

J. Dennis Hastert  
Fourteenth District  
Illinois



(202) 225-0600

Office of the Speaker  
United States House of Representatives  
Washington, DC 20515

October 27, 2000

Honorable William Jefferson Clinton  
President of the United States  
The White House

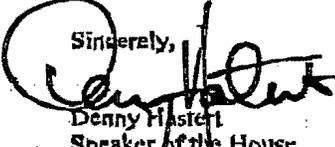
Mr. President:

I was very disappointed to hear your comments today regarding the Taxpayer Relief Act and the Commerce State Justice Appropriations legislation. I am especially disappointed that you have threatened to veto the tax bill that contains so many joint victories for the Congress and your Administration.

While I will not question your motives, I must wonder about the reasons you cite to veto this bill. You said that we did not address the issue of school construction, but we included three provisions that will encourage billions of dollars that will help build schools all across America. In fact, our proposal dedicates more money for school construction than your proposal. You said that we did not address the issue of long-term health care, but we include a \$10,000 tax deduction for people who want to take care of sick parents or disabled children. You said that we did not compromise, but this bill contains the minimum wage increase that you wanted, with the FSLA and FLTA provisions that you found objectionable taken out. You said that this bill helps HMO's, but failed to mention that it helps keep hospitals open, nursing homes open and health plans available to seniors who need health care. Our proposal has been endorsed by close to fifty health care organizations, including the American Cancer Society, the National Kidney Association and the National Association of Rural Health Associations. These organizations know that this bill will help people.

Think of the good that this bill accomplishes. It contains the New Markets/Community Renewal initiative that will help the most impoverished rural and urban communities. We have worked on that bill for so long together, and now you say you will veto it. It contains provisions to encourage retirement savings so that our country will become a nation of savers. It contains tax provisions to help small business survive in the face of additional government regulations. This bill gives individuals the same power to deduct health costs that big corporations currently have.

This bill does so much good, and yet your reasons to veto this bill are so weak. You say that we did not adequately negotiate with House Democrats. It is difficult to negotiate with House Democrats when their leader puts on war paint and wields a spear to show his readiness for battle. Mr. President, this shouldn't be a battle. We should work together to get the nation's work done. This bill is the product of legislative compromise. You didn't get everything you wanted. I didn't get everything I wanted. But in the end, we produced a good bill that deserves your signature. Mr. President, for the good of the American people, for their retirement security, for their health care needs, for their educational needs, for the most impoverished communities in the nation and for minimum wage workers who need a raise, please sign this bill.

Sincerely,  
  
Denny Hastert  
Speaker of the House

J. Dennis Hastert  
Seventh District  
Illinois



(202) 225-0600

Office of the Speaker  
United States House of Representatives  
Washington, DC 20515

October 25, 2000

The Honorable William Jefferson Clinton  
President of the United States  
The White House

Dear Mr. President:

Thank you for your letter today regarding the Taxpayer's Relief Act of 2000. I agree with you that we should work together in a bipartisan fashion, and I believe that this work product is the result of a hard fought compromise. Outside of the concerns you raised in the letter, I would submit that this tax bill does not contain the Marriage Penalty tax relief and the Death Tax relief that you vetoed earlier this year. We in the Congress believe that getting rid of the taxes on death and marriage were plain common sense. You had a different view, and as a result we have not attempted to include those provisions on this tax bill.

We have included the minimum wage increase on this bill as I suggested in my letter to you in August of this year. This minimum wage increase will not include the FLSA or the FUTA provisions because of your objections.

This bill includes the Community Renewal/New Markets initiative that you and I have worked on for over a year. This provision is a remarkable bipartisan victory, which will have an immediate impact on the most distressed urban and rural communities in our nation. You should be proud of your work on this provision. This legislation will include an expansion of the Qualified Zone Academy Bond program created in the 1997 Taxpayer Relief Act, which meets many of the objectives of your school construction proposal. It does this without adding unnecessary costs to school construction, thereby making certain that more money will go to education and less money will go to waste.

We have included the Foreign Sales Corporation change we all agree is necessary. We have also included a long-term health care tax deduction, which you told me was acceptable to your Administration. To deal with the increasing problem of the uninsured, we have included the A+ Health Care deduction, which gives the same deductibility to individuals that big corporations currently enjoy. While we understand your concerns with this proposal, we believe this is an important breakthrough in helping the uninsured pay for health insurance.

Perhaps the most important provision of this bill is the 401(k)IRA expansion bill that enjoyed the overwhelming support of the Congress. This bipartisan provision will give Americans of all ages more resources for their retirement security.

You should be as proud of the many accomplishments that this legislation represents for your priorities, as we in the Congress are proud of the many victories this bill represents for the American people. You may disagree with some of the details in this bill, just as some of our members disagree with other details. But all Americans will see this bill as a victory for common sense, and I urge you to support it.

Sincerely,

Dennis Hastert  
Speaker of the House

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## THE WHITE HOUSE

WASHINGTON

October 25, 2000

The Honorable J. Dennis Hastert  
Speaker of the  
House of Representatives  
Washington, D.C. 20515

Dear Mr. Speaker:

We are well beyond the time when Congress should have finished its work, with many of our most important issues still left unresolved. It is crucial that we now take all possible steps to find common ground.

In that spirit, I would like to put forward a consensus tax offer to help resolve the impasse on taxes. This offer does not contain everything that my Administration and Congressional Democrats would prefer; nor does it contain all that Congressional Republicans hope to see. Rather, it recognizes that both sides need to give a little in order to accomplish bipartisan tax legislation this year and that we should keep the overall tax cut size to an amount that ensures we continue on our path of debt reduction and fiscal discipline.

First, we can raise the minimum wage without eroding traditional worker protections, while at the same time providing reasonable and targeted tax relief for small businesses. Accordingly, in exchange for my proposed minimum wage increase, I would accept the core elements of Speaker Hastert's offer on a small business tax package, costing approximately \$30 billion over 10 years, provided that the FLSA and FUTA provisions are eliminated, the welfare-to-work tax credit is extended, and modifications are made to the meals and entertainment deduction and amortization of reforestation expenses. I discuss your health care proposal later in this letter.

Second, it is essential that the Labor/HHS bill include the Rangel/Johnson proposal to build and modernize 6000 schools through \$24.8 billion in school construction financing, costing \$8.5 billion over 10 years. Considering the estimated need for \$125 billion to meet our nation's demand for safe and modern schools, this proposal is the least we should do for our children.

Third, the offer includes pension legislation adopted by the House and Senate, costing about \$50-60 billion over 10 years, provided that certain modifications that the Treasury Department has discussed with the tax-writing committees are made to ensure that employer-provided pensions for workers are not harmed, to provide meaningful protections for workers affected by cash balance conversions, and to provide progressive savings incentives for low- and moderate-income workers.

Fourth, the package includes the tax and other incentives from the bipartisan New Markets/Community Renewal legislation, at a cost of about \$25 billion over 10 years, with some changes that we have previously discussed and other associated items upon which we can agree. This will be an historic commitment to expand the promise of free enterprise and entrepreneurship to our nation's poor and underserved urban and rural areas.

It is also important that we provide the bipartisan credit for vaccine research and purchases, which will save lives and advance public health, costing about \$1.5 billion over 10 years.

Finally, it is essential for our commitment to economic growth to include the replacement of the Foreign Sales Corporation regime, which has passed the House and Senate with broad bipartisan support, costing about \$4.5 billion over 10 years.

I believe the package I have outlined above can be the basis for bipartisan consensus on a tax package.

While Congress has failed to send me a strong, enforceable Patients' Bill of Rights and a voluntary Medicare prescription drug plan for all seniors, I believe it is possible to forge a bipartisan agreement that would expand health care coverage for uninsured working Americans. The best way to do this is through the FamilyCare plan that builds on the successful Children's Health Insurance Program and expands affordable insurance to over four million parents. A deduction for the purchase of private health insurance in the individual nongroup market is an inefficient and costly way to do coverage, is far less equitable than other options that use refundable tax credits, and could lead to private employers dropping health coverage. However, in the spirit of bipartisanship and breaking gridlock, I propose that your deduction be modified to a credit with necessary consumer protections in the individual insurance markets and that the credit be coupled with the bipartisan FamilyCare proposal.

3

I further believe we should find a common agreement to ease the burden of long-term care on American families. The best means to accomplish this goal is through our proposal to provide a \$3,000 tax credit for people with long-term care needs or the families who care for them. This tax credit would provide immediate assistance to those burdened by these long-term care costs today. While I cannot support your proposal to turn this into a deduction, on grounds of both equity and effectiveness, if you are willing to support our \$3,000 tax credit, I would be willing to agree to your proposal to provide an enhanced deduction for the purchase of private long-term care insurance provided there are appropriate consumer protections. This bipartisan, long-term care package has already been endorsed by the AARP, the Alzheimer's Association, and the Health Insurance Association of America.

In the spirit of compromise, I believe we can work together quickly to pass this balanced legislation that I can sign into law and that can benefit the American people.

Sincerely,

*Bill Clinton*

## A Senseless Health Deduction

The House speaker, Dennis Hastert, called this week for President Clinton and the Democrats to help Republicans pass a tax deduction for uninsured families that buy health policies with little or no help from their employers. The Democrats should not take the invitation seriously. ~~The proposed tax deduction would be ineffective, expensive, and stacked in favor of high-income families.~~

The Republicans propose to give individuals who buy coverage on their own, or who pay for half or more of their employer-provided coverage, a 100 percent tax deduction. The idea, say the Republicans, is to give those whose employers do not chip in much for coverage the same break as people who work for employers that do provide ample coverage.

But as recent estimates by Prof. Jonathan Gruber of M.I.T. show, tax deductions do almost nothing to persuade the uninsured to buy coverage. About 90 percent of the tax cut will go to individuals who are already buying coverage without the government's help. ~~A tax deduction provides no financial relief to families that do not pay taxes, and it saves other low-income families a mere 15 cents for~~

~~every dollar spent on premiums. Those two categories include some 95 percent of the nation's uninsured families. The Republican proposal will cost \$40 billion over 10 years and yet do almost nothing to reduce the number of uninsured people.~~

If the Republicans truly wanted to help the uninsured, they would propose a refundable tax credit. Tax credits offset the cost of insurance dollar for dollar. For families too poor to owe tax, the credit is provided as a cash payment. Tax credits, unlike deductions, help families at the bottom of the income ladder.

To make a sizable dent in the ranks of the uninsured, Congress would need to pass a large tax credit, costing tens of billions of dollars a year, like that proposed by Bill Bradley during his campaign for president. Short of that, Congress could spend a modest amount of money to expand the existing Children's Health Insurance Program that each state has set up to insure uninsured children. ~~But under no circumstance does it make sense to throw away money on a tax deduction that few low-income families currently without insurance would ever bother to use.~~

The New York Times

SATURDAY, OCTOBER 14, 2000



**DEPARTMENT OF THE TREASURY  
OFFICE OF TAX ANALYSIS**

1500 PENNSYLVANIA AVENUE, NW  
WASHINGTON, DC 20220

Number of pages to follow: 7

Date: October 13, 2000

To: Chris Jennings

Addressee's Fax Number: 456-5557

Addressee's Confirmation Number: 456-5560

From: Len Burman

Deputy Assistant Secretary (Tax Analysis)

Sender's Fax Number: 622-1051

Sender's Confirmation Number: 622-0120

Comments/Special Instructions:

We will send information on refundable credit. Note the talking point that half of uninsured has no tax liability and thus get zero from deduction. Refundable credit is obviously lots better for them. More data on refundable credits will be sent later.

NOTE: THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND/OR RESTRICTED AS TO OR EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. If the recipient of this message is not the addressee (i.e., the intended recipient), you are hereby notified that you should not read this document and that any dissemination, distribution, or copying of this communication except insofar as necessary to deliver this document to the intended recipient, is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone, and you will be provided further instruction about the return or destruction of the this document. Thank you.

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## JCT Scoring on the Above-the-Line Deduction for Purchased Insurance

- The JCT estimate, cited in Mr. Hastert's press release, that 1.6 million currently uninsured persons will purchase health coverage under an above-the-line deduction is too large as it does not take into account the likely response of employers
  - Some employers now providing health benefits would almost certainly cease to do so were additional tax benefits provided to those purchasing health coverage individually
- Outside experts estimate that the number of newly insured after implementation of an above-the-line deduction will be much smaller
  - A study by Professor Jonathan Gruber of MIT finds that an above-the-line deduction would result in extension of coverage to only 580,000 previously uninsured
  - A Kaiser Family Foundation study estimates the number of newly insured, should 80 percent of the cost of health insurance purchased by individuals be made tax deductible, to be only 420,000
- The cost of an above-the-line deduction, measured per newly insured person, is extremely high
  - Using the JCT numbers, the annual revenue cost to the government per newly insured under a fully phased-in program is approximately  $\$11 \text{ billion} / 1.6 \text{ million} = \$6,875$
- In addition, an above-the-line deduction provides the greatest benefits to those with high incomes, who are statistically less likely to be previously uninsured
  - In fact, approximately 50 percent of the uninsured have no present tax liability
- We believe that the administration's proposals would provide assistance to those with the greatest needs in a more efficient fashion
  - Proposed credits would help meet the cost of COBRA continuation coverage and a new Medicare buy-in option, and thereby assist 200,000 persons, mainly downsized workers and early retirees, to maintain high-quality coverage
  - The proposed expansion of the SCHIP program to include parents of eligible children would provide coverage to approximately 3 million low-income adults, 69 percent of whom were previously uninsured
    - According to the Kaiser Family Foundation study, the cost to the government per new insured under this program would be approximately \$2,300 per year

- All of the administration's proposals would work to strengthen rather than undermine the employment-based health insurance market which is at present the only effective risk pooling mechanism, and therefore essential to insuring that less healthy and older American can obtain quality coverage

Conly/Eichner/Toma  
Office of Tax Policy  
October 13, 2000

DEPARTMENT OF THE TREASURY  
WASHINGTON, D.C.

