

**ESTIMATING THE REVENUE EFFECTS OF THE  
ADMINISTRATION'S FISCAL YEAR 2008 PROPOSAL  
PROVIDING A STANDARD DEDUCTION FOR HEALTH INSURANCE:  
MODELING AND ASSUMPTIONS**

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of the  
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## CONTENTS

	<u>Page</u>
INTRODUCTION .....	1
A. Description of Assumptions Relating to the Administration Proposal .....	2
B. Administration and Compliance Issues .....	7
C. Issues Relating to the Earned Income Tax Credit.....	10
D. Baseline Assumptions for Employer-Provided Health Coverage.....	11
E. Effects on Employer Health Plans and Insurance Coverage .....	12
F. Effects on Employer-Provided Health Coverage Premiums and Employee Compensation .....	14
G. Application of Individual Income Micro-Simulation Tax Model.....	17
H. Revenue Estimate.....	18

## INTRODUCTION

The Administration's Fiscal Year 2008 Budget includes a proposal to create a new standard deduction for health insurance, while generally repealing the present-law tax subsidies relating to health coverage. The Administration provided a brief description of this proposal in the *General Explanations of the Administration's Fiscal Year Revenue Provisions* (Feb. 2007) prepared by the Treasury Department (the "Blue Book").<sup>1</sup> While a number of the details of the proposal remain unclear, this document,<sup>2</sup> prepared by the staff of the Joint Committee on Taxation ("Joint Committee staff"), describes the economic modeling that the Joint Committee staff has undertaken to assess the revenue effects of this proposal.

Any revenue estimate is measured as the difference between the Federal receipts expected to result after enactment of the proposal and the Congressional Budget Office's projections of baseline Federal receipts. In preparing any revenue estimate, the Joint Committee staff identifies key economic decisions that must be made by taxpayers, assesses the likely behavioral responses they will make and the effect of these responses on the growth of important baseline economic variables, and considers important administrative design features of the proposal. This document describes this estimating process with respect to the Administration's health care proposal. As described in more detail below, among the important economic variables with respect to this proposal are the number of taxpayers presently in employer group health care plans and the projected rate of growth of health care costs. Among the important economic decisions are the decision by employers to offer group health care as an employee benefit and the decision of taxpayers to purchase health insurance outside of an employer group context. This document also discusses administrative issues expected to arise under the proposal and the assumptions made by the Joint Committee staff where the Administration's description of the proposal provided insufficient details. The document also describes how the staff's individual tax model is used to estimate the aggregate effects of the proposal. The Joint Committee staff assesses the effects of these decisions on Federal receipts under the proposal as compared to Federal receipts under present law in order to arrive at the revenue estimate.

The Joint Committee staff welcomes comment on its modeling from other analysts in the field.

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<sup>1</sup> The description of this proposal is on pages 18-20 of the Blue Book.

<sup>2</sup> This document may be cited as follows: Joint Committee on Taxation, *Estimating the Revenue Effects of the Administration's Fiscal Year 2008 Proposal Providing a Standard Deduction for Health Insurance: Modeling and Assumptions*, (JCX-17-07), March 20, 2007. This document is also available on the web at [www.house.gov/jct](http://www.house.gov/jct).

## **A. Description of Assumptions Relating to the Administration Proposal**

### **Repeal of existing tax subsidies**

The Administration's health proposal would repeal the income and FICA tax exclusions for employer-provided health coverage, including coverage that is provided under health reimbursement arrangements ("HRAs") and health flexible spending accounts ("FSAs"). Employers would be required to include the value of employer-provided health coverage in wages on each employee's W-2 and the value of the coverage would be subject to income and FICA tax withholding. The Joint Committee staff has assumed that the value of employer-provided health coverage generally would be determined as under the COBRA continuing health care rules. That is, each employer would divide total health plan costs by the number of employees in the health plan to obtain an average cost per employee (with separate calculations for single and family coverage), and this average cost would be included in the taxable income of each employee.

The Joint Committee staff assumes that the repeal of the income and FICA tax exclusions for employer-provided health coverage would also apply to any health coverage that employers provide to retirees, and that the valuation method for such coverage would be the same as for active employees. That is, each employer would divide total retiree health plan costs by the number of retirees in the health plan to obtain an average cost per retiree (with separate calculations for single and family coverage), and this average cost would be treated as wages received by the retiree and would be subject to income and FICA taxes.

The proposal would retain the present-law income and FICA tax exclusions for employer contributions to health savings accounts ("HSAs").

The proposal would repeal the deduction for the health insurance expenses of self-employed individuals (sec. 162(l)).

Present law provides an itemized deduction for medical expenses (including qualifying long-term care expenses) in excess of 7.5 percent of adjusted gross income.<sup>3</sup> The Administration's proposal would repeal the itemized deduction for medical expenses (including qualifying long-term care expenses) with respect to individuals not enrolled in Medicare. The deduction would be retained for Medicare enrollees.

Under present law, qualifying long-term care insurance premiums and expenses fall within the definition of health insurance and, with certain exceptions, receive the same tax treatment as health insurance expenses. In particular, present law provides an income and FICA tax exclusion for employer-provided long-term care insurance, self-employed individuals may claim an above-the-line deduction for long-term care insurance premiums, and qualified long-term care services and premiums are treated as medical expenses for the purpose of the itemized deduction for medical expenses. The Joint Committee staff assumes that the Administration's proposal would repeal these exclusions and deductions, except that the itemized deduction would be retained for individuals enrolled in Medicare.

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<sup>3</sup> For alternative minimum tax purposes, the 7.5-percent threshold is increased to 10 percent.

After the repeal of the income and FICA tax exclusions, employer contributions toward the cost of health coverage would be taxable to the enrollee, and for income tax purposes the enrollee would be viewed as having paid the employer share of the premium. For employer-sponsored health insurance enrollees who are also enrolled in Medicare, the employer share of the premium would qualify as an itemized medical expense. This would provide income tax savings for Medicare enrollees who itemize deductions (in lieu of the standard deduction) and have itemized medical expenses (including newly-taxable employer premium contributions) that exceed 7.5 percent of adjusted gross income.

### **New deduction for health insurance**

Beginning in 2009, the Administration's proposal would provide a new deduction for health insurance for individuals who are covered by qualified health insurance. The health deduction would apply for both income and employment tax purposes. The Joint Committee staff understands that the deduction would only apply to the earned incomes of the taxpayers who qualify for the deduction. For this purpose, the Joint Committee staff has assumed that earned income means wages as reported on the W-2 for FICA tax purposes plus any net earnings from self employment. The Joint Committee staff assumes that taxpayers who have only unearned income would not benefit from the deduction, and those who earn less than the deduction would not receive the full benefit of the deduction. The maximum annual deduction (in 2009) would be \$7,500 for individuals with single coverage for the entire year and \$15,000 for individuals with family coverage for the entire year. The deduction would be determined on a monthly basis and would be based on insurance coverage as of the first day of each month. That is, one-twelfth of the annual maximum deduction would apply for each month of qualifying coverage. In years after 2009, the maximum annual deduction would be indexed to changes in the Consumer Price Index. The health deduction would apply for purposes of the regular income tax and the alternative minimum tax.

