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Statement of

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Before the
Senate Committee on Finance

Roundtable on Financing Healthcare Reform[*]

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[*] I thank Fiona Blackshaw, Stu Kantor, and Bob Williams for helpful comments and advice. Surachai Khitatrakun, Katie Lim, and Jeff Rohaly developed the models and provided the estimates.

Senator Baucus, Ranking Member Grassley, and Members of the Committee. Thank you for inviting me to present my views on financing health care reform. Views expressed are my own and do not represent those of the Tax Policy Center or the Urban Institute.

I applaud the committee for its leadership in finding ways to expand access to health care in a fiscally responsible manner. The latest statistics show that 46 million Americans were uninsured in 2007. In the current economic downturn, millions more have likely lost their health insurance either because they have lost their jobs or because their employer cannot afford to continue offering health insurance. All told, 50 million or more people in the richest country in the world may lack health insurance coverage

People without health insurance often delay seeking medical care when ill, and when they do visit an emergency room, they often receive substandard care. Those who have savings can get better care, but at the risk of financial ruin from any serious illness. And the uninsured impose costs on the rest of society. For example, I'd like to think that everyone infected with the H1N1 virus ("swine flu") would contact their medical provider, but people without health insurance often do not have a primary care provider and will postpone seeking care until they are very ill. This puts them at heightened risk of death and puts everyone they come into contact with while they postpone receiving care at risk of infection.

I especially applaud the committee and the president for insisting that health reform be accomplished in a fiscally responsible manner. As you well know, health care costs threaten to bankrupt the nation if we can't figure out a way to slow their growth and pay for the government's growing share. Adding to the government's unfunded health care obligations would be reckless and irresponsible.

In this brief statement, I will discuss some issues involved in measuring the impact of health care financing options, discuss an option to pay for universal health care coverage with a value added tax (VAT), and examine several incremental options to pay for all or part of health care coverage expansions.[1]

Issues in Designing and Measuring the Impact of Health Care Financing Options

One major issue to be addressed in evaluating options to pay for expanding access to health care is how to assess the distribution of benefits and costs. It is important to look at the effects of the coverage expansion and the revenue offset together, as a package. Otherwise, the coverage expansion looks unrealistically good (ignoring the fact that someone has to pay for it) and the revenue offsets look especially bad (ignoring the fact that they pay for a valuable new benefit).

[1] The Tax Policy Center has analyzed a number of ways to expand revenues. These estimates were prepared specifically for this hearing. They are very preliminary and subject to revision. A much more extensive set of revenue and distribution tables for the options presented here is available on our web site at http://www.taxpolicycenter.org/taxtopics/health_financing_options.cfm.

Examining tax and spending together should be done whether the health care expansions are accomplished via tax credits or spending programs. Otherwise there will be a bias in favor of tax subsidies, which may not be the most efficient mechanism. For example, a voucher and refundable tax credit may be economically equivalent, but the credit may result in less coverage because tax credits are generally paid after the taxpayer has filed a tax return, whereas a voucher can be advanced or transferred directly to the insurer or health provider. There are ways to make tax credits look more like a direct spending program, but this is often at the cost of unnecessary complexity.

There will be a strong temptation to target new health care expansions directly at those with low incomes. Obviously, lower-income people most need help in affording health care, and the current system is heavily skewed in favor of those with high incomes. And, targeting any subsidies can significantly reduce their cost.

But targeting itself comes at a cost. First of all, tying eligibility to income can create large implicit taxes: households whose incomes increase may lose eligibility for a valuable subsidy. Just like direct taxes, the tax implicit in income-testing can discourage labor force participation or extra work effort, which can undermine efforts to build self-sufficiency among low-income households. There are also timing problems. Low-income households often have very volatile incomes. Presumably policymakers want insurance to be available and affordable when incomes are low, but tax information is only available with a lag. This raises the possibility that the subsidy may come too late to help a family in distress.

A better option would be to make health insurance broadly available and pay for it with broad-based taxes. This carries the political disadvantage of replacing a hidden tax (income eligibility requirements) with an explicit one, but the explicit program is far simpler to administer. Everyone is eligible for health insurance, and people pay according to their ability to do so. It spreads the pain over more taxpayers rather than just on families who are on the cusp of attaining a moderate income.

