

Embargoed until 10am  
March 8, 2006

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Before the  
United States Senate Committee on Finance

**Taking a Checkup on the Nation's Health Care Tax Policy: a Prognosis**

March 8, 2006

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\* This testimony draws heavily on Burman and Gruber (2005). Views expressed are mine alone and do not necessarily reflect the views of any organization with which I am affiliated.

Chairmen Grassley, Ranking Member Baucus, and Members of the Committee:

Thank you for inviting me to share my views on the state of tax policy with respect to health care in the United States. This hearing is extremely timely. Over 45 million Americans under age 65—the overwhelming majority of them in working families—lack health insurance. They are less likely to obtain important preventive screenings while healthy, and they receive lower-quality care when sick.<sup>1</sup> And, the public ultimately shoulders the burden of paying for the medical treatment of those lacking insurance, through either higher taxes or higher health care costs.

The tax system has played an important role in the evolution of the market for health care, and tax reform will inevitably be a part of the solution to the market's problems. Tax subsidies for health insurance and health care will reduce federal income and payroll tax revenues by over \$200 billion in fiscal year 2007. Almost all of that revenue loss is attributable to the exclusion from income and payroll taxes of employer contributions to employer-sponsored health insurance. Thus, it is no surprise that most Americans under age 65 get their insurance at work. What may be surprising, however, is that even with such huge subsidies, more and more people are becoming uninsured, especially the young, those with low incomes, and those who work for small firms.

Some observers have suggested that the tax subsidies are a significant part of the problem. The subsidies encourage people to get insurance at work, stifling the individual nongroup market, and they encourage employers to provide overly generous insurance since the cost is subsidized. What's more, the subsidy is upside down—aiding most the high-income families that would probably purchase insurance under any scenario, and providing little aid to those of modest means.

Some, such as former Council of Economic Advisers chairman R. Glenn Hubbard and colleagues, have suggested that the best option would be to eliminate the employer exclusion altogether and let the market come up with cost-effective ways to supply health insurance to the public. But, in an unfettered free market, health insurance is likely to be too expensive for four reasons. First, the very act of having insurance increases utilization. People spend more when someone else is writing the check, but this causes insurance to be more expensive than it might be (a phenomenon known as moral hazard). Second, insurance is most attractive to people who expect to benefit most from it—such as those with chronic conditions and people who plan to have children. Because insurers can only imperfectly match premiums to expected utilization, they have to assume that purchasers have higher costs than the population average. That means that healthy people get a relatively bad deal from insurance—unless they can align themselves with a large group. (This feature of insurance is called adverse selection.) Third, the existence of free—even if inadequate—emergency health care for those with low incomes serves as a deterrent for purchasing health insurance, both because the free care provides a safety net and because uncompensated care raises the cost of care for those with insurance. Finally, healthy people—especially in the non-group market—can only imperfectly insure against the costs of

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<sup>1</sup> Hadley (2003) estimates that mortality declines by 4.5 to 7.0 percent for people when they gain health insurance.

developing chronic illnesses, because premiums for non-group health insurance increase over time for sick people.

Subsidizing individuals who get insurance at work mitigates some of these problems and exacerbates others. On the one hand, encouraging individuals to get insurance at work reduces the problem of adverse selection, because people choose employment for reasons unrelated to health status, and also offers those who work for large firms a kind of renewable insurance. But this pooling works less well for small employers whose costs may be heavily influenced by the poor health status of one or several employees. On the other hand, the tax subsidies encourage over-use of medical services because people don't face the true costs of insurance. And, as noted, the current tax subsidies are poorly targeted. The value of a tax exclusion grows with income and is worth little or nothing to those with low incomes, even though they are most likely to be deterred by the cost of insurance.

On balance, despite its failings, the current employer-based system supplies health insurance coverage to almost 70 percent of American workers under age 65. Reform should build upon that coverage base instead of eroding it. Simplistic market-based solutions, though appealing, are likely to come up short. Market reforms that ignore adverse selection, for example, or the fact that a growing fraction of Americans simply cannot afford to pay for health care and meet other basic needs are bound to fail. The best option is to retarget existing subsidies, guarantee that low-income people can afford adequate insurance and that affordable health insurance exists either at work or in a reformed nongroup market, without encouraging excessive spending. And the best option might be one that works outside the tax system.

In the rest of my testimony, I summarize the latest data on who has health insurance and who doesn't, outline the various tax subsidies that exist for health insurance, examine how those subsidies affect the market for health insurance and employment, and briefly comment on some reform options.

### ***Summary Data and Historical Trends***

Most working-age Americans and their families receive health insurance through employers. According to the March 2005 Current Population Survey (CPS), 156 million non-elderly Americans (61 percent) in 2004 received primary health insurance coverage from either their own or a family member's employer (see figure 1). Of the 39 percent without employer-sponsored insurance (ESI), almost half were uninsured and most of the rest were enrolled in a public health plan (including Medicaid, Medicare, or a program sponsored by the Department of Veterans Affairs).<sup>2</sup> Only 5 percent of Americans under age 65 were covered by private non-group insurance in 2004.

The number of non-elderly people who lack health insurance has grown dramatically over the past two decades. In 1987, fewer than 32 million reported no source of health insurance (see figure 2). After a temporary reversal in the late 1990s, when a tight labor market and moderate growth in health insurance premiums caused more employers to offer health insurance,

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<sup>2</sup> VA insurance includes CHAMPUS, CHAMPVA, and any government-sponsored military health insurance plan.

the declining trend in insurance coverage resumed in 2000. By 2004, more than 45 million individuals under age 65 had no health insurance, according to the CPS.<sup>3</sup>

The uninsured are disproportionately young, poor, and working in small firms (see table 1). Only 12 percent of workers between ages 55 and 64 were uninsured in 2004, but nearly 27 percent of workers between ages 18 and 34 lacked health insurance coverage. Workers in poor households are much less likely to have insurance coverage than those with modest or higher incomes. Over half of poor workers (those in families with incomes below the federal poverty level) and about 40 percent of near-poor workers (those in families with incomes up to twice the federal poverty level) lacked insurance in 2004. In contrast, only 23 percent of workers with incomes between two and three times the federal poverty level and 6 percent of those with incomes greater than four times the federal poverty level were uninsured.

Small firms are much less likely than larger firms to offer health insurance. In 2004, about 52 percent of workers at firms with fewer than 25 employees were covered through their own or their spouse's employer; 33 percent were uninsured. In contrast, 78 percent of workers at firms with more than 1,000 employees were enrolled in an employer-sponsored health insurance plan, while 14 percent remained uninsured.

Although much of the disparity between small and large firms probably stems from the higher premiums charged to small groups, another factor is the difference in income levels between workers at small and large firms. Employees at small firms often earn less than employees at large firms, and so are less likely to have health insurance coverage for that reason. Indeed, Nichols et al. (1997) found that high-income workers at small firms in 1993 were more likely to be offered ESI than low-income workers at large firms.<sup>4</sup> Nonetheless, workers at every income level were much more likely to be offered insurance by a large employer than by a small one.

