

# **A Brief Analysis of the Bush Administration's Tax Proposals in the Context of SCHIP Reauthorization**

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## Executive Summary

As one response to Congressional proposals for reauthorizing the State Children's Health Insurance Program (SCHIP), the Bush Administration urges Congress to provide all Americans, not just children, with affordable access to basic health insurance. To achieve that goal, the Administration suggests policy changes in two areas, neither of which would increase net federal spending:

- As part of its 2008 budget proposal, the Bush Administration recommended replacing current tax preferences for employer-sponsored insurance (ESI) with a flat deduction of \$15,000 for family coverage and \$7,500 for insurance covering one adult – amounts that would increase after 2009 based on general inflation. As an alternative, Administration officials have also discussed a refundable tax credit paying \$4,500 for family coverage and \$2,500 for worker-only insurance. Both the deduction and credit would apply equally to ESI and to nongroup plans, unlike current tax law, which subsidizes ESI much more than nongroup plans.
- State Medicaid programs could take away federal money from institutional health care providers (such as hospitals that see a disproportionate number of indigent and uninsured patients) and use it to help uninsured, poor adults or the chronically ill buy private insurance.

Unfortunately, these proposals would not reach their objective of providing all Americans with affordable access to health coverage, for several reasons:

- Most (55 percent) of the uninsured earn too little to owe federal income taxes, and two thirds (67 percent) have incomes below 200 percent of the Federal Poverty Level. The Administration's proposed tax subsidies would be too small to make coverage affordable for these low-wage workers and their families. Recent research suggests that no more than 3 percent of the uninsured would use such subsidies to buy health coverage.
- Current law already permits waivers for states to redirect funds from institutional providers to health coverage for the otherwise uninsured. Very few states have taken advantage of this option, because it provides no new federal dollars, and it can be politically challenging to take money away from powerful stakeholders. The Administration's proposal would not change either factor, and so would be unlikely to induce changes in state health policy. More broadly, this proposal does not appear to give states significant flexibility they now lack.

On the other hand, these proposals could have serious, unintended consequences:

- The proposed tax subsidies are much more limited for family coverage than for worker-only insurance.
  - In 2009 – its first year - the proposed deduction would exceed average premiums for family coverage by only 9 percent, suggesting that many family policies slightly more generous than the average would no longer receive full subsidies. By contrast, the deduction would exceed average worker-only coverage by 48 percent, leaving behind very few worker-only policies.
  - In 2013 and later years, the proposed deduction would no longer cover the projected cost of average family insurance offered by employers. By 2016, the deduction would be 9 percent below the projected cost of average family insurance but fully 23 percent above the cost of average worker-only coverage.
  - The proposed tax credit likewise disadvantages family coverage. If it first becomes effective in 2009, it would finance 33 and 49 percent, respectively, of average employment-based insurance premiums for families and workers.
  - Smaller subsidies for family insurance may reduce the number of dependents enrolled in coverage. Moreover, one of the proposal's goals, according to the Treasury Department, is to reduce the generosity of covered benefits. If employers use the deduction as an "official" benchmark of appropriate coverage, family

insurance would indeed become less generous, reducing covered services and increasing out-of-pocket costs for adult dependents and children. Even if these outcomes are felt by only some recipients of dependent coverage through employers, the consequences could be significant. In 2005, ESI covered 39 million adult dependents, more than two-thirds of whom were women, as well as 45 million children.

- Eliminating the tax advantages that employer-based coverage has enjoyed for more than 60 years creates a serious risk of unraveling ESI, which now covers 60 percent of all Americans. Under current law, differential tax treatment raises the post-tax cost of nongroup coverage as much as 50 percent above ESI. This comparative advantage of ESI would fall to 0 percent under the proposal, which Administration officials describe as “revolutionary,” and which President Bush has stated is intended to “grow” the nongroup market. Such changes pose risks that include the following:
  - More than 2 million small companies offer coverage today, including more than 1.3 million businesses with fewer than 10 workers. Such firms report that insuring their employees improves recruitment, retention, and worker productivity. Under the Administration’s proposal, many of these businesses would lose the ability to offer coverage. Insurers typically will not sell to a firm unless a certain percentage of its workers enroll. If employees shift from ESI to the nongroup market, some small companies that cover their workers today will no longer be able to meet insurers’ participation requirements and so will be denied insurance.
  - Among firms of all sizes, ending ESI’s tax advantages would cause some employers to drop coverage and have their workers use the reconfigured tax subsidies to buy nongroup coverage. Many who lose employer-sponsored coverage, in which enrollment is nearly automatic, would find it difficult to navigate through the much more challenging nongroup market and purchase insurance. As a result, many would fall between the cracks and become uninsured.
  - In most states, the nongroup market raises premiums and denies coverage based on health risk. Accordingly, older workers would disproportionately lose coverage in a general shift from ESI to nongroup insurance. Not only could many suffer health harm, Medicare would spend more for their care when they turn 65.
  - Administrative costs are much higher for nongroup plans than for ESI. As a result, shifting coverage from ESI to the nongroup market will reduce the efficiency of American health spending.