The maximum amount of the deduction (in 2009) would be limited to \$15,000 per tax return. Thus, for example, if a husband and wife have two children and file a joint return, and each spouse has qualifying health coverage that covers that spouse and one child, the maximum deduction for the joint return would be \$15,000. In this situation, each spouse would be allowed a health deduction, but the sum of the deductions would not be permitted to exceed \$15,000.

The Joint Committee staff assumes that eligibility for the deduction would be limited to individuals who are policyholders with qualifying health insurance, and that individuals who have health insurance coverage as a spouse or dependent would not qualify for the deduction. Thus, in the case of a married couple with one policy that provides family coverage, the deduction would apply to the earned income of the spouse who is the policyholder. The inclusion of the other spouse on the policy would qualify the policyholder for the \$15,000 family coverage deduction.

Individuals who are enrolled in Medicare, Medicaid, or SCHIP would not qualify for the deduction and would not qualify as covered dependents for purposes of the family coverage deduction. Individuals who claim the health coverage tax credit ("HCTC") or pay for health insurance from an HSA or MSA would not qualify for the deduction.

The Blue Book does not specifically discuss the treatment of active duty and retired military personnel with Tricare health coverage. The Joint Committee staff assumes that the repeal of the income and FICA tax exclusions for employer-provided health benefits would not apply to Tricare health coverage and that individuals with Tricare coverage would not qualify for the proposed health deduction.

The Joint Committee staff assumes that employers who provide qualifying health insurance to their employees would reduce FICA tax withholding from each employee's wages in accordance with the health deduction. Employees could elect to reduce income tax withholding. The deduction would also serve to reduce the FICA taxes imposed on employers. The Joint Committee staff assumes that employers would be required to report insurance coverage information to employees and the IRS.

The Joint Committee staff assumes that individuals who purchase qualifying non-group coverage would receive similar information from their insurers and that this information would be provided to the IRS. In addition, the staff assumes that this information would be provided to employers to verify coverage for the purpose of adjustments in income and FICA tax withholding.

### **Minimum coverage requirements for qualifying insurance**

Eligibility for the proposed health deduction would be limited to individuals with health coverage that satisfies certain minimum coverage requirements, including: (1) a limit on out-of-pocket exposure for covered expenses that is not higher than that currently allowable for HSA-eligible high-deductible health plans (e.g., for 2007, \$5,500 for single coverage and \$11,000 for family coverage); (2) a reasonable annual and/or lifetime benefit maximum; (3) coverage for inpatient and outpatient care, emergency benefits, and physician care; and (4) guaranteed renewability by the provider. The minimum level of coverage is not intended to preempt State laws mandating certain coverage. Thus, eligible coverage is subject to applicable State minimum coverage rules. Under regulations to be promulgated by the Department of the Treasury, the health deduction would be denied for policies that do not meaningfully limit individual economic exposure to extraordinary medical expenses.

In the absence of draft legislative language that provides greater specification of the minimum coverage requirements, it is difficult to determine the effect of the requirements on the premiums that would be paid for insurance that satisfies only the minimum requirements. The Joint Committee staff assumes that some individuals who are presently uninsured will be comparing the tax savings from the deduction with the premium they would pay for the least expensive qualifying health insurance, i.e., insurance that provides little or no benefits beyond the minimum requirements. The Joint Committee staff assumes that tighter requirements would result in higher premiums for coverage that satisfies only the minimum requirements, and these higher premiums would lead to smaller gains in health insurance coverage. Less strict requirements would result in lower premiums for coverage that satisfies only the minimum requirements, and this would lead to larger gains in insurance coverage.

If an uninsured individual has sufficient earned income, the health deduction will provide substantial income and FICA tax savings. For an individual in the 15-percent Federal income tax

bracket who is under the OASDI wage limit, the \$7,500 deduction would provide \$1,125 in Federal income tax savings and about \$574 in employee FICA tax savings (and perhaps some State income tax savings).<sup>4</sup> It is expected that an individual in this situation would be interested in comparing the total tax savings of \$1,699 with the premium for a health plan that provides the minimum in benefits. If the individual is young and healthy (or lives in a State with relatively low average premiums), the premium could be less than the tax savings from the health deduction. Thus, under the Administration's health plan, some individuals who are presently uninsured might receive a net gain from the purchase of health insurance. Some individuals who place little or no value on health insurance might purchase the insurance just to obtain this net gain.

It may be difficult to specify minimum coverage requirements that would disqualify any health plan that offers limited benefits with a correspondingly low premium. Assume, for example, that the minimum coverage requirements for single coverage are a \$1,500 annual deductible, a 30-percent copayment, and a \$5,500 annual limit on out-of-pocket expenses. As a general rule, these plan deductibles, copayments, and out-of-pocket maximums would apply only to provider billings that fall within the allowable charges under the health plan. The health plan would have a schedule of allowable charges for each type of service. For example, a fee-for-service health plan might list \$100 as the allowable charge for a physician office visit. If the enrollee visited a physician who charged \$120, only \$100 would be counted toward the plan deductible. If the enrollee had already exceeded the deductible for the year, the health plan (in this example) would pay 70 percent of \$100, and the enrollee would be responsible for the remaining 30 percent plus the additional \$20 not covered under the plan. Furthermore, the additional \$20 would not count toward the annual limit on out-of-pocket expenses. Thus, the schedule of allowable charges is an important determinant of plan benefits. If the minimum coverage requirements provide no minimums for the allowable charges for various services, an insurer could offer a health plan with an allowable charge of only \$30 for a physician office visit. Schedules with very low allowable charges could be used to create inexpensive policies that offer severely limited benefits.

Even if the minimum coverage requirements were to contain lists of minimums for allowable charges, there would still be an opportunity for insurers to create inexpensive policies with limited benefits. Insurers could offer preferred-provider organization ("PPO") or exclusive-provider organization ("EPO") health plans that would only comply with the minimums for allowable charges for physicians and hospitals within their networks. Health plan benefits could be severely limited (in the case of a PPO) or non-existent (in the case of an EPO) for enrollees who use physicians and hospitals outside the plan networks. Insurers could create inexpensive policies by limiting the numbers of physicians and hospitals within their networks.

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<sup>4</sup> It is assumed here that the individual is employed and pays half of the FICA taxes associated with his wages. The health deduction would also reduce the FICA tax liability of the individual's employer. An employee in a large firm would likely have little ability to renegotiate his individual compensation package to account for the reduction in the employer's FICA tax liability. Thus, in the short run, the Joint Committee staff expects that the reduction in employer FICA tax liability would not be a factor that the individual would consider in deciding whether to buy insurance.