While few people rely on non-group health insurance plans for primary coverage, those without access to ESI are much more likely to do so. Non-group coverage is especially important to workers in small firms. Nearly 8 percent of workers in firms with fewer than 25 employees were covered by non-group coverage. For workers in firms with 100 or more employees, the figure was 3 percent.

There are also significant differences in coverage between adults and children: children are much more likely to be insured. While 20 percent of adults lacked health insurance in 2003, less than 12 percent of children did. (Burman and Gruber, 2005) This pattern holds across

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<sup>3</sup> The two lines on the figure reflect an inconsistency in the data series. Starting with the March 2000 CPS, which collected data for 1999, interviewers asked respondents who did not report any type of health insurance whether they were, in fact, uninsured. Of the 42.1 million persons who did not report health insurance coverage prior to the verification question, 3.1 million responded that they were not uninsured and did in fact have health insurance coverage (Nelson and Mills 2001). This reduces the number of uninsured in 1999 to 39.0 million. Again, in 2001, 3.5 million people who did not report having insurance said that they were not uninsured in response to the verification question. Based on this evidence, the number of people without health insurance in 1987 was likely under 30 million rather than the 31.8 million reported.

<sup>4</sup> In addition, lower-income workers are less likely to accept an offer of health insurance than those with high incomes because they cannot afford to pay their share of the premium.

income levels. Poor children are about half as likely to be uninsured as poor adults. Even among higher-income households, adults are more likely to be uninsured than children. Several factors explain this dichotomy. First, few childless families qualify for Medicaid, regardless of income, and State Children's Health Insurance Programs (S-CHIP) cover some children ineligible for Medicaid. Second, at higher incomes, families with children may value health insurance more than childless households do. Third, childless non-elderly adults are probably younger on average than those with children. As mentioned, younger adults are much less likely to have insurance.

### ***Current-Law Treatment of Employer-Sponsored Insurance***

The tax law provides substantial subsidies for employment-based health insurance. Employer contributions to employee health insurance are treated as nontaxable fringe benefits and are not considered part of total compensation for both income tax and payroll tax purposes.<sup>5</sup> However, if the employer contribution does not cover the entire premium, the employee pays for the remainder out of after-tax dollars. In other words, the tax exclusion applies only to the employer's share of the premium. But employees with access to flexible spending accounts (FSAs) may be able to pay their share out of pre-tax dollars.<sup>6</sup>

Employers may purchase insurance for their employees or provide insurance themselves (i.e., self-insure—typically, in a plan managed by a third-party administrator). Section 105 of the Internal Revenue Code sets out nondiscrimination rules for benefits provided by self-insured plans. These rules aim to prevent highly compensated managers from providing generous tax-free benefits for themselves that are not available to the rank-and-file workers.<sup>7</sup> The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandates and health insurance premium taxes that apply to third-party insurers.

Section 125 of the Internal Revenue Code allows employers to set up so-called “cafeteria plans” for administering certain employee benefits. A cafeteria plan allows employees to choose to receive part of their compensation either as cash wages or as one or more nontaxable fringe benefits, including health insurance. Flexible spending accounts are similar to cafeteria plans. They allow employees to set aside a fixed dollar amount of annual compensation to pay for out-of-pocket expenses for medical and dental services, prescription drugs and eyeglasses, and the employee's share of the cost of employer-sponsored health insurance. An FSA is financed through regular salary reductions. Any amount unspent at the end of the year is forfeited to the employer.<sup>8</sup> Employees pay no income or payroll taxes on the medical-related benefits paid

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<sup>5</sup> See Lyke (2006) for an excellent summary of current-law tax provisions and proposals related to health insurance.

<sup>6</sup> These employees tend to be at larger firms. FSAs are discussed later.

<sup>7</sup> In contrast, no nondiscrimination rules apply to the provisions of commercially purchased health insurance. The Tax Reform Act of 1986 included a new Section 89, which sets out nondiscrimination rules for employee health and welfare benefits, but the new restrictions raised a firestorm of protest among business interests and others and were repealed in 1989.

<sup>8</sup> Treasury Notice 2005-86 allows employees a grace period of up to two and a half months beyond the end of the calendar year to submit charges for reimbursement under a health FSA if the employer permits.

through a cafeteria plan or FSA. As a result, employees with access to such plans may pay for all or most of their medical costs with pre-tax dollars.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended ERISA to require employers with 20 or more employees who provide health insurance (whether self-insured or not) to allow participants and other beneficiaries (i.e., family members) to purchase continuing coverage for at least 18 months after it would otherwise cease for any reason, including termination, death, or divorce. Employers can charge covered employees up to 2 percent more than active employees for continuation of coverage.

The Trade Adjustment Assistance Reform Act of 2003 created a 65-percent refundable tax credit for health insurance purchased by workers certified by the Department of Labor as having lost their jobs due to foreign competition. Workers covered by a pension taken over by the Pension Benefit Guaranty Corporation also qualify.

Most individuals who purchase their own insurance directly, whether through COBRA or not, cannot deduct the cost. However, individuals may deduct the portion of premiums they pay for health insurance plus other medical expenses that exceed 7.5 percent of adjusted gross income (AGI). In addition, starting in 2003, the self-employed could deduct their health insurance premiums from income tax (though not payroll tax).<sup>9</sup>

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a four-year pilot program to make Medical Savings Accounts (MSAs) available to a limited number of people who are self-employed or work for small firms. The Medicare Prescription Drug Improvement and Modernization Act of 2003 renamed MSAs Health Savings Accounts (HSAs) and made them available to workers regardless of firm size. To qualify, individuals must be under age 65 and covered by a high-deductible health insurance plan, either offered at work or purchased in the non-group market. The deductible must be at least \$1,050 for single coverage and \$2,100 for family coverage. The maximum deductibles in 2006 are \$2,700 and \$5,450, respectively.<sup>10</sup> Employer contributions to an employee's HSA up to the deductible are excluded from taxable income for both income and payroll tax purposes—just as contributions to ESI are. Individuals' contributions to an HSA are deductible for income tax purposes.<sup>11</sup> Individuals 55 to 64 may make additional "catch-up" contributions of up to \$700 in 2006.<sup>12</sup> Balances in an HSA may be withdrawn to pay for qualifying medical expenses without penalty; non-medical withdrawals are subject to income tax, and withdrawals made before age 65 are subject to an additional 10 percent penalty. Unspent balances in an HSA can accumulate tax-free.

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<sup>9</sup> Before 2003, self-employed people could only deduct a portion of their health insurance premiums.

<sup>10</sup> The deductible limits are indexed for inflation.

<sup>11</sup> If the individual contributions are made through a cafeteria plan, they are also excluded from income for payroll tax purposes.

<sup>12</sup> The catch-up contribution limit phases up to \$1,000 by 2009. The concept of a catch-up contribution was implemented for individual retirement accounts and defined contribution plans in the Economic Growth and Taxpayer Relief and Reconciliation Act of 2001, based on the logic that women had to make additional contributions to catch up for the time spent out of the labor force. This is a dubious justification for a provision that mostly benefits men, but its application to HSAs is truly puzzling since their ostensible purpose is to offset unusually high medical expenses, not provide another retirement savings vehicle.

