

The Benefits and Drawbacks of Alternative Tax Subsidization Approaches for Health Insurance

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Preface

This report describes tax-based approaches to subsidizing health insurance enrollment in the individual insurance market. We summarize different ways of structuring tax credits or deductions and discuss how these approaches may affect such outcomes as consumer premium payments, health insurance enrollment, and federal costs. The report will inform the ongoing debate over health policy reforms that affect the individual health insurance market and may be of interest to the media, policymakers, and consumers, among others. This work was sponsored by the Robert Wood Johnson Foundation through a Policy-Relevant Insurance Study (PRIS) grant. The research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.

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Abbreviations

ACA	Affordable Care Act
AHCA	American Health Care Act
BCRA	Better Care Reconciliation Act
CBO	Congressional Budget Office
FPL	federal poverty level

Overview

One way to make health insurance more affordable and to increase enrollment is to subsidize the purchase of insurance through tax policy. Along with numerous other reforms, the Patient Protection and Affordable Care Act (hereafter, ACA) introduced tax credits for consumers who did not have access to affordable health insurance from an employer or another source. Because there are already substantial tax benefits associated with employment-based health insurance, the ACA's tax credits focused on the individual market, or the market for nonemployer insurance. The tax credits under the ACA were intended to improve the affordability of coverage for low- and middle-income consumers; however, the credits represent only one of many ways that the tax code can be used to increase the affordability of coverage. The precise design and implementation of tax incentives to encourage enrollment can affect how many people enroll in insurance, which people choose to enroll, and costs to consumers and the government.

In this report, we review the implications of tax-based approaches to subsidizing health insurance enrollment in the individual market. We compare three approaches: (1) pegging a tax credit to the price of a benchmark plan, as is done under the ACA and proposed under the Senate's Better Care Reconciliation Act (BCRA); (2) capping the federal government's contribution for each consumer, as proposed under the House's American Health Care Act (AHCA); and (3) using a tax deduction method, as was proposed by President Donald Trump during the 2016 election campaign. We also consider possible adjustments to these tax-based subsidies that address variation in the price of health insurance and in consumers' ability to afford coverage. Our goal is to consider how various design options for tax policy may affect outcomes, including health insurance enrollment and federal costs, and to discuss possible unintended consequences. For example, targeting tax subsidies based on income could penalize people whose incomes increase because of new employment opportunities or promotions. Hence, a possible unintended consequence of tax-based subsidies that decline in value as income rises is that they could discourage employment.

Tax subsidies for health insurance are often proposed in the context of other reforms that could affect insurance prices. Although we mention these other factors where appropriate, we aim to compare various tax subsidization approaches while holding constant the regulatory environment. We also do not provide a quantitative analysis of the costs and benefits of choosing alternative tax subsidization approaches, because doing so would require greater specifics about eligibility and the size of the subsidy under each alternative approach. However, the optimal tax policies to support the health insurance market should take into account anticipated costs and benefits.

Description of Approaches to Subsidizing Health Insurance Through the Tax Code

Tax subsidies can be offered as either credits or deductions. Tax credits directly reduce the amount that a person or family has to pay in taxes. For example, a tax credit of \$1,000 reduces an individual's tax liability by \$1,000. Credits can be set to a fixed amount for each person or can vary based on the value of the health insurance premium or the individual's income. Credits can also be adjusted to account for factors that make health insurance more expensive for some groups, such as age or location. Tax credits can be structured to be *refundable*, meaning that if the individual's tax liability is lower than the amount of the credit, the consumer receives the difference in the form of a refund. Tax credits can also be *advanceable*, meaning that they are provided to the individual before taxes are due. The ACA's tax credits are both refundable and advanceable, and—as a result—eligible individuals receive the credit when they enroll in health insurance, based on estimated income for the coming year. The ACA's tax credits must then be reconciled with actual income, requiring some consumers to pay back excess tax credits (e.g., if actual income exceeds estimated income).

Tax deductions, on the other hand, are subtracted from a person's income before calculating his or her tax liability when income taxes are due. A tax deduction of \$1,000 reduces taxable income by \$1,000, and the value of the reduction in taxes depends on the person's marginal tax rate. Deductions for health insurance can be standardized so they are the same amount for everyone purchasing health insurance, or they can be set at the value of the health insurance purchased. Tax deductions are not advanceable, nor are they refundable. Furthermore, tax deductions have no value for households whose incomes are too low to be taxable.

Below, we describe the three main approaches to providing tax credits or deductions for insurance that have been recently considered in the debate over ACA reform, summarized in Table 1. We compare the approaches across several important dimensions (the columns): consumer premium payments, enrollment, federal costs, total health spending, and labor market effects. When discussing the effects of proposed approaches, we use the ACA as the baseline, because it is current law.

In the sections that follow, we describe the three approaches to subsidizing health insurance through the tax code and then provide a conceptual discussion of how each approach affects the outcomes listed in Table 1.

Table 1. Effects of Various Tax Subsidization Approaches

Tax Code Approach		Consumer Premium Payments	Enrollment (Take-Up)	Federal Costs	Total Health Spending	Labor Market Effects
Benchmark-plan-based credits	Income-based premium caps (ACA)	Consumer payments capped at a percentage of income for benchmark plan	Encourages take-up for low-income, older consumers and those in high-cost areas	Federal government at risk for paying for premium variation and growth	Encourages consumer selection of silver or bronze plans	May tend to reduce labor supply; could be different in non-Medicaid expansion states
	Income- and age-based premium caps (e.g., BCRA)	Consumer payments capped at a percentage of income for given age for benchmark plan	Encourages take-up for some groups but discourages for others relative to the ACA	Federal government at risk for paying for premium variation	Encourages consumer selection of plans nearest to or less than value of subsidy	May tend to reduce labor supply at upper income-eligibility threshold
Fixed-dollar credits	No adjustment	Credit fixed for all consumers	Enrollment likely lower than under the ACA for low-income, older consumers in high-cost areas	Capped per person; consumers at risk for paying for premium variation	Encourages selection of lower-cost plans; may increase insurers' bargaining leverage with providers	Likely minimal in comparison with the ACA
	Adjusted for age (e.g., AHCA)	Older individuals receive higher credit	Discourages enrollment at top of age bracket relative to no adjustment because of threshold effect	Federal costs less than the ACA; consumers at risk for paying for premium variation beyond adjustment	Encourages consumer selection of lower-cost plans	Likely minimal in comparison with the ACA
	Adjusted for income	Lower-income individuals receive higher credits	Increases enrollment among low-income consumers relative to no adjustment	Federal costs less than the ACA; consumers at risk for paying for premium variation beyond adjustment	Uncertain	May tend to reduce labor supply, similar to the ACA
	Adjusted for location	Those in high-cost areas will receive higher credits	Increases enrollment in high-cost areas relative to no adjustment	Federal costs less than the ACA; consumers at risk for paying for premium variation beyond adjustment	Uncertain; may reduce insurer incentives to offer lower-cost plans	Likely minimal in comparison to the ACA
	Adjusted for age, income, location	Similar to the ACA	Take-up may depend on affordability	Federal costs increase with adjustments but may still be less than the ACA	Uncertain; may reduce insurer incentives to offer low-cost plans	May tend to reduce labor supply, similar to the ACA
Tax deduction	Standard deduction	Value of deduction does not vary with premiums	May reduce enrollment for low-income consumers compared with the ACA	Uncertain; consumers at risk for paying for premium variation beyond age adjustment	Encourages consumer selection of lower-cost plans	Uncertain
	Deduct full premium	Value of deduction proportional to premiums	Take-up may depend on affordability	Could increase with generosity of plans; federal government at risk for some premium variation	Encourages consumer selection of more-generous plans for larger tax breaks	Uncertain

NOTE: The ACA requires consumers to pay a portion of their income toward premiums, and the federal government pays the difference between this required contribution and the benchmark plan (the second lowest-cost silver plan available to the consumer).