For the purpose of preparing a revenue estimate for the Administration's health proposal, the Joint Committee staff has assumed that the proposal will contain legislative language that specifies in detail the minimum coverage requirements for insurance that qualifies for the health deduction. The Joint Committee staff has also assumed that the Department of the Treasury will issue detailed regulations concerning the minimum coverage requirements and that the IRS will be able to enforce compliance with these regulations.

If the legislative language for the health proposal and the associated regulations provide only limited specification of the minimum coverage requirements, the revenue estimate for the proposal would need to be revised. In such a case, it is expected that some insurers would take advantage of the lack of specific requirements by creating low-premium health insurance policies with very limited benefits and marketing these policies to individuals who are presently uninsured. Some of the uninsured would purchase these policies because the tax savings from the health deduction would exceed the policy premium. If the minimum coverage requirements provided insurers with an opportunity to market policies with premiums that are 20 percent lower than the average premiums now being charged for limited-coverage policies, the revenue loss from the health deduction might increase by as much as \$60 billion over the fiscal years 2009 through 2017. (In other words, the revenue loss might be as much as \$60 billion higher than the revenue estimate in Table 1.) The additional revenue loss would be associated with an increase in insurance coverage of 3 million individuals beyond what is assumed in the current estimate.

## **B. Administration and Compliance Issues**

Under present law, employers are required to withhold FICA taxes from all wages and, in general, the amount of FICA taxes withheld is equal to the amount owed. One exception is the case in which an employee works for two or more employers (either concurrently or consecutively) and has total wages that exceed the OASDI wage limit. In this case, FICA taxes are overwithheld and the taxpayer must file a tax return to claim a refund of the overpaid taxes. There are few situations in which FICA taxes are underwithheld by employers who are in compliance with the FICA withholding law and regulations.

The Administration has not provided any details on the manner in which the proposed health deduction will be administered for FICA tax purposes, but it appears that the deduction would pose some administrative problems. The health deduction may lead to many situations in which FICA taxes are underwithheld. In general, it is more difficult for the IRS to collect underwithheld taxes than to verify claims for refunds of overwithheld taxes.

Consider the situation in which a husband and wife are employed and each has employer-provided insurance. If one spouse has single coverage and the other has family coverage, or both have family coverage, the sum of their health deductions will exceed the \$15,000 limit per tax return. Thus, total FICA taxes for the couple will be underwithheld. The employee portion of the underwithheld taxes could be computed on the taxpayer's tax return and paid when the return is filed, but collecting the employer portion of the underwithheld FICA taxes would present additional difficulties. Any method for collecting the unpaid employer FICA taxes is likely to be cumbersome and, to some degree, ineffective. Thus, it is possible that some employer FICA taxes would go uncollected.

In the example of a husband and wife who each have employer insurance, there is also the problem of determining the allocation of the maximum \$15,000 deduction between the spouses. Suppose that the husband has a single coverage policy through his employer and the wife has a family coverage policy through her employer. The husband's employer would apply the \$7,500 deduction for employment tax purposes and the wife's employer would apply the \$15,000 deduction for employment tax purposes. However, at some point, perhaps at the time of income tax filing, one or both of these deductions would need to be reduced to satisfy the \$15,000 maximum. The proposal does not specify how the maximum deduction would be allocated between the spouses for payroll tax purposes. In some cases, the allocation could affect the total FICA tax liability of the couple. Assume, for example, that one spouse is under the OASDI wage limit and the other spouse is over the limit. Total FICA taxes for the couple could be reduced by allocating as much of the maximum deduction as possible to the spouse under the limit. Regardless of how the allocation is made, there would need to be coordination with the employers because the allocation would determine the extent to which each of the two employers owes additional FICA taxes. The need to allocate the FICA tax deduction between spouses with differing employers will tend to exacerbate the problem of collecting underwithheld employer FICA taxes.

Another example of incorrect FICA tax withholding would be the situation in which a taxpayer claims the health deduction for non-group insurance and works at two part-time jobs (either consecutively or concurrently) that each pay less than the health deduction. If the

taxpayer provides appropriate proof of insurance coverage to only one of the two employers, FICA taxes will be overwithheld. If he provides proof of coverage to both employers, FICA taxes will be underwithheld. Again, in the case of the underwithheld FICA taxes, it is not clear how the IRS would collect the unpaid employer FICA taxes, and it is not clear which employer would be liable for the unpaid FICA taxes.

Another administrative issue is the problem of individuals who are covered by more than one insurance policy. Consider, for example, the case of divorced parents who each have a family policy that covers their child. Under the proposal, it is unclear whether only one parent can claim the \$15,000 deduction (and if so, which parent), or whether both can claim the \$15,000 deduction. In this situation, one approach would be to give the family coverage health deduction to the parent who claims a personal exemption for the child. However, this could result in the loss of otherwise legitimate claims for the health deduction, because the proposal requires that the deduction be determined on a monthly basis.<sup>5</sup>

Another administrative issue relates to taxpayers who are underwithheld with respect to FICA taxes but have gross incomes that are below the filing threshold. The health deduction applies to income as well as FICA taxes, so the deduction could increase the number of taxpayers who have income but are not required to file returns. Filing requirements might need to be expanded so that insurance coverage for the health deduction can be verified by the IRS and a reconciliation can be made of FICA taxes withheld and FICA taxes owed.

The proposed health deduction may create an additional incentive for fraud. The use of false dependents has been an issue with respect to other tax benefits such as the earned income tax credit.<sup>6</sup> The health deduction may create a similar incentive because family coverage would provide a deduction that is twice as large as the deduction for single coverage, and in some cases the tax savings from the larger deduction might more than offset the additional premium cost to the enrollee. The potential for fraud may vary depending upon the minimum coverage requirements (which would affect premiums for policies that satisfy only the minimum requirements) and the enforcement mechanisms that are developed under the proposal.

For the purpose of preparing a revenue estimate for the Administration's health proposal, the Joint Committee staff assumes the following:

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<sup>5</sup> Consider, for example, the situation in which a child is covered under his father's health plan for the entire year. Assume the child lives with his father for the first five months of the year but lives with his mother for the remainder of the year and obtains additional primary (or secondary) coverage under her health plan. Under the Administration's health proposal, the husband would be entitled to the family health deduction for (at a minimum) the first five months of the year. The father would lose the family health deduction if eligibility for the deduction requires the claiming of a personal exemption for the child.

<sup>6</sup> The EITC provides an example of a tax benefit that is larger for individuals with qualifying dependents. It appears that some taxpayers are claiming fictitious or non-qualifying dependents in order to obtain a larger EITC. In a 1999 EITC compliance study, the IRS estimated that over one million EITC tax returns claimed children that were not the qualifying children of the taxpayers.