These supplemental tax subsidies for health insurance are small compared with the exclusion for employment-based health insurance. They will reduce income tax revenues by an estimated \$13 billion in fiscal year 2007. In contrast, the employer exclusion will reduce income tax revenues by between \$102 and \$147 billion in the same year.<sup>13</sup> Including payroll taxes, the total revenue loss could exceed \$200 billion per year.<sup>14</sup>

### **Health Insurance Market Failure**

One of economics' great insights is that, under certain circumstances, unfettered free markets can produce the most efficient (though not necessarily the fairest) outcomes. As Adam Smith noted, however, the invisible hand operates only if a number of conditions are met. *And virtually all of the conditions for market efficiency fail in the market for health insurance.*

For example, market efficiency requires that buyers and sellers have complete product information. Yet lack of information is an endemic problem for both suppliers and consumers in the health insurance market. Insurers have only a limited ability to determine the health status—or actuarial risk—of any individual. So a health insurance company that sets a fixed price for individuals in a particular class is most attractive to those with the highest risk. Thanks to this so-called adverse selection, the average insurance purchaser is riskier than average, which raises the insurer's costs and forces premiums to rise. Higher premiums then drive out lower-risk individuals, and the “death spiral” continues. If adverse selection is severe enough, a market might even disappear (Rothschild and Stiglitz 1976).

Medical care is a unique commodity—when people become sick, they'll do almost anything to get well. And because information on the effectiveness of various therapies is often lacking, physicians trying to provide the best care possible may prescribe tests or treatments even without evidence that they will lead to improved health. Aside from any moral or ethical objections, this lack of information renders cost-benefit analysis nearly impossible for the physician or patient. That means that healthcare decisions are often made with little regard for cost (Aaron 1991). This price-blindness may be a virtue for the ill, but it is a vice from an economic perspective.

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<sup>13</sup> The official government estimates are done for Congress by the Joint Committee of Taxation (JCT) and for the administration by Treasury's Office of Tax Analysis (OTA). Their estimates for the deduction for medical expenses and for health insurance premiums of the self-employed are similar, but their estimates for the exclusion from income tax of ESI diverge markedly. OTA estimates that the latter provision will reduce revenues by \$147 billion in fiscal year 2007; JCT estimates a \$102 billion revenue loss. The JCT estimates are smaller because they assume that, absent the tax exclusion, individuals who itemize deductions would be able to deduct the part of their health insurance premiums that, combined with other medical expenditures, exceeds 7.5 percent of AGI. OTA does not account for this offsetting deduction because it would logically require an increase in the tax expenditure estimate for the itemized deduction for health expenditures. Note that tax expenditure estimates are different from revenue estimates because, by convention, they do not take into account most behavioral responses or interactions with other tax expenditures. See Office of Management and Budget (2006) and JCT (2005).

<sup>14</sup> Payroll tax revenue losses are more than half of the income tax revenue cost. (See Burman et al. 2003.) Thus, conservatively, the payroll tax expenditure would be at least \$76 billion, based on Treasury numbers, or \$51 billion, based on JCT's estimates. This yields a range of \$153 to \$223 billion or more for the combined revenue loss.

Insurance gives individuals an incentive to use too much health care because they have to pay only a fraction of the cost (the deductible and coinsurance). They will demand medical procedures until the marginal benefit to them equals their out-of-pocket expense.<sup>15</sup> Fully-insured individuals may consume care until its marginal benefit is nil. To counteract this tendency, many insurers rely on managed care schemes that limit unnecessary medical expenditures.

But how much of the cost of medical care is due to this moral hazard that arises from the low net-of-insurance price of insured care? Newhouse (1992) argues that the lion's share of growth of health expenditures stems from advances in medical technology, not moral hazard. He concludes that overzealous efforts to limit moral hazard could do more harm than good if they reduce the incentive for medical innovation.

So-called free riders create another classic market failure. Because hospitals generally do not turn away very sick people who need care, the incentive to purchase insurance is diminished, especially for people who have little wealth to protect. So a small part of the health cost incurred by insured people and taxpayers is the cost of providing care for other individuals who did not provide for their own insurance—that is, those who choose to “free-ride” (Olson 1982).

Finally, full economic efficiency requires the existence of complete markets against not only current, but also future, risks. But it is virtually impossible to insure fully against future illness. Individuals cannot generally contract for health insurance at fixed rates, or under fixed terms, for more than one year in advance. While individuals can buy policies with rates determined by the experience of a subscriber group who purchased at a certain time, adverse selection makes such pools too expensive for healthy members over time. Members of the pool who turn out to be healthier than average can find insurance elsewhere with lower premiums. As the healthiest drop out, those who become sick and remain in the pool end up paying very high premiums. Thus, even in a set pool, insurance costs are based on health status in the future as well as when the policy is purchased (Hall 2000a).

The 1996 Health Insurance Portability and Accountability Act requires that all non-group insurance be renewable, but there is no limit on annual premium increases. Some states attempt to regulate premiums in the non-group market, but insurers can often find ways to circumvent such regulations (Hall 2000b).

Inability to renew on favorable terms may also arise in the employer market because premiums are underwritten. A large employer group partially solves this problem by continually refreshing the pool with healthy members who participate in the group for reasons largely unrelated to health status. Small employers, however, may be even more vulnerable to poor health outcomes than individuals in the non-group market are.

### ***Effects of Current Tax Subsidies***

The federal government spends \$200 billion or more a year on tax incentives for employer-sponsored health insurance. Those incentives encourage employees to participate in health

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<sup>15</sup> The marginal benefit is net of non-pecuniary costs, such as pain and discomfort, and other costs, such as lost time from work.

insurance plans, reducing adverse selection and free riders. At the same time, the subsidy prompts employees to demand more comprehensive health insurance than they would if they had to pay the full price. More comprehensive insurance exacerbates moral hazard (Congressional Budget Office 1994). The tax incentive thus contributes to high health care costs.<sup>16</sup> Combined with state laws and courts that put pressure on insurers to provide more and more benefits, health insurance costs in the small group and individual markets climb out of reach of low- and moderate-income households.

Health Savings Accounts are intended to mitigate the moral hazard problem by encouraging individuals to make more cost-conscious healthcare decisions. But HSAs may exacerbate the problem of adverse selection because the high-deductible plans will be most attractive to healthy individuals.

Similarly, there are both advantages and disadvantages to tying health insurance to employment. The main advantage of subsidizing ESI is that employment is a natural way to pool health insurance risks since people choose employment for many reasons other than their expected use of health care. Employment pooling works best for large firms, but Pauly and Herring (1999) claim that even relatively small groups can effectively pool most risks.

