The Economic Effects of the President’s Proposal for a Standard Deduction for Health Insurance

Abstract - Health care costs continue to rise rapidly in the United States, claiming an increasing share of economic resources. One factor contributing to this rise is the favorable tax treatment for employer-sponsored health insurance, whereby employees pay neither income nor payroll taxes on health care that is provided through their employers. This tax treatment, which amounts to a $300–$400 billion per year subsidy for health insurance, has led to greater reliance on employer-sponsored insurance and lower deductible plans. Moreover, individuals who purchase insurance on their own often receive no tax subsidy. This paper discusses a health tax proposal included in President Bush’s FY 2009 Budget that would reduce or eliminate these tax biases through a new standard deduction for health insurance (SDHI). The SDHI would be available to all individuals purchasing qualifying insurance and improve incentives by breaking the link between how much an individual pays for insurance and the value of the tax subsidy. The SDHI would increase the number of individuals with health insurance by roughly six to nine million and reorient the tax subsidy more towards lower-income individuals. The paper also considers alternatives to the SDHI proposal, principally a flat refundable health insurance tax credit.

INTRODUCTION

Health care costs continue to rise rapidly in the United States. The growth in health care costs has been exceeding GDP growth by two percentage points annually since 1940. In 1960, health expenditures were just 5.3 of Gross Domestic Product (GDP). More recently, national health expenditures as a percentage of GDP were 13.8 percent in 2000, 16 percent in 2004, and are expected to rise to nearly 20 percent by 2015 (Figure 1) (Borger, Smith, Truffer, Keehan, Poisal, and Clemens, 2006). These rising costs impose a substantial burden on the U.S. economy. Higher spending on public programs like Medicare and Medicaid strains state and federal budgets. Higher insurance premiums pose a challenge for employers and burden workers with higher health costs and lower wage increases.

The burden of rising health care costs is particularly problematic for small businesses, who tend to have much
smaller pools of workers to spread risk and increasingly choose not to offer any health insurance to employees. According to the Kaiser Family Foundation’s annual survey, nearly 100 percent of firms with 200 or more workers offer health insurance to their employees. Yet only 60 percent of firms with fewer than 200 workers offered insurance in 2006, a decline from 69 percent in 2000 (Kaiser Family Foundation, 2006).

At the same time health care costs are rising, the number of uninsured also continues to grow. To a large extent, individuals are uninsured because the cost of health insurance exceeds the value people place on insurance coverage. As health care costs grow faster than incomes, an increasing number of individuals are unwilling to purchase health insurance. The latest estimates indicate that 45 million people are without insurance at any given time during the year.

A substantial portion of rising health care costs is due to the effects of the insurance system itself. Health insurance provides valuable protection against unforeseen illness. However, many insurance policies are structured in a way that dulls consumer sensitivity to price and, in some cases, a price signal is absent from the market place altogether. The direct expenditure for health care by an insured person may be only a small portion of his or her total health care costs. This is characteristic of low deductible or first dollar health insurance, whereby an individual covers little of the direct cost of health care. Moreover, the prevalence of this type of insurance is rooted in the tax treatment of health care generally.

Today the single largest tax expenditure in the tax code is the employee exclusion for employer–provided health insurance that, together with the other health care tax subsidies, averages roughly $300–$400

![Source: Department of Health and Human Services, Centers for Medicaid and Medicare Services.](image-url)
The Economic Effects of the President’s Proposal for a Standard Deduction

billion per year. Individuals pay neither income nor payroll taxes on health care that is financed through employer-provided health insurance. Thus, the tax code reduces the cost of health care when it is “pre-paid” or purchased in advance through an employer sponsored insurance plan. This has contributed to the prevalence of low deductibles, low co-insurance rates, and pre-paid coverage and may lead to the over-consumption of health care.

President Bush announced in his State of the Union address and in the Administration’s FY 2008 Budget a proposal to dramatically reform the tax treatment of health care with the twin goals of making basic insurance more broadly affordable and improving the economic incentives that underlie the provision of health care and health insurance. Addressing the tax biases that encourage people to purchase overly generous health insurance and receive more of their compensation in the form of tax-preferred health care, rather than wages, is an important first step in dealing with the rapid rise in health care spending. This paper explores some of the analyses of the effects of this proposal and discusses other approaches for reforming the tax treatment of health care.