The basic thrust of the Bush Administration’s proposals could be restructured to cover large numbers of uninsured without placing ESI at risk. For example, refundable, advanceable tax credits could be large enough to make coverage affordable to the low-income uninsured, and health coverage that meets consumers’ anticipated need for health care could be arranged for credit use. But providing such credits while preserving the tax-favored status of ESI would not be budget neutral. And states could receive various types of flexibility that could help expand coverage, but new resources may be needed to cover more than a small number of uninsured. Unfortunately, making major progress in covering America’s uninsured, without harming people who have coverage today, will not be free.

# A Brief Analysis of the Bush Administration's Tax Proposals in the Context of SCHIP Reauthorization

## Introduction

As one response to SCHIP reauthorization proposals, the Bush Administration has suggested broadening the conversation to tackle the larger problem of uninsurance, explaining that “Our goal is to have every American have access to an affordable basic [health insurance] plan.”<sup>1</sup> This brief paper describes the Administration’s proposals to achieve that goal. It then analyzes whether the proposals are likely to accomplish their objectives and whether they would create unintended consequences.

## I. Bush Administration proposals

The Administration’s proposals involve tax policy and state flexibility. Each of these two components is intended to be deficit-neutral, shifting either tax subsidies or mandatory expenditures from current to new uses.

### A. Tax proposals

The tax policy recommendation has taken two forms. In its budget plan for Fiscal Year 2008, the Bush Administration proposed replacing the current exclusion of employer-sponsored insurance (ESI) with a tax deduction that could be claimed for health insurance obtained either from employers or nongroup insurers. The full deduction would apply starting in 2009, regardless of a taxpayer’s actual expenditures for health insurance. The deduction would be \$15,000 for family coverage and \$7,500 for individual coverage. After 2009, these dollar figures would be indexed to rise with general inflation.

An alternative form of the tax proposal was recently described by Allan Hubbard, assistant to the president for economic policy and director of the National Economic Council. Under this approach, the current tax exclusion for ESI would be replaced by a fully refundable, advanceable tax credit of \$4,500 for family coverage and \$2,500 for individual coverage.<sup>2</sup> Like the deduction, the credit could be used for either ESI or nongroup coverage.<sup>3</sup>

### B. State flexibility

The Administration proposes to allow states to redirect federal Medicaid funding now targeted to health care providers (such as hospitals seeing a disproportionate share of indigent and uninsured patients) to other uses that could benefit needy residents. For example, such funds could be used to subsidize private insurance for poor adults who are ineligible for Medicaid or to establish high-risk pools that serve the chronically ill who lack affordable access to nongroup insurance.

## II. These proposals would cover very few uninsured

Neither element of the Bush Administration’s plan would reach its goal of giving all Americans affordable access to basic health insurance. In fact, neither would make a significant reduction in the number of uninsured.

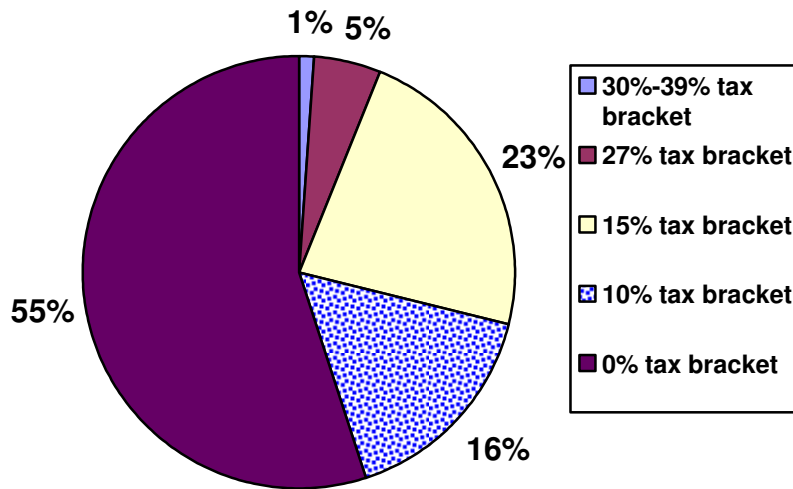
### A. Tax proposals

The tax deduction would be of little use to most uninsured, since more than half (55 percent) owe no federal income tax.<sup>4</sup> Altogether, 94 percent of the uninsured are in the 15 percent tax bracket or lower (Figure 1). For these individuals, the deduction would reduce health insurance costs by less

than 40 percent in post-tax income, even taking into account payroll taxes and the maximum possible state income tax rate.<sup>5</sup>