VAT to Pay for Health Care

In my view, the best option to pay for universal health care is a value-added tax (VAT). A value-added tax is basically a sales tax on all goods and services that is collected in stages from all the producers in the supply chain. Almost every country in the world, with the notable exception of the United States, has a VAT. TPC estimates that a VAT of less than 10 percent would be sufficient to pay for health care for all people who are not currently covered by government provided health insurance (under Medicaid, SCHIP, Medicare, and veterans' health programs).

Here are the main advantages of a VAT to finance health care reform:

- It is the only plausible revenue source that could pay for universal access to health insurance without very tight targeting by income.

- Although a VAT by itself is regressive (falls most heavily on those with lower incomes), a VAT combined with free health insurance is highly progressive.
- Although a VAT by itself might fuel the growth in government, a VAT that is earmarked to pay for health care would serve as a brake on health care spending because otherwise the VAT rate would tend to increase.
- Announcing a *future* VAT would stimulate spending in the short term and help boost the economy out of the current recession.
- When fully phased in, a VAT would encourage saving (since it is untaxed by the VAT), which will boost long-term economic growth and provide a cushion against future recessions.

Table 1 estimates the cost and required VAT rate to finance providing health insurance to everyone who is not covered by a government-run plan (Medicaid, Medicare, S-CHIP, and veterans' programs). It is assumed that households receive a voucher whose value equals the cost of insurance for each eligible individual. The voucher varies by age and gender and may be transferred to an employer who provides qualifying insurance or directly to an insurer. Insurers would have to offer insurance to all applicants to qualify for the voucher (to avoid cherry picking). The voucher would replace the income and payroll tax exclusion for employer-sponsored health insurance as well as the income tax deduction for premiums paid by the self-employed.[2]

We estimate that such a program would cost roughly $600 billion in 2009 (Table 1). The cost would double over the budget period, to $1.2 trillion by 2019. The required VAT rate, assuming a comprehensive VAT base, would be about 6.7 percent in 2009 and 8 percent in 2019. The rate increases because health spending grows faster than other consumption. If the rate of growth of health costs could be slowed by 1 percentage point a year, the VAT rate would increase much more slowly, reaching only 7 percent in 2019.

The VAT plus a voucher is highly progressive (Table 2). The bottom 60 percent of households would gain far more in health insurance than they would lose from the VAT. The top 20 percent would pay significantly more on average. Because they spend so much, the highest-income 0.1 percent would face an average tax increase of $243,000 over and above the value of the health insurance voucher.

Some low-income households would be made significantly worse off, however, because they already receive free health insurance and would thus not benefit from the voucher. This could be rectified by providing a refundable tax credit for every individual. Table 3 shows the distribution of tax changes assuming a $500 per person refundable tax credit.[3] To offset the cost of the tax credit, the VAT rate would have to be 8.4 percent in 2009. Under this option, 60 percent of households would receive benefits in excess of the

[2] Tax subsidies for flexible savings accounts and health savings accounts should probably also be eliminated, but we lack the data necessary to estimate the effect of those programs. JCT tax expenditure estimates suggest that their revenue cost is very small compared with the ESI exclusion, so the error from excluding them is small.

[3] This is similar to the "prebate" proposed by advocates of the national retail sales tax (or FairTax). A VAT is preferable to a sales tax because the latter is very easy to avoid.

VAT tax paid, and more than 90 percent of households in the bottom 20 percent would be better off.

The actual VAT rate would have to be higher to account for the IRS's cost in administering it and the fact that, like all taxes, there would be some evasion. Assuming that the VAT could be applied to a very broad base, a 10 percent rate would probably be sufficient at the outset to pay for the health insurance voucher and tax credit.

For several reasons, the VAT should probably be phased in slowly. One important one is that a VAT during a recession would discourage consumption and potentially deepen the economic slide. However, when the end of the recession is in sight, the prospect of a *future* VAT would boost current consumption as people would accelerate purchases to avoid the tax increase.

That is, the VAT can be a powerful fiscal policy tool, and it could be used in future recessions. Indeed, the United Kingdom cut its VAT rate in an effort to boost spending during the downturn. When the economy is fully recovered and the VAT is fully phased in, it could provide an incentive to save more, which would boost our long-term economic growth and cushion the effects of future recessions (since taxpayers with savings need cut their spending by less than those without).