Another advantage with large groups is that administrative and marketing costs are lower (Monheit, Nichols, and Selden 1995). Collecting premiums as a part of payroll processing is less expensive than direct billing. Collecting insurance premiums, either explicitly or implicitly as a part of payroll processing, may also be an especially effective way to encourage participation because individuals like to break up large expenses into small, automatically collected pieces (Thaler 1992). Also, participation rates are higher if the choice facing workers is framed in terms of opting out rather than opting into an insurance plan. Large groups also have bargaining power to lower costs when dealing with insurers and providers. And, to the extent that workers can count on long-term employment with an established firm, ESI may provide more protection against premium increases than does the individual market.<sup>17</sup>

But ESI has drawbacks as well. It is an imperfect pooling mechanism. In a small firm, if one person gets sick, average costs can jump. Also, ESI provides limited renewability at best. People can lose their jobs or employers can decide to drop coverage—for example, because of

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<sup>16</sup> Indeed, Steuerle (2004) argues that, by pushing up the price of medical services and insurance, the tax subsidy actually reduces the number of people with insurance.

<sup>17</sup> An actuarially fair premium for a long-term health insurance contract would be one that does not vary over time in response to *unexpected* changes in health status. The long-term health insurance contract could allow premiums to vary with age to reflect the normal increase in health expenditures that accompanies aging, much as term life insurance contracts call for increasing premiums with age to reflect higher expected mortality risk. Initial premiums under such a contract would probably be higher than those in the current individual market because they would provide insurance protection not only against the health care costs incurred during that year, but also against increased premiums due to unexpected declines in health status. (A mitigating factor, however, is that long-term insurance might be more attractive to people who are healthier than average because they would value the insurance against future declines in health status.) As discussed earlier, individuals may find that their non-group health insurance premiums increase over time if they turn out to be sicker than average, even if they were healthy when they first purchased insurance (Hall 2000a). However, as discussed later, it may not be feasible for any single insurer to offer an actuarially fair premium schedule set for periods longer than one year because of adverse selection among individuals covered by such insurance.

unacceptably large premium increases.<sup>18</sup> Although no better mechanism for pooling or renewability currently exists in the individual market, such a mechanism might have arisen were it not for the large tax subsidy for ESI. For example, if they were subsidized, professional associations, unions, or religious institutions might also offer group health insurance policies to their members, much as they do with life insurance (Pauly and Herring 2001).

Finally, the subsidy for ESI amplifies the advantage of large firms over small ones as payers for health insurance. To see why, imagine a world without a tax exclusion for ESI. Many large firms might still offer health insurance even without a tax subsidy because of their advantages in pooling and lower administrative costs. Few if any small firms would. Now, after a tax exclusion is introduced, taxes fall for employees of firms that offer health insurance, but not for employees of other firms. Firms that do not offer health insurance now would face pressure from their employees to offer this valuable tax-free fringe benefit, and many would do so, but their compensation costs would increase relative to the large firms because, for a given package or benefits, health insurance is more expensive for small firms. The higher benefit costs place smaller firms at a competitive disadvantage. Effectively, the tax exclusion for ESI is a differential labor subsidy that is most valuable to large firms. It distorts the allocation of labor in favor of large firms and reduces production efficiency because workers who might be more productive at small firms are induced to shift to large firms by the tax subsidy.

The subsidy for ESI also creates other production inefficiencies. It gives employers an incentive to outsource low-income and younger workers (who would not value the insurance as much) and distorts workers' decisions about work and retirement (CBO 1994).

For all its imperfections, however, ESI covers almost 70 percent of American workers. Although some analysts believe that a better mechanism would arise if there were no ESI, there is a risk that major tax changes could significantly reduce insurance coverage. Removing or reducing employers' incentives to sponsor health insurance would have mixed effects on coverage. Although some young, healthy people might be induced to acquire coverage in the individual non-group market under a different set of incentives, the loss of ESI could be particularly devastating to old and unhealthy workers who would face prohibitively high health insurance premiums in the private non-group market.

Thus, the conundrum: almost 45 million Americans lack health insurance. Subsidizing the purchase of private non-group insurance for those who cannot obtain it at work seems a natural remedy. But subsidizing private non-group insurance makes employment-based insurance less valuable to those who could enroll in subsidized private insurance. Some employers will stop sponsoring health insurance if their workers do not demand it. Certainly, not all the workers at those firms would purchase non-group coverage. Others may increase the employee share of premiums or increase the cost-sharing requirements under the company health insurance plan (i.e., provide less generous insurance). Depending on how employers respond, a new coverage initiative could ultimately reduce the number of people with health insurance.

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<sup>18</sup> HIPAA requires insurers to offer insurance to terminated employees who have exhausted their COBRA coverage, but insurers can and do charge much higher rates for HIPAA customers. For example, CareFirst (Blue Cross-Blue Shield) charges a markup of about 80 percent for HIPAA coverage in Virginia compared with otherwise identical underwritten policies (<http://www.carefirst.com>, March 6, 2006).

## **Who Benefits from the ESI Subsidy?**

The current tax exclusion for employment-based health insurance benefits some workers more than others. Clearly, the exclusion does not help uninsured workers. Even among workers with employer-sponsored coverage, the benefits of the tax exclusion vary widely. Individuals in low tax brackets—mostly low-income people—get little or no benefit from the tax exclusion. Those—mostly higher-income families—with more generous coverage, such as family coverage or insurance with low deductibles, benefit more because the premiums for their health insurance policies are higher.

For three reasons, the subsidy for ESI most benefits those with high incomes. First, because the subsidy is provided in the form of an exclusion from income, it is most valuable to those who face high marginal tax rates. Second, those with low incomes are much less likely than people with higher incomes to be in jobs that offer health insurance. Third, lower-income people who do get health insurance at work tend to get less generous coverage than those with higher incomes do and their employers tend to pay a smaller share of the premium.

### **The value of the tax exclusion increases with income**

Earning compensation in the form of health insurance rather than wages produces indirect tax benefits. It can reduce both income tax and payroll tax liability. For example, people in the 15 percent federal income tax bracket save \$150 in income taxes for every \$1,000 of wages converted to employer contributions toward health insurance premiums. They save another \$76.50 in Social Security and Medicare payroll taxes. In most states, they also pay less state income tax. So the combined value of income and payroll tax exclusions can reduce the overall cost of health insurance by 25 percent or more for middle-income families.

The value of the tax exclusion increases sharply with income because income tax rates rise with income. The Tax Policy Center estimates that almost 31 percent of households were exempt from income tax filing or were in the zero tax bracket in 2005.<sup>19</sup> Most of them did not save anything in federal income taxes from reducing their taxable wages.<sup>20</sup> Another 15 percent were in the 10 percent bracket and 34 percent were in the 15 percent bracket. The income tax exclusion is worth 15 cents on the dollar or less to those households. Only about 20 percent of households were in the 25 percent or higher tax bracket.

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<sup>19</sup> Table T06-0054, available at [www.taxpolicycenter.org/estimates](http://www.taxpolicycenter.org/estimates). In 2005, 14.4 percent of tax filing units (generally, households) did not file and another 16.2 percent filed but were in the zero tax bracket (meaning that they had zero taxable income after claiming deductions).

<sup>20</sup> Some people in the zero bracket who receive ESI may benefit from the exclusion of employer-sponsored health insurance from taxable income. Some people's incomes are below the filing threshold simply *because* their health insurance premiums are excluded from income. For example, an individual earning \$8,200 in 2005 had no taxable income. However, if her employer stopped contributing \$2,000 toward health insurance and instead increased her wages by that amount, she would have positive taxable income and owe \$200 in income tax (before any credits). Note, though, that few people at this income level receive ESI (see table 1). There are also families in the 10-percent and higher tax brackets that would receive no benefit from the tax exclusion because nonrefundable tax credits such as education and dependent care tax credits offset all their income tax liability.