Very few uninsured would gain coverage from a tax subsidy paying 40 percent or less of health insurance costs. According to researchers at Rand and the University of California, even a 50 percent subsidy for insurance in the nongroup market would induce only 3 percent of the uninsured to purchase coverage.<sup>6</sup> Along similar lines, the Health Coverage Tax Credit, which pays 65 percent of premiums for workers displaced by international trade and for certain early retirees, has reached no more than 21 percent of eligible individuals, primarily because the subsidy is too small to make coverage affordable.<sup>7</sup>

Figure 1. The Uninsured, by Tax Bracket: 2002



Source: Glied and Remler, 2005.

The same is true of the proposed tax credits. Most insured Americans receive coverage from employers. For ESI, the average premium in 2006 was \$11,480 for family coverage and \$4,242 for worker-only coverage.<sup>8</sup> Based on the Administration's projected increases in future health insurance premiums,<sup>9</sup> these averages would reach \$13,718 and \$5,069, respectively, in 2009 (presumably the effective date of this alternative proposal as well). The proposed tax credits would thus finance 33 and 49 percent, respectively, of average insurance premiums for families and workers, inducing less than 3 percent of the uninsured to buy coverage, based on the above research.

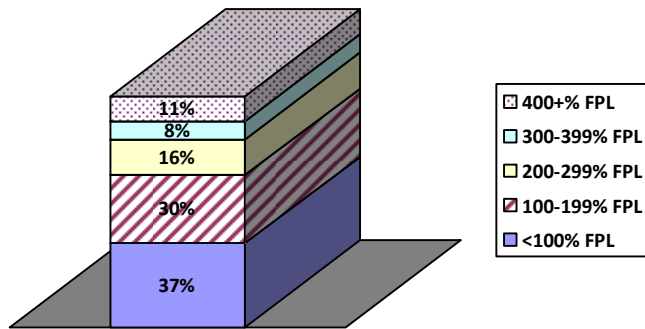
Of course, uninsured consumers could use the credits to buy policies less generous and thus less costly than those offered by most employers. But that same study by Rand researchers found that, when health insurance premiums are cut by reducing generosity of benefits, consumers are even less likely to purchase coverage.

For some uninsured, additional obstacles would result from the proposed use of the nongroup market. In most states, this market places older adults and those with chronic illness at a serious disadvantage. Premiums increase along with predicted medical risk, and benefits can often be excluded when they are needed to treat known health problems. According to one survey 71 percent of individuals with health problems who sought insurance in the nongroup market reported that it was very difficult or impossible to find coverage they could afford.<sup>10</sup> While the many uninsured who are relatively young and healthy would be charged lower prices in the nongroup market, coverage would often be unavailable or unaffordable for older adults and the chronically ill, for whom insurance may yield the greatest benefit in terms of health status. One analysis by Urban Institute researchers concluded that if all Americans age 55 to 64 received health coverage, the death rate in that age group would fall from 6.7 percent to 3.9 percent.<sup>11</sup> Those gains would be nearly impossible

to realize from proposals (like the Administration's) that use the current nongroup market to cover the uninsured.

At a basic level, the Bush Administration's proposals do not take into account that the bulk of uninsured are low-wage workers and their families. Two-thirds (67 percent) have incomes at or below 200 percent of the Federal Poverty Level (FPL)\* (Figure 2). The modest tax subsidies included in the Administration's proposals are simply not large enough to make coverage affordable for the vast majority of uninsured.

Figure 2: Uninsured by income: 2005



Kaiser Commission on Medicaid and the Uninsured and The Urban Institute, May 2007.<sup>12</sup>

## B. State Flexibility

In some ways, the Administration's budget proposal for state flexibility resembles current law. Presently, states can request waivers under Section 1115 of the Social Security Act to redirect federal funds from their projected uses (including institutional spending on disproportionate share hospitals and other providers) to health coverage subsidies for otherwise ineligible adults. However, because such waivers cannot increase net federal spending, and because politically powerful, institutional recipients of federal dollars rarely part willingly with their money, as of 2004, only 12 states had used this waiver authority to extend coverage to adults who otherwise could not qualify for federally-funded Medicaid.<sup>13</sup> It is hard to see why the Administration's proposal would change this result.