CURRENT TAX TREATMENT

The tax code generally allows people who purchase insurance through their employer to exclude the value of their health insurance from both income and payroll taxes. People who purchase insurance on their own typically receive no tax benefit, with the exception of the self-employed who can deduct insurance premiums from income tax, but not the payroll tax. Other major health tax subsidies include flexible spending accounts (FSAs), health savings accounts (HSAs), and the itemized deduction for medical expenses above 7.5 percent of a taxpayer’s adjusted gross income. These other subsidies also allow taxpayers to exclude some out-of-pocket expenses from tax. FSAs apply for both income and payroll tax purposes, while HSAs and the itemized medical-expense deduction generally only apply for income tax purposes. As shown in Figure 2, together these tax subsidies total over $300 billion per year, with the employee exclusion for employer-provided insurance comprising nearly 90 percent of the total tax subsidies for health care.

The current tax treatment distorts health care decisions in several important ways by changing the price of health care relative to other consumption and depending on how health care spending is financed.

1 The Treasury Department estimates that repeal of most of the existing tax subsidies for health care would raise roughly $3 trillion in revenue between 2009 and 2017, averaging $300 billion per year. The Joint Committee on Taxation’s estimate is large at roughly $3.6 trillion in revenue between 2009 and 2017, averaging $400 billion per year.

2 The RAND Health Insurance Experiment found health spending to be sensitive to price and that more generous insurance policies generally result in higher total health spending (Newhouse, 1993).

3 HSA contributions made by an employer are subject to neither income nor payroll taxes.

through an employer plan is just 70 cents, while the person purchasing insurance on his own receives no tax benefit and pays the full dollar. Only employees who work for businesses that offer insurance receive the tax subsidy. Moreover, linking health insurance to employment creates “job lock,” whereby people with poor health status may be more reluctant to switch jobs because of concerns of finding adequate health insurance. Job lock is a significant concern because nearly 40 percent of businesses do not offer any health insurance.

Second, there is a tax bias to channel health care spending through employer–provided insurance because this ensures that the health care spending is exempt from income and payroll taxes. The individual can purchase a dollar of “pre–paid” health care through an employer–provided health insurance policy for every dollar of wages received. Thus, the current tax system builds in a large tax subsidy for “pre–paid” health care in the form of employer–provided health insurance. This tax distortion has encouraged overly broad, first–dollar insurance coverage. Equivalently, this tax bias discourages individuals from purchasing high–deductible health plans. The consequence is an overreliance on first–dollar coverage, which dulls the incentives for consumers to shop carefully for cost–effective health care. Research has indicated that there is considerable responsiveness of health care spending to price (Newhouse, 1993).

Also, the existing health care tax subsidy creates an incentive for individuals to receive compensation in the form of employer–provided health insurance rather than wages. Compensation received as health insurance is free of income and payroll taxes, while compensation received as wages is not. The more compensation that can be funneled through employer–provided insurance (or simply health care for those with FSAs), the larger is the tax benefit. These features of the current tax treatment help fuel higher expenditures on health care.

Note: Estimates include the tax expenditure related to both income and payroll taxes.

Source: U.S. Department of the Treasury, Office of Tax Analysis.

Figure 2. The Health Care Tax Subsidies Are the Single Largest Tax Expenditure, 2011

Note: Estimates include the tax expenditure related to both income and payroll taxes.

Source: U.S. Department of the Treasury, Office of Tax Analysis.
PRESIDENT’S PROPOSAL FOR A STANDARD DEDUCTION FOR HEALTH INSURANCE

The President announced in his State of the Union address and included in his FY 2008 Budget a proposal to replace most existing health care tax subsidies with a standard deduction for health insurance (SDHI) set at $15,000 for family coverage and $7,500 for individual coverage. The SDHI would apply for both income and payroll taxes, and the SDHI amounts would be indexed by the Consumer Price Index (CPI). The SDHI would be fully available to those purchasing qualifying insurance that meets certain minimum standards regardless of how much individuals spend on health care or health insurance.\(^5\)