1. In the case in which a husband and wife both qualify for health deductions and the sum of the deductions exceeds the \$15,000 limit, the deductions would be reduced proportionately to satisfy the \$15,000 limit.
2. In the case in which individuals are covered by more than one insurance policy (e.g., a child covered by the policies of each divorced parent), all coverage would be counted for the purpose of determining eligibility for the family deduction, regardless of whether individuals are covered on other policies.
3. A small percentage of the taxpayers who are presently insured would claim health deductions that are greater than the deductions to which they would be entitled given their current coverage. For example, it is assumed that some individuals who now have single coverage would switch to a family policy that covers individuals who are already insured.<sup>7</sup> This assumption increases the estimated revenue loss from the health deduction by a total of \$11 billion over the fiscal years 2009 through 2017.
4. All taxpayers claiming the deduction would be required to file income tax returns and all taxpayers would comply with this filing requirement. This would give the IRS an opportunity to verify the insurance coverage and the FICA tax liability of taxpayers claiming the health deduction.<sup>8</sup>
5. The legislative language for the proposal will provide an effective administrative procedure for collecting underwithheld FICA taxes from employers.<sup>9</sup> If the legislative language provides no means of collecting underwithheld employer FICA taxes, our revenue estimate for the proposal will need to be revised. The Joint Committee staff estimates that, under the proposal, the underwithholding of employer FICA taxes will total about \$50 billion over the fiscal years 2009 through 2017.

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<sup>7</sup> The family policy could cover (1) someone who is already covered by another policy, in which case their would be duplicate (primary and secondary) coverage, or (2) someone who had been covered as a dependent on another policy and drops off that policy. An example of the latter would be the situation in which a divorced father had a family policy covering himself and two children, and the mother had single coverage. One child could switch from the father's policy to the mother's policy so that both could qualify for the family coverage health deduction.

<sup>8</sup> The Joint Committee staff assumes that either (a) the regulations would allow such coverage to count for purposes of the deduction, or (b) the regulations would not allow such coverage to count but the IRS would not have the resources to uncover and disallow deductions in cases in which individuals have multiple coverage.

<sup>9</sup> Under present law, taxpayers may claim a refund for overpayment of the employee share of FICA taxes on earnings, but there is no administrative procedure for refunding to employers the overpaid employer share of FICA taxes. An overpayment of FICA taxes occurs when an individual works two jobs and earns total wages that exceed the OASDI wage limit. In tax year 2003, taxpayers claimed refunds of \$1.6 billion in overpaid employee FICA taxes. The employer share of the overpaid FICA taxes would also be about \$1.6 billion.

### **C. Issues Relating to the Earned Income Tax Credit**

The Joint Committee staff assumes that both the repeal of the income tax exclusion for employer-provided health coverage and the proposed health deduction would be reflected in the measure of earned income that is used to compute the earned income tax credit (“EITC”).<sup>10</sup> Assume, for example, that an employee has single coverage through an employer health plan, and assume that the coverage is qualifying coverage for purposes of the \$7,500 health deduction. If the employer-provided coverage is valued at \$4,000 per year, the employee’s earned income for purposes of the EITC would be reduced by \$3,500. If the employer-provided coverage is valued at \$8,000, the employee’s earned income for purposes of the EITC would be increased by \$500.

Under the Administration’s health proposal, the phaseout rate for the EITC for taxpayers with qualifying children would be reduced to 15 percent. This would help some taxpayers who might otherwise lose the EITC as a result of the income effects of the repeal of the exclusion for employer health benefits and the health deduction. It would also help all EITC recipients in the phaseout range of the credit.

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<sup>10</sup> The proposal is not clear as to whether the SDHI applies in measuring earned income for purposes of the earned income tax credit.

#### **D. Baseline Assumptions for Employer-Provided Health Coverage**

Our baseline estimates of employer-provided health coverage and premiums are based on data from the 2004 Medical Expenditure Panel Survey (Insurance Component), and data from Office of Personnel Management with regard to the Federal Employees Health Benefits Program. According to these two sources, there were 89.1 million policyholders with employer-provided health coverage in 2004. Total premiums were \$641 billion, of which \$464 billion were paid by employers, \$120 billion were paid by active employees on a tax-preferred basis, and \$57 billion were paid by active employees, COBRA enrollees, and retirees on an after-tax basis. These figures include premiums for basic insurance and optional insurance (primarily dental and vision insurance), and employee contributions to health flexible spending arrangements (“FSAs”).

The Joint Committee staff baseline assumption is that there will be 94.1 million policyholders with employer-provided insurance in 2017. This is based on the assumption that the number of policyholders will grow by a total of 5.5 percent from 2004 to 2017. The Census Bureau estimates that the total United States resident population will grow by 11.9 percent over the same period. However, the population of individuals between the ages of 18 and 55 is expected to grow by only 5.5 percent, and it seems reasonable to assume that the number of policyholders with employer insurance will grow at about the same rate.

The Joint Committee staff baseline assumes that premiums for employer-provided coverage increased by about 13 percent from 2004 to 2006 and will increase by an average of 7 percent per year from 2006 to 2017. The Joint Committee staff estimates that in 2017 under present law, total premiums for employer-provided coverage will be \$1,638 billion, with \$1,145 billion paid by employers, \$338 billion paid by active employees on a tax-preferred basis, and \$155 billion paid by active employees, COBRA enrollees, and retirees on an after-tax basis.

Under the proposal, the maximum single and family coverage health deductions would be indexed to changes in the Consumer Price Index (“CPI”). The Congressional Budget Office baseline for the CPI has been used to forecast changes in the health deductions. Under the CBO baseline, the CPI increases at an average annual rate 2.2 percent from 2009 to 2017. The Joint Committee staff estimates that the single coverage deduction would increase from \$7,500 in 2009 to \$8,930 in 2017, and the family coverage deduction would increase from \$15,000 in 2009 to \$17,850 in 2017.

## **E. Effects on Employer Health Plans and Insurance Coverage**

Under present law, large employers have a strong incentive to provide health insurance to employees. The income and FICA tax exclusions for employer-paid insurance reduce the after-tax cost of the insurance far below what employees would pay for non-group insurance that provides comparable benefits, and large employers also have the advantage of lower administrative costs. In large firms (over 1,000 employees), administrative costs for health plans are equal to about 10 percent of benefits. Thus, a health plan that provided average benefits of \$5,000 per employee would have administrative costs of about \$500 per employee, and the total premium would be about \$5,500. In contrast, a non-group policy would have administrative costs equal to about 50 percent of benefits, and a policy providing benefits of \$5,000 per employee would have a total premium of about \$7,500.

The Administration's health proposal would, in general, equalize the tax treatment of employer-provided insurance and non-group insurance.<sup>11</sup> However, employers would retain the advantage of lower administrative costs for insurance. This advantage would be greatest for large employers and minimal for very small employers. The Joint Committee staff assumes that administrative costs would equal about 10 percent of benefits in firms with 1,000 or more employees, about 13 percent in firms with 500 to 999 employees, about 16 percent in firms with 100 to 499 employees, about 20 percent in firms with 25 to 99 employees, about 25 percent in firms with 10 to 24 employees, and about 48 percent in firms with fewer than 10 employees.