In fact, the Administration's proposal seems to provide less flexibility than current law. With 1115 waivers, states can fund expansions by shifting federal Medicaid dollars from any projected use, not just payments to hospitals and other health care providers. For example, waiver states have enrolled beneficiaries in managed care organizations, saved money by lowering capitated payments below projected fee-for-service levels, and used the savings to cover otherwise ineligible individuals. These alternatives have been particularly important to the states that, for largely historical reasons, have small allocations of federal dollars for so-called "disproportionate share" hospitals. Similarly, 1115 waivers permit states to provide the uninsured with either traditional Medicaid or coverage that more closely resembles privately-financed coverage. The Bush Administration's proposal appears to allow only the latter, ruling out traditional Medicaid. Put simply, this new proposal appears to authorize only some of the state flexibility allowed under current law.

## III. Unintended consequences of the Administration's proposal

The Administration's tax proposal could result in consequences that are unintended and problematic, including the creation of tax subsidies that would finance a much lower proportion of premiums for family coverage than for coverage of adult workers; and a potential weakening of the system of employer-sponsored insurance that now covers 60 percent of all Americans.

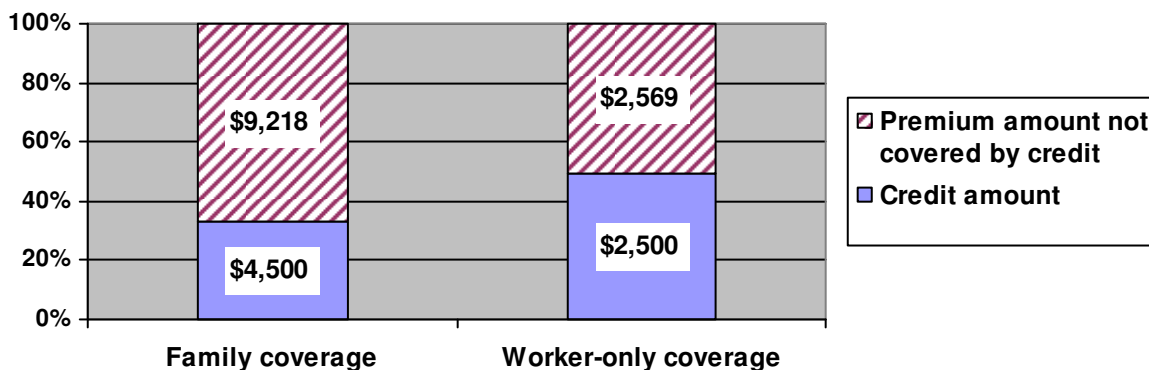
\* In 2007, the FPL is \$1,431 a month for a family of three; \$1,721 for a family of four; etc.

## A. The proposed tax subsidies will cover a much smaller proportion of premiums for family coverage than for plans covering individual adults

Under current law, tax subsidies for ESI apply equally to family coverage and worker-only coverage. All payments for both classes of coverage are excluded from income.

By contrast, as noted above, the contemplated tax credit would pay 49 percent of premiums for average worker-only ESI in 2009 but only 33 percent of premiums for family coverage (Figure 3). As a result, take-up would likely be lower for dependent coverage than for worker-only insurance, so the newly uninsured would disproportionately come from children and adult dependents who now receive ESI. Moreover, if the tax credit amount varies with the amount of premium payments, pressure to bring premiums closer to the level of the credit by cutting benefits and increasing cost-sharing would affect dependent coverage more heavily than worker-only insurance.

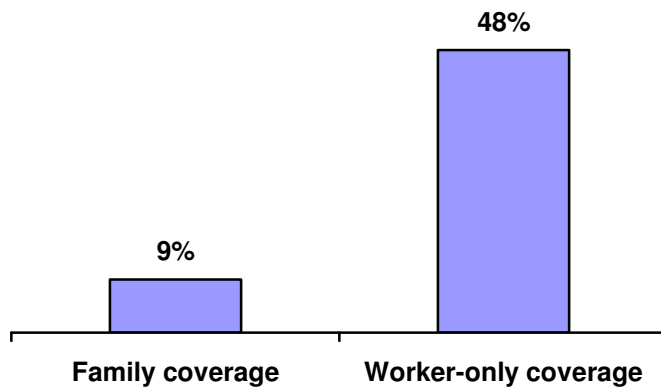
Figure 3. Proposed tax credits and projected average premiums for employer-sponsored insurance: family vs. worker-only coverage, 2009



Sources: KFF/HRET, 2006; CMS, 2007;<sup>14</sup> 2006 Medicare Trustees Report.<sup>15</sup> Note: Average premiums are based on the KFF/HRET 2006 Employer Survey and CMS' projected increases in per capita private insurance costs.

A similar pattern applies to the proposed deduction. Even during the proposed policy's first year (2009), the deduction will exceed average family premiums by only 9 percent, which suggests the deduction will not cover the cost of numerous family policies that have premiums modestly above the national average. By contrast, the deduction will exceed average coverage for single adults by fully 48 percent, so very little worker-only coverage will have premiums higher than the deduction (Figure 4).