Repeal or Cap the ESI Exclusion

Under current law, employer contributions toward their employees' health insurance (employer-sponsored insurance, or ESI) are exempt from income and payroll taxes. Insurance purchased by self-employed individuals is deductible from taxable income.[4] Together, TPC estimates that these provisions will reduce individual income tax revenues by about $240 billion in 2010 (Table 4).

The ESI exclusion has been very successful in one sense—most working-age individuals and families get insurance through an employer—but it also suffers from serious flaws. The subsidy is very poorly targeted. High-income people get federal income and payroll tax subsidies worth on average more than 35 percent of income, while low-income households only benefit from the payroll tax exclusion (and saving on the payroll tax is a mixed blessing since reduced payroll taxes translate into substantial reductions in future Social Security benefits for low earners). (Figure 1.) Meanwhile, premiums are a much, much bigger burden for low-income people than for those with high incomes. It is no wonder that most low-income workers do not get ESI and many are uninsured.

[4] In addition, contributions to flexible spending accounts (FSAs) to pay for the employer portion of health insurance premiums and out-of-pocket expenses are also excluded from income, as are are retiree health insurance, supplemental insurance, and contributions to Health Savings Accounts. Lacking data, we did not model these provisions. Those tax expenditure are dwarfed by the exclusion for ESI, so this omission is unlikely to substantially affect our estimates.

The open-ended subsidy encourages employees to demand more generous insurance, which contributes to the rapid growth of health care costs. Individuals who have to pay little or nothing out of pocket for medical care are likely to overconsume such services.

The ESI system is especially burdensome for small employers and their workers since insurance typically costs much more for small than for large groups, and it can become prohibitively expensive if one worker in a small group experiences an expensive medical condition. Tying insurance to employment means that a job loss can lead to loss of insurance. COBRA and tax credits for workers who lose their jobs are aimed at mitigating this effect, but many workers fall through the cracks. And there is little recourse for a worker whose employer stops offering insurance in response to a decline in profits—likely a significant problem now.

Eliminating ESI would raise a lot of revenue—an estimated $240 billion in 2010 and over $3.5 trillion over 10 years (Table 4). This policy would be undesirable as a stand-alone measure because tens of millions of Americans would likely lose their health insurance. However, as a way to finance universal access to health care with a more progressive subsidy mechanism (as proposed by both Senator McCain and President Obama), this option has much to recommend it.

Alternatively, the exclusion could be capped. We estimated the effect of two sets of options. Under one variant, the exclusion would be capped at the average cost of health insurance in 2009, which we estimate to be $5,370 for single coverage, $10,227 for single plus one other person coverage, and $13,226 for family coverage. If those caps are held fixed in nominal terms, the option would increase income and payroll tax revenues by about $1.1 trillion over 10 years. Initially, few people would be affected—only 30 percent of households would pay higher taxes in 2010. However, because health care costs grow fast, by 2019, 43 percent of households—virtually all of those with ESI coverage—would be paying higher taxes. The actual effect of the policy and the distribution of winners and losers will depend on how the revenue gained is used.

We also show estimates assuming that the cap grows with at rate of overall price inflation (CPI) and at the rate of health care costs inflation. These options would reduce10-year revenues to $848 billion and $165 billion, respectively. The number of people who would face higher taxes would also decrease.

In isolation, a cap would reduce the number of people with ESI. It would also disproportionately affect those who live in high-cost areas, those who work for small firms, the self-employed, older workers, and people with poor health since they all tend to face higher premiums. It would be feasible, although not easy, to adjust the caps for all these factors, but we do not have sufficient information in our tax model to estimate the effect of such a cap. One option might be to set up a publicly sponsored market, like the Federal Employees' Health Benefits Program, where anyone could purchase inexpensive insurance and tie the cap to the cost of such insurance in each market.

Both repeal and caps on the ESI exclusion are very progressive because higher-income people are much more likely to get ESI than those with lower incomes, and their tax savings are greater because they are in higher brackets.

A less draconian variant would be to cap the ESI exclusion and deduction for the self-employed at the 90th percentile for premiums. At this premium level, 90 percent of households with ESI get insurance with lower premiums. We estimate the 90th percentile premiums to be $6,004 for single coverage, $11,974 for single plus one, and $15,290 for family coverage in 2009. Table 4 shows that the revenue raised with the higher caps would, not surprisingly, be smaller, but still substantial. For example, with an unindexed cap, the option would raise almost $500 billion over 10 years, even though few would be affected initially.