The SDHI would also be available regardless of whether a person purchases insurance through their employer or directly, thereby providing the same tax benefits currently available through employer–based insurance to those who purchase insurance on their own in the non–group market.\(^6\) The flat, uniform nature of the SDHI is a crucial feature of the proposal that effectively breaks the link between the size of the tax subsidy and how much a person spends on health care or health insurance. Under the SDHI proposal, consumers of health care no longer receive a larger tax benefit if they consume more health care. Also, the tax subsidy would be no larger or smaller if consumers choose to channel health care spending through an insurance policy or pay for health care out–of–pocket, provided they have a least the minimal insurance coverage needed to qualify for the SDHI. Individuals would have a substantial incentive to purchase at least basic coverage in order to claim the SDHI. The proposal, in effect, provides a substantial incentive to purchase basic insurance, but removes taxes from most other health care decisions.

Figures 3 and 4 compare the value of the current tax subsidies to the subsidy associated with the SDHI for a family of four at different income levels (in 2009). Figure 3 compares the $15,000 SDHI to an average policy costing $14,000 in 2009.\(^7\) The value of the SDHI to a taxpayer generally exceeds the value of the current tax subsidy for taxpayers with incomes over $42,000. For lower–income taxpayers, the SDHI proposal has important interactions with the Earned Income Tax Credit (EITC) because repeal of the current employee exclusion reduces earnings for purposes of computing a taxpayer’s EITC. In the phase–in range of the EITC, additional earnings increase the EITC. Thus, for very–low–income taxpayers, the SDHI proposal has the effect of increasing a taxpayer’s EITC payment and lowering his or her overall taxes. This works in the opposite direction for taxpayers in the phaseout range of the EITC, where EITC payments fall as earnings rise. The SDHI proposal lowers the EITC rate from 21.06 percent to 15 percent in order to partially address this interaction between the EITC and the SDHI.

Figure 4 compares the $15,000 SDHI to a policy costing $6,000 in 2009, which is what a basic insurance policy is expected to cost in 2009 in the non–group market. The SDHI provides a substantially larger subsidy than a $6,000 plan purchased though an employer. Of course, if the

\(^5\) Qualifying insurance could not have deductibles in excess of the out–of–pocket maximum for HSA–type high deductible health plans ($11,000 for family coverage in 2007) and would be required to have an annual and lifetime benefit similar to what is currently in place for HSA–type plans or roughly $1 million.

\(^6\) As mentioned above, leveling the playing field between the group and non–group markets would reduce job lock because non–group insurance is generally not dependent on an individual’s place of work.

\(^7\) It is estimated that the current average tax–preferred premium of $11,000 (in 2007) will grow to roughly $14,000 by 2009 based on the projected growth in private health care premiums provided by CMS.
Figure 3. Tax Subsidy for Employer–Provided Health Insurance: Current Law ($14,000 Policy) v. SDHI

Figure 4. Tax Subsidy for Employer–Provided Health Insurance: Current Law ($6,000 Policy) v. SDHI
$6,000 policy were purchased directly in the non–group market, the current tax subsidy would be close to zero. Thus, the SDHI proposal provides a substantial incentive for those currently without insurance to purchase at least basic coverage.

**What Are the Expected Effects of the SDHI Proposal on the Number of Uninsured?**

As suggested by Figures 3 and 4, the SDHI proposal can provide a substantial incentive for the uninsured to purchase insurance. This incentive is generally larger for people who pay both income and payroll taxes, but lower–income earners still benefit because the SDHI would at least apply for payroll taxes. By leveling the playing field between the group and non–group markets, however, the SDHI may also have important effects on the incentive for individuals to purchase insurance through their employers and for employer to offer insurance. The net effect of the SDHI proposal on the number of uninsured reflects these two possibly offsetting effects.

There are also non–tax reasons for firms to offer health insurance. Principally, health insurance is a valued employee benefit used to attract and retain workers. Also, large and medium–sized firms have the advantage of lower administrative costs relative to small firms and the non–group market. Table 1 summarizes recent estimates of these effects developed by the Treasury Department, the Joint Committee on Taxation (JCT), the Congressional Budget Office, and the Lewin Group.