Benchmark-Plan–Based Approach

Under the benchmark-plan based approach, the value of the tax credit is pegged to the value of a certain plan, called the *benchmark*. Consumers are required to pay for a certain portion of the benchmark premium, and the federal government pays the remainder. The ACA and the BCRA, proposed in the Senate on June 22, 2017, follow this approach but select different benchmark plans and set different credit values.

Health insurance plans under the ACA are categorized into four tiers—bronze, silver, gold, and platinum—based on the average amount of health spending that the plan covers. With a silver plan, the plan pays on average 70 percent of enrollees’ health care expenditures; enrollees’ pay for the remaining 30 percent of expenditures through cost-sharing at the point of service (e.g., deductibles, copays). A gold plan pays for an average of 80 percent of enrollees’ health expenditures, which is similar to the generosity of employer-sponsored insurance (Gabel et al., 2012). Under the ACA, eligible enrollees can receive tax credits that equal the difference between the second lowest-cost silver plan in a consumer’s area (the *benchmark plan*) and an income-based percentage contribution. For 2016, the income-based contribution ranged from 2.03 percent of income for those with incomes between 100 and 133 percent of the federal poverty level (FPL) to 9.66 percent of income for those with annual incomes between 300 and 400 percent of the FPL.¹ This required contribution to purchase the benchmark plan translates to approximately \$239 annually for a consumer making 100 percent of the FPL and \$4,548 for a consumer making 400 percent of the FPL for 2016. The federal government then pays the difference between the required contribution and the cost of the benchmark plan. Each year, the required percentage contribution is adjusted based on the ratio of premium growth in the employer insurance market to income growth. This approach caps the enrollee’s premium contribution as a percentage of his or her income as long as the enrollee purchases the benchmark plan. If consumers purchase a cheaper plan, they pay less, and if they purchase a more expensive plan, they pay the difference between the premium and the tax credit. To be eligible for the ACA’s tax credits, consumers must have incomes between 100 and 400 percent of the FPL and no alternative source of affordable coverage, such as through an employer or Medicaid.

While the ACA’s approach caps the required contribution as a percentage of income, an alternative method is to cap the required contribution based on both age and income. Under this

¹ Under the ACA, the tax credit is applied for those with incomes between 100 and 400 percent of the FPL. For states that expanded Medicaid, those up to 138 percent of the FPL would be eligible for Medicaid and thus not eligible for a tax credit. See IRS Form 8962 (<https://www.irs.gov/pub/irs-pdf/i8962.pdf>). The 2016 required contributions were calculated using the 2015 poverty levels. Annual income at 100 percent of the FPL was \$11,770 for 2015.

approach, older consumers with higher incomes are required to pay a higher percentage of their income toward premiums than younger or lower-income consumers are, reflecting that premiums are higher for older individuals. The BCRA uses this approach, setting the required cap to 2 percent (for all ages) for those under the FPL, ranging up to 16.2 percent for those ages 60–64 making 350 percent of the FPL (which is \$41,580 annually for 2016) (U.S. Senate, 2017). The BCRA lowers the ACA’s upper income-eligibility threshold from 400 percent of the FPL to 350 percent. These required contributions translate to \$238 annually for those under the FPL and \$6,736 annually for those ages 60–64 making 350 percent of the FPL.² Under the BCRA, the benchmark is the median premium among plans with an actuarial value of 58 percent, which currently is roughly equivalent to a bronze plan. Consumers would pay approximately 42 percent of the costs out-of-pocket compared with the ACA’s 30 percent under the silver plan.

Fixed-Dollar Tax Credit

An alternative approach to subsidizing health insurance would be to give everyone (or a subset of individuals) a fixed-dollar tax credit to purchase coverage that reduces tax liabilities by the amount of the credit. This approach caps the federal government’s contribution per person. For example, in the 2008 presidential election, Senator John McCain proposed giving all single adults a \$2,500 tax credit to purchase insurance (families would have received \$5,000) (Oberlander, 2008). This type of tax credit could be adjusted for age, income, or location, and eligibility could be limited based on such factors as whether the enrollee had an offer of job-based coverage. The AHCA, the recent reform proposal that passed the House of Representatives on May 4, 2017, would provide age-adjusted tax credits ranging from \$2,000 for those under age 30 to \$4,000 for those over age 60 (U.S. House of Representatives, 2017). The AHCA would also limit eligibility to those without job-based or public coverage, and the credits would be phased out for individuals with annual incomes over \$75,000 (\$150,000 for married couples).

Tax credits could be further adjusted for differences in health insurance premiums across locations. Geographic adjustments could be set using a price index based on the price of local medical care, using Medicare data, for example. One approach could be to create an index based on actual and standardized costs to capture differences in local wages and prices but avoid capturing the practice patterns or preferences of Medicare enrollees for types of care that may differ across locations (Cubanski, Neuman, and White, 2015; Eibner and Nowak, 2016).

² These values assume that the BCRA credits would be calculated in a similar fashion to the ACA’s, where the 2016 poverty thresholds are used to calculate the value of the 2017 tax credit.

Tax Deduction

Numerous politicians, including Bob Dole, Mitt Romney, George W. Bush, and Donald Trump, have proposed tax deductions for individual market coverage (Dole Kemp 96, 1996; Reischauer, 2007; Romney, 2012; Collins et al., 2012; Levey, 2016). A standard deduction would allow people with insurance to deduct a fixed sum from their taxable incomes. For example, the House Republican Study Committee recently proposed a \$7,500 standard deduction for individuals and \$20,500 for families (Republican Study Committee, 2017). Alternatively, a tax deduction could allow enrollees to deduct the full cost of the premium from their taxable incomes. A hybrid approach might allow enrollees to deduct the full cost of the premium, as long as it did not exceed a prespecified amount.

A tax deduction approach that allows for the full premium (or a large portion of it) to be deducted is similar to the current tax subsidization approach used to support employer health insurance. Americans who receive health insurance through their employers have long benefited from a tax exclusion that allows the costs of health insurance to be deducted from income, thus lowering a person's income and payroll taxes. Premiums paid by employers are exempt from income and payroll taxes, as is the portion paid by employees, under specific circumstances. Those who are self-employed can deduct the full cost of the price of the insurance from their income taxes but not payroll taxes.

Effects of Tax Approaches

Consumer Premium Contributions

Both the structure and the size of the tax subsidy approach can alter how much consumers contribute toward premiums. The main difference between benchmark-plan–based approaches and fixed-dollar tax credits is that, under benchmark-plan–based approaches, consumers bear less risk in terms of variation in premiums over time or across locations. Tax deduction–based approaches tend to subsidize higher-income households that pay higher taxes, while both benchmark-plan–based approaches and fixed-dollar tax credits tend to do more to subsidize lower-income households.