The Joint Committee staff assumes that employers would maintain their health plans after enactment of the Administration's health proposal if (and only if) the administrative cost savings provide a sufficient advantage over non-group insurance. To measure this advantage, it is useful to consider the situation of a young and healthy employee who might consider dropping the employer coverage to obtain less expensive non-group coverage. If young and healthy workers drop employer coverage to obtain cheaper non-group coverage, average premiums are increased for the workers who remain in the employer plan. The higher premiums will persuade other relatively young and healthy workers to drop employer coverage, and average premiums are increased further for those who remain in the employer plan. This cycle could continue to the point where the employer drops the health plan due to insufficient enrollment.

For example, assume that a young and healthy worker has single coverage in a large employer health plan. The total premium is \$5,500, and the worker's share of the premium is 20 percent or \$1,100. The employer would pay the remaining \$4,400. The administrative costs would be about 10 percent of benefits (in a firm with 1,000 or more employees), so the policy would provide enrollees with an average benefit of about \$5,000. But this young and healthy worker would be expected to use far less than the average in medical services. The expected benefit for this worker might be only \$2,500. If this worker switched to a non-group plan providing comparable benefits, the premium would be \$2,500 plus administrative costs of \$1,250,

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<sup>11</sup> Under the Administration's health proposal, employer contributions to HSAs would remain excludable for purposes of income and FICA taxation. Individuals who make direct contributions to HSAs receive a deduction for income tax purposes only. Thus, employer coverage would retain a tax advantage over non-group coverage to the extent that employers provide high-deductible HSA-eligible coverage and contribute to the HSAs of employees.

for a total premium of about \$3,750. If the worker chose to remain in the employer plan, the total cost to the worker would be the \$1,100 employee premium plus the income and FICA taxes that the worker would owe on the \$4,400 employer contribution. If the worker is in the 15-percent bracket for Federal income tax purposes, and the 5-percent bracket for State income tax purposes, and is under the OASDI wage limit, the taxes on the \$4,400 employer contribution would be about \$1,217. Thus, under the Administration's health proposal, the total cost of the employer insurance for this worker would be \$1,100 plus \$1,217, or \$2,317. This is \$1,433 less than the cost of the comparable non-group plan. Thus, it would appear that the typical young worker in a large employer health plan would be better off staying in the plan.

The comparison would be quite different for a young and healthy worker in a firm of fewer than 10 employees. The administrative costs for a very small employer health plan could be almost as large as the administrative costs for a non-group plan, and under the Administration's proposal, it would be difficult for very small employers to maintain their health plans. The Joint Committee staff assumes that, under the Administration's health plan, many small employers would drop their health plans and the total number of individuals covered by employer insurance would be less than under present law.

The Joint Committee staff estimates that in calendar year 2017, the Administration's health proposal will reduce the number of individuals covered by employer-provided insurance by about 6 million. Fewer than 500,000 of the individuals losing employer-provided health insurance would become uninsured. The remainder would purchase non-group insurance.

The Joint Committee staff estimates that in calendar year 2009, well over 9 million tax returns would claim the health deduction for newly-purchased insurance (i.e., insurance that would not have been purchased in the absence of the deduction). This newly-purchased insurance would cover over 12 million individuals for all or part of the year. On any given day in 2009, about 8.5 million fewer people would be uninsured as a result of the health deduction.

The Joint Committee staff estimates that in calendar year 2017, over 8 million tax returns would claim the health deduction for newly-purchased insurance. This newly-purchased insurance would cover over 11 million individuals for all or part of the year. On any given day in 2017, about 8 million fewer people would be uninsured as a result of the health deduction.

## **F. Effects on Employer-Provided Health Coverage Premiums and Employee Compensation**

Present law provides a tax subsidy for employer-paid health insurance that is generally proportional to the size of the health insurance premium. If an employee with \$5,000 of employer-paid health insurance receives \$1,000 in tax savings from the income and FICA tax exclusions, the same employee with \$10,000 of employer-paid health insurance would receive \$2,000 in tax savings. The income and FICA tax exclusions provide a subsidy for each additional dollar of health insurance, and average premiums for employer-sponsored health insurance are likely to be higher than they would be in the absence of this tax subsidy.

The Administration's health proposal would replace the income and FICA tax exclusions with a deduction of \$7,500 or \$15,000 for the purchase of any health insurance that satisfies the minimum coverage requirements. A taxpayer with a \$4,000 family coverage policy that satisfies the minimum requirements would receive the same deduction as a taxpayer with a \$12,000 family coverage policy that provides benefits far above the minimum requirements. The proposal provides no additional tax subsidy for insurance that exceeds the minimum coverage requirements. Thus, the Joint Committee staff assumes that the proposal would lead to a decline in average premiums for employer-paid health insurance. It is expected that employees would ask for (or agree to) reductions in health insurance coverage (i.e., leaner coverage with reduced benefits) in exchange for higher cash wages or increases in other forms of compensation.<sup>12</sup>

One might think that a decline in average premiums for employer-paid health insurance would reduce the revenue gain from the repeal of the income and FICA tax exclusions. However, any changes in premiums that are assumed to occur as a result of the proposal are generally immaterial to the revenue estimate of the proposal. An estimate of the revenue effects of a proposal is a comparison of what revenues are expected to be under the proposal compared to what revenues would have been under present law. It is the cost of premiums under present law, with the existing exclusion, that determines how much income would be taxable under the proposal that is not taxable under present law.

If premiums decline under the Administration's health proposals, this would reduce the income and FICA taxes that employees would pay on their health benefits, but it is highly unlikely that employees would agree to a reduction in health benefits with no offsetting increase in cash wages or other benefits.<sup>13</sup> If a reduction in employer-paid health insurance is offset by an increase in cash wages, the reduction in employer-paid health insurance will have no revenue

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<sup>12</sup> Reductions in health insurance coverage will increase the employee share of the cost of health care services and products, and this should lead to a decline in the demand for health care services and products. In the longer run, the prices of health care services and products would either decline or increase more slowly than under the present-law baseline.

<sup>13</sup> Economists generally assume that each employee receives a compensation package that equals the value of his contribution to the revenues of the firm. If the employee is making the same contribution to the firm before and after the enactment of the Administration's health proposal, the employee should be receiving the same total compensation. Any reductions in employer-provided health coverage should be offset by increases in other forms of compensation so that total compensation remains unchanged.

effect, because cash wages and employer-paid health insurance are both taxable under the Administration's health proposal.

The Joint Committee staff assumes that any declines in average premiums for employer-paid health insurance will be offset by increases in cash wages, so that total employee compensation remains unchanged. Assume, for example, that an employee is now receiving \$50,000 in cash wages and \$10,000 in employer-paid health insurance. Under the Administration's health proposal, the employer and employee might agree to a leaner health plan that costs only \$8,000. In this case, it is assumed that the switch to the leaner health plan would be accompanied by a \$2,000 increase in cash wages, so that total employee compensation is unchanged.<sup>14</sup>

If total compensation is unchanged, a decline in average premiums for employer-paid health insurance will have little or no effect on the revenue gain from the repeal of the income and FICA tax exclusions. The size of the revenue gain from repeal of the exclusions is determined by the size of the tax-excluded premiums under present law, and is unaffected by the size of the taxable premiums under the Administration's proposal.