The lowest-income taxpayers receive no benefit from the income tax exclusion and only a small benefit from the exclusion of Medicare payroll taxes.<sup>21</sup> The exact amount of savings depends on whether workers or employers ultimately pay the employer's portion of payroll taxes. Most economists believe that workers pay the tax indirectly because wages are lower than they would be if the employer weren't paying for health insurance. To see why wages are lower, suppose an employer is willing to pay \$20,000 to a particular worker before considering taxes. If the employer has to pay payroll taxes at a rate of 7.65 percent, the employee now costs more than he or she is worth to the employer. Either the employee will not be hired or retained, or compensation would have to decline to \$18,579 or less to make the employee attractive to the employer. (Payroll tax on \$18,579 is \$1,421, so the total after-tax cost of the employee is \$20,000.)

### The Tax Price of Health Insurance

The tax price of health insurance to employees measures how taxes alter the price of health insurance.

The tax price of ESI is  $1 - as$ , where  $a$  is the share of the premium paid by the employer and  $s$  is the subsidy rate for ESI. Thus, if there are no tax subsidies ( $s = 0$ ) or the employee pays the entire premium ( $a = 0$ ), the tax price is 1. If  $s$  is 0.5 and  $a$  is 1, the tax price is 0.5. The lower the tax price, the less expensive health insurance is after tax savings are subtracted. If the employer pays 50 percent ( $a = 0.5$ ), the tax price increases to 0.75. Thus, the smaller the share paid by employers, the higher the tax price.

At least in the long run, employees are likely to pay the cost of the employer portion of payroll taxes in the form of lower wages. The exception to this rule would be situations where compensation is not set freely in a competitive labor market. An obvious example would be workers earning the minimum wage whose employers are prevented by statute from passing along payroll taxes (or most other labor expenses) in the form of lower wages.<sup>22</sup>

In 2005, the subsidy created by the exclusion from income and Medicare payroll taxes was worth about three cents on the dollar to the roughly 30 percent of households who were non-filers or in the zero tax bracket in 2005 (see figure 3). That is, the after-tax "price" of the portion of health insurance provided by employers was 97.1 percent of the pre-tax price for employees in the zero tax bracket. If employers cannot lower wages to offset their payroll tax costs, the employee's tax price would be close to 99 percent of the pre-tax price of health insurance.

Employees in the 10 percent income tax bracket pay a tax price of 87.3 percent, those in the 15 percent bracket pay 82.4 percent, and those in the 25 percent tax bracket face a tax price of 72.5 percent. The 0.4 percent of tax filing units in the highest 35 percent tax bracket face a tax price of 62.6 percent. Put differently, the richest 0.4 percent of tax filers get subsidies 12 times bigger than the poorest 30 percent get.

<sup>21</sup> They would also save on Social Security payroll taxes, but that saving comes at the expense of lost benefits at retirement, a significant factor for low-income workers, as discussed later. Very low income workers may also save unemployment insurance taxes, but those savings also come at the expense of lost potential benefits.

<sup>22</sup> This is one reason small firms and those with low-wage workers are less likely to offer ESI.

The issue is a bit more complex in the case of Social Security taxes. If we include savings in Social Security taxes, the tax price faced by low-income workers would fall from 97.1 percent to 85.8 percent of premiums. Social Security benefits, however, are highly progressive, so reduced future benefits are likely to offset much or all of a low-income person's payroll tax savings. Feldstein and Samwick (1992) estimate that the lifetime effective Social Security tax rate (including both payroll taxes and benefits) for employees with low covered earnings was negative in 1990. That is, the present value of future benefits more than offsets the tax paid for people with very low earnings. If employees understand that their current taxes will produce a valuable future benefit, then it may be inappropriate to treat Social Security payroll contributions as a tax for lower-income people.<sup>23</sup> So workers with low lifetime incomes may view the tax savings from health insurance as conveying no benefit at all since they sacrifice more than a dollar of retirement benefits for every tax dollar saved now.

The connection between Social Security benefits and taxes is weaker for higher-income people. For them, it might be more appropriate to treat Social Security payroll taxes as a pure tax. If so, someone in the 15 percent federal income tax bracket faces a tax price for health insurance of as little as 72 percent of premiums. In the 25 percent tax bracket, the price is under 63 percent. For very high income taxpayers, the price can fall near 50 percent, but most primary earners in the 35 percent tax bracket do not pay Social Security taxes on the margin, so the 63 percent tax price is more appropriate.<sup>24</sup>

### **Effective tax subsidy rates**

The tax exclusion for ESI provides a subsidy for health insurance that varies both among individuals and among firms. An individual gets no benefit from the tax exclusion if his or her employer does not offer health insurance. Even if the employer offers insurance, the employee may not be eligible for it because he or she works part-time. The subsidy rate generally depends on the percentage of the health insurance premium that is paid for by the employer. One exception is if the employer offers employees access to a flexible spending account, which allows employees to pay for their own share of premiums with pre-tax income. For employees with access to ESI, the overall size of the subsidy is governed by the amount of the premiums, and the subsidy rate depends on their income and payroll tax rates.

Virtually all factors that lead to high subsidy rates on health insurance increase with income. Burman et al. (2003) estimated effective subsidy rates by income in 1998.<sup>25</sup> As noted, the likelihood of having employer-sponsored insurance coverage increased dramatically with

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<sup>23</sup> Feldstein and Samwick (1992) point out that many individuals with low covered earnings were not in fact poor, but earned most of their income working for state and local governments that were exempt from the Social Security payroll tax.

<sup>24</sup> On the other hand, phantom taxes caused by the phaseout of itemized deductions and other provisions can increase the effective tax rate for upper-middle- and upper-income taxpayers. However, since these taxes are obscured by the complexity of the tax law, it is unclear that they would affect most taxpayers' decisions (Burman and Gale 2001).

<sup>25</sup> These estimates are the most recent available to my knowledge. They would tend to overstate subsidy rates at all income levels except the bottom (which is generally not subject to income tax) because of the income tax rate reductions enacted in 2001 through 2003. However, the basic picture of a tax subsidy that increases with income and premium costs that decrease as a share of income is still accurate.

income. Only 11 percent of families with incomes below \$10,000 had health insurance through their job, compared with over 80 percent of families with incomes above \$40,000. Lower-income families were less likely to work in jobs that offered health insurance coverage (Cooper and Schone 1997). Even if their employer offered it to full-time employees, low-income people are more likely to work either part-time or part-year, and therefore be ineligible for health coverage.

Accordingly, the value of the tax exclusion also increases dramatically with income. Among families with employer-sponsored health insurance, the premiums for those with incomes below \$20,000 averaged less than \$2,800 in 1998 (Burman et al. 2003). Average premiums more than doubled for families with incomes above \$75,000. Higher-income families average higher premiums because they are more likely to be covered by multiple policies and have family rather than self-only coverage. Indeed, the average family size for those with incomes below \$20,000 is about 1.9, compared with 3.1 for those with incomes above \$75,000. In addition, lower-income families are more likely to have coverage for less than a full year because of part-year employment.<sup>26</sup> The average employer premium share also increased with income, from 66 percent for families with incomes less than \$10,000 to 79 percent for families with incomes of \$200,000 or higher.