Other Financing Options

We examined a number of other options to raise significant revenue to help finance health care reform (Table 5). The first option would replace itemized deductions with a 15 percent tax credit for those who choose not to take the standard deduction. The rationale for the change—as with the Obama administration's proposal to limit the benefit of itemized deductions to 28 percent—is that itemized deductions largely represent subsidy programs rather than adjustments in the ability to pay tax. Thus, there is no good reason in principle to provide a larger subsidy rate for donations to Princeton by a millionaire than for donations to a house of worship by a lower earner.[5] The president's proposal, however, is quite complex. It is effectively an "alternative maximum deduction."

A nonrefundable 15 percent credit would raise $141 billion in 2011 and $1.5 trillion over 10 years compared with current law. If refundable, the credit would raise revenues by $113 billion in 2011 and $1.3 trillion over the budget period. The proposal, however, would generate opposition from charities, home builders, realtors, and state and local governments, all of which benefit from the current arrangement.

Two options would increase payroll taxes. Option 3 would increase the Social Security payroll tax rate on both employers and employees by 1 percentage point. It would raise $101 billion in 2011 and $1.1 trillion over 10 years. Option 4 would eliminate the earnings cap on earnings subject to Social Security tax. It would raise about $944 billion over 10 years. Option 4 would affect only relatively high-income people, whereas option 3 would affect those with modest incomes. All would raise marginal tax rates on work. Also, the revenues gained in the short run from Option 4 would be partially offset by higher Social Security benefits paid when the affected workers retire.

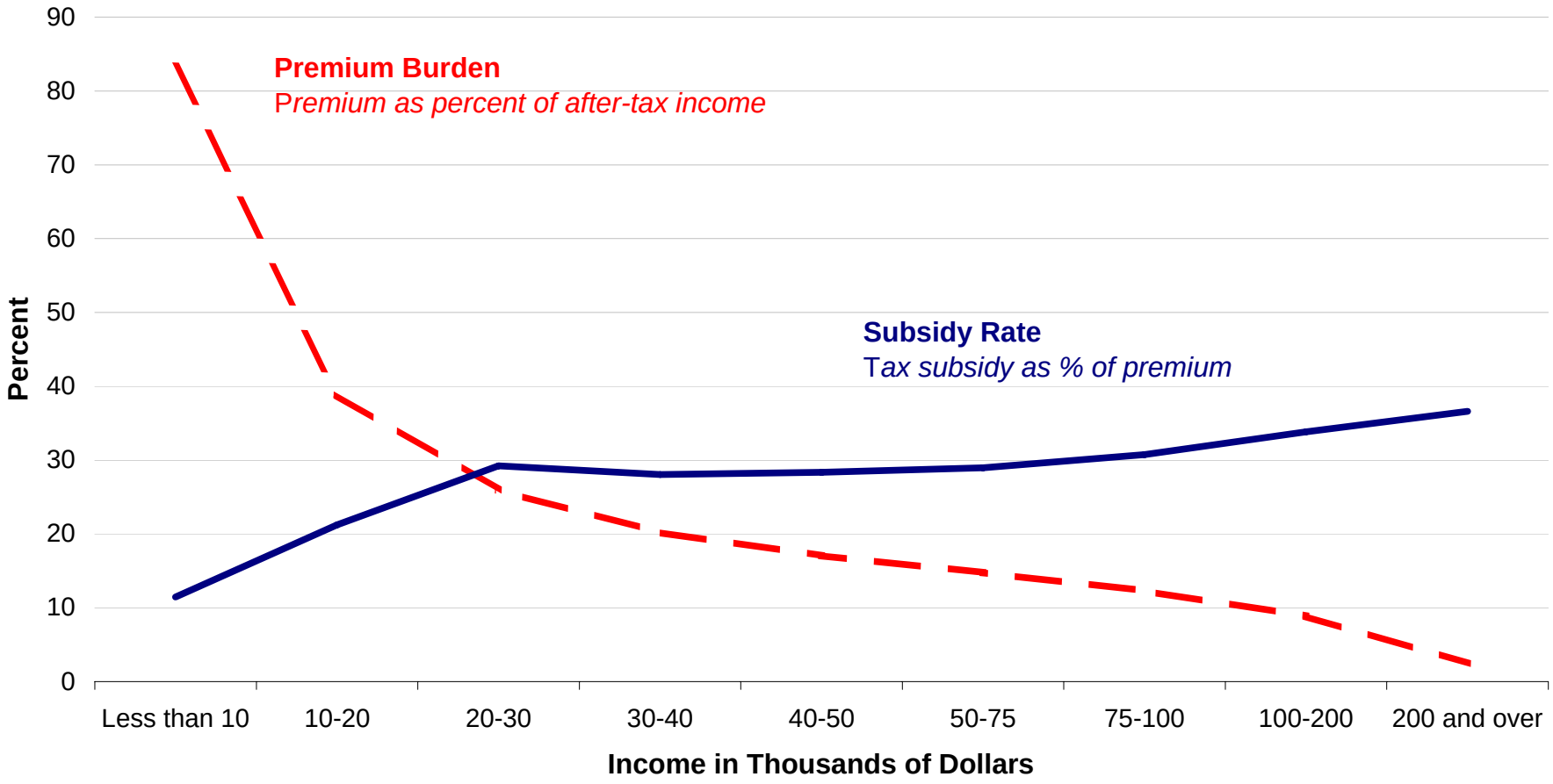
Option 5 would reduce the rate at which income tax parameters are indexed for inflation by 1 percentage point. (CBO considered an option to cut the CPI by about 0.3 percentage points.) The rationale is that the CPI overstates the effect of inflation on living