Benchmark-Plan–Based Approach

For eligible individuals, this approach ensures that consumers who choose either the benchmark or a cheaper plan will not pay more than a fixed percentage of income toward health insurance. If consumers wish to enroll in a plan that is more generous than the benchmark, they must finance the additional premiums out-of-pocket. Total premiums can vary with geographic location and with an individual’s age. Under this approach, individuals are insulated from geographic variation in premiums if they choose the benchmark or a cheaper plan.

While eligible individuals are assured that they will not pay more than a fixed percentage of income if they choose the benchmark or a cheaper plan, both the ACA and the BCRA limit eligibility at certain income levels. The ACA’s approach leaves some people without access to the credits. The ACA, as passed, intended that all states would expand their Medicaid programs to include adults up to 138 percent of the FPL. However, a Supreme Court ruling determined that states could choose whether they wanted to expand their Medicaid programs under the ACA (*National Federation of Independent Business v. Sebelius*, 2012). As a result, individuals with incomes below 100 percent of the FPL cannot claim the credit, leaving an estimated 2.6 million low-income consumers in states that did not expand their Medicaid programs without access to affordable coverage (Garfield and Damico, 2016). Those with incomes above 400 percent of the FPL (for reference, 400 percent of the FPL is \$48,240 for a single individual in 2017) are also ineligible regardless of premium levels. Because older individuals in high-cost areas can face high premiums, some individuals with incomes just above the 400 percent the FPL eligibility threshold may also find it difficult to afford insurance. For example, benchmark premiums for 60-year-olds exceed \$10,000 in approximately 38 percent of ratings areas.³ Finally, although the

³ Author analysis of the HIX Compare Dataset; see Robert Wood Johnson Foundation, 2017.

ACA allows people with access to employer coverage to claim the credit if their employer offer is determined to be unaffordable, the definition of *affordability* leaves some families with expensive employer insurance unable to access the credits (Burkhauser, Lyons, and Simon, 2011; Nowak, Saltzman, and Cordova, 2016).⁴

The BCRA would provide tax credits to low-income individuals in states that have not expanded their Medicaid programs, a population left without affordable coverage under the ACA. Because the BCRA also proposes to reduce federal funding for the Medicaid program, it is possible that current enrollees may lose access to the Medicaid program. Reductions in Medicaid eligibility could increase the number of people who are eligible for tax credits compared with the ACA. The BCRA approach proposes lowering the upper income-eligibility threshold for the tax credits from 400 to 350 percent of the FPL and extending tax credits to individuals with incomes below the poverty level. Reducing the upper limit for receiving tax credits relative to the ACA could increase the number of middle-income families that find it difficult to afford insurance.

Because the credit under the BCRA would be tied to the median bronze plan (plans with 58 percent actuarial value), the credit value will be lower than under the ACA (the ACA uses the second lowest-cost silver plan as a benchmark, which has an actuarial value of approximately 70 percent). This means that consumers may need to make higher premium contributions under the BCRA to purchase insurance with similar levels of coverage.

Fixed-Dollar Tax Credit

Under a capped-tax-credit approach, the federal government would contribute the same amount per person, regardless of premium prices. Such credits could provide the same benefit to all enrollees, regardless of age, income, or local costs. Because premiums can vary with age and location, older individuals and those who live in high-cost areas would pay more to enroll in coverage. Further, without any adjustments, the same level of subsidization would be provided to low- and high-income individuals, regardless of their ability to pay. Under this strategy, certain consumers must pay higher premiums because of age or geography, and all consumers take on the risk of paying for fluctuations in premiums over time.

Capped federal tax credits could be adjusted for such factors as age, income, and geography. If adjusted for all three factors, the capped approach would be similar to the approach used under the ACA. However, a key distinction is that, with flat federal contributions, the tax credit does not necessarily respond to changes in health insurance premiums that may occur over time. Tax credits would be set at specific amount, perhaps with variation for age or other factors, and indexed over time to a prespecified inflation factor, such as the consumer price index. If health

⁴ Specifically, the affordability of the employer offer is based on the employee premium contribution for *single* coverage, regardless of whether the worker has a family. Because employee premium contributions for family coverage are typically higher than the contribution for single coverage, some families may not have an affordable option but are unable to access the ACA's tax credits.

care costs outpace inflation, consumers would be required to pay an increasing share of the premium. The ACA’s required consumer contribution is also adjusted over time based on premium growth in the *employer* market relative to income growth. As a result, the federal government bears more of the risk of premium inflation under the ACA’s approach, particularly if premiums in the individual market grow at a faster rate than employer-sponsored insurance premiums.

Tax Deduction

Tax deductions provide a premium subsidy that is proportional to the individual’s marginal tax rate. Because tax rates in the United States increase with income, higher-income individuals pay more in taxes but also benefit more from this approach. Table 2 provides a stylized example in which premium payments are fully tax-deductible for individuals making \$50,000 annually (with a 25 percent marginal tax rate) and \$200,000 annually (with a 33 percent marginal tax rate). The after-tax value of the deduction is equal to the premium multiplied by the marginal tax rate. For a \$5,000 premium, the deduction would be worth \$1,250 at a 25 percent marginal tax rate and \$1,650 at a 33 percent marginal tax rate.

Table 2. Example of Savings from Tax Deduction for Health Insurance

	\$50,000 Annual Income, 25 Percent Marginal Tax Rate		\$200,000 Annual Income, 33 Percent Marginal Tax Rate	
	No Deduction Allowed	Deduction Allowed	No Deduction Allowed	Deduction Allowed
Income	\$50,000	\$50,000	\$200,000	\$200,000
Premium	\$5,000	\$5,000	\$5,000	\$5,000
Taxable income	\$50,000	\$45,000	\$200,000	\$195,000
Marginal tax rate	25%	25%	33%	33%
Taxes owed	\$8,271	\$7,021	\$49,529	\$47,879
Savings from reduction		\$1,250		\$1,650

NOTE: This table reflects the 2016 marginal tax rates.

Some recent proposals have called for a standard deduction that allows individuals to deduct a fixed amount (e.g., \$7,500) from their tax returns if they purchase insurance. A standard deduction is invariant to the premium level and thus provides the same benefit regardless of age, geographic location, or plan benefit generosity. This implicitly benefits those who are younger and those who live in lower-cost areas but who have the same income, since these groups of consumers will face less costly premiums. However, because higher-income individuals face higher marginal tax rates, the standard deduction would provide a greater benefit to higher-income individuals.

Eligibility and Enrollment

Tax subsidy approaches, either credits or deductions, can affect health insurance enrollment by making health insurance coverage more affordable. Many policymakers view increased enrollment in health insurance as a desirable outcome in and of itself because health insurance provides financial protection for enrollees, may improve health outcomes, and is associated with lower mortality (Hadley, 2003; Finkelstein et al., 2012; Saksena, Hsu, and Evans, 2014; Sommers, Long, and Baicker, 2015). Additionally, enrollment can affect the insurance risk pool, the base of individuals paying into the system to help subsidize the cost of those with significant health care needs. In general, larger risk pools are less susceptible than smaller risk pools to premium variation and swings in insurer profitability from year to year. Because people who are on the fence about enrolling tend to be healthier and less expensive than those who enroll, increasing enrollment may also reduce average spending and therefore lead to lower premiums. However, the effect on premiums may depend on how tax-based subsidies are targeted. For example, tax credits that provide more support to older and lower-income individuals may tend to bring in older or less healthy individuals than would tax credits targeted to younger and middle-class enrollees.