## INFORMATION

ASSISTANT SECRETARY

October 11, 2000

MEMORANDUM FOR SECRETARY SUMMERS  
DEPUTY SECRETARY EIZENSTAT

FROM:

Jon Talisman *JT*  
David Wilcox *DW*  
Len Burman *LEB*  
Douglas Elmendorf *DE*

SUBJECT:

**Expanding Health Coverage: SCHIP versus Tax Incentives**

You asked about the relative merits of increasing health coverage through SCHIP expansions versus new tax incentives. We believe that SCHIP expansion is a better approach in terms of targeting, quality of insurance, ease of administration, and federal cost. This memo elaborates on those points.

- **The primary advantage of SCHIP expansion compared with most tax proposals is that it would more effectively target available resources to low-income people. Although a refundable tax credit could be designed to aid a similar group, credits are likely to be less effective at expanding coverage, and would raise other administrative issues.**
- Low-income people are much less likely to have private health insurance. Targeting any new subsidy toward low-income people would thus maximize the number of people who gain coverage and minimize the number of people who lose coverage as a consequence of adverse selection within employer groups (see below).
- A **tax deduction** for the purchase of health insurance is poorly targeted. It would provide the largest subsidy for households with the highest incomes, and little or no subsidy for most uninsured individuals. Half of the uninsured have no income tax liability and thus receive no benefit from a tax deduction.
- A **nonrefundable tax credit** would be much better targeted than a deduction. Qualifying households whose tax liability is as large as the credit would all receive the full value of the subsidy. However, a nonrefundable credit would provide no subsidy for households with zero tax liability, and a reduced subsidy for households with liability less than the credit. Credits would have to be very large to mirror the value of

proposed SCHIP expansions and significantly reduce the number of uninsured. Even then, most people who would qualify for a targeted credit would receive less than the full subsidy because they have little or no tax liability.

- **A refundable (or transferable) tax credit** would provide the same subsidy for all households regardless of their tax liability. However, this approach would still not be targeted as well as SCHIP:

- For political reasons it may be difficult to limit a tax credit (refundable or not) to the SCHIP income range. But if credits are made available to middle-income and high-income individuals, who usually have access to employment-based health insurance, some employers may drop coverage because the healthiest employees could choose to purchase insurance outside the employer group. Moreover, some employees may drop their employer's health insurance if adverse selection causes premiums to increase.

- Since people would receive credit amounts long after they paid for health insurance, tax credits might do little to induce cash-strapped families to purchase insurance. (If claimants want the credits in real time, it might be possible to let them apply, through a government agency, for a transferable credit. Insurers to whom these credits were then transferred would reduce their tax payments by that amount. This approach combines all the administrative hassles of a voucher program and a tax credit.)

- States have flexibility in administering SCHIP that would not be possible under a tax credit. It would be difficult to design a tax-based subsidy that is responsive to changing family circumstances such as marital status, income, and health insurance coverage. Moreover, unlike SCHIP, a tax-based approach could not adjust for variation across states in income and health costs.

- The outreach apparatus of SCHIP is already in place and is being strengthened.

- **A second advantage of SCHIP expansion compared with tax proposals is that people would end up with better insurance – which might also mitigate the crowding out problem a little.**

- With SCHIP, the states determine the health insurance product, and everyone joins the same insurance pool. As a result, people are prevented from buying a poor product because of ignorance or salesmanship.

- With tax subsidies for private insurance instead, insurers would design their products to try to avoid the sickest people within the pool.
  - Although a tax credit would apply only to "qualified" health insurance, political pressures would probably require that the standard for qualifying be inferior to SCHIP coverage.
  - Insurers might try to avoid adverse selection by offering low-cost "upside-down" policies, which cover the first \$x,000 of health expenses but provide no insurance against high health expenses (similar to current Medigap drug policies). Such insurance attracts a healthier pool and limits a company's exposure to risk.
  - Upside-down insurance would tend to attract healthy people who would otherwise participate in employer pools. Thus, the crowding-out problem is likely to be worse than under SCHIP.
  - If there is substantial adverse selection, tax subsidies that are set equal to *average* insurance premiums for the entire population may fall far short of the *actual* insurance premium that less healthy individuals pay. To avoid this problem, significant health insurance regulation would be needed – which would be very difficult to design and to administer.
- Of course, there is also a downside to standardization under SCHIP: people cannot choose insurance policies in accord with their preferences for risk. However, society may have good reason to require minimum benefits to protect children and other vulnerable groups.
- **A third advantage of SCHIP expansion compared with tax proposals is lower administrative costs.**
  - Refundable tax credits create serious administrative problems for the IRS and have a substantial potential for abuse. Expansions of SCHIP would raise similar issues, but SCHIP has an existing administrative apparatus that could handle many of these problems at lower additional cost.
    - Refundable credits for individuals who are not otherwise required to file tax returns increase the IRS's administrative burden. Although many low-income working families currently file tax returns (often to claim the EITC), other low-income families are more likely to interact with state welfare agencies than the IRS.

- Determining eligibility for a tax credit would also be difficult for the IRS. In particular, verifying the purchase of qualified health insurance and receipt of other employer or public subsidies raises issues beyond those now encountered with the EITC.
  - If transferable tax credits were provided, they would require an additional administrative mechanism.
  - A credit to cover the full cost of family health insurance could be as large as \$6,000 – which would create a substantial incentive for abuse by ineligible individuals.
  - In contrast, SCHIP could be modified at less cost to raise the income limit or to offer coverage to the parents of children currently eligible (as in the Administration's FamilyCare proposal).
- **A fourth advantage of SCHIP expansion from the federal perspective is that states contribute part of the subsidy.**
  - **Despite these differences between SCHIP expansion and tax proposals, there is no magic bullet to avoid crowding out existing health insurance coverage.**
    - Many near-poor families lack health insurance – but many are insured as well. The fundamental problem in expanding coverage is that programs that encourage the uninsured to buy coverage inevitably encourage others to leave their existing coverage. For example, the Medicaid expansions of a decade ago appear to have significantly crowded out private coverage.
    - Crowding out of private insurance has two main consequences:
      - The net increase in coverage per dollar spent is likely to be small for two reasons. First, the gain in coverage for people who take advantage of the subsidy is offset in large part (or even entirely) by other people losing coverage (the numerator is small). Second, benefits are provided to many people who are currently insured (the denominator is large).
      - An unraveling of employer-sponsored insurance will cause some people who are not eligible for the newly subsidized insurance to lose insurance or pay more for it. Depending on the magnitude and phase-out of the subsidy, many people might lose coverage.

- To limit crowd out and cost, any targeted subsidy – SCHIP or tax-based – needs to be phased out as income rises. Because a meaningful subsidy must be large, phasing it out quickly could create high implicit marginal tax rates – while phasing it out slowly would worsen crowd-out.
- Expanding insurance coverage by increasing take-up of existing programs makes sense, although it is difficult. The Administration included several budget proposals for strengthening SCHIP outreach.
- Expanding SCHIP eligibility to low-income adults without children also makes sense. This approach would be well targeted, provide horizontal equity, increase the quality of early pre-natal care, and cause less crowd-out than pushing eligibility further up the income distribution for families with children.

## Above-the-line Health Insurance Deduction and Coverage

- According to the Joint Committee on Taxation, an above-the-line deduction as specified in the Patients' Bill of Rights would increase the number of insured individuals by 1.6 million in 2007.
  - However, this estimate assumes that an above-the-line deduction would have no impact on employer-provided health insurance. An assumption that we and other experts believe to be erroneous.
- According to Treasury estimates, 1.2 million additional individuals would purchase health insurance directly from insurers, but 600,000 individuals would lose employer-provided health insurance for a net 600,000 in increased coverage in 2010.
  - As a result, the proposal has winners and losers.
- Jonathan Gruber of MIT estimated that net coverage would increase by 250,000 under a slightly different deduction proposal.
  - Although Gruber did take into account some employer and employee dropping, he did not take into account second round effects that may lead to even more dropping in the long run. He agrees that these second round effects are important and need to be taken into consideration.
- There is considerable uncertainty in estimating the impact of an above-the-line deduction and it is quite plausible that the number of insured could even decrease. For example, under alternative reasonable assumptions the net change could be an increase of 1.1 million insured individuals or a decrease of 2.0 million insured individuals.
- A recent report by the Council of Economic Advisors, "Reaching the Uninsured: Alternative Approaches to Expanding Health Insurance Access" concludes that "tax deductions will do little to improve coverage". The report goes on to say that "direct provision of health insurance through public programs is the most efficient way of targeting low-income families", a group that comprises the bulk of the uninsured.
  - The Administration's FamilyCare proposal that expands health insurance coverage to parents of children in the SCHIP and Medicaid program would increase coverage by 5 million individuals.

### Background:

Henry Aaron of the Brookings Institution and discussant of the Gruber paper at a National Tax Association conference believes that Gruber underestimated employer and employee dropping.

## **Above-the-Line Deduction for Individually-Purchased Health Insurance**

### **Proposal**

Under the provisions, individuals would be allowed to claim an above-the-line deduction for individually-purchased health insurance. The deduction would also be available for the employee share of premiums for insurance provided by employer, as long as the employer share does not exceed 50% of the plan cost.

**Position:** Oppose.

### **Issues**

- **A tax deduction creates new inequities.** Although the proposal increases equity for individuals in similar income groups, it broadens tax preferences which are by design worth much less to low- and moderate-income individuals than to higher income individuals.
  - Under a progressive tax system the benefits of a deduction increase with income.
  - About half of uninsured individuals have no income tax liability.
- **Ineffective at increasing coverage.** The deduction will provide a large windfall to many who already have health insurance while producing at most a small net increase in the number of covered individuals.
  - The cost of comprehensive family coverage is quite high, typically exceeding \$5,000 per year, yet the value of the deduction to low-income families who are most likely to be uninsured is small or non-existent. Even with a tax deduction, health insurance will still be unaffordable for most uninsured individuals. According to analysis by the Congressional Budget Office "subsidies approaching the full cost of insurance might be necessary to induce most low-income people who were uninsured to purchase coverage..."
- **Cost per newly insured.** The cost of the proposal per newly insured individual is expected to be at least \$18,000 at 2010 levels. According to a study of a slightly different proposal in which the deduction was allowed only for non-employer insurance, the cost per newly insured individual would be \$3,544 at 1999 levels. At 2010 levels this would be roughly \$7000 per newly insured. The cost of the current proposal per newly insured persons is much higher since roughly 75% of the cost is attributable to persons with employer contributions of less than 50%. It is quite possible that employer dropping of insurance and switching of low cost employees to the individual market will result in a long run net effect of virtually no change in insurance or even a loss. Therefore, the cost per net increase in insurance could be much higher. The high cost occurs because most of the revenue loss is attributable to individuals who are currently insured.

- According to the previously mentioned study, on net only 250,000 additional individuals would become insured. On average, those individuals would have higher income than currently uninsured individuals.
- **Potential to disrupt the employer-provided health insurance system.** A broad, above-the-line deduction has the potential to disrupt the pooling function of employer-sponsored health plans and to encourage employers to reduce contributions.
  - Healthier persons may disproportionately leave employer-sponsored plans, leaving less healthy persons behind to face higher costs or drop coverage.
  - The proposal may provide new incentives for some employers to reduce their contribution toward the cost of health plans.
    - An employer currently paying 60% of the cost can reduce the contribution to 49% and, because of the tax benefit, lower the after-tax cost to employees.
    - A substantial fraction of employees receive employer contributions of sixty percent or less for family plans. Data from the Medical Expenditure Panel Survey indicate that 30 percent of family plans have employer contributions in this range.
    - According to the Employee Benefit Research Institute's (EBRI) analysis of William M. Mercer, Inc. data, large employers requiring employee contributions for family plans pay *on average* 71 percent of premiums for traditional indemnity plans and 62 percent of premiums for preferred provider organizations. Required contributions for health maintenance organization plans and point-of-service plans fall within this range. Clearly, many firms are within striking distance of a 49 percent contribution for family plans.
    - Some employers may choose to eliminate contributions altogether. New firms may not decide to offer coverage. There may be an acceleration of the trend to provide employer insurance to early retirees without an employer contribution.
    - As employers reduce, or eliminate contributions, low risk persons would be further encouraged to leave employer group plans. Many may drop coverage altogether. Under the study cited above, *one million* individuals were estimated to leave employer plans for the nongroup market. An additional *330,000* individuals were estimated to *become uninsured* because of the proposal.
- **Potential downside risk much greater than upside risk.** Both the estimates of the uptake in new coverage and the reduction in coverage are uncertain. However, because employers cover most workers, small changes in employer behavior can have large effects on the number of uninsured. For example, in the previously cited study, only 0.2 percent of individuals with employer-provided health insurance were estimated to lose coverage. If instead, exactly 99.0 percent of individuals with employer-provided health insurance keep

coverage, the net impact of the proposal would increase the number of uninsured by over one million individuals.