Figure 4. As a percentage of premium, amount by which proposed deduction exceeds projected average premiums for employer-sponsored insurance: family vs. worker-only coverage, 2009



Sources and notes are the same as for the previous figure.

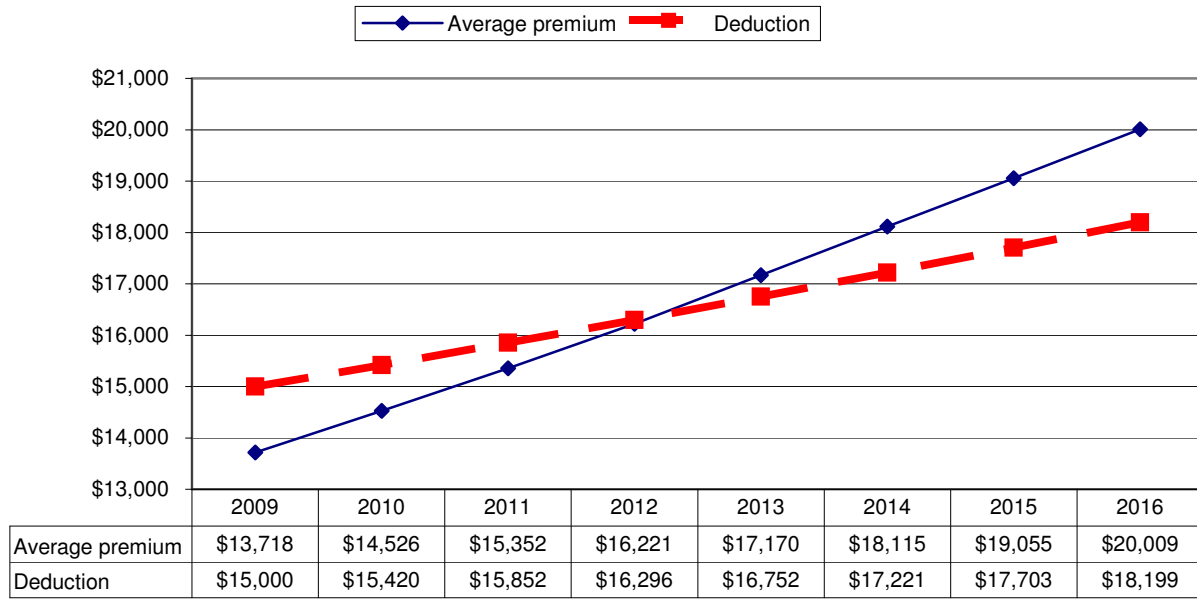
Moreover, the amount of the deduction is indexed based on general inflation, which rises much more slowly than health insurance premiums. Based on projections of the U.S. Department of Health and Human Services' Center for Medicare and Medicaid Services' (CMS), the deduction will stop covering average family insurance in 2013 and thereafter decline, as a percentage of projected average premiums (Figure 5). By contrast, the deduction would *exceed* projected average premiums for worker-only coverage during CMS' entire projection period, through 2016 (Figure 6). By the latter year, the deduction will be 9 percent below the projected average premium for family coverage but 23 percent above the average for worker-only coverage.

One of the purposes of this proposed tax law change is to encourage less generous coverage. According to the Treasury Department, "The value of the current exclusion rises with the amount of insurance an employee purchases. This creates a tax bias in favor of more expensive insurance." By contrast, the proposed deduction is not affected by the amount of insurance premiums, so "the tax bias for overly generous insurance would be eliminated."<sup>16</sup> However, an apparently unintended feature of the Administration's proposal is that the subsidy provided by the deduction is much more limited for dependents than for employees.

This lower level of subsidy has several implications. First, a lower level of subsidy could translate into lower take-up, hence less coverage. Second, employers may lower the generosity of the benefits they provide to conform to the "official" deduction. If this happens, very few recipients of worker-only coverage will be harmed, but many dependents would experience fewer covered benefits and higher out-of-pocket costs.