The impacts of benchmark-plan-based approaches, fixed-dollar tax credits, and tax deductions on enrollment largely depend on the size of the credit or deduction and on any eligibility restrictions, rather than on the general approach of the programs. Groups who are eligible for larger credits or deductions are more likely to choose to enroll. The benchmark-plan-based approach or the fixed-dollar tax credits can be adjusted to make the size of the credits larger for certain groups, such as older consumers or those living in high-cost areas. Eligibility restrictions, such as limiting eligibility for certain income groups, would affect enrollment for all three approaches. Further, credits paid in advance may encourage enrollment more than deductions, especially among credit-constrained households.

Benchmark-Plan-Based Approach

The benchmark-plan-based approach may restrict eligibility based on income and other factors and may affect enrollment through the generosity of the credit.

The ACA's tax credits reduce individual market premiums for those with incomes between 100 and 400 percent of the FPL who have no other affordable source of coverage.⁵ In part because of these tax credits, studies estimate that individual-market enrollment grew from 11.4 percent of the U.S. population in 2013 to 16.3 percent in 2015—a growth of nearly 5 percentage points, according to the Census Bureau's estimates of directly purchased health insurance (not purchased through an employer) (Barnett and Vornovitsky, 2016). At the same time, there is

⁵ Consumers living in states that chose to expand their Medicaid eligibility to adults are eligible for ACA marketplace credits starting at 138 percent of the FPL.

evidence that enrollees in the ACA's individual market may be somewhat sicker and more expensive than those who would have enrolled prior to the law. For example, insurers reported large losses in the individual market in the first three years of the ACA marketplaces (Mathews, 2016). Some sources expect these losses to level off as insurers become more adept at pricing for the risk in this market (S&P Global Market Intelligence, 2017). The worsening of the risk pool is likely due to factors other than the tax credits, such as the ACA's requirement that insurers offer coverage to all applicants and that premiums cannot vary based on health status. The tax credits themselves almost certainly stabilize the risk pool by providing an incentive for younger and healthier people to remain enrolled (Eibner and Saltzman, 2014; Blumberg, Buettgens, and Holahan, 2015).

As described above, the ACA's credits are available to a limited group of individuals—those with incomes between 100 and 400 percent of the FPL and no affordable option for coverage from another source. The BCRA would decrease eligibility for those with annual incomes between 350 and 400 percent of the FPL, compared with the ACA, but proposes to expand eligibility to lower-income individuals in states that chose to expand their Medicaid programs (as the Medicaid expansion is phased out). The age and income structure of the BCRA approach encourages healthier and younger individuals to enroll in the marketplaces while potentially reducing enrollment among those who are older, who will need to pay more toward premiums than under the ACA.

Fixed-Dollar Tax Credit

A capped contribution would likely be made available to a broader group of enrollees than the ACA's tax credits are. Some proposals, such as Health and Human Services Secretary Tom Price's Empowering Patients First Act (H.R. 3400), have proposed making capped tax credits available to all Americans, regardless of income or eligibility for other programs. Other proposals limit the scope of capped tax credits. For example, the AHCA would provide credits to everyone without access to job-based or public coverage, and the full credit amount would be available to all families with incomes below \$75,000 for single filers and \$150,000 for married couples filing jointly. The credits would be capped at \$14,000 per family and would phase out by \$100 for every \$1,000 above the thresholds; this means that a minimal level of credit could potentially be available to large families with incomes as high as \$290,000.⁶ The AHCA's tax credit would also be available to low-income adults in states that have not expanded their Medicaid programs.

⁶A family owed the maximum credit would get \$14,000 if its income was below \$150,000; above \$150,000, the tax credit would decline by \$100 for every \$1,000 in income above the cap, reaching zero at \$290,000. There are many family configurations that could receive the maximum credit—one example would be a family with two married parents in their 40s and four children.

Under a capped approach, consumers' ability to afford health insurance coverage could depend on characteristics that influence premiums, such as location and age. Without adjustment for income, we would expect to see lower take-up among lower-income relative to higher-income people. Older people likely have higher demand for health insurance than younger people do, so they may be willing to enroll even if tax credits are small relative to the premium. However, because older individuals are still sensitive to premium prices, we would expect enrollment to increase with larger tax credits. RAND's analysis of the AHCA—which would incorporate tax credits that are less generous for older adults relative to the ACA—found that, in 2026, the number of uninsured individuals over the age of 50 would increase by 139 percent relative to current law, and the number of uninsured individuals with incomes below 200 percent of the FPL would increase by 102 percent relative to current law (Eibner, Liu, and Nowak, 2017). We would expect similar results for geographic areas with higher costs, assuming that capped tax credits were not adjusted for local variation in premiums. For example, it is likely that the AHCA's tax credit for a 40-year-old would cover the full premium in parts of Texas but less than a quarter of the premium in Alaska.⁷ Several other analyses estimate that those in high-cost areas may find coverage unaffordable with AHCA tax credits (Cox, Claxton, and Levitt, 2017; Cutler, Bertko, and Spiro, 2017).

Under current proposals (e.g., the AHCA), health insurers can charge more for each additional year of age, but the tax credit is flat within age brackets and varies across brackets (e.g., \$2,500 for ages 30–39 and \$3,000 for ages 40–49). This credit structure has the potential to result in “notches” or cliffs in which the consumer's out-of-pocket premium falls at certain ages even though the total premium increases. For example, a 39-year-old could be required to pay more in premiums than a 40-year-old to purchase the same plan. This could reduce enrollment among those at the upper end of each age group.

Tax Deduction

A deduction would be available to everyone who files a tax return, unless there were limits on who could take the deduction that were included as part of the policy. Because low-income individuals have low marginal tax rates and in some cases pay no income taxes, a tax deduction may be of little value to this group. Yet low-income individuals are more likely to be uninsured than higher-income individuals are. Prior to the introduction of the Medicaid expansion and the ACA marketplaces in 2014, 26 percent of nonelderly with incomes below the FPL were uninsured, compared with only 7 percent for those with incomes above 400 percent of the FPL. These numbers dropped to 19 percent and 5 percent, respectively, in 2015 (Kaiser Family

⁷ Benchmark premiums for a 40-year-old individual range from \$2,473 in parts of Texas to \$11,400 in parts of Alaska for 2017. Author analysis of the HIX Compare Dataset (Robert Wood Johnson Foundation, 2017).

Foundation, undated). Without providing sufficient incentive to lower-income individuals, a tax deduction may be a relatively ineffective method of increasing insurance enrollment.

Under a tax deduction, the timing of the payout of the credit differs from the other approaches. The ACA and some current proposals that cap the federal contribution pay the credits in advance directly to insurers so individuals receive the help at the time of purchase. In contrast, tax deductions are only realized when individuals file their taxes. This means that consumers have to pay the premium up front and receive the benefit in terms of lower tax payments later. This could be problematic for low-income consumers who might not have the ability to pay the whole health insurance premium up front. Further, a tax deduction cannot reduce the individual's tax liability by more than his or her total taxable income. Hence, for some low-income consumers who pay little or no income tax, the value of the tax deduction may be further limited.

Federal Costs

The cost to the federal government will depend on the approach chosen, the size of the subsidy (credit or deduction), the number of people eligible, and the number of people purchasing health insurance (thus taking up the subsidy). The government bears the most risk under benchmark-plan-based approaches and deductions of the full amount of premiums, relative to fixed-dollar tax credits or fixed-dollar deductions. This occurs because the government will bear the additional costs of premium increases over time.