- **Better way to increase coverage.** Once a deduction were fully phased in, it would cost at least \$100 billion over a ten year period and expand coverage by less than 750,000 individuals (and possibly even result in a small reduction of coverage over the long run). In contrast, the Administration's proposed State Children's Health Insurance Program (S-CHIP) expansion for parents of eligible children would cost \$76 billion over 10 years, and is estimated to newly insure 4 million people.



October 6, 1999

## **Tax Provisions in "Quality Care for the Uninsured Act"**

### **Largely Benefit High-Income Taxpayers And Do Not Help Most Uninsured**

by Iris J. Lav

When it takes up managed care legislation this week, the House of Representatives is expected to consider a bill that claims to help the nation's uninsured families gain access to health care — H.R. 2990, sponsored by Reps. Jim Talent and John Shaddey. Examination of this bill, however, indicates it would do little to reduce the ranks of the uninsured but would provide a new set of expensive tax breaks that would overwhelmingly benefit higher-income taxpayers who already enjoy adequate health insurance.

Furthermore, the bill's Medical Savings Accounts provisions would risk making insurance more expensive for less healthy individuals. As a consequence, it could result in some individuals who now have insurance becoming uninsured because they could no longer afford health insurance.

The cost of the bill is estimated at approximately \$50 billion over the next 10 years. It would reach more than \$11 billion a year when all of its provisions were fully in effect. This cost is not paid for; it is simply assumed to be covered by the non-Social Security surplus.

That surplus, however, has yet to materialize; projections of a sizeable non-Social Security surplus rest on the assumption that Congress will make substantial cuts in discretionary spending, an assumption that action on the current appropriations bills belies. Whether a non-Social Security surplus of any magnitude will materialize remains to be seen. Furthermore, this bill would make its inadequately designed and targeted tax cuts the first claim on such a surplus, ahead of needs in Social Security, Medicare, other emerging needs, and paying down more of the debt.

The bill would, among other provisions, create a new "above-the-line" deduction for health insurance premiums paid by individuals who purchase their own insurance. It also would allow a deduction for the full cost of premiums paid for long-term care insurance and provide families taking care of an elderly member an extra personal exemption. In addition, it would prematurely end the demonstration period established in the Health Insurance Portability and Accountability Act of 1996 to test the effects of Medical Savings Accounts; it would allow universal access to MSAs and remove a number of safeguards included in the MSA demonstration project currently underway. None of these provisions would or could do much to broaden coverage among the lower-income and less-healthy segments of the population that constitute the bulk of those who currently cannot afford or obtain coverage.

#### **Health Insurance Deductions**

The bill includes a new tax deduction for the purchase of health insurance by taxpayers who pay at least 50 percent of the cost of the premium. At first glance, this deduction may seem an attractive idea. Closer examination indicates, however, that this deduction — which would cost upwards of \$8 billion a year when fully in effect — would provide little help to most of those lacking insurance and would not significantly reduce the ranks of the uninsured.

Census data show that at least 93 percent of uninsured individuals either pay no income tax or are in the 15 percent income tax bracket. For them, this deduction would do little or nothing to make insurance more affordable, since it would reduce the cost of insurance by no more than 15 percent. Those who would benefit most from such a deduction are, by and large, individuals in higher tax brackets who already purchase individual insurance.

- Some 18 million uninsured individuals — 43 percent of all of the non-elderly uninsured — owe no income tax; their earnings are too low for them to incur an income tax liability.<sup>(1)</sup> These uninsured individuals would receive no benefit from a tax deduction; a deduction would do nothing to make health insurance more affordable for them.
- Another 20 million uninsured individuals — 50 percent of the non-elderly people without health insurance — pay income tax at a 15 percent marginal tax rate. A deduction would provide these taxpayers with a subsidy equal to 15 percent of the cost of insurance not covered by an employer. For low- and moderate-income families and individuals without employer-sponsored coverage, a 15 percent subsidy that leaves them with the other 85 percent of the premium cost is much too small a subsidy to make insurance affordable.

For a family earning \$35,000 whose employer does not offer insurance, the proposed deduction would reduce the out-of-pocket cost of a typical family health insurance policy that carries a \$1,000 deductible from \$6,700 to \$5,860 — or from 19 percent of income to 17 percent of income.<sup>(2)</sup> An Urban Institute study shows that more than three-quarters of low- and moderate-income uninsured individuals will not purchase insurance that consumes more than *five* percent of their income.<sup>(3)</sup> Few families that have forgone health coverage because they cannot afford to spend 19 percent of income on it would find coverage affordable because a deduction had lowered its cost to 17 percent of income. (By contrast, the child health block grant established in 1997 set a limit on the premiums and co-payments that can be charged under programs receiving block grant funds, with the limit being *five* percent of income for families above 150 percent of the poverty line and smaller amounts for poorer families.)

- This provision might be of modest help to some moderate-income families whose employer pays half or nearly half of the premium costs since the deduction would be in addition to the employer subsidy. But even families whose employers pay 50 percent of the premium would receive only very modest help from the deduction. The deduction would reduce the proportion of the premium these families have to pay only from 50 percent of the premium to 42.5 percent.

While that might help some families afford insurance, the number of such families likely would be small. Moreover, the deduction could induce some employers currently paying more than 50 percent of premium costs to scale back their contribution to 50 percent (or possibly

less).

- The group that would appear to benefit most from this deduction would be higher-income taxpayers. A health insurance deduction is worth more than twice as much to affluent individuals in the 31 percent, 36 percent, and 39.6 percent brackets than to moderate- and middle-income families in the 15 percent bracket. Although few higher-income individuals and families are uninsured, a significant number do buy insurance on the individual market. Under this provision, these higher-income taxpayers could deduct the cost of the premiums they pay for health insurance coverage that they already have.

### **Long-term Care Insurance Deduction**

The bill also would allow a new deduction for 100 percent of the premiums paid to purchase long-term care insurance. This provision would cost approximately \$2 billion a year when fully in effect.

There are major problems relating to access to long-term care that need to be addressed. This proposal for a deduction for long-term care insurance premiums, however, would not help most middle-income people and could exacerbate the inequities in access and affordability that currently exist.

Three-quarters of all taxpayers — most moderate- and middle-income taxpayers — pay federal income taxes at no higher than the 15 percent marginal tax rate. For this three-quarters of all taxpayers, a deduction would provide at most a subsidy of 15 percent of the cost of purchasing long-term care insurance. Long-term care insurance premiums are relatively expensive, and a 15 percent subsidy is unlikely to make long-term care insurance fit into the budgets of many middle-income families.<sup>(4)</sup>

Here, too, the primary beneficiaries of the proposed deduction are likely to be higher-income taxpayers who currently carry long-term care insurance, and taxpayers in higher tax brackets for whom a 36 percent or 39.6 percent subsidy makes purchase of long-term care insurance an attractive option. But these are likely to be the same taxpayers for whom long-term care access is not a major problem.

### **Additional Personal Exemption for Elderly Care in Home**

H.R. 2990 would establish a new, additional personal exemption that could be taken by taxpayers providing long-term care in their homes for qualified elderly relatives. This sounds as though it would help families that undertake this difficult task. But a personal exemption, like a deduction, is worth more to taxpayers in higher tax brackets than in lower. In 1999, for example, an additional personal exemption is worth \$413 to a taxpayer in the 15 percent tax bracket ( $\$2,750 \times .15 = \$413$ ), while being worth \$990 to a taxpayer in the 36 percent bracket. Again, the families that would receive the most help from this provision are the families that least need the assistance.

### **Medical Savings Accounts**

The bill includes a number of changes in policies relating to Medical Savings Accounts that risk driving up health insurance premiums for individuals who are less healthy than average. In addition, the changes could create a major new tax shelter that circumvents the income limits that govern tax-advantaged deposits to Individual Retirement Accounts.

The bipartisan Health Insurance Portability and Accountability Act of 1996 established a demonstration to test and evaluate Medical Savings Accounts, which are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies. The demonstration is designed to provide information about the effects of MSAs on workers, employers, and insurers without creating widespread irreparable harm to any of the participants or to the insurance market as a whole. Participation in the demonstration is limited to no more than 750,000 participants who are employees of small businesses (businesses with 50 or fewer employees) and self-employed individuals. The demonstration is scheduled to run through December 31, 2000, after which time Congress will be able to examine the evaluation authorized by the 1996 law and determine future policy.

The Talent-Shadegg bill would end the MSA demonstration. It would open up MSAs to use by all individuals and employees, remove the numerical cap on participation, and eliminate the sunset date for MSAs contained in current law.

- Universal availability for MSAs now — before the impact of MSA policy has been studied under more controlled conditions — would mean that any negative consequences that MSAs may have for the insurance market could rapidly become pervasive and difficult to reverse. A significant body of evidence suggests that widespread use of MSAs will lead to "adverse selection" in the insurance market because young, healthy people with low medical costs will choose to use high-deductible insurance policies and MSAs and thereby retain their unspent dollars in their own accounts. This could isolate people who are *less* healthy and have higher medical costs in conventional, low-deductible health insurance plans.
- Such a division of the market would drive up the cost of low-deductible insurance for the less healthy segments of the population who most need it. Research suggests that premiums for conventional insurance could *more than double* if MSA use becomes widespread.<sup>(5)</sup> According to the American Academy of Actuaries, a disproportionate share of those left in conventional insurance would be older employees and pregnant women.

H.R. 2990 also would increase the maximum amount allowed to be deposited each year in the tax-advantaged Medical Savings Accounts. The current demonstration project places strict limitation on such deposits to prevent use of MSAs as general purpose tax shelters.

- MSAs are similar to conventional Individual Retirement Accounts; contributions are deductible from income, and tax is deferred on the amounts the accounts earn. While deposits and earnings are never taxed if MSA funds are used to pay medical costs, the tax advantages of MSAs can be substantial even if the funds in the accounts are later withdrawn and used primarily or exclusively for *non*-medical purposes.
- MSAs differ from IRAs in one key respect — there are no income limits on MSAs that prevent wealthy people from using them as tax shelters. As a result, opening up MSAs to all individuals and increasing the amounts that may be deposited in them, as the proposed legislation would do, would

enable high-income taxpayers who cannot use IRAs because of the income limits to begin using MSAs as significant tax shelters.

The proposed MSA changes also would circumvent the rules under the current MSA demonstration that prevent employers from setting up MSAs in a manner that primarily benefits highly paid executives and effectively discriminates against lower-paid employees.

- Under the MSA demonstration now underway, deposits can be made to an MSA account by either an employer or an individual, but not by both in the same year. The demonstration also includes nondiscrimination rules requiring employers to make comparable contributions for all participating employees.
- The Talent-Shadegg bill would allow both employees and employers to make deposits to an MSA in the same year. That would make the nondiscrimination rules meaningless. An employer could make small, token deposits to the MSA accounts of all employees. Higher-income employees could add substantial additional funds to their accounts and exclude these additional amounts from their taxable income, but most lower-paid staff would not be able to afford substantial additional contributions.

#### Endnotes:

1. General Accounting Office, Letter to The Honorable Daniel Patrick Moynihan, June 10, 1998, GAO/HEHS-98-190R, Enclosure II. The analysis is based on the 1996 Current Population Survey.
2. A General Accounting Office study found that in 1996, the middle of the range of premium costs was \$5,700 for a family-coverage policy that included a \$1,000 deductible. The proposed tax deduction would provide a subsidy of \$840 for the purchase of a policy with a \$5,700 premium (\$840 equals 15 percent of \$5,700). This means the family would have to pay the remaining \$4,860, or 14 percent of its income, to purchase the health insurance policy. Since this premium is for a policy with a \$1,000 deductible, another three percent of income would have to be expended before any benefits would be available. The family's net expenditure for health coverage — the premium plus the deductible — would total \$5,860, or 17 percent of the family's income. Without the proposed tax deduction, the full cost of the policy plus the \$1,000 deductible is equal to 19 percent of the family's income.
3. Leighton Ku, Teresa Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs*, Urban Institute, March 1997.
4. Long-term care premiums vary by the age at which the policy is purchased and the type and amount of long-term care expenses the policy will reimburse. A 1997 study by Consumers Union found premiums at age 55 ranged from \$588 to \$1,474 a year, while premiums at age 65 ranged from \$1,042 to \$3,100 a year. These policies cover individuals, so the costs for a couple would generally be double those amounts. *Consumer Reports*, October 1997.
5. Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *JAMA*, June 5, 1996, p. 1666-71; Len M. Nichols, et. al., *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, The Urban Institute, April 1996; and American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995. The conclusions of these studies are summarized in Iris J. Lav, *MSA Demonstration: Research Suggests Controls Needed To Prevent Adverse Affect on Insurance Market*, Center on Budget and Policy Priorities, July 10, 1996.

