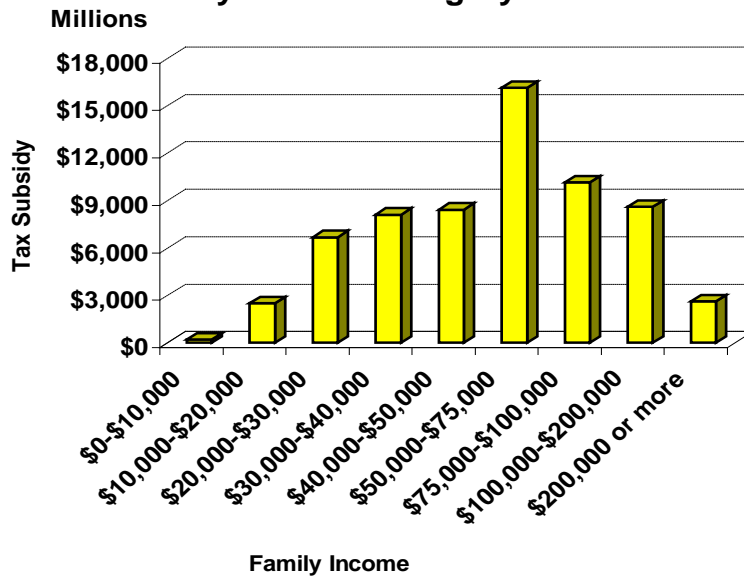
Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.

**Exhibit 1: Average Tax Subsidy Under Current Law, by Income Category**



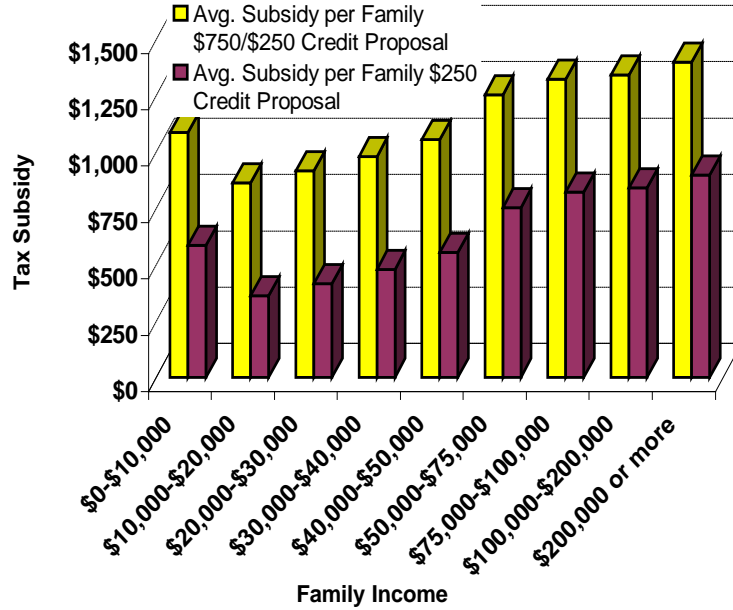
Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.

**Exhibit 2: Total Tax Subsidy Under Current Law, by Income Category**



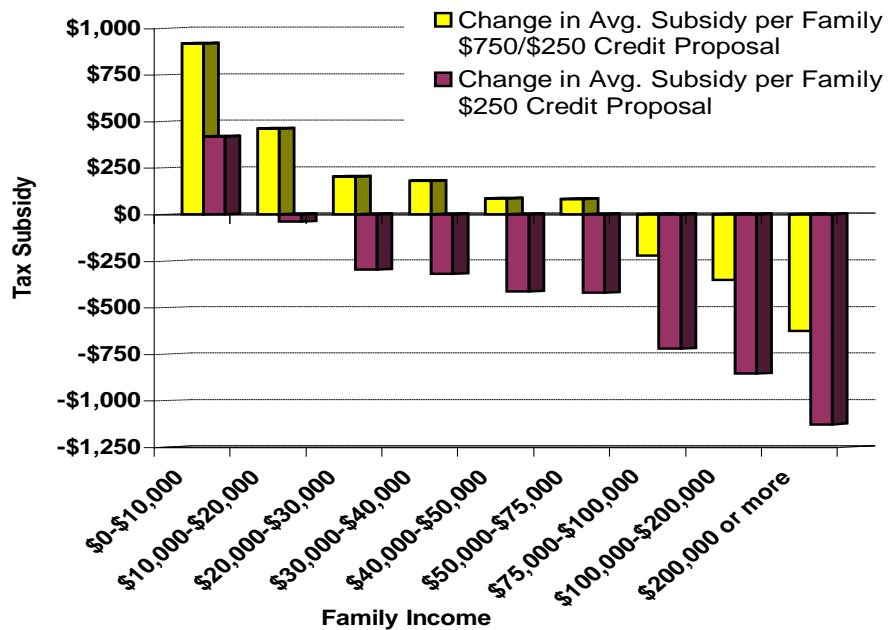
Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.

**Exhibit 3: Average Tax Subsidy - \$750/\$250 and \$250 Credit Proposals, by Income Category**



Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.

**Exhibit 4: Change in Average Tax Subsidy - \$750/\$250 and \$250 Credit Proposals by Income Category**



Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.