Benchmark-Plan-Based Approach

The ACA's approach limits eligibility for the credit to certain incomes and, among those eligible, requires higher payments from those with higher incomes, both of which place some limits on the extent of federal spending. The BCRA modifies this approach by selecting a less generous benchmark plan and requiring older and higher-income individuals to pay a larger share of their incomes toward premiums. The Congressional Budget Office (CBO) estimated that there would be fewer individuals insured under the BCRA and that federal costs for the credits would be less than under the ACA, but it is uncertain whether this is due to the changing of the tax credit structure from the ACA or whether it might be due to other changes in the BCRA, such as eliminating the individual mandate (CBO, 2017b).

In both the ACA and the BCRA approaches, the federal government pays the difference between the required contribution as a percentage of income for the benchmark plan and the cost of the benchmark plan in the consumer's location. This results in higher federal payments for older individuals (for whom insurance is more expensive), lower-income individuals, and those living in high-cost areas. Because consumers do not pay more if the benchmark plan costs more, the federal government bears the risk of sharp increases in insurance costs over time or because some areas are more expensive than others. Although the ACA's method established a provision

to update the enrollees' percentage contribution amounts over time based on the ratio of premium costs to income growth, the adjustment is based on premium costs in the *employer* market (IRS, 2014). Hence, the federal government is at particular risk for excess spending growth if premium growth in the individual market diverges from growth in employer insurance costs. This structure means that adverse selection into the individual market will tend to increase the federal government's tax credit liability, because individual market premiums will rise without commensurate increases in the employer market.

In one interesting example, Alaska's relatively small individual insurance market⁸ suffered from substantial adverse selection problems, with a small number of expensive individuals contributing to high premiums for the entire risk pool. One insurer, Premera Blue Cross, said that 37 individuals accounted for over \$11 million in health spending in 2015 (Feidt, 2015). To stabilize the individual market, the state created a reinsurance program to reimburse insurers for high-cost cases in 2016 (State of Alaska Office of the Governor, 2016). Subsequently, the state filed a waiver request with the federal government to share the cost of the reinsurance program. In its waiver application, Alaska cited savings to the federal government of approximately \$51.6 million in premium tax credits by lowering average premiums with the reinsurance program (State of Alaska, 2016).

Fixed-Dollar Tax Credits

Fixed-dollar tax credits would limit the federal government's per-person contribution to a known amount each year, requiring consumers to pay premiums in excess of the credit. Under a capped contribution, the federal government does not bear additional risk if insurance premiums increase over time and may spend less if fewer consumers choose to claim the credit when premiums rise (e.g., because of affordability issues). Conversely, with a capped contribution, the federal government does not achieve any savings if premiums grow more slowly than the inflation rate used to adjust the credit.

It is unclear whether a capped contribution would be more or less expensive than an alternative subsidization method—this would depend on the total value of the capped contribution. However, there are some features of capped contributions that could make them more costly from the federal government's perspective:

- The higher the credit value, the more expensive the credit will be from the federal government's perspective. This is due both to the larger credit amount and because a higher tax credit may lead to greater take-up.
- If credits are available to a larger segment of the population, the federal government's credit liability will be larger. If credits are broadly available—to those with higher incomes or those with job-based coverage, for example—credits may be claimed by

⁸ Approximately 23,000 consumers in 2016 were enrolled in Alaska's ACA marketplace compared with Florida's approximately 1.7 million, for example (Assistant Secretary for Planning and Evaluation, 2016).

people who would have enrolled in coverage without the credit. This will increase the cost to the federal government without commensurate increases in insurance enrollment among the uninsured.

- The lower the cost of insurance, the higher the total cost of the credit to the federal government. If insurance premiums are low, more people will claim the credit, and this will increase the federal government's credit liability. Proposals that would allow insurers to offer limited-benefit plans—for example, by eliminating key benefits or reducing the generosity of coverage—may make it easier for insurers to offer plans that are close to or under the value of the credit. This could make insurance relatively costless to individuals, increasing the number of people who will claim the credit. In some scenarios, the federal government's tax credit liability could increase while the quality of insurance diminishes, leaving consumers with plans that expose them to significant financial risk. In its score of the AHCA, the CBO estimated that “a few million people would buy policies that would not cover major medical risks” (CBO, 2017a), since the AHCA, as passed by the House of Representatives, would allow some states to opt out of the pricing rules for insurers and the requirement that insurance plans cover essential health benefits.

Tax Deductions

The tax deduction approach could increase federal spending if eligibility is expanded or could decrease federal spending if the average dollar value per person decreases, although both of these effects are dependent on the other. Increasing the eligibility to upper-income individuals could increase federal spending, since more individuals would be eligible than under the ACA. Using a method that allows for the full premium to be deducted could also increase federal spending over the standard-deduction approach, by encouraging consumers to select more-generous health plans to receive a larger tax break. However, the tax deduction method is likely to result in a lower average per-person subsidy than under the ACA, which will likely decrease costs to the federal government. For example, a RAND analysis of Trump's health plan during the 2016 election campaign found that a full ACA repeal and replacement with a tax deduction for full premiums would result in higher consumer payments (including premiums and out-of-pocket payments) and would reduce federal spending on health insurance by approximately \$39 billion (Saltzman and Eibner, 2016).⁹ If the value of the tax deduction is less than the ACA's credit and results in fewer people taking the deduction, then this will also reduce federal spending, compared with the ACA. Given that consumers will have to pay the full premium up front, this may be a significant deterrent for lower-income individuals. Additionally, there are many lower-income individuals who may pay little or no tax for whom the deduction results in a negligible reduction in their tax liabilities, thus further dampening enrollment.

⁹ However, the full repeal of the ACA's taxes and other revenue-generating mechanisms would result in a *net* \$41 billion increase in the deficit under a tax deduction approach, according to RAND's analysis.

Total Health System Costs

Approaches to subsidizing health insurance through the tax code may have consequences for total health spending through several mechanisms. First, increasing enrollment in health insurance coverage will increase total health system spending because consumers are able to access health services at a reduced cost, which may be a desired policy outcome. Second, an approach that encourages individuals to enroll in high-deductible plans, which have lower premiums but higher out-of-pocket costs, might result in lower utilization (Manning et al., 1987; Goldman, Joyce, and Zheng, 2007), thus lowering total health system spending, compared with a scenario with more-generous health plans. Third, tax subsidization approaches may have a secondary effect on health system costs through their effects on health insurers' bargaining power. With a smaller enrollment base, health plans could have less negotiating power, an effect that could lead to higher prices and hence higher spending per enrollee.

The size of the credit or deduction, under any approach, will affect consumers' plan choices, and lower credits or deductions would encourage the selection of less generous plans. The fixed-dollar credit would likely give insurers the most bargaining leverage with providers.

Benchmark-Plan–Based Approach

Since the ACA's major coverage expansions took effect, health spending in the United States increased, a factor that is at least partially attributable to the increase in insurance enrollment (A. Martin et al., 2017). Per capita spending in the individual market also increased because the ACA expanded the scope of health insurance benefits available in these plans and instituted community rating (Assistant Secretary for Planning and Evaluation, 2017; Pauly, Harrington, and Leive, 2015). As discussed, previous studies have shown that people enrolled in more-generous plans tend to use more care. Nevertheless, the ACA's approach to subsidizing individual-market enrollment has some features that may reduce spending through encouraging the selection of certain plans. In particular, because the tax credit is pegged to the cost of a silver plan, enrollees have a disincentive to enroll in high actuarial-value plans (e.g., 80 or 90 percent), and, in fact, the majority of enrollees selected silver (68 percent) or bronze plans (23 percent) (Assistant Secretary for Planning and Evaluation, 2016).