[5] Some miscellaneous itemized deductions actually do represent costs of earning income and probably should be allowed as a deduction. .

standards if price changes are not uniform. People substitute away from higher-priced items in favor of those with smaller price increases, which reduces the impact of inflation. The drawback is that more and more people would drift into higher tax brackets over time—a phenomenon known as bracket creep. This proposal has the advantage of raising more and more revenue over time—$54 billion in 2019 versus less than $8 billion in 2011.[6]

[6] The revenue gained is significantly more under the administration's baseline because the AMT parameters would be indexed under that baseline. Thus, a proposal to reduce the rate of indexing raises revenues under both the ordinary income tax and under the AMT. Under current law, the AMT is not indexed and those on the AMT would be unaffected. Also, many more people are subject to the AMT under the current law baseline.

Figure 1. ESI Subsidy Rate versus Premium Burden, 2004



Source: Urban-Brookings Tax Policy Center.
Note: Subsidy includes income tax and Medicare payroll tax savings.

Table 1. Replace ESI Exclusion and Self-Employment Health Insurance Deduction with Voucher to Purchase Private Insurance[a]

	Calendar Year											5 Year	10 Year
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010–14	2010–19
Revenue Loss Assuming Baseline Growth (billions$)	602.9	640.9	670.9	717.1	768.4	825.2	884.1	948.6	1,016.5	1,090.2	1,167.8	3,622.5	8,729.8
Required VAT Rate[b]	6.7%	6.9%	6.9%	6.9%	7.0%	7.1%	7.3%	7.5%	7.6%	7.8%	8.0%		
Revenue Loss Assuming Lower Growth Rate for Medical Costs (billions$)	602.9	632.6	653.4	688.9	728.2	771.4	815.2	862.7	911.8	964.3	1,018.3	3,474.5	8,046.8
Required VAT Rate	6.7%	6.8%	6.8%	6.6%	6.6%	6.7%	6.7%	6.8%	6.9%	6.9%	7.0%		

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-2).

a. Calendar year. Baseline is current law. Proposal replaces the ESI exclusion and health insurance deduction for the self-employed with a voucher to purchase private insurance, either directly or through an employer. Individual voucher value depends on age and gender; the total voucher for each tax unit is the sum of each individual's voucher. Only individuals not covered by public insurance receive a voucher.

b. The rate is based on a VAT applied to a comprehensive consumption base.