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Health

MEMORANDUM TO GENE SPERLING

FROM: EDWIN C. PARK

SUBJECT: HEALTH INSURANCE TAX CREDIT PROPOSALS

DATE: October 2, 2000

You had requested information related to refundable tax credit proposals to purchase health insurance by Congressmen Arney and Stark. Stark has expressed support for refundable tax credits for health insurance in order to take away the issue from the Republicans and to ensure that if a tax credit proposal is ever enacted, it provides affordable and accessible insurance. Stark wrote the attached op-ed with Arney supporting the idea of tax credits in June, 1999. A brief summary and analysis of the Arney and Stark proposals follows.

Arney Proposal

Arney (the attached H.R. 4113) provides a \$1,000 refundable tax credit for individual coverage and a \$2,000 credit for family coverage. Jeffords has a similar bill in the Senate (S. 2320). Persons currently eligible for employer subsidized coverage would not be eligible for the tax credit. The tax credit starts to phase out at adjusted gross income of \$35,000 for individuals and \$55,000 for families. It phases out completely at adjusted gross income of \$45,000 for individuals and \$65,000 for families. The tax credit may be used for purchase of non-group health insurance in the private market. It should be noted that Arney usually opposes any refundable tax credits.

Stark Proposal

Stark (the attached H.R. 2185) proposes a \$1,200 refundable tax credit for an adult and a spouse and \$600 tax credit for up to 2 dependents, up to a total of \$3,600 per household. Persons currently eligible for employer-subsidized coverage, Medicare and Medicaid would not be eligible. There is no phase-out. The tax credits can be used to only purchase "qualified" private health insurance overseen by a new HHS Office of Health Insurance. Insurers would have to provide coverage through the Office of Health Insurance if they wish to continue to offer insurance under the Federal Employees Health Benefits Program (FEBHP). The coverage would be equivalent to the coverage offered under FEBHP by the insurer. In addition, insurers would have to provide consumer protections such as guaranteed issue, no waiting period, no pre-existing conditions, and community rated premiums.

Concerns with Tax Credit to Purchase Health Insurance

The first concern related to any tax credit proposal is that a tax credit provides little assistance to low-income working families. The General Accounting Office (in the attached correspondence) estimates that premiums for individual non-group health insurance range anywhere from \$744 to \$7,154 in 1998 (with a medium estimate of \$2,658). The GAO estimates that premiums for a family of four non-group health insurance range from \$3,180 to \$14,233

(with a medium estimate of \$7,352). As a result, under either proposal, a \$2,000 tax credit will be insufficient for a family of four.

Second, assuming no community rating and no guaranteed issue on the current private insurance market, even if the family had sufficient disposable income to pay out-of-pocket the remaining premiums, they may not even have access to such insurance. For example, one of the children in the family could have a pre-existing condition such as a severe disability. It should be noted that even with consumer protections included as under the Stark proposal, premiums may still not be affordable. The Stark proposal creates a separate risk pool for policies overseen by the new Office of Health Insurance which could raise risk selection concerns.

Third, tax credit proposals may crowd-out employer insurance. Jonathan Gruber estimated that a similar proposal to the Arney plan (\$1,000 for singles, \$2,000 for couples) would have one million persons lose coverage after firms no longer provide health insurance.

Fourth, another concern with any tax credit proposal is that it will be extremely expensive and does not target the uninsured. Gruber estimated the cost at \$13.3 billion per year and coverage of the uninsured at only 25.7 percent (4.0 million) of total participants (18.4 million). Only 53 percent of participants would be below 200 percent of poverty (\$17,000 for a family of four). As a contrast, a Kaiser study estimates that our FamilyCare proposal to cover the parents of children eligible for Medicaid and S-CHIP would cost \$6.7 billion per year and coverage of the uninsured at 69 percent (2.1 million) of total participants (3.0 million). 94 percent of participants would be below 200 percent of poverty. OMB estimates the cost of the FamilyCare proposal at \$7.6 billion per year.

#### Administration Position

The Administration has supported limited tax credits in its budget for the purchase of health insurance such as our Medicare and COBRA 25 percent buy-in programs and our tax credit to small businesses for employees through group purchasing cooperatives. However, we have taken the firm position that expansion of public health insurance for working families (such as our FamilyCare proposal to cover the parents of children enrolled in Medicaid and S-CHIP) is the better approach because it better targets the uninsured at a more affordable cost. We also do want to give credence to Republican tax credit proposals including one proposed by Governor Bush. The FamilyCare approach also ensures a meaningful insurance product for those persons receiving coverage while access/type of product is not guaranteed under the Arney approach. The Council of Economic Advisors has released the attached report which supports our position (and includes summaries of the Gruber and Kaiser studies).

DRAFT

**Proposed Long-Term Care Credits and Deductions**  
(Fully Phased in 2000 Levels)

**Couple Providing Care for a Parent (who is not a dependent)**

Example 3.1

**Couple with \$25,000 of Income**

	Current Law	Proposals		
		\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	\$10,000 Extra Personal Exemption <sup>3</sup>
Gross income	25,000	25,000	25,000	25,000
Deduction for long-term care			10,000	
AGI	25,000	25,000	15,000	25,000
Standard or itemized deductions <sup>4</sup>	7,350	7,350	7,350	7,350
Exemptions	5,600	5,600	5,600	14,415
Taxable income	12,050	12,050	2,050	3,235
Tax before credits	1,808	1,808	308	485
Long-term care tax credit		1,808		
Tax after credits	1,808	0	308	485
Change in tax from current law		-1,808	-1,500	-1,322

Example 3.2

**Couple with \$50,000 of Income**

	Current Law	Proposals		
		\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	\$10,000 Extra Personal Exemption <sup>3</sup>
Gross income	50,000	50,000	50,000	50,000
Deduction for long-term care			10,000	
AGI	50,000	50,000	40,000	50,000
Standard or itemized deductions <sup>4</sup>	10,000	10,000	10,000	10,000
Exemptions	5,600	5,600	5,600	14,415
Taxable income	34,400	34,400	24,400	25,585
Tax before credits	5,160	5,160	3,660	3,338
Long-term care tax credit		2,644		
Tax after credits	5,160	2,516	3,660	3,338
Change in tax from current law		-2,644	-1,500	-1,322

1. A tax credit of up to \$3,000 (when fully phased in by 2005: \$2,644 in 2000 dollars) for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses. The credit is phased out between: \$110,000 and \$170,000 for joint filers and between \$75,000 and \$135,000 for single filers.
2. \$10,000 above-the-line deduction for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.
3. \$10,000 (when fully phased in by 2005; \$8,815 in 2000 dollars) extra personal exemption for individuals with long term care needs or their caregivers, irrespective of actual long-term care expenses.
4. Taxpayers are assumed to use the larger of the standard deduction or itemized deductions. Itemized deductions are assumed to be 20% of income for taxpayers with incomes of \$50,000 or less, 18% for taxpayers with incomes of \$100,000, 17% for taxpayers with incomes of \$150,000 and 16% for taxpayers with incomes of \$200,000.

**Proposed Long-Term Care Credits and Deductions**  
(Fully Phased in 2000 Levels)

**Couple Providing Care for a Parent (who is not a dependent)**

**Example 3.3**

**Couple with \$100,000 of Income**

	Current Law	Proposals		
		\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	\$10,000 Extra Personal Exemption <sup>3</sup>
Gross income	100,000	100,000	100,000	100,000
Deduction for long-term care			10,000	
AGI	100,000	100,000	90,000	100,000
Standard or itemized deductions <sup>4</sup>	18,000	18,000	18,000	18,000
Exemptions	5,600	5,600	5,600	14,415
Taxable income	76,400	76,400	66,400	67,585
Tax before credits	15,692	15,692	12,892	13,223
Long-term care tax credit		2,444		
Tax after credits	15,692	13,248	12,892	13,223
Change in tax from current law		-2,444	-2,800	-2,468

**Example 3.4**

**Couple with \$150,000 of Income**

	Current Law	Proposals		
		\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	\$10,000 Extra Personal Exemption <sup>3</sup>
Gross income	150,000	150,000	150,000	150,000
Deduction for long-term care			10,000	
AGI	150,000	150,000	140,000	150,000
Standard or itemized deductions <sup>4</sup>	24,869	24,869	25,169	24,869
Exemptions	5,600	5,600	5,600	14,415
Taxable income	119,532	119,532	109,232	110,717
Tax before credits	28,176	28,176	24,983	25,443
Long-term care tax credit		0		
Tax after credits	28,176	28,176	24,983	25,443
Change in tax from current law		0	-3,193	-2,733

1. A tax credit of up to \$3,000 (when fully phased in by 2005; \$2,644 in 2000 dollars) for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses. The credit is phased out between \$110,000 and \$170,000 for joint filers and between \$75,000 and \$135,000 single filers. These thresholds are not indexed. In 2000 dollars, the phase-out for joint filers would be between \$96,960 and \$149,847.
2. \$10,000 above-the-line deduction for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.
3. \$10,000 (when fully phased in by 2005; \$8,815 in 2000 dollars) extra personal exemption for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.
4. Taxpayers are assumed to use the larger of the standard deduction or itemized deductions. Itemized deductions are shown net of the limitation for higher income taxpayers. Before limitation, itemized deductions are assumed to be 20% of income for taxpayers with incomes of \$50,000 or less, 18% for taxpayers with incomes of \$100,000, 17% for taxpayers with incomes of \$150,000 and 16% for taxpayers with incomes of \$200,000.

**Proposed Long-Term Care Credits and Deductions**  
(Fully Phased in 2000 Levels)

**Couple Providing Care for a Parent (who is not a dependent)**

**Example 3.3**

**Couple with \$100,000 of Income**

	Current Law	Proposals		
		\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	\$10,000 Extra Personal Exemption <sup>3</sup>
Gross income	100,000	100,000	100,000	100,000
Deduction for long-term care			10,000	
AGI	100,000	100,000	90,000	100,000
Standard or itemized deductions <sup>4</sup>	18,000	18,000	18,000	18,000
Exemptions	5,600	5,600	5,600	14,415
Taxable income	76,400	76,400	66,400	67,585
Tax before credits	15,692	15,692	12,892	13,223
Long-term care tax credit		2,444		
Tax after credits	15,692	13,248	12,892	\$13,223
Change in tax from current law		-2,444	-2,800	-2,468

**Example 3.4**

**Couple with \$150,000 of Income**

	Current Law	Proposals		
		\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	\$10,000 Extra Personal Exemption <sup>3</sup>
Gross income	150,000	150,000	150,000	150,000
Deduction for long-term care			10,000	
AGI	150,000	150,000	140,000	150,000
Standard or itemized deductions <sup>4</sup>	24,869	24,869	25,169	24,869
Exemptions	5,600	5,600	5,600	14,415
Taxable income	119,532	119,532	109,232	110,717
Tax before credits	28,176	28,176	24,983	25,443
Long-term care tax credit		0		
Tax after credits	28,176	28,176	24,983	25,443
Change in tax from current law		0	-3,193	-2,733

1. A tax credit of up to \$3,000 (when fully phased in by 2005; \$2,644 in 2000 dollars) for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses. The credit is phased out between \$110,000 and \$170,000 for joint filers and between \$75,000 and \$135,000 single filers. These thresholds are not indexed. In 2000 dollars, the phase-out for joint filers would be between \$96,960 and \$149,847.

2. \$10,000 above-the-line deduction for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

3. \$10,000 (when fully phased in by 2005; \$8,815 in 2000 dollars) extra personal exemption for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

4. Taxpayers are assumed to use the larger of the standard deduction or itemized deductions. Itemized deductions are shown net of the limitation for higher income taxpayers. Before limitation, itemized deductions are assumed to be 20% of income for taxpayers with incomes of \$50,000 or less, 18% for taxpayers with incomes of \$100,000, 17% for taxpayers with incomes of \$150,000 and 16% for taxpayers with incomes of \$200,000.

**Proposed Long-Term Care Credits and Deductions**  
(Fully Phased in 2000 Levels)

**Couple Providing Care for a Parent (who is not a dependent)**

**Example 3.5**

**Couple with \$200,000 of Income**

	Current Law	Proposals		
		\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	\$10,000 Extra Personal Exemption <sup>3</sup>
Gross income	200,000	200,000	200,000	200,000
Deduction for long-term care			10,000	
AGI	200,000	200,000	190,000	200,000
Standard or itemized deductions <sup>4</sup>	29,869	29,869	30,169	29,869
Exemptions <sup>5</sup>	5,264	5,264	5,600	13,550
Taxable income	164,868	164,868	154,232	156,581
Tax before credits	42,401	42,401	38,933	39,661
Long-term care tax credit		0		
Tax after credits	42,401	42,401	38,933	39,661
Change in tax from current law		0	-3,468	-2,740

1. A tax credit of up to \$3,000 (when fully phased in by 2005; \$2,644 in 2000 dollars) for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses. The credit is phased out between \$110,000 and \$170,000 for joint filers and between \$75,000 and \$135,000 single filers. These thresholds are not indexed. In 2000 dollars, the phase-out for joint filers would be between \$96,960 and \$149,847.

2. \$10,000 above-the-line deduction for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

3. \$10,000 (when fully phased in by 2005; \$8,815 in 2000 dollars) extra personal exemption for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

4. Taxpayers are assumed to use the larger of the standard deduction or itemized deductions. Itemized deductions are shown net of the limitation for higher income taxpayers. Before limitation, itemized deductions are assumed to be 20% of income for taxpayers with incomes of \$50,000 or less, 18% for taxpayers with incomes of \$100,000, 17% for taxpayers with incomes of \$150,000 and 16% for taxpayers with incomes of \$200,000.