Finally, as discussed earlier, the benefit of any tax exclusion is greatest for high-income families because the income tax is progressive. That is, excluding a dollar of income from tax is worth much more to someone in the 35 percent tax bracket than to one in the 10 percent or 0 percent tax brackets.

Putting all these factors together, the picture is of a tax subsidy that overwhelmingly favors middle- and upper-income households. Families in the lowest income group received an average tax subsidy (including both income and payroll taxes) worth 9 percent of their premiums in 1998, compared with a subsidy of 33 percent of premiums for the highest-income group.<sup>27</sup> Consequently, while high-income families on average receive ESI worth three times as much as that received by low-income families, it only costs 2.3 times as much after tax savings are considered. (Note, however, that lower-income employees may receive some indirect benefits if employers subsidize their premiums to induce participation and to the extent that employer-based health insurance is less expensive than nongroup insurance.)

The bottom line is that the subsidy is not at all targeted to those who most need help paying for health insurance. Health insurance premiums were 40 percent of income for the poorest households in 1998, but their subsidy rate was less than 10 percent (see figure 4). Those with incomes over \$200,000 received subsidies equal to one-third of premiums even though premiums would amount to only 3 percent of their income without a subsidy.

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<sup>26</sup> It is probably also true that higher-income people demand more generous health insurance coverage from their employers than their lower-income counterparts, just as higher-income people are more likely to drive a Lexus than a Chevy. Unfortunately, I am not aware of any evidence on the quality and comprehensiveness of health insurance plans offered by employers to employees at different income levels.

<sup>27</sup> The measure of the tax subsidy shown here reflects both the federal income tax and the payroll tax, and applies to premiums only. It does not consider any worker premiums paid on a pre-tax basis or other pre-tax contributions made to a flexible savings account, each of which will also favor higher-income workers relative to lower-income workers.

## **Conclusion and Policy Options**

The government provides \$200 billion or more in annual tax subsidies for employment-based health insurance. Consequently, over 60 percent of Americans under age 65 are insured through an employer. (Americans age 65 and over are primarily covered by Medicare.) However, there are significant gaps in coverage, especially among small firms and low-income workers. Current tax subsidies are poorly suited to addressing those gaps because they favor higher-income workers and large firms that face the lowest insurance costs.

Because of the rampant failures in the health market, solutions are not simple. The data, however, suggest some obvious directions for improvement. To start, the upside down tax subsidy should be set right. Currently the largest subsidies go to those who have a strong incentive to get health insurance, even absent a subsidy, while those for whom health insurance is unaffordable get little or nothing. A better option would replace the tax exclusion with a refundable credit targeted at those earning less than the median income.

The President has proposed such a subsidy, but it was limited to purchases in the nongroup market, and so would tend to undermine ESI, which still covers many low-income people. A better option would be to allow the subsidy for group and nongroup insurance. The President's proposals would also deal with a fundamental limitation of traditional tax subsidies—they come too late to help cash-constrained families pay for services. Those proposals would advance the credit based on prior year income and allow the credit to be transferred directly to insurers. Allowing the credit to be also transferable to employers who provide health insurance would be a significant improvement.

Rearranging the upside-down subsidy is much easier said than done. One option would be to phase out the subsidy at higher incomes. This would reduce the incentive of employers to provide overly generous health insurance, while still providing an incentive for many currently uncovered individuals and families to obtain coverage. However, it would generate a lot of political opposition. (See the reaction to the Tax Reform Panel's relatively modest cap proposal.) An alternative (not without its own political challenges) would be to come up with a dedicated revenue source, such as a VAT. (Some portion of VAT revenues could also be dedicated to another looming health crisis, the exploding unfunded costs of Medicare and Medicaid as the baby boomers reach retirement.)

A more incremental option would be to help small employers to offer health insurance—for example, by providing a refundable tax credit (or direct subsidy) to defray the higher administrative costs that small employers face in purchasing health insurance. A more far-reaching reform would guarantee that small employers who continually pay at least a certain percentage of their employees' premiums would be able to purchase insurance at large-group rates, for example, from a pool similar to the Federal Employee Health Benefits Program.<sup>28</sup>

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<sup>28</sup> It is important that purchasing reforms not become a new avenue for adverse selection in the health insurance market. For example, CBO (2000) estimated that a proposal to allow so-called Association Health Plans to skirt certain state regulations, including community-rating requirements, would save an average of 13 percent in premiums for employees in the plans, but at the expense of other (less healthy) employer groups, which would pay an average of 2 percent more in premiums because of unfavorable selection.

Some options, however, could undermine the current system of employment-based health insurance without dealing with the endemic problems in the nongroup market. For example, former Council of Economic Advisers chairman Glenn Hubbard and colleagues recently suggested that the best option would be to eliminate the employer exclusion altogether and let the market come up with cost-effective ways to supply health insurance to the public. The President's Advisory Panel on Tax Reform recommended limiting the employer exclusion and allowing individuals to get the same tax benefits in the individual nongroup market as they can get through employment-based coverage. And the President has proposed a major expansion of tax subsidies for health savings accounts (HSAs), including income tax deductions and payroll tax credits for individuals who purchase the companion high-deductible health insurance plans.

These proposals would likely reduce insurance coverage—at least over the short- to medium-term. While it is possible that an unfettered free market might develop institutional arrangements to deal with the problem of adverse selection (and the other health insurance market failures) over time, nobody knows how those mechanisms would work and they might not exist. Meanwhile, a small employer who can get the same tax benefits as her employees without going through the hassle and expense of providing ESI would be sorely tempted to drop insurance coverage. Indeed, the healthiest workers would be happy to take a small increase in wages in exchange for dropped ESI coverage because cheap tax-subsidized insurance would exist outside of work. Left out in the cold would be those who are older or less healthy than average, for whom nongroup insurance premiums would be much higher, and low-income people to the extent that they benefited from cross-subsidization within the firm. It is largely for that reason that Jon Gruber (2006) recently estimated that the president's proposals for expanded HSA tax subsidies would reduce coverage. And, even if the subsidies caused coverage to increase, it would be at great cost per new worker covered.<sup>29</sup>

Other more far-reaching options, such as an individual mandate with vouchers sufficient to help low-income households afford health insurance, might achieve universal or near universal coverage, but analysis of those options is beyond the scope of this hearing.

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<sup>29</sup> See Burman and Gruber, 2005, for example.