Table 2
Replace ESI Exclusion and Self-Employment Health Insurance Deduction With Voucher to Purchase Private Insurance
Impose Comprehensive VAT at Tax Exclusive Rate of 6.7%
Distribution of Federal Tax Change by Cash Income Percentile, 2009
Summary Table

Cash Income Percentile[a]	Percent of Tax Units[b]		Percent Change in After-Tax Income[c]	Share of Total Federal Tax Change	Average Federal Tax Change ($)	Average Federal Tax Rate[d]	
	With Tax Cut	With Tax Increase				Change (% Points)	Under the Proposal
Lowest Quintile	61.5	36.0	22.1	-6,370.8	-2,464	-22.1	-22.4
Second Quintile	53.1	46.3	6.1	-3,692.2	-1,585	-5.6	2.3
Middle Quintile	49.3	50.7	2.0	-1,818.9	-865	-1.7	12.8
Fourth Quintile	42.5	57.4	0.0	28.1	16	0.0	17.2
Top Quintile	21.8	78.2	-4.3	12,161.5	7,739	3.3	25.8
All	48.0	51.2	0.0	100.0	10	0.0	18.0
Addendum							
80–90	30.7	69.3	-2.3	1,818.5	2,285	1.9	21.1
90–95	17.8	82.2	-3.4	1,788.9	4,688	2.7	23.6
95–99	8.3	91.7	-5.3	3,818.6	12,150	4.1	26.8
Top 1 Percent	5.6	94.4	-5.8	4,735.4	59,344	4.3	30.3
Top 0.1 Percent	2.7	97.3	-5.8	1,949.7	243,260	4.2	32.3

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-2).

Number of AMT Taxpayers (millions). Baseline: 3.8 Proposal: 4.1

Notes: Calendar year. Baseline is current law. Proposal replaces the ESI exclusion and health insurance deduction for the self-employed with a voucher to purchase private insurance, either directly or through an employer. Individual voucher value depends on age and gender; the total voucher for each tax unit is the sum of each individual's voucher. Only individuals not covered by public insurance receive a voucher. The proposal imposes a revenue-neutral comprehensive VAT at tax exclusive rate of 6.7% to finance the voucher. The VAT is distributed to labor earnings plus all capital.

a. Tax units with negative cash income are excluded from the lowest income class but are included in the totals. For a description of cash income, see http://www.taxpolicycenter.org/TaxModel/income.cfm. The cash income percentile classes used in this table are based on the income distribution for the entire population and contain an equal number of people, not tax units. The breaks are (in 2009 dollars): 20% $19,792, 40% $38,213, 60% $65,692, 80% $104,318, 90% $150,433, 95% $203,190, 99% $522,025, 99.9% $2,131,606.

b. Includes both filing and nonfiling units but excludes those that are dependents of other tax units.

c. After-tax income is cash income less individual income tax net of refundable credits, corporate income tax, payroll taxes (Social Security and Medicare), and estate tax.

d. Average federal tax (includes individual and corporate income tax, payroll taxes for Social Security and Medicare, and the estate tax) as a percentage of average cash income.

Table 3
Replace ESI Exclusion and Self-Employment Health Insurance Deduction With Voucher to Purchase Private Insurance
Impose Comprehensive VAT at Tax Exclusive Rate of 8.4% With $500 Individual Cash Subsidy
Distribution of Federal Tax Change by Cash Income Percentile, 2009
Summary Table

Cash Income Percentile[a]	Percent of Tax Units[b]		Percent Change in After-Tax Income[c]	Share of Total Federal Tax Change	Average Federal Tax Change ($)	Average Federal Tax Rate[d]	
	With Tax Cut	With Tax Increase				Change (% Points)	Under the Proposal
Lowest Quintile	90.5	9.5	27.8	-8,032.1	-3,106	-27.9	-28.1
Second Quintile	71.2	28.8	8.1	-4,863.0	-2,087	-7.4	0.5
Middle Quintile	56.0	44.0	2.5	-2,310.2	-1,099	-2.2	12.3
Fourth Quintile	45.2	54.8	-0.1	133.0	74	0.1	17.3
Top Quintile	19.6	80.4	-5.4	15,400.8	9,801	4.2	26.7
All	60.7	39.2	0.0	100.0	10	0.0	18.0
Addendum							
80-90	28.3	71.7	-2.9	2,265.2	2,847	2.3	21.6
90-95	14.5	85.6	-4.3	2,270.6	5,950	3.4	24.3
95-99	7.4	92.6	-6.7	4,841.2	15,403	5.2	27.9
Top 1 Percent	5.2	94.8	-7.4	6,023.7	75,488	5.5	31.5
Top 0.1 Percent	2.5	97.5	-7.4	2,483.1	309,804	5.3	33.5