5. Exemptions are shown net of the personal exemption phaseout.

Example 2.1

Proposed Long-Term Care Credits and Deductions  
(Fully Phased in 2000 Levels)

Elderly Couple with \$35,000 of Income (\$17,000 of income is Social Security benefits)

Couple Has \$500 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	0	0	0	0	0
Other income	18,000	18,000	18,000	18,000	18,000
Gross income	18,000	18,000	18,000	18,000	18,000
Deduction for long-term care			10,000	500	
AGI	18,000	18,000	8,000	17,500	18,000
Standard or itemized deductions <sup>5</sup>	9,050	9,050	9,050	9,050	9,050
Exemptions	5,600	5,600	5,600	5,600	14,415
Taxable income	3,350	3,350	0	2,850	0
Tax before credits	503	503	0	428	0
Long-term care tax credit		503			
Tax after credits	503	0	0	428	0
Change in tax from current law		-503	-503	-75	-503

Couple Has \$10,000 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	0	0	0	0	0
Other income	18,000	18,000	18,000	18,000	18,000
Gross income	18,000	18,000	18,000	18,000	18,000
Deduction for long-term care			10,000	10,000	
AGI	18,000	18,000	8,000	8,000	18,000
Standard or itemized deductions <sup>5</sup>	14,600	14,600	15,350	9,050	14,600
Exemptions	5,600	5,600	5,600	5,600	14,415
Taxable income	0	0	0	0	0
Tax before credits	0	0	0	0	0
Long-term care tax credit		0			
Tax after credits	0	0	0	0	0
Change in tax from current law		0	0	0	0

1. A tax credit of up to \$3,000 (when fully phased in by 2005; \$2,644 in 2000 dollars) for individuals with long-term care needs or their caregivers.
2. \$10,000 above-the-line deduction for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.
3. Above-the-line deduction for long-term care expenses up to \$10,000 for individuals with long-term care needs. Expenses deducted above the line reduce itemizable expenses.
4. \$10,000 (when fully phased in by 2005; \$8,815 in 2000 dollars) extra personal exemption for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.
5. Taxpayers are assumed to use the larger of the standard deduction (including the special deduction for the elderly) or itemized deductions. Nonmedical itemized deductions are assumed to be 20% of income for taxpayers with incomes under \$25,000, 17% for taxpayers with incomes between \$25,000 and \$50,000, and 15% for taxpayers with incomes above \$50,000.

Example 2.2

Proposed Long-Term Care Credits and Deductions  
(Fully Phased in 2000 Levels)

Elderly Couple with \$55,000 of Income (\$17,000 of income is Social Security benefits)

Couple Has \$500 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	8,125	8,125	2,250	7,700	8,125
Other income	38,000	38,000	38,000	38,000	38,000
Gross income	46,125	46,125	40,250	45,700	46,125
Deduction for long-term care			10,000	500	
AGI	46,125	46,125	30,250	45,200	46,125
Standard or itemized deductions <sup>5</sup>	9,050	9,050	9,050	9,050	9,050
Exemptions	5,600	5,600	5,600	5,600	14,415
Taxable income	31,475	31,475	15,600	30,550	22,660
Tax before credits	4,721	4,721	2,340	4,583	3,399
Long-term care tax credit		2,644			
Tax after credits	4,721	2,077	2,340	4,583	3,399
Change in tax from current law		-2,644	-2,381	-139	-1,322

Couple Has \$10,000 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	8,125	8,125	2,250	2,250	8,125
Other income	38,000	38,000	38,000	38,000	38,000
Gross income	46,125	46,125	40,250	40,250	46,125
Deduction for long-term care			10,000	10,000	
AGI	46,125	46,125	30,250	30,250	46,125
Standard or itemized deductions <sup>5</sup>	14,791	14,791	15,981	9,050	14,791
Exemptions	5,600	5,600	5,600	5,600	14,415
Taxable income	25,734	25,734	8,669	15,600	16,919
Tax before credits	3,860	3,860	1,300	2,340	2,538
Long-term care tax credit		2,644			
Tax after credits	3,860	1,216	1,300	2,340	2,538
Change in tax from current law		-2,644	-2,560	-1,520	-1,322

1. A tax credit of up to \$3,000 (when fully phased in by 2005; \$2,644 in 2000 dollars) for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

2. \$10,000 above-the-line deduction for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

3. Above-the-line deduction for long-term care expenses up to \$10,000 for individuals with long-term care needs. Expenses deducted above the line reduce itemizable expenses.

4. \$10,000 (when fully phased in by 2005; \$8,815 in 2000 dollars) extra personal exemption for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

5. Taxpayers are assumed to use the larger of the standard deduction (including the special deduction for the elderly) or itemized deductions. Nonmedical itemized deductions are assumed to be 20% of income for taxpayers with incomes under \$25,000, 17% for taxpayers with incomes between \$25,000 and \$50,000, and 15% for taxpayers with incomes above \$50,000.

Example 2.3

Proposed Long-Term Care Credits and Deductions  
(Fully Phased in 2000 Levels)

Elderly Couple with \$75,000 of Income (\$17,000 of income is Social Security benefits)

Couple Has \$500 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	14,450	14,450	14,450	14,450	14,450
Other income	58,000	58,000	58,000	58,000	58,000
Gross income	72,450	72,450	72,450	72,450	72,450
Deduction for long-term care			10,000	500	
AGI	72,450	72,450	62,450	71,950	72,450
Standard or itemized deductions <sup>5</sup>	11,250	11,250	11,250	11,250	11,250
Exemptions	5,600	5,600	5,600	5,600	14,415
Taxable income	55,600	55,600	45,600	55,100	46,785
Tax before credits	9,868	9,868	7,068	9,728	7,399
Long-term care tax credit		2,644			
Tax after credits	9,868	7,224	7,068	9,728	7,399
Change in tax from current law		-2,644	-2,800	-140	-2,468

Couple Has \$10,000 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	14,450	14,450	14,450	14,450	14,450
Other income	58,000	58,000	58,000	58,000	58,000
Gross income	72,450	72,450	72,450	72,450	72,450
Deduction for long-term care			10,000	10,000	
AGI	72,450	72,450	62,450	62,450	72,450
Standard or itemized deductions <sup>5</sup>	15,816	15,816	16,566	11,250	15,816
Exemptions	5,600	5,600	5,600	5,600	14,415
Taxable income	51,034	51,034	40,284	45,600	42,219
Tax before credits	8,589	8,589	6,043	7,067	6,333
Long-term care tax credit		2,644			
Tax after credits	8,589	5,945	6,043	7,067	6,333
Change in tax from current law		-2,644	-2,546	-1,522	-2,256

1. A tax credit of up to \$3,000 (when fully phased in by 2005; \$2,644 in 2000 dollars) for individuals with long-term care needs or their caregivers.
2. \$10,000 above-the-line deduction for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.
3. Above-the-line deduction for long-term care expenses up to \$10,000 for individuals with long-term care needs. Expenses deducted above the line reduce itemizable expenses.
4. \$10,000 (when fully phased in by 2005; \$8,815 in 2000 dollars) extra personal exemption for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.
5. Taxpayers are assumed to use the larger of the standard deduction (including the special deduction for the elderly) or itemized deductions. Nonmedical itemized deductions are assumed to be 20% of income for taxpayers with incomes under \$25,000, 17% for taxpayers with incomes between \$25,000 and \$50,000, and 15% for taxpayers with incomes above \$50,000.

### Example 1.1

#### Proposed Long-Term Care Credits and Deductions (Fully Phased in 2000 Levels)

Elderly Single Person with \$20,000 of Income (\$10,000 of income is Social Security benefits)

#### Individual Has \$600 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	0	0	0	0	0
Other income	10,000	10,000	10,000	10,000	10,000
Gross income	10,000	10,000	10,000	10,000	10,000
Deduction for long-term care			10,000	500	
AGI	10,000	10,000	0	9,500	10,000
Standard or itemized deductions <sup>5</sup>	5,500	5,500	5,500	5,500	5,500
Exemptions	2,800	2,800	2,800	2,800	11,615
Taxable income	1,700	1,700	0	1,200	0
Tax before credits	255	255	0	180	0
Long-term care tax credit		255			
Tax after credits	255	0	0	180	0
<b>Change in tax from current law</b>		<b>-255</b>	<b>-255</b>	<b>-75</b>	<b>-255</b>

#### Individual Has \$10,000 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	0	0	0	0	0
Other income	10,000	10,000	10,000	10,000	10,000
Gross income	10,000	10,000	10,000	10,000	10,000
Deduction for long-term care			10,000	10,000	
AGI	10,000	10,000	0	0	10,000
Standard or itemized deductions <sup>5</sup>	13,250	13,250	14,000	5,500	13,250
Exemptions	2,800	2,800	2,800	2,800	11,615
Taxable income	0	0	0	0	0
Tax before credits	0	0	0	0	0
Long-term care tax credit		0			
Tax after credits	0	0	0	0	0
<b>Change in tax from current law</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

1. A tax credit of up to \$3,000 (when fully phased in by 2005; \$2,644 in 2000 dollars) for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

2. \$10,000 above-the-line deduction for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

3. Above-the-line deduction for long-term care expenses up to \$10,000 for individuals with long-term care needs. Expenses deducted above the line reduce itemizable expenses.

4. \$10,000 (when fully phased in by 2005; \$8,815 in 2000 dollars) extra personal exemption for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

5. Taxpayers are assumed to use the larger of the standard deduction (including the special deduction for the elderly) or itemized deductions. Nonmedical itemized deductions are assumed to be 20% of income for taxpayers with incomes under \$25,000, 17% for taxpayers with incomes between \$25,000 and \$50,000, and 15% for taxpayers with incomes above \$50,000.

Example 1.2

Proposed Long-Term Care Credits and Deductions  
(Fully Phased in 2000 Levels)

Elderly Single Person with \$30,000 of Income (\$10,000 of income is Social Security benefits)

Individual Has \$500 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	0	0	0	0	0
Other income	20,000	20,000	20,000	20,000	20,000
Gross income	20,000	20,000	20,000	20,000	20,000
Deduction for long-term care			10,000	500	
AGI	20,000	20,000	10,000	19,500	20,000
Standard or itemized deductions <sup>5</sup>	5,500	5,500	5,500	5,500	5,500
Exemptions	2,800	2,800	2,800	2,800	11,615
Taxable income	11,700	11,700	1,700	11,200	2,885
Tax before credits	1,755	1,755	255	1,680	433
Long-term care tax credit		1,755			
Tax after credits	1,755	0	255	1,680	433
Change in tax from current law		-1,755	-1,500	-75	-1,322

Individual Has \$10,000 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	0	0	0	0	0
Other income	20,000	20,000	20,000	20,000	20,000
Gross income	20,000	20,000	20,000	20,000	20,000
Deduction for long-term care			10,000	10,000	
AGI	20,000	20,000	10,000	10,000	20,000
Standard or itemized deductions <sup>5</sup>	13,600	13,600	14,350	5,500	13,600
Exemptions	2,800	2,800	2,800	2,800	11,615
Taxable income	3,600	3,600	0	1,700	0
Tax before credits	540	540	0	255	0
Long-term care tax credit		540			
Tax after credits	540	0	0	255	0
Change in tax from current law		-540	-540	-285	-540

1. A tax credit of up to \$3,000 (when fully phased in by 2005; \$2,644 in 2000 dollars) for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

2. \$10,000 above-the-line deduction for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

3. Above-the-line deduction for long-term care expenses up to \$10,000 for individuals with long-term care needs. Expenses deducted above the line reduce itemizable expenses.

4. \$10,000 (when fully phased in by 2005; \$8,815 in 2000 dollars) extra personal exemption for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

5. Taxpayers are assumed to use the larger of the standard deduction (including the special deduction for the elderly) or itemized deductions. Nonmedical itemized deductions are assumed to be 20% of income for taxpayers with incomes under \$25,000, 17% for taxpayers with incomes between \$25,000 and \$50,000, and 15% for taxpayers with incomes above \$50,000.

### Example 1.3

#### Proposed Long-Term Care Credits and Deductions (Fully Phased in 2000 Levels)

Elderly Single Person with \$40,000 of Income (\$10,000 of income is Social Security benefits)

#### Individual Has \$500 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	5,350	5,350	0	4,925	5,350
Other income	30,000	30,000	30,000	30,000	30,000
Gross income	35,350	35,350	30,000	34,925	35,350
Deduction for long-term care			10,000	500	
AGI	35,350	35,350	20,000	34,425	35,350
Standard or itemized deductions <sup>5</sup>	6,800	6,800	6,800	6,800	6,800
Exemptions	2,800	2,800	2,800	2,800	11,615
Taxable income	25,750	25,750	10,400	24,825	16,935
Tax before credits	3,863	3,863	1,560	3,724	2,540
Long-term care tax credit		2,644			
Tax after credits	3,863	1,219	1,560	3,724	2,540
Change in tax from current law		-2,644	-2,303	-139	-1,322

#### Individual Has \$10,000 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	5,350	5,350	0	0	5,350
Other income	30,000	30,000	30,000	30,000	30,000
Gross income	35,350	35,350	30,000	30,000	35,350
Deduction for long-term care			10,000	10,000	
AGI	35,350	35,350	20,000	20,000	35,350
Standard or itemized deductions <sup>5</sup>	14,149	14,149	15,300	6,800	14,149
Exemptions	2,800	2,800	2,800	2,800	11,615
Taxable income	18,401	18,401	1,900	10,400	9,586
Tax before credits	2,760	2,760	285	1,560	1,438
Long-term care tax credit		2,644			
Tax after credits	2,760	116	285	1,560	1,438
Change in tax from current law		-2,644	-2,475	-1,200	-1,322

1. A tax credit of up to \$3,000 (when fully phased in by 2005; \$2,644 in 2000 dollars) for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

2. \$10,000 above-the-line deduction for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

3. Above-the-line deduction for long-term care expenses up to \$10,000 for individuals with long-term care needs. Expenses deducted above the line reduce itemizable expenses.