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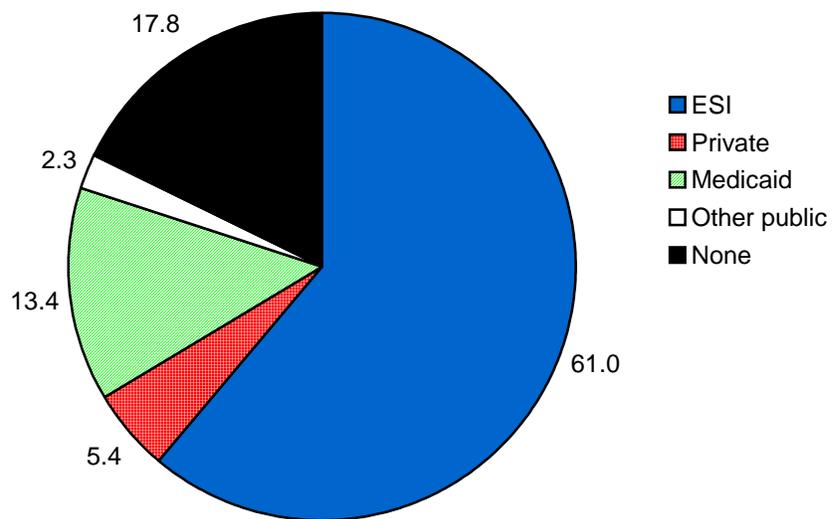
**Table 1. Primary Source of Health Insurance for Workers Age 18 to 64, by Demographic Category, 2004**

	Workers (millions)	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other	
<b>Total - Workers</b>	<b>143.0</b>	<b>69.6%</b>	<b>5.7%</b>	<b>4.4%</b>	<b>1.2%</b>	<b>19.1%</b>
<b>Age</b>						
18-34	52.6	59.1%	6.7%	6.7%	0.9%	26.7%
35-54	70.8	75.5%	4.7%	3.3%	0.9%	15.5%
55-64	19.7	76.7%	6.5%	2.3%	2.7%	11.8%
<b>Worker's Annual Income</b>						
<\$20,000	44.4	46.0%	8.0%	9.6%	1.7%	34.6%
\$20,000-\$39,999	46.9	72.6%	4.8%	3.1%	1.0%	18.5%
\$40,000+	51.7	87.2%	4.5%	1.1%	0.8%	6.4%
<b>Family Poverty Level</b>						
<100%	12.6	20.2%	9.7%	18.0%	1.3%	50.8%
100-199%	22.1	42.1%	7.3%	10.0%	1.6%	39.0%
200-299%	23.6	66.3%	5.7%	3.5%	1.3%	23.2%
300-399%	21.6	78.9%	5.4%	1.9%	1.0%	12.9%
400%+	63.0	87.3%	4.4%	1.0%	1.0%	6.4%
<b>Work Status</b>						
Full-time/Full-year	99.1	76.6%	4.2%	2.5%	0.8%	15.8%
Full-time/Part-year	18.9	54.6%	6.3%	8.8%	1.7%	28.6%
Part-time/Full-year	13.3	55.7%	11.1%	6.0%	2.0%	25.1%
Part-time/Part-year	11.7	50.3%	10.6%	11.6%	2.5%	25.0%
<b>Business Size (# Workers)</b>						
Self-employed	13.2	47.6%	19.4%	3.6%	1.8%	27.7%
<25	29.7	51.9%	7.7%	6.0%	1.4%	33.0%
25-99	16.7	69.5%	4.5%	4.2%	0.9%	20.9%
100-499	16.3	75.2%	3.3%	4.7%	0.8%	16.0%
500-999	6.0	79.4%	2.3%	4.1%	0.6%	13.7%
1000+	40.0	77.6%	3.3%	4.4%	0.9%	13.7%
Public Sector	21.0	86.2%	2.4%	2.8%	1.6%	6.9%
<b>Race/Ethnicity</b>						
White (non-Hispanic)	99.7	74.7%	6.4%	3.4%	1.2%	14.3%
Black (non-Hispanic)	15.5	63.6%	3.5%	8.1%	1.5%	23.4%
Hispanic	18.9	48.8%	3.2%	6.9%	0.7%	40.4%
Asian/S. Pacific Islander	6.5	70.1%	6.9%	3.7%	1.0%	18.3%
Am. Indian/Alaska Native	0.7	50.4%	3.7%	11.4%	1.2%	33.2%
Two or more races	1.7	64.0%	6.9%	5.8%	2.2%	21.1%

Source: Catherine Hoffman, Alicia Carbaugh, Hannah Yang Moore, and Allison Cook, *Health Coverage in America: Data Update 2004*. November 2005. The Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/uninsured/upload/Health-Coverage-in-America-2004-Data-Update-Report.pdf>,

Note: Medicaid includes S-CHIP. Other includes other public insurance (mostly Medicare and military-related).

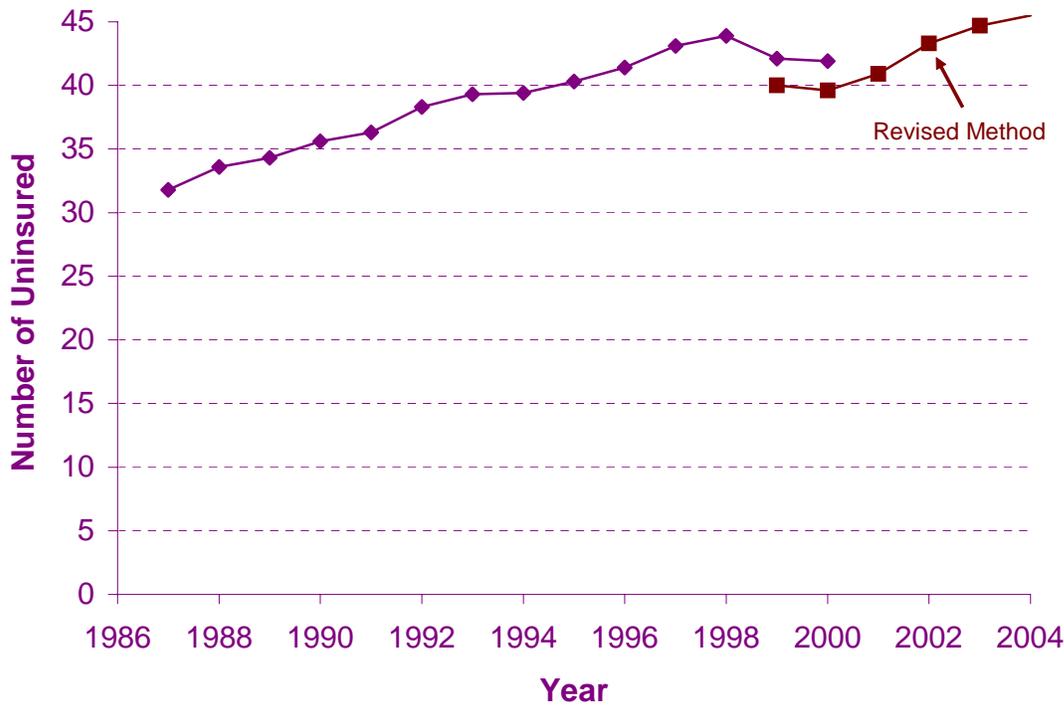
**Figure 1. Primary Source of Insurance for Non-Elderly Americans in 2004**



*Source: Health Coverage in America: Data Update 2004. November 2005. The Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/uninsured/upload/Health-Coverage-in-America-2004-Data-Update-Report.pdf>, accessed 3/06/06.*