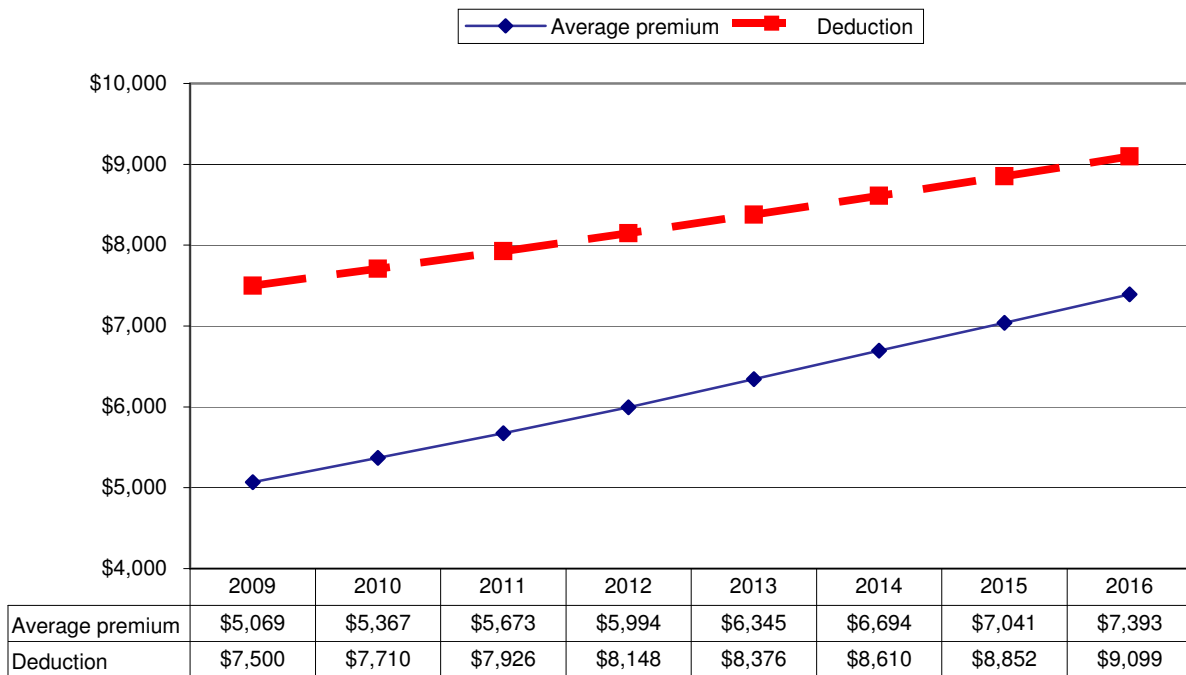
In 2005, 45 million children and 39 million adult dependents received employer-based coverage.<sup>17</sup> More than two-thirds of these adult dependents were women.<sup>18</sup> Even if only some of these women and children become uninsured or see their benefits reduced, millions of people could be affected.

Figure 5. Projected average family health insurance premiums for employer-sponsored insurance vs. proposed deduction, 2009-2016



ources: KFF/HRET, 2006; CMS, 2007;<sup>19</sup> 2006 Medicare Trustees Report.<sup>20</sup> Note: Average premiums are based on the KFF/HRET 2006 Employer Survey and CMS' projected increases in per capita private insurance costs through 2016. Proposed deductions for 2009 are calculated for later years based on CPI-U forecasts from the 2006 Medicare Trustees Report, which CMS used in making its projections.

Figure 6. Projected average worker-only health insurance premiums for employer-sponsored insurance vs. proposed deduction, 2009-2016



Sources and notes are the same as for the previous figure.

## B. Risks to employer-sponsored insurance (ESI)

The Bush Administration's proposal would eliminate the tax preferences enjoyed by ESI since the 1940s. Under current law, employer insurance payments are exempt from all income and payroll taxes. By contrast, individually-purchased nongroup coverage receives no federal income tax

preference unless the taxpayer itemizes deductions and the household's total medical expenses exceed 7.5 percent of income. According to the Treasury Department, "This disparate tax treatment can increase the after-tax cost of insurance purchased directly by individuals by as much as 50 percent."<sup>21</sup> Under the administration's proposal, that cost differential would fall to 0 percent, making nongroup coverage significantly more attractive, relative to ESI, than under current law.

Presidential advisor Hubbard recently described the plan as "revolutionary."<sup>22</sup> In 2005, 60 percent of all Americans received employer-based health insurance, compared to only 7 percent who bought nongroup coverage.<sup>23</sup> These proportions would likely change with the Administration's proposal.

Of course, ESI would not be outlawed, and many would continue to receive coverage from employers. But the express goal of the Administration plan is to encourage recipients of ESI to switch to nongroup insurance. As recently explained by President Bush, once "the tax code is a level playing field," then "an individual market begins to grow."<sup>24</sup>

One effect would be felt by small firms. Typically, they cannot buy insurance unless a certain percentage of their employees participate in the plan. If enough of their workers buy coverage elsewhere, many small companies that now provide insurance may be unable to meet that participation requirement and so would lose access to group coverage.