4. \$10,000 (when fully phased in by 2005; \$8,815 in 2000 dollars) extra personal exemption for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

5. Taxpayers are assumed to use the larger of the standard deduction (including the special deduction for the elderly) or itemized deductions. Nonmedical itemized deductions are assumed to be 20% of income for taxpayers with incomes under \$25,000, 17% for taxpayers with incomes between \$25,000 and \$50,000, and 15% for taxpayers with incomes above \$50,000.

Example 1.4

Proposed Long-Term Care Credits and Deductions  
(Fully Phased in 2000 Levels)

Elderly Single Person with \$60,000 of Income (\$10,000 of income is Social Security benefits)

Individual Has \$500 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	8,500	8,500	8,500	8,500	8,500
Other income	50,000	50,000	50,000	50,000	50,000
Gross income	58,500	58,500	58,500	58,500	58,500
Deduction for long-term care			10,000	500	
AGI	58,500	58,500	48,500	58,000	58,500
Standard or itemized deductions <sup>5</sup>	9,000	9,000	9,000	9,000	9,000
Exemptions	2,800	2,800	2,800	2,800	11,615
Taxable income	46,700	46,700	36,700	46,200	37,885
Tax before credits	9,664	9,664	6,864	9,524	7,195
Long-term care tax credit		2,644			
Tax after credits	9,664	7,020	6,864	9,524	7,195
Change in tax from current law		-2,644	-2,800	-140	-2,468

Individual Has \$10,000 of Long-Term Care Expenses

	Proposals				
	Current Law	\$3,000 Credit <sup>1</sup>	\$10,000 Deduction <sup>2</sup>	Actual Expenses Deduction <sup>3</sup>	\$10,000 Extra Personal Exemption <sup>4</sup>
Taxable Social Security benefits	8,500	8,500	8,500	8,500	8,500
Other income	50,000	50,000	50,000	50,000	50,000
Gross income	58,500	58,500	58,500	58,500	58,500
Deduction for long-term care			10,000	10,000	
AGI	58,500	58,500	48,500	48,500	58,500
Standard or itemized deductions <sup>5</sup>	14,613	14,613	15,363	9,000	14,613
Exemptions	2,800	2,800	2,800	2,800	11,615
Taxable income	41,088	41,088	30,338	36,700	32,273
Tax before credits	8,092	8,092	5,082	6,864	5,624
Long-term care tax credit		2,644			
Tax after credits	8,092	5,448	5,082	6,864	5,624
Change in tax from current law		-2,644	-3,010	-1,228	-2,468

1. A tax credit of up to \$3,000 (when fully phased in by 2005; \$2,644 in 2000 dollars) for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

2. \$10,000 above-the-line deduction for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

3. Above-the-line deduction for long-term care expenses up to \$10,000 for individuals with long-term care needs. Expenses deducted above the line reduce itemizable expenses.

4. \$10,000 (when fully phased in by 2005; \$8,815 in 2000 dollars) extra personal exemption for individuals with long-term care needs or their caregivers, irrespective of actual long-term care expenses.

5. Taxpayers are assumed to use the larger of the standard deduction (including the special deduction for the elderly) or itemized deductions. Nonmedical itemized deductions are assumed to be 20% of income for taxpayers with incomes under \$25,000, 17% for taxpayers with incomes between \$25,000 and \$50,000, and 15% for taxpayers with incomes above \$50,000.

## REPUBLICAN TAX DEDUCTION FOR LONG-TERM CARE EXPENSES

Speaker Hastert has proposed a \$10,000 tax deduction as an alternative to the Administration's \$3,000 tax credit in an attempt to obtain support from Chairman Archer for immediate tax assistance for chronically ill Americans and their caregivers. While potentially appealing at first glance, this approach is flawed on both policy and political grounds, including:

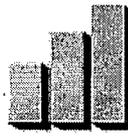
- **Skewed to wealthy:** This long-term care expense deduction would give a higher subsidy to a person with higher income, even if the lower income person had the same exact expenses. This is compounded by the fact that middle-income families are less likely to rely on formal long-term care, instead providing care themselves.
  - **Americans in the lowest tax bracket would get only half the assistance provided by a \$3,000 tax credit.** Those who are in the lowest tax bracket would get maximum help of only \$1,500 – half of what they would get under the President's bipartisan proposal.
  - **Wealthy get twice the subsidy.** For example a woman caring for her husband with Alzheimer's would get \$1,500 for her \$10,000 long-term care for adult day care, respite, and other services if her income is \$20,000. A similar woman whose family income is \$80,000 would get twice the subsidy – \$3,000 – for the exact same long-term care expenses.
  - **Alzheimer's Association opposes replacing a tax credit with a tax deduction.** This week, the Alzheimer's Association wrote Chairman Archer that they would oppose a tax deduction because it would "shift help away from those who are most in need." This is because "Alzheimer caregivers are not wealthy. A tax credit will help low and moderate income taxpayers who do not have the resources to pay for needed long-term care services."
- **Requires taxpayers to itemize receipts for long-term care expenses, and provides no assistance for informal long-term care.** This tax proposal requires taxpayers to collect and itemize receipts for formal long-term care services. It does nothing to offset the costs of informal family caregiving, including the lost wages of caregivers who leave work to care for chronically ill caregivers.
- **Democratic Congressional and aging advocate support for deducting long-term care insurance is contingent on including a tax credit for informal long-term care expenses.** Many advocates and experts oppose subsidizing private long-term care insurance because of problems in this market – but will support the deduction if that ensures passage of the \$3,000 tax credit because it provides immediate, real assistance to all people with long-term care needs and the families that care for them.
  - Senator Graham (D-FL) and Congresswoman Thurman (D-FL) have cosponsored legislation with Senator Grassley and Representative Johnson in support of a long-term care insurance deduction in return for Republican support for your \$3,000 tax credit.
  - Similarly, AARP joined with the Health Insurance Association of America to endorse both the tax credit and the tax deduction for private insurance as a package deal.

**Validates Bush long-term care approach over Clinton-Gore policy.** Should a tax deduction policy pass the Congress, it would represent an initiative that is actually more conservative and regressive than even the long-term care policy advocated by Governor Bush.

## REPUBLICAN DEDUCTION FOR INDIVIDUAL HEALTH INSURANCE

Congressional Republicans are proposing a tax deduction for individual health insurance that the New York Times concludes is "a senseless health deduction" because it "would be ineffective, expensive and stacked in favor of high income families." [NYT Editorial 10/14/00].

- **Would do virtually nothing to expand coverage of the uninsured.**
  - Costs nearly \$48 billion/10 years and \$9.9 billion/year when fully phased in
  - Covers only 600,000, less than 1.4 percent of the uninsured population, at a cost of \$18,000 per additional insured person.
  - Extending CHIP to uninsured parents costs \$56 billion /10 years according to CBO and coverage about 4 million parents at about one-fourth the cost per uninsured person.
- **Disproportionately benefits higher income individuals – who are less likely to be uninsured.** A deduction is regressive, providing greater benefits to higher income taxpayers.
  - A "tax deduction provides no financial relief to families that do not pay taxes, and it saves other low-income families a mere 15 cents for every dollar spent on premiums." Nearly 95 percent of the uninsured are in these two tax categories.
  - A study of a similar policy that 90 percent of the benefit would go to the already insured.
- **Employer-based coverage at risk.** The availability of a deduction would encourage firms to drop coverage for their workers. Healthy workers would now have an incentive to purchase individual insurance, leaving employers with sicker and more expensive workers, making them more likely to drop coverage. Other firms may drop coverage because they believe that employees would have access to health insurance through the deduction.
- **Individual insurance is the most expensive, unreliable and unstable kind.** The Republican proposal includes no insurance reforms and would continue the frequently used practices of insurers in the non-group market to deny coverage to persons with preexisting conditions, charge higher premiums based on a person's health status, and limit benefits.
- **If policymakers want to ensure equity, a better alternative would be to provide a 25 percent refundable tax credit combined with needed reforms in the individual market.**
  - Tax credits would benefit working families equally, not just the higher income. More likely to help the uninsured who are middle-income workers.
  - Tax credits could also be tied to buy-ins to Medicare for early retirees, COBRA for displaced workers, and Medicaid and S-CHIP. These initiatives would help to level the playing field between individual non-group and employer-based coverage.



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September 19, 2000

**ARCHER MSA EXPANSIONS COULD DRIVE UP  
HEALTH INSURANCE PREMIUMS AND CREATE NEW TAX SHELTER**

by Iris J. Lav

**Summary**

Few would propose a tax cut for the affluent paid for with increased health insurance premiums on the sick. That is the probable consequence, however, of a proposal to expand Medical Savings Accounts (MSAs) that Representative Bill Archer recently has named as one of his top priorities for passage this year. Representative Archer hopes to attach the provisions to other legislation moving at the end of the session.<sup>1</sup>

The new Archer proposal would dramatically expand an MSA demonstration project that Congress established in 1996 and that is scheduled to end this year. In general, the proposal would permit universal access to MSAs and remove a number of safeguards included in the demonstration project. These proposed expansions are identical to MSA provisions included in the version of the Patient's Bill of Rights passed by the House of Representatives last year.

- The Archer proposal seeks major expansions of MSAs, including universal access, despite the fact that the General Accounting Office's report on the current demonstration finds evidence that MSA availability encourages "adverse selection" in insurance markets. Adverse selection is a circumstance in which healthy and less healthy segments of the population become segregated in different types of insurance plans. When adverse selection occurs, health insurance premiums rise for the less-healthy individuals (because they are no longer pooled with the healthier individuals), and the resulting increase in costs may cause some individuals to lose insurance coverage because it becomes unaffordable for them.
- If MSAs are expanded from the current limited demonstration to universal access, it is highly likely that the types of problems the GAO found during the demonstration period would become widespread and result in substantially higher premium costs for conventional insurance.

Premiums for conventional insurance would be higher because of the effect of MSAs on the insurance market, the phenomenon known as adverse selection.

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<sup>1</sup> Medical Savings Accounts are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies. Funds in MSAs may be used to pay for a wide range of health care expenditures, including types of expenditures not covered by the MSA-holder's insurance policy.

- Adverse selection would occur because substantial numbers of young, healthy people with low medical costs would choose to use the high-deductible insurance policies and MSAs and thereby to retain their unspent dollars in their own accounts. This would leave people who are less healthy and have higher medical costs in conventional, low-deductible health insurance plans.
- Such a division of the market would drive up the cost of low-deductible insurance for the less healthy segments of the population who most need it. Research conducted by the Urban Institute, RAND, and the American Academy of Actuaries suggests that premiums for conventional insurance could *more than double* if MSA use becomes widespread. According to the American Academy of Actuaries, "The greatest savings [from MSAs] will be for the employees who have little or no health care expenditures. The greatest losses will be for the employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women."<sup>2</sup>

When Congress was debating MSAs in 1996 as part of its deliberations on the Health Insurance Portability and Accountability Act, there was concern about the effects that widespread adverse selection could have on the insurance market. Accordingly, Congress allowed MSAs only as a limited demonstration policy so it could secure more information on this matter. The demonstration period is scheduled to expire at the end of this year, but limited use of MSAs during the demonstration period has made it impossible to conduct the comprehensive evaluation of MSAs the 1996 law envisioned. Despite the absence of information indicating that MSAs would not cause serious problems, the Archer proposal would make MSAs universally available and relax a number of other safeguards in the 1996 demonstration design. Any negative consequences MSAs may have for the insurance market consequently could become pervasive and difficult to reverse.

- Evidence suggests adverse selection in the usage of MSAs already is occurring under the demonstration project. A survey of insurers offering MSA plans notes that "Insurers expect relatively better health status and lower service utilization by enrollees selecting high-deductible plans and *price their products accordingly.*" [Emphasis added.] In other words, the insurers can afford to set lower premiums for insurance policies used with MSAs, because they know it will be healthier people who are attracted to using MSAs. This survey of insurers was conducted by Westat under contract with the General Accounting Office in partial fulfillment of the terms of the demonstration project Congress established in 1996.

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<sup>2</sup> American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues, May 1995*, p. 23.

- The Archer proposal would make the accounts universally available. If MSAs become widely popular among consumers with relatively better health, an adverse selection cycle could be triggered that would drive up the cost of conventional, more comprehensive insurance. The resulting premium increases are likely to be large enough to make such insurance unaffordable and unavailable for substantial numbers of Americans.