The BCRA proposes to use the median premium plan among those with 58 percent actuarial value, which are the bronze plans under the ACA. These plans have lower premiums and higher cost sharing than the silver plans under the ACA and thus will likely reduce spending since consumers will be paying a larger share of medical expenses out-of-pocket. In their evaluation of the provisions in the BCRA, the CBO finds that the average deductible of a bronze plan is \$6,000, combining both medical and prescription drugs, compared with \$3,600 for a silver plan (CBO, 2017b). Given that high-deductible plans have been shown to reduce utilization, this approach may lower overall health system spending (Buntin et al., 2011).

Additionally, pegging the credit to a benchmark plan (the second lowest-cost silver plan under the ACA or the median plan with an actuarial value of 58 percent under the BCRA) should encourage insurers to compete on price to offer the benchmark or a lower-priced plan. The competitive effect of the ACA's approach may be tempered in areas with only one or two insurers—for 2017, approximately 13 percent of the country's 498 ratings areas will have one insurer, and 21 percent will have two (Holahan, Blumberg, and Wengle, 2017).¹⁰ It is likely that the same competitive effect would occur under the BCRA as under the ACA—insurers would want to have plans that are at or below the median bronze plan. The maximum subsidy might apply to more plans in the given area than under the ACA's method, since 50 percent of the plan offerings would be at or below the median, instead of pegging the subsidy to the second lowest-cost silver plan. However, using the median as the benchmark could have an unintended consequence: Insurers might increase the number of higher-cost bronze plans offered, with the goal of raising the median premium. This could be done by offering plans with broad networks or by negotiating less forcefully with providers.

Insurers have at least two leverage points to negotiate lower provider reimbursement rates. First, they could threaten to leave the provider out of their networks. Second, they could leverage the fact that, if prices are too high, premium costs could become too high to maintain high levels of enrollment, ultimately leading to reductions in provider revenue. With price-linked subsidies, insurers lose the second bargaining chip. This loss may be especially important in markets that have few providers, and hence where the threat of leaving a provider out of the network may not seem credible. Since the ACA's tax credits are linked to premiums, insurers may have less leverage to negotiate prices with providers than they would if there were no tax subsidies or if the tax subsidies were capped.

Outside the ACA's credit structure, some have argued that price-linked credits can increase health system costs. Jaffe and Shepard use data from the Massachusetts health insurance expansion that preceded the ACA and concluded that using a price-linked subsidy results in 5–10 percent higher subsidies than using a fixed-dollar credit that is set independently of prices (Jaffe and Shepard, 2017). This phenomenon has been shown to exist in other markets, such as Medicare Advantage. To set premiums in Medicare Advantage, the Centers for Medicare and Medicaid Services establishes a county-level benchmark price for covering the cost of the average fee-for-service enrollee, against which Medicare Advantage insurers can bid. If the insurer bids a lower price than the benchmark, the insurer can keep some of the difference to provide extra benefits to Medicare beneficiaries. Recent work finds that Medicare Advantage plans increase their bids \$0.53 for every dollar the benchmark price increases (Song, Landrum, and Chernew, 2013), and other work finds that only a small amount of increased reimbursement

¹⁰ The number of ratings areas across the United States continues to be in flux as states modify their ratings areas. For example, Idaho is switching to six rather than seven ratings areas for the 2018 plan year (State of Idaho, 2017).

to plans is passed to beneficiaries in additional benefits (Duggan, Starc, and Vabson, 2016). While some have made this argument in relation to the ACA, the benchmark-linked credit is structured so that it may avoid these pitfalls. As we discussed, pegging the value of the subsidy to the benchmark plan may encourage competition among insurers to offer the benchmark or a lower-priced plan under the ACA's approach. It is unclear whether other approaches to selecting the benchmark, such as the median bronze plan proposed in the BCRA, would have the same competitive effect if insurers offer more higher-priced plans to increase the value of the median plan.

Fixed-Dollar Tax Credit

Capping the federal contribution per consumer could reduce total spending relative to the ACA by incentivizing consumers to choose plans that cost near or less than the value of the credit. Under this method, consumers pay any difference between the credit and the premium, encouraging them to choose the plan with the lowest premium after taking into account the credit value. This may result in consumers choosing a less generous plan. In plans with lower premiums, there are fewer benefits, more-limited networks, or consumers face greater out-of-pocket costs, which may reduce their health care consumption, as has been seen with the introduction of high-deductible health plans (Buntin et al., 2011; Reddy et al., 2014). Consumers would be less likely to pick lower-cost plans if the level of the credit is higher or if adjustments for age or income allow for the purchase of more-generous coverage.

The advantage of the capped federal contribution method is that it may give insurers greater bargaining power with providers to lower negotiated prices and premiums. As the number of adjustment factors is increased, the credit becomes more similar to the ACA credits, and insurers' bargaining is thus reduced.

Tax Deduction

A standard deduction could potentially decrease total spending compared with the ACA, since the deduction does not vary by the type of plan selected, and consumers may decide to select less generous plans than the ACA's silver or bronze plans. Insurers' ability to sell less generous plans is dependent on whether ACA replacement plans allow states to waive the essential health benefit requirements.

Allowing the full cost of the premium to be deducted could increase consumer selection of more-generous plans. In the example in Table 2, premiums are fully tax deductible, which is similar to the approach currently used in the employer-based insurance system. With this approach, the value of the deduction increases with premiums, which can vary because of local premium costs or benefit generosity, for example. Because plans with more-generous benefits (e.g., low deductibles, small copayments, more services covered, broad networks) cost more, allowing premiums to be fully tax-deductible may encourage people to enroll in more-expensive plans and use more services, leading to health care cost growth (Gruber and Washington, 2005).

Labor Market Effects

Tax subsidies—either credits or deductions—can affect the decision to work and the number of hours worked. Economists have identified at least four pathways through which tax subsidies can influence labor supply:

1. **Income effects:** A tax credit or deduction could lead some individuals to decrease the amount worked, because the tax subsidy allows them to maintain the same level of after-tax income with fewer labor hours.
2. **Substitution effects:** In some cases, tax subsidies may change individuals' marginal tax rates, affecting their after-tax wages. Policies that reduce an individual's marginal tax rate may cause the individual to work more, because the income earned after accounting for taxes is higher.
3. **Cliff effects:** Limiting eligibility for deductions or credits to certain income levels may encourage individuals to enter or exit the workforce or alter income (e.g., by working more or fewer hours) to stay within the eligibility thresholds. Once eligible, there may be additional incentives to adjust hours worked or take a lower-paying job to qualify for increased subsidy levels.
4. **Job-lock effects:** In some cases, individuals may remain in their jobs to retain access to employer-sponsored health insurance, a phenomenon also known as *job-lock* (U.S. Government Accountability Office, 2011). Employer-sponsored health insurance is already heavily subsidized in the tax code. By reducing the price of nonemployer coverage, the expansion of tax subsidies to nongroup health insurance may reduce job-lock. Job-lock may be particularly relevant for workers close to age 65, or workers with chronic health conditions, who use more health care and thus are in greater need of health insurance.