This is not a trivial issue. In 2005, health insurance was offered by more than 2 million firms with less than 50 employees, including 1.3 million companies with fewer than 10 workers.<sup>25</sup> These small businesses report that providing their employees with health insurance improves worker recruitment, retention, productivity, and morale.<sup>26</sup> These advantages would shrink or disappear for small firms that could no longer offer insurance, even if some of their employees gained coverage in the nongroup market.

Among firms of all sizes, some employers could take this change in tax policy as a signal to stop providing health coverage. Such employers could take some of their savings in labor costs and provide additional income that employees could use to buy tax-advantaged plans in the nongroup market. In recent years, ESI coverage has dropped significantly. The percentage of companies offering insurance declined from 66 percent in 2002 to 61 percent in 2006.<sup>27</sup> Experts anticipate the potential for continued weakening of employer-sponsored coverage over the long term, due to technology-driven increases in health costs as well as other factors.<sup>28</sup> Between these structural problems and ever-growing employer frustration with health insurance costs, the current health insurance system that serves most of the country has become fragile, and a major change in the tax status of health coverage could tip the balance for a number of firms, potentially inducing significantly deeper reductions in ESI than are currently anticipated.

If coverage shifts out of the employer-based system and into the nongroup market, many who currently have health insurance could lose it. The nongroup market is confusing for many consumers. One survey of ESI enrollees found that only 7 percent would prefer to purchase insurance on their own, and more than 70 percent felt that finding an appropriate plan and handling other administrative tasks would be more difficult with nongroup coverage.<sup>29</sup> Another study found that, among people *without* health problems who attempted to purchase nongroup coverage, more than half (51 percent) found it somewhat difficult, very difficult, or impossible to find the coverage they needed, and only 14 percent wound up enrolling in a plan.<sup>30</sup> According to a third survey, only 61 percent of ESI enrollees were very or extremely confident that they would purchase coverage on their own if their employer dropped coverage and gave employees the money to buy insurance.<sup>31</sup>

The nongroup market contains nothing like the nearly automatic enrollment into ESI that covers most American families. Shifting from such an automatic system to one where consumers must take the initiative to purchase coverage inevitably means that many will fall through the cracks and lose insurance.

In addition, workers who are older or chronically ill would be particularly likely to become uninsured, since they could be denied coverage or face significantly higher premiums in most states' nongroup markets, as noted above. If these workers lose coverage, many will not obtain the health care they need. Not only will this increase their risk of bad health outcomes, they will need more Medicare services and so increase taxpayer costs when they turn 65, according to a study published in this month's *New England Journal of Medicine*.<sup>32</sup>

Moreover, administrative costs are much higher for nongroup coverage than for employer-sponsored insurance.<sup>33</sup> If nongroup coverage increases at the expense of ESI, administrative costs will likewise increase, reducing the efficiency of American health spending.

## Conclusion

In its attempt to cover the uninsured without any net increase in federal spending, the Bush Administration has proposed policy changes that would cover few uninsured but would place at risk employer-sponsored insurance that today covers millions of Americans. These proposals would provide much shallower subsidies for family coverage than for worker-only insurance, risking coverage losses and less generous benefits for dependents. Providing less assistance to women and children seems an ironic result from a proposal advanced in the context of SCHIP reauthorization.

The basic thrust of the Administration plan could be retained with modifications that provide significant help to the uninsured. For example, refundable, advanceable tax credits could be large enough to make coverage affordable to the uninsured, and arrangements could be made that allow such credits to provide access to insurance that meets consumers' anticipated need for health care. Along similar lines, increased state flexibility could permit significant coverage expansion, provided that states received access to new resources. However, if current tax preferences for ESI remain undisturbed, these adjustments to the Administration's tax reform and state flexibility agendas would cost money. The disappointing but unsurprising finding of this paper is that major progress covering millions of low-income, uninsured Americans, without harming others who have coverage today, is unlikely to be achieved for free.

## Endnotes

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<sup>1</sup> White House Office of the Press Secretary, *Press Briefing on Health Care by Senior Administration Officials*, June 27, 2007. (Press Briefing)

<sup>2</sup> Press Briefing, op cit.

<sup>3</sup> It is not clear whether, under this alternative, the credit would replace the deduction or households could choose between the credit and the deduction. The former approach could involve a major redistribution of tax subsidies from higher-income to somewhat lower-income taxpayers.

<sup>4</sup> S. A. Glied and D. K. Remler, *The Effect of Health Savings Accounts on Health Insurance Coverage*, The Commonwealth Fund, April 2005.

<sup>5</sup> The payroll tax rate is 15.3 percent. In 2007, the highest marginal tax rate in any state is 9.5 percent, which Vermont applies to households with more than \$336,551 in income. Federation of Tax Administrators, *State Individual Income Taxes (Tax rates for tax year 2007 -- as of January 1, 2007)*.