In addition, the changes in the Archer proposal could create a major new tax shelter. The tax shelter would come about because of the similarities between MSAs and Individual Retirement Accounts. Under current law, married taxpayers who are covered by an employer-sponsored pension plan may deduct from their income up to \$4,000 a year for deposits to an IRA if their income is below \$62,000. By 2007, they will be able to make such deposits if their income is below \$100,000.<sup>3</sup> Earnings on funds deposited in an IRA compound free of tax; no tax is due on either the deposits or the earnings until funds are withdrawn after retirement (or for a limited number of other purposes).

Taxpayers with incomes above these limits who have pension coverage under employer-sponsored plans are not eligible to use deductible IRAs. When IRA policies were revised in 1986 and again in 1997, Congress determined that such income limits were appropriate largely because the evidence indicates that higher-income individuals can and will save without a taxpayer subsidy; giving high-income taxpayers a tax subsidy for saving is not an efficient use of government funds.

Nevertheless, MSAs could be used by high-income taxpayers as a means to circumvent the income limits that govern tax-advantaged deposits to Individual Retirement Accounts. Under the proposed MSA expansion, *all* high-income taxpayers who choose to use MSAs would be allowed to make tax deductible deposits, and the earnings on these MSA deposits would compound free of tax. Like funds deposited in an IRA, funds on deposit in an MSA may be invested in stocks, bonds, or similar types of assets. MSA deposits and earnings are never taxed if MSA funds are used to pay medical costs. Moreover, the tax advantages of MSAs can be substantial even if the funds in the accounts are later withdrawn and used primarily or exclusively for *non*-medical purposes. If deposits are held until retirement age, for example, there is no penalty for withdrawal for non-medical purposes. Even if funds are withdrawn for non-medical purposes before retirement age, there are a number of circumstances under which the value of the tax-free compounding of the deposits over a number of years would outweigh the penalty that must be paid for a non-medical withdrawal.

The Westat survey of MSA insurers indicates that the market may indeed be developing in this manner.

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<sup>3</sup> Single taxpayers with incomes below \$42,000 may deduct up to \$2,000 a year. These income limits apply for tax year 2000; the limits are increasing gradually though 2007 under legislation enacted in 1997.

- According to the Westat survey, "Insurers reported targeting some segments of the insurance market, including highly-paid professionals, farmers and ranchers, partnership firms, and association groups."
- In discussing changes in the ways MSAs were marketed between 1997 and 1998, the Westat report noted: "The entry of Merrill Lynch and other investment firms into the MSA trustee arena and the maturing of the market have led to increased investment choices for MSA holders. This trend may be affected as well by some insurers' perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for paying medical expenses."
- Universal availability of MSAs, along with other changes in the proposal such as larger allowable deposits into MSAs, would likely accelerate this trend.

The Archer proposal also includes a provision that deals with employer and employee contributions to MSAs. This provision would undermine the rules under the current MSA demonstration that prevent employers from setting up MSAs in a manner that primarily benefits highly paid executives and effectively discriminates against lower-paid employees.

- Under the MSA demonstration now underway, deposits can be made to an MSA account by either an employer or an individual, but not by both in the same year. The demonstration also includes nondiscrimination rules requiring employers to make comparable contributions for all participating employees.
- The Archer proposal would allow both employees and employers to make deposits to an MSA in the same year. That would make the nondiscrimination rules meaningless. An employer could make small, token deposits to the MSA accounts of all employees. Higher-income employees could add substantial additional funds to their accounts and exclude these additional amounts from their taxable income. Most lower-paid staff would not be able to afford substantial additional contributions and, because they generally are in lower tax brackets than better-paid employees, would get less subsidy for making their own deposits.

The Medical Savings Account expansions proposed by Representative Archer and included in the House-passed Patients' Bill of Rights represent a dramatic departure from the current design of MSAs that would likely have adverse consequences for health care consumers. They carry the strong potential to drive up the cost of comprehensive, conventional insurance to the point where many Americans, including those most in need of health services, cannot afford to buy coverage. Moreover, the expansions would significantly increase the appeal of MSAs as a tax shelter for higher-income individuals, further compounding the risk of triggering adverse selection in the health insurance marketplace.

## The MSA Demonstration

The bipartisan Health Insurance Portability and Accountability Act of 1996 established a demonstration to test and evaluate Medical Savings Accounts, which are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies. The demonstration was designed to provide information about the effects of MSAs on workers, employers, and insurers and to do so without creating widespread, irreparable harm to the participants or the insurance market as a whole. Participation in the demonstration was limited to no more than 750,000 participants who are either employees of small businesses (businesses with 50 or fewer employees) or self-employed individuals. In addition, a number of the rules governing use of MSAs during the demonstration were designed to assure that these tax-advantaged savings accounts were used largely for the purpose of obtaining medical care and would not become a general-purpose tax shelter. The demonstration is scheduled to run through December 31, 2000.

The legislation required an evaluation to determine the effects of MSAs on the insurance market and on consumers. Among other issues, the evaluation was to study the extent to which MSAs fostered "adverse selection" — a situation in which younger and healthier individuals find MSAs financially advantageous and choose MSAs while older and less healthy individuals remain in conventional insurance. The evaluation also was to study the effect of MSAs on health care costs, including any impact on the premiums of individuals with comprehensive coverage. The intention was that Congress would be able to examine the results of the evaluation and, on the basis of those results, determine future policy regarding MSAs.

Few consumers, however, have chosen to use MSA during the demonstration period; fewer than 75,000 policies were sold through 1998. As a result of the light usage, a full evaluation of the effects of MSAs could not be conducted. One portion of the evaluation was completed — a survey of insurers, which was conducted by Westat under contract to the General Accounting Office.

MSA proponents attribute the lack of popularity of MSAs during the demonstration period in part to various safeguards included in the demonstration legislation that were intended to prevent abuse of the accounts. Almost as soon as the demonstration was put in place, bills were introduced in Congress to relax the safeguards.

Another possible interpretation of the sparse usage of MSAs during the demonstration project is that MSAs are not attractive as a health insurance product per se and can gain acceptance only if MSA policies allow substantial abuse of the accounts as tax shelters. The provisions now being considered in conference would remove many of the anti-abuse protections while also making MSAs universally available.

## MSAs and Adverse Selection

A major concern is that universal access to MSAs would trigger widespread adverse selection in the insurance market. Adverse selection in the health insurance market takes place when healthy and less healthy segments of the population become segregated in different types of insurance plans. If healthier people choose high-deductible insurance with MSAs, the pool of people covered by comprehensive health insurance will tend to be sicker on average than it would be without MSAs. And if the pool of people who are conventionally insured incurs higher-than-average health care costs because some of the healthier people are no longer in the pool, the premiums for conventional insurance will rise. MSAs pose a strong risk of engendering this type of effect.

Young, healthy people who anticipate having low health care costs in the near future would likely choose to participate in MSA plans. They would do so because the MSA legislation allows participants to retain unspent health care dollars in their own accounts. Thus, people with low health care costs can accumulate tax free earnings on those funds and use them as retirement savings or for other purposes.

On the other hand, older and less healthy people who judge they are likely to incur significant health care costs would be better off financially if they remained covered by conventional health insurance, which generally has lower deductible amounts and relatively low caps on out-of-pocket expenditures. As a result, the pool of workers who will retain conventional insurance if MSA use becomes widespread could incur much-higher average health care costs than the larger pool of workers who are covered by conventional insurance today. To accommodate those higher average health care costs, the premiums charged for conventional insurance policies would have to increase, perhaps dramatically.

Research suggests that the premiums for coverage under a conventional health insurance policy could nearly double or even increase as much a four-fold, depending on the degree of adverse selection that MSAs trigger in the insurance market.<sup>4</sup> At those increased premium rates, it is likely that significant numbers of employers would be unwilling to offer their employees conventional insurance and also that the resulting decline in the market for conventional insurance would lead some insurers to cease selling it.

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<sup>4</sup> Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *Journal of the American Medical Association*, June 5, 1996, p. 1666-71; Len M. Nichols, et. al., *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, The Urban Institute, April 1996; and American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995.

## Provisions in the Archer proposal and the House-passed Patients' Bill of Rights

Both the Archer proposal and the House-passed Patients' Bill of Rights (H. R. 2990) would end the MSA demonstration. They would open up MSAs to use by all individuals and employees, removing the numerical cap on participation and eliminating the sunset date for MSAs contained in current law.

- Universal availability for MSAs would mean that any negative consequences that MSAs may have for the insurance market could become pervasive and difficult to reverse.
- The available evidence from the survey of insurers conducted under the demonstration project suggests that insurance companies set premiums for MSAs based on the assumption that adverse selection will take place. According to the report, "Insurers view high deductible plan enrollees as presenting a lower claims risk than enrollees in traditional low deductible plans....*Insurers expect relatively better health status and lower service utilization by enrollees selecting high deductible plans and price their products accordingly.* Insurers confirmed this conclusion in the survey."<sup>5</sup> [Emphasis added.]

The Archer proposal and H.R. 2990 also would increase the maximum amount allowed to be deposited each year in the tax-advantaged Medical Savings Accounts. The current demonstration project places strict limitations on such deposits to prevent use of MSAs as general-purpose tax shelters.<sup>6</sup>

- MSAs are similar to conventional Individual Retirement Accounts: contributions are deductible from income, and tax is deferred on the amounts the accounts earn. While deposits and earnings are never taxed if MSA funds are used to pay medical costs, the tax advantages of MSAs can be substantial even if the funds in the accounts are later withdrawn and used primarily or exclusively for *non*-medical purposes. If deposits are held until retirement age, for example, there is no penalty for withdrawal for non-medical purposes. Even if funds are withdrawn for non-medical purposes before retirement age, there are a number of circumstances under which the value of the tax-free compounding of the deposits for a number of years would outweigh the penalty that must be paid for a non-medical withdrawal.

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<sup>5</sup> U.S. General Accounting Office, Medical Savings Accounts: Results From Surveys of Insurers, December 31, 1998, GAO/HEHS-99-34, Appendix, p.14.

<sup>6</sup> For individuals, the maximum amount that can be contributed annually under current law is 65 percent of the insurance policy's deductible amount; for family coverage, it is 75 percent of the deductible amount. The House and Senate bills would allow annual contributions equal to the full deductible amount.

- MSAs differ from IRAs in one key respect — there are no income limits on MSAs that prevent wealthy people from using them as tax shelters. As a result, opening up MSAs to all individuals and increasing the amounts that may be deposited in them, as the proposed legislation would do, would enable high-income taxpayers who cannot use IRAs because of the income limits to begin using MSAs as significant tax shelters.
- When the MSA demonstration was established, a number of financial experts pointed out the possibilities for use of the accounts as tax shelters. An Associated Press article cited Eclipse MediSave America Corp., an MSA servicing company, as having calculated that “a family making \$3,375 annual MSA contributions (the maximum allowed under federal guidelines), and earning 8 percent interest a year could accumulate \$1.4 million in the account over 45 years. Even if they withdrew \$1,000 a year, they still would accumulate \$991,000.”<sup>7</sup> The family would have accumulated these amounts tax-free. A *New York Times* article at that time included an example of a relatively well-off MSA holder who chose to pay medical expenses with other funds, leaving his MSA deposits to grow tax-free.<sup>8</sup>
- The Westat Report indicates the MSA market may indeed be developing in this way. According to the survey, “Insurers reported targeting some segments of the insurance market [for MSAs], including highly-paid professionals, farmers and ranchers, partnership firms, and association groups.”
- In discussing changes in the ways MSAs were marketed between 1997 and 1998, the Westat report noted: “The entry of Merrill Lynch and other investment firms into the MSA trustee arena and the maturing of the market have led to increased investment choices for MSA holders. This trend may be affected as well by some insurers’ perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for paying medical expenses.”<sup>9</sup>

Finally, both the Archer proposal and H.R. 2990 include changes that would circumvent the rules under the current MSA demonstration that prevent employers from setting up MSAs in a manner that primarily benefits highly paid executives and effectively discriminates against lower-paid employees.

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<sup>7</sup> Associated Press release by Vivian Marino, August 15, 1997.

<sup>8</sup> Margaret O. Kirk, “Medical Accounts: Mixed Reviews,” *The New York Times*, July 5, 1998.

<sup>9</sup> U.S. General Accounting Office, *Medical Savings Accounts: Results From Surveys of Insurers*, December 31, 1998, GAO/HEHS-99-34, Appendix, pp. 15-16.

- Under the MSA demonstration now underway, deposits can be made in an MSA account either by an employer or an individual, but not by both in the same year. The demonstration also includes nondiscrimination rules requiring employers to make comparable contributions for all participating employees.
- The House bill would allow both employees and employers to make deposits in an MSA in the same year. That would make the nondiscrimination rules meaningless. An employer could make small, token deposits to the MSA accounts of all employees. Higher-income employees could add substantial additional funds to their accounts and exclude these additional amounts from their taxable income, but most lower-paid staff would not be able to afford substantial additional contributions.

Together, these provisions would greatly increase the potential for abuse of MSAs and use of the accounts as a tax shelter. These changes would make MSAs substantially more attractive and lead to much more widespread use by healthy, wealthy individuals. As a result, these expansions greatly compound the risk that MSAs pose to health care consumers, particularly those in need of comprehensive, affordable health care coverage.