Below, we discuss how the alternative approaches to subsidizing health insurance may affect labor force participation, bearing in mind income, substitution, cliff, and job-lock effects. Income and cliff effects are possible in all approaches, because each approach can be designed to have eligibility or the value of the subsidy vary with income. Furthermore, any approach that decouples access to insurance from employment could reduce job-lock.

Benchmark-Plan–Based Approach

In theory, the benchmark-plan–based approaches (including the ACA and the BCRA) could affect labor supply through all four pathways, as long as either the value of the credit or eligibility depends on income. The ACA has considerable potential to reduce job-lock because people with access to job-based coverage are ineligible for the tax credits, weakening the incentive to work to obtain health insurance. Some have argued that this subsidy design could encourage individuals who would otherwise work more than 30 hours per week (the threshold for determining a full-time worker under the ACA) to reduce hours to qualify for a tax credit in the ACA marketplaces. Early evidence suggests that the ACA might have increased part-time work (Mulligan, 2014; Dillender, Heinrich, and Houseman, 2016). However, it is not clear whether this is due to workers voluntarily reducing their hours in the manner described above or

to other factors.¹¹ Furthermore, either the ACA or the BCRA could decrease the amount of labor supplied through a substitution effect. The value of the credits decreases as income rises up to 400 percent of the FPL (or 350 percent, in the BCRA). As the credit decreases, this also decreases individuals' after-tax wages, which may cause them to reduce the amount of labor they supply.

The ACA and the BCRA also create eligibility cliffs that may affect individuals' labor supply. However, in the case of the ACA, these effects vary depending on states' Medicaid expansion decisions. In states that have expanded their Medicaid programs, individuals lose eligibility for Medicaid at 138 percent of the FPL and then face diminishing tax credits as their incomes rise, losing access to tax credits entirely at 400 percent of the FPL (or sooner, if their total premium is below the income-dependent contribution requirement). These changes in program and tax credit eligibility create disincentives to work, particularly for people close to key eligibility thresholds (100 percent of the FPL and 400 percent of the FPL for the ACA, and 350 percent of the FPL for the BCRA). Under the ACA, people in nonexpansion states with incomes below 100 percent of the FPL may be ineligible for Medicaid and are caught in a coverage gap since they qualify for neither Medicaid nor premium tax credits in the ACA marketplaces. For those in this coverage gap, the ACA marketplace eligibility cliff at 100 percent of the FPL may *encourage*, rather than discourage, work. Specifically, someone just below the 100 percent the FPL eligibility threshold may increase labor hours to qualify for tax credits. For those with incomes above 100 percent of the FPL, however, the fact that tax credits fall as income rises may tend to reduce labor supply.

Because of these labor market incentives and other requirements for employers to supply health coverage that may affect employers' demand for labor, the CBO estimated that between 2017 and 2024, the ACA would reduce hours worked by 1.5 to 2 percent and would reduce the number of full-time workers by 2 to 2.5 million (CBO, 2014). However, to date, there is mixed evidence that the ACA led to reduced labor supply thus far (Abraham and Royalty, 2017; Kaestner et al., 2015; Gooptu et al., 2016; Moriya, Selden, and Simon, 2016; Mulligan, 2014; Dillender, Heinrich, and Houseman, 2016).

Capped Federal Contribution

In discussing his *A Better Way* health reform proposal, which included fixed-dollar credits that do not vary with income, House Speaker Paul Ryan argued that “a flat, simple form of assistance . . . would grow the economy and ensure that work pays” (Ryan, 2016). Because a flat contribution that does not vary with income would eliminate cliff effects, this approach removes

¹¹ One key factor is the ACA's employer mandate to offer affordable health coverage to full-time workers (30 or more hours per week) or pay a penalty, which may encourage employers to reduce the number of full-time positions they offer.

one channel through which tax subsidization could discourage work. However, capped contributions could still lead to income effects and reduce job-lock, decreasing labor supply relative to what might be expected if nongroup health insurance were unsubsidized. Further, recent policy proposals allow capped contributions to vary with individuals' incomes, an approach that would reinstate cliff effects. The AHCA, for example, phases out the tax credits for those making more than \$75,000 annually (\$150,000 for married couples filing jointly). Eligibility cliffs at these relatively high income levels might have little effect on labor force participation, because higher-income individuals often have access to employer-sponsored coverage.

Tax Deduction

A tax deduction for individual-market health insurance could create both incentives and disincentives to work. Because the deduction would increase after-tax income for those purchasing health insurance, it could reduce labor supply through an income effect. However, for some individuals, the ability to claim the deduction may push them into a lower tax bracket and therefore reduce the marginal tax rate. Because a lower marginal tax rate increases the after-tax value of an extra dollar of income earned, those who move into a lower tax bracket may have greater incentive to work (the substitution effect). The tax deduction also reduces the negative impact of moving into a higher tax bracket, because when the marginal tax rate goes up, the value of the deduction also increases. It is unclear whether a tax deduction would lead to significant job-lock effects; although someone could leave a job and still claim the deduction, the value of the deduction diminishes as income falls.

Because these effects move in different directions and may have different implications depending on individuals' income and marginal tax rates, we cannot be sure how tax deductions would affect overall labor force participation.

Other Design Issues

In this section, we describe several other issues related to the design and implementation of the tax subsidization approaches that can affect the cost to the federal government and the take-up of the credit by consumers.

Administrative Complexity

Administrative complexity refers to the level of effort required to implement and administer the tax-based subsidy. In discussing administrative complexity, we focus on the effort required by the federal government. In the "Consumer Understanding of the Credits or Deductions" section below, we consider how alternative approaches to providing tax subsidies may affect consumers.

From the federal government’s perspective, the ACA’s tax credits may be more complicated to administer than the other tax subsidization approaches considered in this report. For example, the U.S. Government Accountability Office states that “[i]mplementing [the ACA’s] tax-related provisions is a significant undertaking for IRS and requires extensive coordination, not only within IRS but also with multiple agencies and external partners” (U.S. Government Accountability Office, 2016). The ACA’s tax credit varies with income, family size, age, and geographic region, so the federal government must calculate a unique tax credit amount for each ACA marketplace enrollee. Further, the ACA marketplaces (the Centers for Medicare and Medicaid Services on behalf of either the federally run or the state-based ACA marketplaces) must verify eligibility using information from several federal agencies, including the IRS, the Social Security Administration, and the Department of Homeland Security, which they then provide to the IRS (IRS, 2017). Forms must be filed on behalf of taxpayers by either the ACA marketplace, the insurance provider, or the employer to document that the person had coverage through one of these channels (IRS, 2016). Credits then must be paid to insurance companies, with adjustments for cost-sharing reductions that subsidize out-of-pocket cost-sharing for eligible enrollees with incomes under 250 percent of the FPL.

Finally, because credits are paid in advance based on estimated income, they must be reconciled with actual income when enrollees file their tax returns in the subsequent year. Consumers must file Form 8962 to reconcile the credit, and the IRS must verify the information. Additional complexity may arise because consumers may need to pay back all or part of the credit at the end of the year if their incomes increased. The government may also need to reimburse consumers who experienced an unexpected decline in income and thus were owed more premium tax credit than was paid. This extra amount is paid through a refund to the taxpayer. One report that has documented the IRS’s ability to process and reconcile the tax credits found that, while 97 percent of returns were processed correctly for the 2016 filing season, data lags between agencies continued to hamper the process (Treasury Inspector General for Tax Administration, 2017a). The BCRA builds off the ACA’s method, and therefore is unlikely to be less complex to administer than the ACA.