Expanding upon this last point, consider once again the employee with \$50,000 of cash wages and \$10,000 of employer-paid health insurance. Assume that the \$10,000 policy is a family coverage policy that qualifies the employee for the \$15,000 deduction. Under present law, the employee pays income and FICA taxes on \$50,000 of cash wages. Under the Administration's health proposal, the employee pays income and FICA taxes on cash wages and employer-paid health insurance and receives a \$15,000 health deduction. If total compensation for the employee is unchanged, the cash wages and employer-paid health insurance will sum to \$60,000, and the employee will pay income and FICA taxes on \$60,000 minus the \$15,000 deduction, or \$45,000. Taxable income will be \$45,000 regardless of the size of the health insurance premium, provided that cash wages and the premium sum to \$60,000.

If the Administration's health proposal leads to a reduction in average premiums for employer-paid health insurance that is not fully offset by changes in cash wages, and total compensation declines, there could be a decline in individual income tax revenues, but this would be roughly offset by an increase in business income tax revenues. Firms that spent less on employee compensation would have higher corporate profits and thus would pay more in taxes.

It is possible that a decline in employer-paid health insurance would be partly offset by increases in employer spending on non-taxable fringe benefits such as child care, life insurance, tuition reimbursements, and transit and parking benefits. If this occurred, it could reduce the revenue gain from repeal of the income and FICA tax exclusions for employer-paid health

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<sup>14</sup> The analysis is somewhat more complicated than shown here because the employer's share of FICA taxes is viewed as a part of the total compensation package. In this example, if the income and FICA tax exclusions for employer-provided health coverage were repealed, the \$10,000 of employer-provided health coverage would become taxable, and the employer would owe additional FICA on the \$10,000. In order to keep total compensation unchanged, the employer would need to reduce cash wages (or the health premium, or both) by an amount equal to the increase in the employer's share of FICA taxes.

insurance. However, the total value of these other fringe benefits is very small in comparison with the value of employer-paid health insurance. In addition, it is unclear how the Administration's proposal would affect the demand for these other fringe benefits. The Joint Committee staff assumes that the Administration's health proposal would have a negligible effect on fringe benefits other than health insurance.<sup>15</sup>

In summary, the Administration's health proposal will most likely lead to a decline in average premiums for employer-paid health insurance, but the extent of this decline will have little or no effect on the net revenue effects of the proposal. The size of the revenue gain from the repeal of the income and FICA tax exclusions is determined by the total amount of tax excluded employer-sponsored health insurance under present law, not the amount of taxable employer-sponsored health insurance that would be provided by employers after enactment of the proposal.

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<sup>15</sup> Under the Administration's proposal, non-taxable benefits such as child care and life insurance would be the only means of receiving non-taxable compensation, and one might think that employees would want to receive a larger share of their compensation in the form of these non-taxable benefits. However, some employees now have employer-provided health coverage that is worth more than the \$7,500 and \$15,000 health deductions. These employees will be paying higher taxes under the Administration's health proposal and will see a reduction in their after-tax cash wages. If these employees asked for increases in some non-taxable fringe benefits, the employer would need to reduce their cash wages to pay for these additional benefits. It is not clear that employees would be willing to accept a reduction in cash wages in exchange for the larger fringe benefits. In fact, some employees might prefer a reduction in these other fringe benefits in exchange for higher cash wages.

## G. Application of Individual Income Tax Micro-Simulation Model

Our revenue estimate for the Administration's health proposal was prepared using the Joint Committee staff individual income tax model. This microsimulation model is based on a stratified sample of over 180,000 individual income tax returns prepared by the IRS. The sample is expanded (using information from the Current Population Survey) to include households who did not file tax returns in the sample year. The larger sample is then extrapolated to represent the tax returns that would be filed by taxpayers in future years. The extrapolation is consistent with the Congressional Budget Office ("CBO") baseline forecast of changes in wages, dividends, interest, capital gains, and other income and expense items. The extrapolation is also consistent with the Census Bureau forecast of changes in the demographics of the U.S. resident population.<sup>16</sup>

The individual income tax model contains detailed imputations for the health insurance coverage of each individual on the model. These imputations are supplied in part by a statistical matching of the tax returns and data from a recent Current Population Survey, and in part by a matching of the tax returns with data from a recent Medical Expenditure Panel Survey (Household Component). The matched survey data provide monthly information on non-group health insurance coverage; employer-sponsored insurance coverage (including information on active employee, COBRA, and retiree coverage); Medicaid, SCHIP, and Medicare coverage; and spells of uninsurance. Joint Committee staff provide imputations for health insurance premiums for each tax model individual who is identified as a policyholder with non-group insurance or employer-sponsored insurance. The premium information for employer-sponsored insurance is based on detailed premium distribution statistics from the Medical Expenditure Panel Survey (Insurance Component). This premium information includes (1) the total policy premium, (2) the employer share of the premium, (3) the employee share of the premium, and (4) an indicator for whether the employee premium is paid on a tax-preferred basis or an after-tax basis.

The inclusion of this detailed information on health insurance coverage and premiums enables the Joint Committee staff to simulate proposals affecting the taxation of health insurance. The simulations incorporate the full taxable income profile of each individual on the tax model, and thus account for interactions between provisions affecting the taxation of health insurance and other special exclusions, deductions, and credits in the Internal Revenue Code. Behavioral responses to changes in the taxation of health insurance are incorporated into the tax model.

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<sup>16</sup> For a more detailed description of the individual income tax model, the reader is referred to Joint Committee on Taxation, *Overview of Revenue Estimating Procedures and Methodologies Used by the Staff of the Joint Committee on Taxation*, (JCX-1-05), February 2, 2005.

## H. Revenue Estimate

The Joint Committee staff assumes that all of the provisions of the Administration's health proposal would be effective for taxable years beginning after December 31, 2008. For the purpose of preparing revenue estimates for the Administration's health proposal, the Joint Committee staff has assumed that all of the Administration's tax proposals will be enacted during calendar year 2007. The revenue estimate for the health proposal assumes that it will be enacted after all of the other tax provisions in the Administration's budget proposal, including the extension of the present-law individual tax rates and the proposed modifications to the tax treatment of HSAs. The revenue estimate for the health proposal would change if it were enacted in the absence of the other Administration tax proposals.

The estimated revenue effects of the Administration's health proposal are shown in Table 1. The first line of this table shows the combined effects of repealing the income and FICA tax exclusions for employer-paid health insurance, the deduction for health insurance expenses of self-employed individuals, and the itemized deduction for the medical expenses of the non-elderly. Caution should be used in interpreting this revenue estimate. There are strong interactions among these three tax provisions and separate revenue estimates for the three provisions would vary greatly depending upon the order in which the provisions were enacted.