The estimates in Table 1 indicate that, on net, the SDHI proposal is expected to increase the number of insured from six million to nine million. The estimates suggest the effects of the SDHI proposal on the employer market are highly speculative with the reduction in the number of people with employer coverage falling by anywhere from six million to 12 million, relative to the roughly 160 million people who currently obtain insurance through

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>ESTIMATED EFFECTS OF THE PRESIDENT’S SDHI PROPOSAL</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effect on number of people with insurance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in people with insurance</td>
<td>6 to 7</td>
<td>8.5</td>
</tr>
<tr>
<td>Change in people with employer coverage</td>
<td>NA</td>
<td>–6.0</td>
</tr>
<tr>
<td>People losing employer coverage, but who purchase insurance on their own</td>
<td>NA</td>
<td>5.5</td>
</tr>
<tr>
<td>People losing employer coverage and who choose not to purchase insurance on their own</td>
<td>NA</td>
<td>0.5</td>
</tr>
<tr>
<td>Number of people currently without insurance</td>
<td>50</td>
<td>NA</td>
</tr>
<tr>
<td>Average growth in private insurance premiums (2009–2017) (%)</td>
<td>6.3</td>
<td>7.0</td>
</tr>
<tr>
<td>Year of analysis</td>
<td>2011</td>
<td>2009</td>
</tr>
<tr>
<td>Revenue effect (ten–year budget window: 2008–2017; billions)</td>
<td>17.6&lt;sup&gt;3&lt;/sup&gt;</td>
<td>333.7</td>
</tr>
</tbody>
</table>

<sup>1</sup>Includes a 1.3 million increase in the number of people who purchase insurance through their employer.

<sup>2</sup>Does not include the 1.1 million people estimated to switch to public coverage.

<sup>3</sup>Estimates are for the Administration’s Mid–Session Review of the FY 2008 Budget.
their employer. The number of those who lose employer coverage and choose not to claim the SDHI and purchase insurance on their own is even more variable, with estimates ranging from 500,000 (JCT, 2007) to 2.3 million (Sheils and Haught, 2007).

What Are the Distributional Effects of the SDHI Proposal?

A key feature of the SDHI proposal is that it redirects the current $300 billion a year tax subsidy for health care to help control health care costs through improved economic incentives and by channeling more of the tax benefits to those without insurance. Based on Treasury Department estimates from the Medical Expenditure Panel Survey, roughly 75 percent to 80 percent of health insurance policies are expected to cost less than the $15,000/$7,500 SDHI amounts in 2009.

Figure 5 below shows the distributional effects of the SDHI proposal. The first four quintiles receive a larger reduction in their taxes as a fraction of their income, and the top quintile pays more. Middle-income taxpayers (the three middle quintiles) tend to benefit more than the lowest-income earners because the benefits that accrue to the later group are primarily limited to payroll taxes. While broadly progressive, there is considerable heterogeneity underlying such an aggregate analysis. Generally, families with tax–preferred health care spending under $15,000 will pay less in taxes under the SDHI proposal. Those with tax–preferred health care spending over $15,000 are likely to have overly generous health plans, but could also live in higher cost regions, be older, and have poor health status or chronic conditions.

Figure 5. The SDHI Is Progressive

Note: Estimates are for 2007 income levels, but reflect the first year of the proposal (e.g., 2009). Quintiles begin at: 2nd $13,310; 3rd $28,507; 4th $50,448; 5th $87,758; top 10% $128,676; top 5% $177,816; top 1% $432,275.

Source: Department of the Treasury, Office of Tax Analysis.

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8 A distributional analysis released by the Tax Policy Center shows a similar pattern across the income distribution.
LABOR SUPPLY EFFECTS

Beyond the effects of the SDHI proposal on the efficiency of health care and the uninsured, the proposal may also have broader economic effects on the taxpayers’ work effort by altering taxpayers’ marginal tax rates. The SDHI proposal would affect taxpayers’ marginal tax rates by changing the amount of their compensation that is taxable as it replaces most existing health tax subsidies with the new SDHI. The repeal of existing health tax subsidies increases taxable compensation, while the SDHI lowers taxable compensation. The effect of the proposal on taxable compensation generally depends on whether the SDHI amounts exceed a taxpayer’s current tax–preferred health care spending. If taxable compensation increases, taxpayers will generally be pushed into higher income tax brackets or have more of their compensation exceeding the Social Security wage cap.