*Note: Medicaid includes S-CHIP. Other includes other public insurance (mostly Medicare and military-related).*

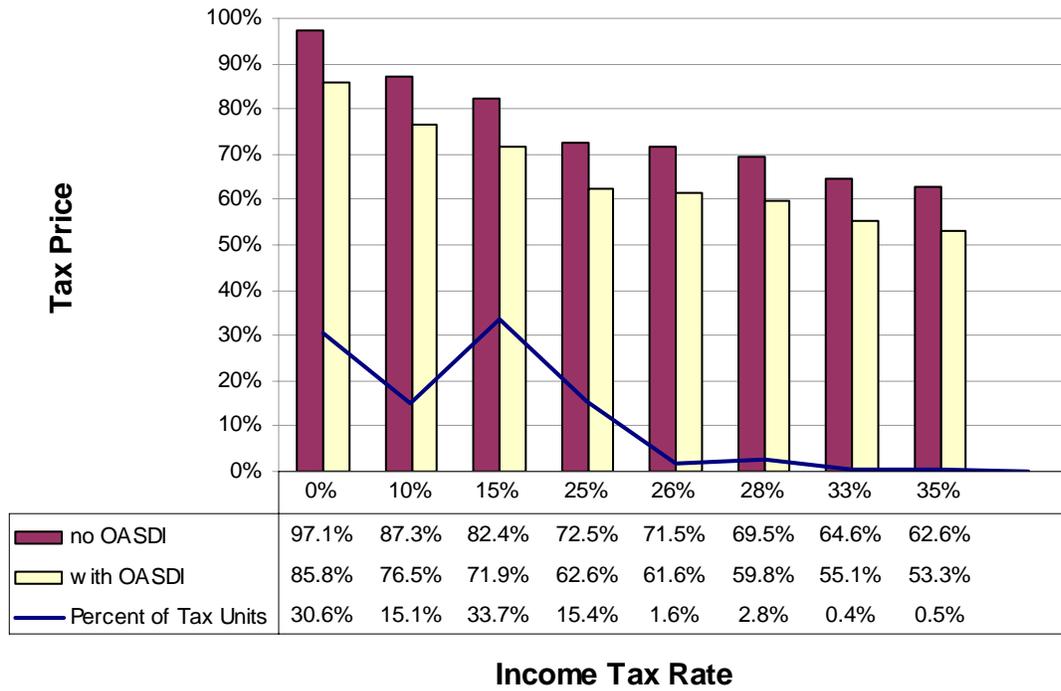
**Figure 2. Non-Elderly Uninsured, 1987–2004, in Millions**



*Source:* Paul Fronstin, Employee Research Benefit Institute (EBRI), "Sources of Health Insurance and Characteristics of the Uninsured," December 2000; and Catherine Hoffman, Alicia Carbaugh, Hannah Yang Moore, and Allison Cook, Health Coverage in America: Data Update 2004. November 2005. The Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/uninsured/upload/Health-Coverage-in-America-2004-Data-Update-Report.pdf>, accessed 3/06/06.

*Notes:* Revised estimates include as insured those who did not report having insurance on the CPS but then said that they were not uninsured in response to a verification question, which was not asked before 1999.

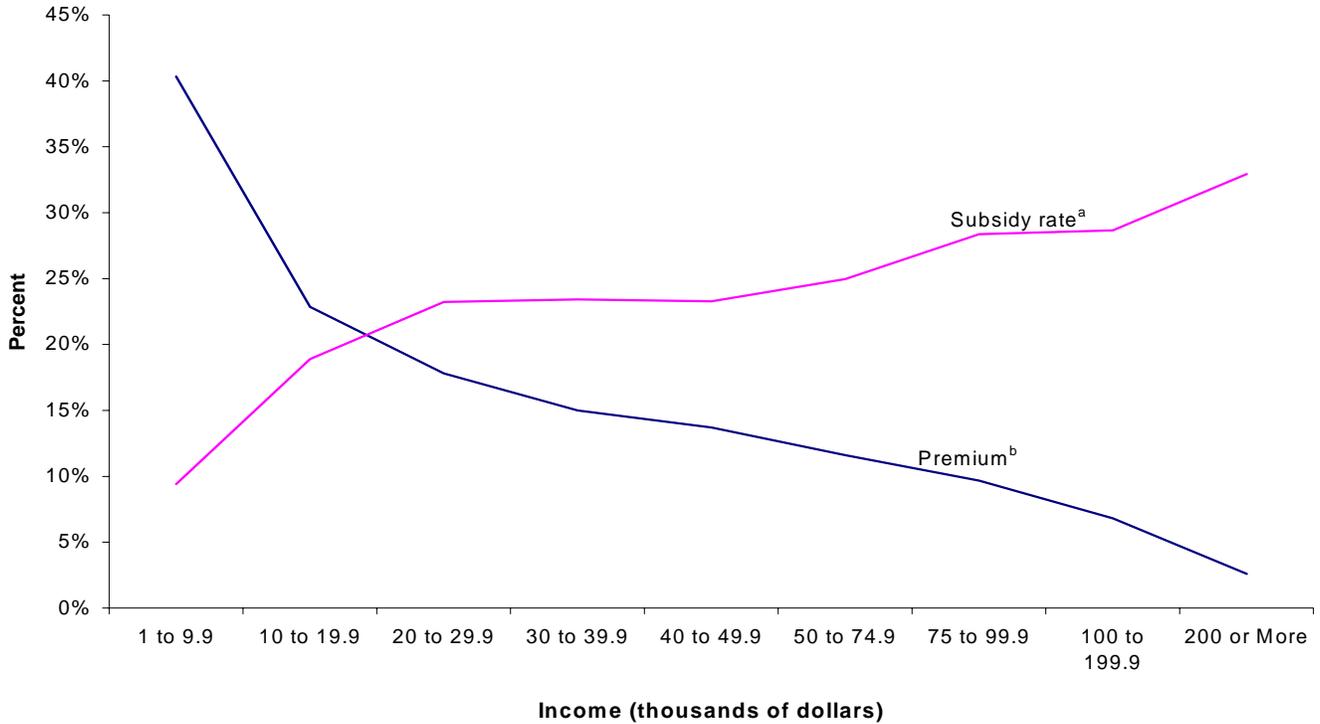
**Figure 3. The Tax Price of Health Insurance, 2005**



*Sources:* Tax Policy Center Table T06-0054 and author's calculations.

*Note:* 26 percent bracket is an AMT rate only; 28 percent bracket includes both regular tax and AMT rates.

**Figure 4. Health Insurance Subsidy Rate Compared with Premium Burden, by Income, 1998**



Source: Leonard E. Burman, Cori E. Uccello, Laura Wheaton, and Deborah Kobes, 2003. “Tax Incentives for Health Insurance.” Tax Policy Center Discussion Paper No. 12. Washington, DC: The Tax Policy Center.

<sup>a</sup> The subsidy rate is defined as the tax subsidy as a percent of premiums.

<sup>b</sup> The premium burden is calculated as the pre-tax premium as a percent of after-tax income.