In any given year, tax-preferred employer and employee contributions for employer-sponsored health insurance far exceed the insurance premiums deducted by self-employed individuals and the medical expenses deducted by taxpayers who itemize their deductions. In calendar year 2007, the Joint Committee staff estimates that (1) employer and tax-preferred employee contributions for health insurance will total \$732 billion, (2) self-employed individuals will deduct \$23 billion in health insurance premiums, and (3) taxpayers will claim about \$120 billion in itemized medical expenses, with about \$80 billion of this total being over the floor and deductible against income. From these figures, one might think that the repeal of the income and FICA tax exclusions for employer-sponsored health insurance would account for a very large share of the total revenue gain shown in the first line of the revenue table. However, a stand-alone provision to repeal the income and FICA exclusions would raise far less revenue than what is shown in the first line of the revenue table. After a stand-alone repeal, the newly-taxable employer and employee contributions for health insurance would be deductible as an itemized medical expense, and many taxpayers who had not previously itemized their medical expenses would now find that their total medical expenses exceed the 7.5-percent-of-AGI floor. This increase in itemized medical expenses would offset some of the revenue gain from the repeal of the exclusions.

The third line of Table 1 shows the revenue effects of the additional HSA deposits that would result from the expansion of high-deductible HSA-eligible insurance under the Administration's health proposal. The repeal of the income and FICA tax exclusions for employer-paid health insurance will result in a significant increase in the marginal after-tax cost of employer-sponsored insurance coverage. The Joint Committee staff assumes that this would lead to leaner employer-sponsored health plans. Leaner plans would tend to have higher deductibles. Thus, an increase in the number of high-deductible HSA-eligible health plans is expected to occur. The Joint Committee staff estimates that under the Administration's health

proposal, an additional 17 million policyholders will have high-deductible health plans by calendar year 2017.

Table 2 shows the effects of the Administration's health proposal on income, OASDI, and HI tax revenues. It also shows the outlay effects of the proposal.

Table 3 shows the number of taxpayers who would be affected by the Administration's health proposal, as classified by adjusted gross income ("AGI") under present law, for calendar years 2009, 2013, and 2017. For reference, the total number of potential filing units for each category under present law is also provided. In 2009, more taxpayers would experience a decrease in tax liability than an increase in tax liability, and this is true for all income categories except for those with AGI above \$200,000. By 2017, more taxpayers would experience an increase in tax liability than a decrease in tax liability, both for all taxpayers, and for taxpayers in all AGI categories above \$40,000. The changing ratio of increased liability to decreased liability is primarily due to the fact that average premiums for employer-sponsored health insurance are assumed to increase much faster in the present-law baseline than the health deductions, which are indexed to changes in the Consumer Price Index. In other words, the tax increases attributable to the repeal of the exclusion for employer-sponsored insurance are increasing faster than the tax reductions attributable to the health deduction.

In all AGI categories for all years, the average tax decrease is smaller than the average tax increase. In all years, only about five percent of taxpayers with AGI less than \$10,000 are affected by the proposal, while more than 75 percent of taxpayers with AGI greater than \$50,000 are affected by the proposal.

Caution is suggested in the use of Table 3, as it does not represent a full distribution analysis of this proposal. Present-law AGI is used because the proposal changes the definition of AGI, and thus movement of filing units between categories after the proposal would largely reflect definitional changes rather than behavioral responses to the policy. However, present-law AGI is not necessarily an ideal classification measure because (1) AGI does not include the value of employer-provided health insurance, non-taxable Social Security benefits, tax-exempt interest, excluded foreign earned income, and other sources of income that arguably enhance a taxpayer's economic well-being, and (2) AGI is reduced by deductions for IRA contributions, self-employed health insurance expenses, and other items that arguably do not reduce the individual's economic well being. In addition, because the AGI categories in Table 3 have not been adjusted for inflation, the numbers of returns in each category are not directly comparable for the different years.

**TABLE 1:  
 ESTIMATED REVENUE EFFECTS OF THE ADMINISTRATION'S PROPOSAL TO  
 PROVIDE A STANDARD DEDUCTION FOR HEALTH INSURANCE [1]**

**Fiscal Years 2007 - 2017**

*[Billions of Dollars]*

<b>Provision</b>	<b>Effective</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2007-12</b>	<b>2007-17</b>
1. Repeal the income and FICA exclusions for employer-paid health coverage, the self-employed health deduction, and itemized medical expenses for individuals not enrolled in Medicare.....	tyba 12/31/08	---	---	206.3	312.8	339.9	369.3	400.8	434.3	470.1	508.6	549.8	1,228.3	3,591.9
2. Provide a health deduction (\$7,500 for single coverage and \$15,000 for family coverage) for individuals with private health insurance.....	tyba 12/31/08	---	---	-219.6	-323.2	-336.5	-350.1	-363.8	-377.6	-391.3	-405.5	-420.1	-1,229.5	-3,187.7
3. Interaction with Health Savings Accounts.....	tyba 12/31/08	---	---	-0.4	-1.0	-1.3	-1.7	-2.2	-2.7	-3.2	-3.8	-4.5	-4.5	-20.8
4. Modify the phase-out rates for the earned income credit....	tyba 12/31/08	---	---	-0.1	-5.5	-5.8	-5.7	-6.0	-6.2	-6.6	-6.7	-7.1	-17.0	-49.7
<b>NET TOTAL .....</b>		<b>---</b>	<b>---</b>	<b>-13.8</b>	<b>-16.9</b>	<b>-3.7</b>	<b>11.7</b>	<b>28.8</b>	<b>47.9</b>	<b>68.9</b>	<b>92.6</b>	<b>118.2</b>	<b>-22.8</b>	<b>333.6</b>

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding. It is assumed that the proposal will be enacted during calendar year 2007.

Legend for "Effective" column: tyba = taxable years beginning after

[1] For the purpose of preparing revenue estimates for these provisions, we have assumed that the provisions would be enacted in the order in which they are listed on the table.

**TABLE 2:**  
**ESTIMATED REVENUE EFFECTS OF THE ADMINISTRATION'S PROPOSAL TO**  
**PROVIDE A STANDARD DEDUCTION FOR HEALTH INSURANCE**

Fiscal Years 2007 - 2017

*[Billions of Dollars]*

Provision	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2007-12	2007-17
1. Income tax revenues [1].....	---	---	-3.8	-5.7	2.5	12.4	23.3	35.7	49.3	64.9	81.7	5.3	260.2
2. Health Insurance ("HI") tax revenues.....	---	---	-1.9	-2.1	-1.1	[2]	1.3	2.7	4.2	5.9	7.7	-5.1	16.7
3. Old Age, Survivors, and Disability ("OASDI") tax revenues.....	---	---	-8.1	-9.0	-5.1	-0.8	4.2	9.5	15.4	21.9	28.7	-23.0	56.7
<b>NET TOTAL</b> .....	---	---	<b>-13.8</b>	<b>-16.8</b>	<b>-3.7</b>	<b>11.6</b>	<b>28.8</b>	<b>47.9</b>	<b>68.9</b>	<b>92.7</b>	<b>118.1</b>	<b>-22.8</b>	<b>333.6</b>

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding. The date of enactment is assumed to be July 1, 2007.