Estimates from Treasury’s Health Care Tax Model indicate that the average marginal tax rate on labor income rises by roughly 2.3 percentage points in 2009 (from 31.4 percent to 33.7 percent), with about 1.2 percentage points attributable to income taxes and the remaining 1.1 percent attributable to payroll taxes. Note that there is considerable heterogeneity in these effects. For example, taxpayers who currently purchase insurance in the non–group market face a reduction in their average marginal income tax rate of roughly 0.4 percentage points in 2009 (18.6 percent to 18.2 percent) because their taxable compensation is lowered by the SDHI, but they are unaffected by the repeal of existing health care tax provisions. Applying a 0.15 labor supply elasticity for primary workers and an elasticity of 0.7 for secondary workers suggests that the proposal would lose an additional $7 billion to $8 billion in revenue in 2009 because of the reduction in labor supply (see Blundell and MaCurdy (1999) for a recent review of the labor supply literature). Note that because the SDHI is designed to grow more slowly than tax–preferred health care spending, the labor–supply effects rise over time. As indicated by CBO (2007), these labor–supply effects can also affect the level of output.

DEDUCTION OR A CREDIT?

Another approach for refocusing the existing tax subsidy for health care would be to provide a flat credit rather than a standard deduction for health insurance. This alternative approach can improve economic incentives in much the same way as the SDHI proposal by:

- Removing the tax bias towards first–dollar coverage;
- Leveling the playing field between insurance purchased in the group and non–group markets; and
- Placing compensation received in the form of health insurance on equal footing with wages.

However, only a credit structure that is independent of how much a person spends on health insurance or health care would improve economic incentives in this manner. Importantly, both a flat credit and the SDHI break the link between spending more on health care and the value of the tax subsidy.

A credit, however, would have very different distributional effects, and, consequently, has very different effects on the number of uninsured. As Figure 6 illustrates, the uninsured are more likely to be lower income. Because a flat credit provides the same tax subsidy, regardless of income, more of the tax benefits are likely to be focused on lower–income earners, who are also more likely to be uninsured. Put another way, a credit channels more of the tax subsidy to those most likely to be left out of the current system.
The Treasury Department estimates that a $4,600 credit for families ($2,300 credit for individuals) would be roughly revenue neutral over the budget window (2009 through 2017). Figure 7 overlays the $4,600 credit onto Figure 3 to compare the tax subsidies under current law, the SDHI proposal, and a credit proposal. Obviously, the credit provides a flat subsidy equal to the credit amount. As is clear from Figure 7, more of the tax subsidy is channeled to low-income earners under a credit than under the SDHI proposal or current law. However, since the proposal is revenue neutral, the larger benefits that accrue to lower-income earners imply that more people elsewhere in the distribution are likely to pay more in tax than under the SDHI proposal.

The progressive nature of credit proposal, as compared to the SDHI, is confirmed in Figure 8 with the lowest-income earners receiving the largest reductions in tax as a percent of their income. These different distributional effects of the credit have a pronounced effect on estimates of the number of people with insurance with the Treasury Department estimating, on net, the number of newly insured would rise by 13 million to 15 million (Table 2).

Several Congressional proposals have been introduced that would scale back or eliminated the existing employee exclusion and provide a refundable credit. A proposal introduced by Senator Martinez and Congressman Ryan (S. 397, H.R. 914) would cap the exclusion for employer-based insurance at $11,500 for family coverage ($5,000 for individual coverage). A refundable (and advanceable) credit would be provided for individually purchased coverage of up to $4,000 for joint filers with incomes below $30,000 and $2,000 for individuals with incomes below $15,000. The credit would phase down to $2,500 for families with incomes over $60,000 and to $1,250 for individuals with incomes over $30,000. The Martinez–Ryan proposal differs from the flat credit in at least three important respects: (1) it would only be available for individually purchased insurance, (2) it
Figure 7. Tax Subsidy for Employer–Provided Health Insurance: SDHI and Flat Credit v. Current Law ($14,000 Policy)

Figure 8. Distributional Effects of a Flat Credit v. SDHI

Note: Quintiles begin at cash income of: second $13,310; third $28,507; fourth $50,448; fifth $87,758; top 10% $128,676; top 5% $177,816; top 1% $432,275.
would be phased–down by income, and (3) the credit would be allowed only up to the cost of health insurance. These three limitations result in a considerably smaller increase in the number of individuals purchasing insurance (net of changes in the group market) of one million to three million.