COMPARISON OF THE ESTIMATED REVENUE EFFECTS OF H.R. 2990  
 AS PASSED BY THE HOUSE AND THE SENATE

Fiscal Years 2000 - 2010

(Millions of Dollars)

Effective	House Bill									Senate Amendment							
	2000	2001	2002	2003	2004	2005	2000-05	2000-10	2000	2001	2002	2003	2004	2005	2000-05	2000-10	
<b>I. Health-Related Revenue Provisions</b>																	
A. Provide an above-the-line deduction for health insurance for which the taxpayer pays at least 50% of the premium, phased in as follows: 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter	tyba 12/31/01	---	---	-491	-1,667	-1,773	-2,122	-6,053	-47,444	No Provision							
B. (H) Accelerate 100% self-employed health insurance deduction; extend eligibility for self-employed health insurance deduction to those who choose not to participate in employer-subsidized health plans; (S) 100% deduction of health insurance for self-employed	H = tyba 12/31/00 S = tyba 12/31/99	---	-287	-1,093	-697	[1]	[1]	-2,077	-2,077	-259	-1,065	-1,093	-697	---	---	-3,114	-3,114
C. Expansion of Availability of Medical Savings Accounts																	
1. Full availability of MSAs and lower minimum deductible (H) permit both employer and employee contributions; allow MSAs to be offered in cafeteria plans; (S) modify additional tax on distributions not used for medical expenses	H = tyba 12/31/00 S = tyba 12/31/99	---	-109	-326	-370	-414	-458	-1,677	-4,630	-40	-281	-326	-370	-414	-458	-1,889	-4,842
2. Federal employee participation in MSAs	pybofa 1/1/00	No Provision									Negligible Revenue Effect						
D. Provisions Relating to Long-Term Care																	
1. (H) Provide an above-the-line deduction for long-term care insurance for which the taxpayer pays at least 50% of the premium, phased in as follows: 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% thereafter; (S) Above-the-line deduction for 100% of premiums for long-term care insurance for individuals not participating in employer-subsidized plan	H = tyba 12/31/01 S = tyba 12/31/99	---	---	-49	-333	-369	-423	-1,174	-9,716	-88	-957	-1,173	-1,419	-1,576	-1,693	-6,305	-17,164
2. (H) Allow long-term care insurance to be offered as part of cafeteria plans, limited to amount of deductible premiums; allow long-term care services to be reimbursed under a flexible spending arrangement (2); (S) Allow long-term care insurance to be offered as part of cafeteria plans (2)	H = tyba 12/31/01 S = tyba 12/31/99	---	---	-106	-149	-167	-185	-806	-1,394	---	-97	-86	-89	-98	-108	-478	-1,199
3. Provide an additional personal exemption to caretakers of elderly family members	tyba 12/31/00	---	-175	-275	-280	-285	-291	-1,303	-2,798	No Provision							
4. Study of long-term care needs in the 21st century	DOE	No Provision									No Revenue Effect						
E. Increase the Time Period for Measuring Eligible Expenses Qualifying for the Orphan Drug Tax Credit	epoia 12/31/00	---	-6	-9	-10	-10	-11	-46	-117	No Provision							
F. (H) Add certain vaccines against Streptococcus Pneumoniae to the list of taxable vaccines in the Federal vaccine insurance program (3); study of Federal vaccine insurance program (3); reduce excise tax on all taxable vaccines to \$0.50 per dose beginning in 2005 (4); (S) Add certain vaccines against Streptococcus Pneumoniae to the list of taxable vaccines in the Federal vaccine insurance program	tyba 12/31/04	---	---	---	---	---	---	-35	-35	-271	Previously Enacted						



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Tel: 202-408-1080 Fax: 202-408-1056 center@cbpp.org http://www.cbpp.org

August 30, 2000

### **Health Insurance Deduction of Little Help to the Uninsured**

One of the principal tax proposals that Speaker Hastert has recommended be part of a minimum-wage package would create a new tax deduction for the purchase of health insurance and other health expenses by people who pay at least 50 percent of the cost of their health insurance premiums. At first glance, such a deduction may seem an attractive idea if it could help the uninsured to obtain coverage or help small businesses to cover their employees. Closer examination indicates, however, that this deduction — which would cost \$11 billion a year when fully in effect — would be unsound policy.

- It would provide little help to most of those who lack insurance and do little to reduce the ranks of the uninsured.
- Because the deduction provides a far deeper percentage subsidy for the purchase of insurance to higher-income business owners and executives than to lower-income wage earners, it could encourage small business owners to drop, or fail to institute, group coverage and rely instead on this deduction to help defray the cost of their own coverage. As a result, some workers could be forced to buy more costly and less comprehensive insurance on the individual market, and the ranks of the uninsured and underinsured could increase.

### **Deduction Would Do Little to Help the Uninsured**

The deduction would provide little subsidy to most workers who currently are uninsured and most workers for whom employers pay inadequate shares of premiums to make insurance affordable. Census data show that 93 percent of all uninsured individuals either have incomes too low to incur income tax liability or pay income tax at the 15 percent marginal rate.<sup>1</sup> These individuals would at most get a subsidy of 15 percent of the cost of purchasing health insurance, too little to enable most of them become insured. For low- and moderate-income families and individuals without employer-sponsored coverage, a 15 percent subsidy — which would leave

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<sup>1</sup> These data show that 18 million uninsured individuals — 43 percent of all of the non-elderly uninsured — owe no income tax; their earnings are too low for them to incur an income tax liability. These uninsured individuals would receive no benefit from a tax deduction; a deduction would do nothing to make health insurance more affordable for them. Another 20 million uninsured individuals — 50 percent of the non-elderly people without health insurance — pay income tax at a 15 percent marginal tax rate. A deduction would provide these taxpayers with a subsidy equal to 15 percent of the cost of insurance not covered by an employer. General Accounting Office, Letter to The Honorable Daniel Patrick Moynihan, June 10, 1998, GAO/HEHS-98-190R, Enclosure II. The analysis is based on the 1996 Current Population Survey.

them with the other 85 percent of the premium cost — is too small subsidy to make insurance affordable.

Rather than helping uninsured workers who cannot afford the premiums required to obtain adequate health coverage, such a deduction would, by and large, provide its principal benefits to individuals in higher tax brackets who already purchase individual insurance. The deduction would offset a much-larger share of the cost of individually purchased insurance for individuals in the 31 percent, 36 percent, or 39.6 percent tax brackets. Yet such individuals generally can afford insurance without a deduction.

- For a family earning \$35,000 whose employer does not offer insurance, the proposed deduction would reduce the cost of a typical family health insurance policy from \$7,350 to \$6,250, or from 21 percent of income to 18 percent of income.<sup>2</sup>
- Few families that have forgone health coverage because they cannot afford to spend 21 percent of income on it would find coverage affordable because a tax deduction had lowered its cost to 18 percent of income. It may be noted that the child health block grant established in 1997 set a limit on the premiums and copayments that can be charged under programs receiving block grant funds, with the limit being *five* percent of income for families above 150 percent of the poverty line and smaller amounts for poorer families.

This provision might be of modest help to some moderate-income families whose employer pays half or nearly half of the premium costs, since the deduction would be in addition to the employer subsidy. Even families whose employers pay 50 percent of the premium, however, would receive only very modest help from the deduction. The deduction would reduce the proportion of the premium these families must pay from 50 percent of the premium to 42.5 percent. While that might help some families afford insurance, the number of such families likely would be small.

In addition, the deduction could induce some employers currently paying more than 50 percent of premium costs to scale back their contribution to 50 percent or less. Also, as noted above, some employers may drop coverage altogether.

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<sup>2</sup> A General Accounting Office study found that in 1998, health insurance premiums for family coverage purchased in the individual, non-group market range from \$3,180 to \$14,233 per year, depending on factors such as age, health status, and region of the country. The GAO identifies a "medium" premium cost for a family of four as \$7,352. U.S. General Accounting Office, *Private Health Insurance: Potential Tax Benefit of a Health Insurance Deduction Proposed in H.R. 2990* (GAO/HEHS-00-104R), April 21, 2000. It should be noted that in addition to premium costs, health insurance policies typically have substantial deductibles and copayments. Families would have to come up with additional funds, over and above the family share of the premium, to cover these costs. While these costs would be deductible under the proposal, a family in the 15 percent tax bracket would still have to bear 85 percent of them.

The group that would appear to benefit most from this deduction would be higher-income taxpayers who purchase insurance as individuals. A health insurance deduction is worth more than twice as much to individuals in the top tax brackets than to moderate- and middle-income families in the 15 percent bracket.

### **Deduction Could Cause Some Erosion in Employer-Based Coverage**

While few low- and moderate-income workers would benefit, some could be harmed by the proposal. The proposed new health insurance deduction would allow small business owners or more highly-paid employees to purchase insurance for themselves, using the more generous subsidy the deduction provides for those in higher tax brackets, without the necessity of providing coverage for lower-paid employees. As a result, the deduction could provide an incentive for some small business employers to drop group coverage, or for some owners newly launching small businesses to decline to offer such coverage. To the extent this occurs, it would adversely affect some of the same workers the minimum-wage legislation is supposed to help.

John - There are Q&As prepared by Treasury on the MSA issue. Thought you might find useful. 

**Question:** If we expect MSAs to undermine the health insurance market, why isn't the revenue loss bigger?

**Answer:**

→ Medical Savings Accounts  
FTL

- The main concern about MSAs, especially in the short run, is not the revenue cost, but that they would undermine the market for conventional low-deductible insurance.
  - They do that by encouraging the healthiest people to opt out of the market for conventional insurance, which increases premiums for those left behind and, ultimately, can threaten the viability of many employer-sponsored plans.
  - In fact, if MSAs got a major foothold in the market, the revenue cost might actually *decrease* for two reasons:
    - (1) the people most likely to take MSAs are young, healthy employees, for whom average premiums are likely to be very small, and
    - (2) the millions of people who would no longer be able to afford insurance when its premium increases will tend to be those with higher than average premiums (the less healthy).
    - As such individuals give up or lose coverage, employers would no longer deduct contributions toward the cost of coverage from their taxable income and could eventually provide compensation in other, less tax-advantaged ways.
- With the present safeguards in place both the revenue cost and the effect on employment-based coverage have been small, but that would change were the current Republican proposals to become law.
  - The 1997 provision making MSAs available to self-employed and small businesses has been extremely unpopular.
    - In part that has occurred because insurance agents, who are a key component in the small employer health insurance market, have little incentive to sell high-deductible plans because commissions are smaller on high deductible plans than on more expensive low deductible plans.
    - People seem to be averse to the risk associated with high deductibles.
    - MSAs are a new product, and it probably will take time for people to understand them.
  - The Republican proposal is likely to be much more popular, for several reasons.
    - It makes MSAs available to tens of millions of working people who are currently covered by employment-based insurance.
    - It would lower the required deductibles, making the insurance policies more attractive to individuals who are slightly averse to risk.
    - Large firms tend to purchase insurance directly from insurers rather than through individual insurance agents, so the commission structure will not be an inhibiting factor for large employers.
    - Participation by larger firms will allow MSA-related catastrophic insurance plans to more easily provide the sort of network arrangements common to other modes of coverage under which doctors and hospitals offer services at large discounts. Thus

many MSA enrollees will be able to obtain discounts from providers rather than paying the "sticker" price as they now generally do

- Young, health workers may clamor for the choice of the high-deductible, low-premium, option, especially if they believe that they will have the option to return to the conventional, low-deductible plans when they become older and more likely to consume substantial amounts of medical care.
- Because the penalty for many non-medical withdrawals is eliminated in the Senate proposal, it effectively converts MSAs into very generous "IRAs"—not subject to the limits that apply to contributions to and withdrawals from real IRAs and employer retirement plans.

### Background

- The MSA provisions in the Republican version of Patient's Bill of Rights (PBOR), which is currently in conference, would cost about \$5.4 billion over ten years.
- Under the Congressional proposals, many workers currently covered by employment-based health insurance would be offered the choice of a high deductible plan and would be allowed to deposit all or a portion of the deductible in a medical savings account.
- The proposals would reduce by one-third the required catastrophic deductible (to \$1,000 for individual and \$2,000 for family coverage).
  - That would not only exacerbate the adverse selection problem (that is, the flight of healthy individuals from conventional insurance plans into "catastrophic insurance"), but also eviscerate the incentive for economizing on health care expenditures, which is the principal rationale for MSAs.
    - Over 90 percent of medical expenditures are incurred by individuals and families whose annual expenditures exceed the deductibles in the Congressional proposals.
    - People with expenditures above the deductible would have additional incentive to economize of health care once their expenditures reach the deductible.

### *Treasury / Ways and Means*

- Congressional Democrats have proposed an alternative as part of the PBOR negotiations that would retain many of the important safeguards built into the original demonstration, while conceding some modest expansions. It would:
  - (1) extend the MSA demonstration for two years,
  - (2) double the size of firms that can participate (from 50 to 100 employees),
  - (3) increase the cap on the total number of individuals that can participate in the demonstration to 1 million, and
  - (4) mandate the GAO to study the impact of MSAs on the cost and availability of traditional health insurance.

→ This is the alternative that Newbold signed off on.

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