[1] Includes the following outlay effects (positive numbers represent an increase in outlays).....	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2007-12</u>	<u>2007-17</u>
[2] Gain of less than \$50 million.	---	---	[3]	10.4	10.5	9.9	9.8	9.5	9.4	8.8	8.7	30.8	77.0
[3] Increase in outlays of less than \$50 million.													

**TABLE 3:**  
**DISTRIBUTION OF NET TAX CHANGES UNDER THE ADMINISTRATION'S HEALTH PROPOSAL [1]**  
 Calendar Year 2009

<u>ADJUSTED GROSS INCOME</u> <u>UNDER PRESENT LAW</u>	Total Filing Units [2] <u>Millions</u>	<u>RETURNS WITH TAX DECREASES</u>			<u>RETURNS WITH TAX INCREASES</u>		
		<u>Returns</u> <u>Millions</u>	<u>Total</u> <u>Billions \$</u>	<u>Average</u> <u>\$ Per Return</u>	<u>Returns</u> <u>Millions</u>	<u>Total</u> <u>Billions \$</u>	<u>Average</u> <u>\$ Per Return</u>
\$10,000 and under .....	53.5	1.5	-0.6	-370	1.2	0.5	426
\$10,000 to \$20,000 .....	20.5	5.9	-1.7	-287	2.4	1.3	523
\$20,000 to \$30,000 .....	17.5	10.1	-5.7	-563	2.7	1.6	587
\$30,000 to \$40,000 .....	14.3	8.7	-8.0	-922	2.8	1.9	691
\$40,000 to \$75,000 .....	11.5	6.7	-5.8	-866	2.7	2.1	797
\$50,000 to \$75,000 .....	20.5	10.6	-8.5	-805	6.2	5.9	942
\$75,000 to \$100,000 .....	12.6	6.3	-5.8	-922	4.5	6.1	1355
\$100,000 to \$200,000 .....	15.7	7.4	-9.0	-1,224	6.5	12.7	1948
\$200,000 and over .....	5.1	2.1	-3.2	-1,540	2.3	5.9	2558
<b>TOTAL .....</b>	<b>171.2</b>	<b>59.2</b>	<b>-48.3</b>	<b>-816</b>	<b>31.3</b>	<b>38.0</b>	<b>1,212</b>

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

[1] Statistics do not include the revenue effects of the additional contributions to health savings accounts ("HSAs") that would result from enactment of the proposal.

[2] Filers and non-filing units under present law.

**TABLE 3:**  
**DISTRIBUTION OF NET TAX CHANGES UNDER THE ADMINISTRATION'S HEALTH PROPOSAL [1] - CONTINUED**  
 Calendar Year 2013

<u>ADJUSTED GROSS INCOME</u> <u>UNDER PRESENT LAW</u>	Total Filing Units [2] <u>Millions</u>	<u>RETURNS WITH TAX DECREASES</u>			<u>RETURNS WITH TAX INCREASES</u>		
		<u>Returns</u> <u>Millions</u>	<u>Total</u> <u>Billions \$</u>	<u>Average</u> <u>\$ Per Return</u>	<u>Returns</u> <u>Millions</u>	<u>Total</u> <u>Billions \$</u>	<u>Average</u> <u>\$ Per Return</u>
\$10,000 and under .....	52.0	1.5	-0.8	-519	1.0	0.5	491
\$10,000 to \$20,000 .....	18.9	3.9	-1.1	-274	2.4	1.2	511
\$20,000 to \$30,000 .....	16.7	7.9	-4.2	-529	3.4	2.5	719
\$30,000 to \$40,000 .....	14.4	7.5	-7.3	-977	3.8	3.2	836
\$40,000 to \$75,000 .....	11.5	5.3	-5.3	-1,004	3.8	3.5	923
\$50,000 to \$75,000 .....	22.2	9.1	-8.1	-889	8.7	10.6	1,214
\$75,000 to \$100,000 .....	14.5	5.4	-5.3	-986	6.7	11.5	1,718
\$100,000 to \$200,000 .....	20.6	7.2	-9.1	-1,258	10.9	26.8	2,448
\$200,000 and over .....	7.1	2.2	-3.5	-1,607	4.0	13.4	3,347
<b>TOTAL .....</b>	<b>178.0</b>	<b>50.0</b>	<b>-44.6</b>	<b>-894</b>	<b>44.8</b>	<b>73.1</b>	<b>1,630</b>

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

[1] Statistics do not include the revenue effects of the additional contributions to health savings accounts ("HSAs") that would result from enactment of the proposal.

[2] Filers and non-filing units under present law.

**TABLE 3:**  
**DISTRIBUTION OF NET TAX CHANGES UNDER THE ADMINISTRATION'S HEALTH PROPOSAL [1] - CONTINUED**  
 Calendar Year 2017

<u>ADJUSTED GROSS INCOME</u> <u>UNDER PRESENT LAW</u>	Total Filing Units [2] <u>Millions</u>	<u>RETURNS WITH TAX DECREASES</u>			<u>RETURNS WITH TAX INCREASES</u>		
		<u>Returns</u> <u>Millions</u>	<u>Total</u> <u>Billions \$</u>	<u>Average</u> <u>\$ Per Return</u>	<u>Returns</u> <u>Millions</u>	<u>Total</u> <u>Billions \$</u>	<u>Average</u> <u>\$ Per Return</u>
\$10,000 and under .....	52.7	1.7	-1.1	-635	1.0	0.5	524
\$10,000 to \$20,000 .....	17.8	2.3	-0.8	-334	2.4	1.5	638
\$20,000 to \$30,000 .....	15.3	5.9	-2.6	-436	3.5	3.4	972
\$30,000 to \$40,000 .....	14.2	6.0	-6.1	-1,018	4.6	5.3	1,158
\$40,000 to \$75,000 .....	11.7	4.3	-5.9	-1,364	4.6	5.8	1,256
\$50,000 to \$75,000 .....	23.0	6.9	-7.9	-1,144	11.1	17.8	1,611
\$75,000 to \$100,000 .....	16.0	4.3	-4.9	-1,134	8.6	19.1	2,232
\$100,000 to \$200,000 .....	25.2	6.1	-8.7	-1,430	15.7	50.5	3,219
\$200,000 and over .....	9.8	2.1	-4.0	-1,920	6.5	28.9	4,466
<b>TOTAL .....</b>	<b>185.5</b>	<b>39.6</b>	<b>-41.9</b>	<b>-1,058</b>	<b>57.9</b>	<b>133</b>	<b>2,295</b>

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

[1] Statistics do not include the revenue effects of the additional contributions to health savings accounts ("HSAs") that would result from enactment of the proposal.

[2] Filers and non-filing units under present law.