Senator Coburn has introduced a comprehensive health care proposal (S.1019) that includes provisions to repeal the current exclusion for employer–based health insurance and allow a refundable credit up to $5,000 for families and $2,000 for individuals. The credit would only be available up to the cost of health insurance, but contributions to HSAs could also qualify for the credit. Thus, individuals purchasing insurance for less than the credit amounts could claim the entire credit provided the excess over the cost of the qualifying health insurance were contributed into an HSA. This feature limits the credit to health care spending, and, as reported in Table 2, lowers the number of additional people with insurance (net of the effects on the group market) somewhat relative to a flat credit: 11 million to 13 million under the Coburn proposal, rather than the 13 million to 15 million under the flat credit.

The four proposals listed in Table 2 have substantially different effects on economic incentives, distributional effects and the number of additional people with insurance. The Martinez–Ryan proposal more closely resembles the current tax system than the other three approaches. The cap improves economic incentives, but it does not go as far as complete repeal of the current exclusion for employer–based insurance. Unlike the Administration’s SDHI proposal and the flat credit, both the Coburn and Martinez–Ryan proposals limit the tax subsidy to health care. The Administration’s SDHI proposal and the flat credit breaks the link between how much a person spends on health insurance or health care and the value of the tax subsidy (provided the person purchases at least minimum insurance). The flat credit, however, involves substantially more redistribution of the existing $300 billion to $400 billion tax subsidy, involves a very different set of individuals who win and lose under the reform, and represents a considerably larger departure from the current tax treatment.

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### TABLE 2

Comparison of President’s SDHI Proposal to Various Proposals for a Refundable Health Insurance Credit

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Description</th>
<th>Budget Effect (2008–2017)</th>
<th>Millions Increase in Number of People with Insurance (OTA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>President’s SDHI</td>
<td>$15,000 ($7,500) deduction for family (individual) coverage; repeals current exclusion for employer–based insurance.</td>
<td>Neutral</td>
<td>6 to 7</td>
</tr>
<tr>
<td>Flat Credit</td>
<td>$4,600 ($2,300) credit for family (individual) coverage; repeals current exclusion for employer–based insurance.</td>
<td>Neutral</td>
<td>13 to 15</td>
</tr>
<tr>
<td>Martinez–Ryan (S. 397, H.R. 914)</td>
<td>Up to $4,000 ($2,000) credit for families (individuals) for lower income, phased–down for higher income; caps current exclusion for employer–based insurance at $11,500.</td>
<td>$400 B</td>
<td>1 to 3 (Prel.)</td>
</tr>
<tr>
<td>Coburn (S. 1019)</td>
<td>Up to $5,000 ($2,000) credit for families (individuals); repeals current exclusion for employer–based insurance.</td>
<td>Roughly Neutral</td>
<td>11 to 13 (Prel.)</td>
</tr>
</tbody>
</table>
of health care than the Administration’s SDHI proposal.

CONCLUSION

The President’s proposal to reorient the largest tax preference in the tax code today—the $300 billion to $400 billion per year tax subsidy for health care—would break the link between the value of the tax subsidy and how much an individual spends on insurance or health care. The policy improves economic incentives by providing a large incentive to buy insurance and removing tax distortions that have encouraged people to purchase overly generous insurance and have likely contributed to the high spending on health care. The policy is progressive and estimated to increase the number of insured by anywhere from six million to nine million people. A flat credit could improve economic incentives in very much the same way as the SDHI proposal, but would refocus much more of the existing health care tax subsidy to lower-income taxpayers. The more–pronounced redistributive effects of a flat credit translate into larger estimated increases in the number of newly insured, but also involve greater heterogeneity in who wins and who loses than under the SDHI proposal and represent a larger departure from the current tax treatment of health care.

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Joint Committee on Taxation.


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Sheils, John, and Randy Haught.