<sup>6</sup> M. S. Marquis, M.B. Buntin, J.J. Escarce, K. Kapur, "The Role of Product Design in Consumers' Choices in the Individual Insurance Market," *Health Services Research* (Online Early Articles published 19 April 2007).

<sup>7</sup> One study estimated a take-up rate between 13 and 21 percent of eligible individuals. S. Dorn, *Take-Up of Health Coverage Tax Credits: Examples of Success in a Program With Low Enrollment*, The Urban Institute, December 11, 2006. The Office of Management and Budget estimated that the program achieved only an 11 percent take-up rate. Office of Management and Budget, *Detailed Information on the Internal Revenue Service Health Care Tax Credit Administration Assessment*, 2006.

<sup>8</sup> Kaiser Family Foundation and Health Education and Research Trust, *Annual Employer Health Benefits Survey: 2006*, September 2006.

<sup>9</sup> Centers for Medicare and Medicaid Services, Office of the Actuary, "National Health Expenditure Amounts, and Annual Percent Change by Type of Expenditure: Calendar Years 2001-2016," *NHE Projections 2006-2016, Forecast summary and selected tables*, Feb. 2007. (NHE Projections)

<sup>10</sup> S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, The Commonwealth Fund, September 2006.

<sup>11</sup> J. Hadley and T. Waidmann. "Health Insurance and Health at Age 65: Implications for Medical Care Spending on New Medicare Beneficiaries," *Health Services Research*, April 2006.

<sup>12</sup> Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, *Health Insurance Coverage In America, 2005 Data Update*, May 2007.

<sup>13</sup> S. Dorn, S. Silow-Carroll, T. Alteras, H. Sacks, and J.A. Meyer, *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States*, prepared by the Economic and Social Research Institute for the Kaiser Commission on Medicaid and the Uninsured, August 2004.

<sup>14</sup> NHE Projections, op cit.

<sup>15</sup> *The 2006 Annual Report Of The Board Of Trustees Of The Federal Old-Age And Survivors Insurance And Federal Disability Insurance Trust Funds*, May 2006. (2006 Trustees Report)

<sup>16</sup> U.S. Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2008 Revenue Proposals*, February 2007 (Blue Book).

<sup>17</sup> U.S. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement. "Table HI01. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2005, All Races."

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- <sup>18</sup> Census Bureau data do not break out the pertinent coverage categories by age and gender. However, other surveys show that, among adults age 18-64, 13 percent of men and 29 percent of women receive employer-sponsored coverage as dependents. Alina Salganicoff, *Women and Health Care: A National Profile*, Kaiser Family Foundation, July 7, 2005.
- <sup>19</sup> NHE Projections, op cit.
- <sup>20</sup> 2006 Trustees Report, op cit.
- <sup>21</sup> Blue Book, op cit.
- <sup>22</sup> Allan B. Hubbard, "A Tax Cure for Health Care," *Wall Street Journal*, July 24, 2007.
- <sup>23</sup> U.S. Census Bureau, op cit.
- <sup>24</sup> White House Office of the Press Secretary, *President Bush Visits Cleveland, Ohio*, July 10, 2007.
- <sup>25</sup> Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, *2005 Medical Expenditure Panel Survey-Insurance Component*. Calculations by S. Dorn, July 2007.
- <sup>26</sup> Employee Benefit Research Institute, *Small Employers and Health Benefits: Findings From the 2002 Small Employer Health Benefits Survey*, EBRI Issue Brief #253, January 2003.
- <sup>27</sup> H. Whitmore, S. R. Collins, J. R. Gabel, and J. D. Pickering, "Employers' Views on Incremental Measures to Expand Health Coverage," *Health Affairs*, Nov./Dec. 2006, 25(6):1668-78.
- <sup>28</sup> J.D. Reschovsky, B.C. Strunk, and P. Ginsburg, "Why Employer-Sponsored Insurance Coverage Changed, 1997-2003," *Health Affairs*, May/June 2006; 25(3): 774-782.
- <sup>29</sup> Kaiser Family Foundation Health Insurance Survey, 2003.
- <sup>30</sup> Collins, et al., op cit.
- <sup>31</sup> P. Fronstin, *The Tax Treatment of Health Insurance and Employment-Based Health Benefits*, EBRI Issue Brief No. 294, June 2006.
- <sup>32</sup> J.M. McWilliams, M.E. Zaslavsky, and J. Ayanian, "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine*, Vol. 357 No. 1, pp. 43, July 12, 2007.
- <sup>33</sup> J.R. Gabel, K. Dhont, and J.D. Pickering, *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets*, The Commonwealth Fund, May 2002.