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-2).
Number of AMT Taxpayers (millions). Baseline: 3.8 Proposal: 4.1

Notes: Calendar year. Baseline is current law. Proposal replaces the ESI exclusion and health insurance deduction for the self-employed with a voucher to purchase private insurance, either directly or through an employer. Individual voucher value depends on age and gender; the total voucher for each tax unit is the sum of each individual's voucher. Only individual not covered by public insurance receive a voucher. The proposal imposes a revenue-neutral comprehensive VAT at tax exclusive rate of 8.4% to finance the voucher and $500 individual cash subsidy. The VAT is distributed to labor earnings plus all capital.

a. Tax units with negative cash income are excluded from the lowest income class but are included in the totals. For a description of cash income, see http://www.taxpolicycenter.org/TaxModel/income.cfm. The cash income percentile classes used in this table are based on the income distribution for the entire population and contain an equal number of people, not tax units. The breaks are (in 2009 dollars): 20% $19,792, 40% $38,213, 60% $65,692, 80% $104,318, 90% $150,433, 95% $203,190, 99% $522,025, 99.9% $2,131,606.

b. Includes both filing and nonfiling units but excludes those that are dependents of other tax units.

c. After-tax income is cash income less individual income tax net of refundable credits, corporate income tax, payroll taxes (Social Security and Medicare), and estate tax.

d. Average federal tax (includes individual and corporate income tax, payroll taxes for Social Security and Medicare, and the estate tax) as a percentage of average cash income.

7-May-09

Table 4. Revenue Gained from Modifying the ESI Exclusion (billions$)

	Calendar Year										2010–19
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	
1. Remove Exclusion											
Individual Income Tax	144.8	161.0	179.4	196.7	213.6	231.4	250.2	269.6	292.7	316.6	2,255.9
Payroll Tax	95.7	100.5	108.4	116.4	123.9	131.9	140.6	149.3	159.8	170.5	1,297.1
Total	240.5	261.4	287.8	313.1	337.6	363.3	390.8	418.9	452.5	487.1	3,553.0
2. Impose Unindexed Cap on ESI Exclusion											
Individual Income Tax	10.8	18.2	29.6	41.7	55.2	69.9	86.2	103.4	124.0	145.8	684.6
Payroll Tax	7.4	11.8	18.6	25.7	33.2	41.3	50.1	59.1	69.7	80.7	397.8
Total	18.2	30.1	48.2	67.4	88.4	111.2	136.2	162.5	193.7	226.5	1,082.4
3. Impose Cap on ESI Exclusion Indexed by CPI											
Individual Income Tax	10.3	16.2	24.9	33.8	43.6	54.2	66.3	79.2	95.1	112.2	535.8
Payroll Tax	7.1	10.5	15.7	20.8	26.3	32.1	38.6	45.4	53.7	62.4	312.6
Total	17.4	26.7	40.6	54.6	69.9	86.3	104.9	124.6	148.8	174.6	848.4
4. Impose Cap on ESI Exclusion Indexed by Medical Expenses											
Individual Income Tax	6.1	6.7	8.2	9.1	10.0	10.9	11.8	12.4	13.8	15.3	104.3
Payroll Tax	4.1	4.2	5.1	5.5	5.9	6.3	6.8	7.0	7.7	8.4	61.0
Total	10.2	10.9	13.3	14.6	15.9	17.2	18.6	19.3	21.5	23.6	165.2
5. Impose 90th Percentile Unindexed Cap on ESI Exclusion											
Individual Income Tax	3.0	6.4	13.4	22.6	34.5	48.1	63.5	80.1	100.0	121.3	492.8
Payroll Tax	2.0	4.1	8.4	13.9	20.9	28.6	37.2	46.1	56.6	67.5	285.2
Total	4.9	10.5	21.8	36.6	55.4	76.7	100.7	126.1	156.5	188.8	778.0
6. Impose 90th Percentile Cap on ESI Exclusion Indexed by CPI											
Individual Income Tax	2.8	5.3	10.1	15.8	23.0	31.6	42.1	53.6	68.0	83.8	336.0
Payroll Tax	1.8	3.4	6.3	9.7	13.9	18.8	24.7	30.9	38.7	46.9	195.1
Total	4.6	8.7	16.4	25.5	36.8	50.5	66.8	84.5	106.7	130.7	531.1
7. Impose 90th Percentile Cap on ESI Exclusion Indexed by Medical Expenses											
Individual Income Tax	1.5	1.6	2.1	2.3	2.5	2.7	3.0	3.1	3.4	3.8	26.0
Payroll Tax	1.0	1.0	1.2	1.3	1.4	1.5	1.6	1.7	1.8	2.0	14.5
Total	2.4	2.6	3.3	3.6	3.9	4.2	4.6	4.7	5.3	5.8	40.5