A capped tax credit may be simpler to administer than the ACA’s method, particularly if the government were to provide the same fixed-dollar amount for all enrollees. In particular, if a fixed-dollar credit were available to all enrollees, the government would not need to assess eligibility, verify income, or calculate unique credit amounts for each enrollee. However, even with a fixed-dollar credit, the government would likely need to assess whether the individual had obtained insurance, which would introduce administrative complexity. The administrative complexity could increase if fixed-dollar credits were paid in advance, or paid directly to insurers. Further, any adjustments to the credit—such as to account for age, income, or geography—would increase the administrative burden. For example, adjustments for geographic variation in premiums would require the government to develop an adjustment methodology (e.g., based on the Medicare price index) and update these adjustment factors over time.

Similarly, rules that preclude certain groups, such as those with employer-based coverage, from accessing the tax credits would increase administrative complexity by necessitating that the government obtain and verify applicants' eligibility. A capped tax credit that varied with age, income, and geography, and that was not available to those with job-based coverage, could become as complicated to administer as the ACA's current tax credits.

A standard deduction for individual-market insurance would probably be simpler to administer than the ACA's tax credits are; however, several design decisions about implementing a standard deduction may add administrative complexity. A standard deduction could be incorporated into the tax-filing process with minor modifications to existing rules and tax forms, although the IRS would need to verify that health insurance had been purchased. Additionally, a deduction for the full premium would require taxpayers to report, and the government to verify, the amount of the health insurance premium. Another design decision for the tax deduction method is whether the deduction would only be available for those who itemize their deductions.

Consumer Understanding of the Credits or Deductions

Consumers' understanding of available subsidies, and how these subsidies ultimately affect premium payments, may vary across approaches. There is little to guide us on what matters more to consumers: the size of the tax-based subsidy or the net premium payment required to obtain insurance. There is evidence from other programs that nonmonetary costs can influence the likelihood that eligible individuals enroll in public programs. Nonmonetary costs can include the application complexity, lack of information, or stigma about the program (such as with programs targeted at those with low incomes) (Remler and Glied, 2003). Several studies have shown low levels of health literacy among consumers, meaning that consumers may not understand all of the financial ramifications of the health plans they select (Barcellos et al., 2014; Loewenstein et al., 2013). For example, a lower-premium plan may have much higher out-of-pocket costs on average, or the plan might have limited benefits or networks. Although tax code approaches may encourage the selection of less generous plans, it is not clear that consumers understand the ramifications of this; we discussed this issue in the "Total Health System Costs" section.

The ACA's approach has not been well understood by many consumers, and it is likely that any other benchmark-plan-based approach would be similarly confusing for consumers. Early reports from the open-enrollment periods showed confusion over how the value of the ACA's tax credit is calculated, particularly for the first years of the ACA marketplaces (Gurley-Calvez et al., 2017; Martin et al., 2014). However, ACA marketplace plan selection and enrollment platforms show premiums net of the person's tax credit, which may reduce confusion for consumers about the amount they are actually paying, even if they do not understand how the credit was calculated. The BCRA would likely be similar to the ACA in this regard, although varying consumers' required premium contributions not only by income but also by age could make it more difficult for consumers to understand.

The capped federal contribution per person may be relatively easy to understand, but it is unclear whether consumers would easily be able to calculate how much they would owe in premiums. Further, if tax credit amounts varied based on such characteristics as age, income, and geography, consumers might not have a clear idea of the size of their credits. In the early 2000s, a special tax credit (called the Health Coverage Tax Credit [HCTC]) was created that now pays 72.5 percent of premiums for individuals who have lost their jobs to international trade (the job moved overseas) or who receive a pension through the Pension Benefit Guaranty Corporation. The take-up of the program has been very low (less than 1 percent of individuals identified as eligible in a recent audit of the program [Treasury Inspector General for Tax Administration, 2017b), and a recent report estimates that approximately 13,000 individuals will take the credit in 2016 (Fernandez, 2016). An early report on the program attributed the low take-up to the unaffordability of insurance premiums even with the credit and consumer confusion regarding the complexity of the program: “At in-person outreach events, many workers have required one-on-one sessions lasting 20 minutes or longer to explain HCTCs. Obviously, a larger-scale program cannot depend on such individualized instruction” (Dorn and Kutyla, 2004).

It is unclear whether consumers would find tax deductions (standard or full premium) confusing. There are some individuals who have opted to take the self-employed deduction for the individual market for health insurance, so there is some evidence that it is possible. Take-up may vary by education or income levels. While not related to health insurance, another common set of tax incentives exists for educational expenses. The Government Accountability Office found that 14 percent of eligible taxpayers did not claim one of the educational benefits in 2009 (U.S. Government Accountability Office, 2012). The report hypothesized that taxpayers might not have been aware of their eligibility or might have been confused about how to claim the benefits.

Conclusions

The main goal of subsidizing the purchase of health insurance through the tax code is to increase health insurance enrollment. There are many ways of providing tax-based subsidies, and there are unavoidable trade-offs between the three approaches. While the ACA's approach is designed to limit consumer premium payments to an affordable level for eligible consumers, it does not directly limit federal spending per enrollee. An alternative approach that provides a capped federal contribution for each enrollee might better constrain federal spending, although this would depend on the value of the credit and the eligibility criteria. As demonstrated with the AHCA or the BCRA, an approach that substantially reduces federal spending might also reduce health insurance enrollment relative to current law. Among the approaches considered, the tax deduction may be the least effective at promoting health insurance enrollment, because it would require consumers to shoulder the full cost of premiums up front and because it provides smaller benefits to low-income consumers, who are also less likely to be insured.

Tax-based subsidies that increase health insurance enrollment are likely to increase health systems costs, because consumers who have health insurance tend to use more care than those who are uninsured. However, some approaches to subsidizing health insurance may do a better job at constraining costs than others. In particular, approaches that encourage the use of high-deductible health plans or that encourage insurers to negotiate lower payments with providers may lead to lower per capita spending than approaches that increase the subsidy as health spending increases. Yet higher deductibles and lower provider payment rates may have other unintended effects, such as leaving consumers with unaffordable out-of-pocket costs or limited access to care.

Any approach using income-based eligibility will have some impact on work incentives, and, of the approaches discussed here, the ACA's may have the largest effect on work incentives because it has multiple income eligibility points. Fixed credits will likely have little impact on work incentives, unless they are scaled with income, and tax deductions will have an uncertain impact on work incentives.

The administrative complexity of each approach must also be taken into account, particularly in the expense incurred by administering the approach compared with the number of individuals likely to purchase the coverage. High administrative costs for few people enrolling may be an inefficient way to increase the take-up of private health insurance. Consumer confusion may also affect the likelihood of taking up the given subsidy. If fewer consumers take up the subsidy, federal costs may decline.

There are pivotal trade-offs inherently involved in any type of subsidy for the purchase of health insurance in the private market. It is easy to criticize each tax code approach when focusing solely on one outcome, such as the number of individuals likely to be insured or the

federal spending involved in each scenario. Policymakers must take into account a broad set of outcomes, as well as potential unintended consequences, when weighing possible alternative reform proposals. This report sheds light on a few of the complex issues policymakers will need to consider as they move to repeal, replace, modify, or repair the ACA.

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