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-2).

Notes: Baseline is current law. The 2009 caps based on average premiums are $5,370 for single coverage, $10,277 for single-plus-one coverage, and $13,226 for family coverage. The 2009 caps based on the 90th percentile of premiums are $6,004 for single coverage, $11,974 for single-plus-one coverage, and $15,290 for family coverage.

Table 5
Revenue Raising Options
Impact on Tax Revenue ($ billions), 2010–19

	Fiscal Year										
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010–19[a]
Current Law Baseline											
Option 1: Replace Itemized Deductions with 15 Percent Nonrefundable Credit	16.7	141.1	130.3	141.4	152.0	161.9	171.3	180.6	190.4	200.8	1,486.6
Option 2: Replace Itemized Deductions with 15 Percent Refundable Credit	11.6	112.6	115.7	124.6	132.7	139.4	145.5	152.3	159.9	168.5	1,262.7
Option 3: Increase Social Security Payroll Tax Rate by 1 Percent[b]	80.0	101.4	98.8	102.7	108.0	112.9	117.7	122.4	127.3	132.1	1,103.4
Option 4: Eliminate Social Security Earnings Cap	53.9	83.8	84.4	87.2	93.1	98.4	103.1	108.7	113.1	118.8	944.4
Option 5: Index Individual Income Tax Using CPI - 1%[c]	3.6	7.8	14.5	20.1	25.6	30.1	35.6	40.9	48.3	53.8	280.3
Administration Baseline[d]											
Option 1: Replace Itemized Deductions with 15 Percent Nonrefundable Credit	16.3	124.0	104.2	114.4	124.1	133.1	141.3	149.3	157.7	166.2	1,230.4
Option 2: Replace Itemized Deductions with 15 Percent Refundable Credit	12.1	93.2	80.5	90.0	98.6	106.2	113.0	119.4	126.2	133.2	972.5
Option 3: Increase Social Security Payroll Tax Rate by 1 Percent[b]	83.1	108.9	108.5	113.4	119.2	124.6	130.0	135.2	140.7	146.2	1,209.8
Option 4: Eliminate Social Security Earnings Cap	56.7	94.8	99.2	103.2	109.9	115.8	121.1	127.5	132.6	139.2	1,100.2
Option 5: Index Individual Income Tax Using CPI - 1%[c]	5.6	10.3	19.1	27.3	36.2	44.6	55.3	66.6	81.0	94.4	440.5

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-2).
Notes: Estimates include microdynamic behavioral response. Estimates assume an elasticity of taxable income with respect to (1 - marginal rate) of 0.25, a labor supply response elasticity for changes in payroll tax rates of 0.1, and that increases in the employer share of payroll taxes are passed along to workers as lower nominal wages. The latter effect is assumed to occur gradually over the first three years of the proposal. Payroll and indexing options assume a 75-25 fiscal split; itemized deduction options assume a 20-80 split for the first year of the proposal and a 60-40 split for future years. All proposals are effective 01/01/10.
a. Numbers might not add due to rounding.
b. Proposal increases both the employee and employer rate by 1 percent.
c. All individual income tax parameters that are currently indexed to inflation using the Consumer Price Index for All Urban Consumers (CPI-U) would instead be indexed using the CPI-U less 1 percentage point. All unindexed parameters would remain unindexed.
d. Administration baseline extends all the individual income tax provisions in EGTRRA and JGTRRA that are set to expire on 12/31/10; maintains the estate tax at its 2009 parameters; extends the 2009 AMT patch including the allowance of personal nonrefundable credits against the AMT, and indexes the AMT exemption, rate bracket threshold, and phase-out exemption threshold for inflation.