Obamacare and Lower-Income Workers

Author : Susan Morse

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David Gamage, *Perverse Incentives Arising From the Tax Provisions of Healthcare Reform: Why Further Reforms Are Needed to Prevent Avoidable Costs to Low- and Moderate-Income Workers*, 65 **Tax L. Rev.** 669 (2013), available at SSRN.

What if Obamacare changes the patterns of lower-income work? Murmurs in the news suggest that this is happening, for example through increased use of part-time schedules. In his forthcoming article, David Gamage explains the powerful incentives that the Affordable Care Act (ACA) presents to employers to ensure that lower-income workers will be insured through public exchanges rather than employer-provided health insurance. These incentives to differentiate apply for a huge number of employees, as they apply until households have income of between 2.25 and 3.5 times the poverty level.

Gamage supports the ACA, but argues that it presents lower-income workers and their employers with a catch-22. If employers provide health insurance, workers will overpay for it. But if employers do not provide health insurance, workers cannot access traditional full-time-with-benefits jobs.

Gamage starts by explaining the reasons for the prevalence of employer-provided health insurance prior to the enactment of the ACA. First, pools of employees "grouped together for reasons other than their health risks" solve the classic insurance problem of adverse selection. Employers elect not to re-group employees according to health risk, perhaps for reasons related to employee morale. Second, employers may also serve helpful intermediation functions by helping to explain and administer health insurance plans, or by providing default options.

Third, employees may exclude the value of employer-provided health insurance from their income. The exclusion costs about $250 billion annually, is the largest single federal income tax expenditure, and survives the ACA. It is an upside-down subsidy, meaning that higher-income taxpayers, who pay higher rates of income tax, obtain a larger monetary benefit as a result of each dollar of excluded employer-provided health insurance they receive.

The ACA provides two subsidies – premium tax credits and cost-sharing subsidies — to individuals who lack an offer of affordable employer-provided health insurance and instead purchase insurance from state-run public exchanges, which are subject to rules designed to foreclose adverse selection. In contrast to the income tax exclusion for employer-provided health insurance, the ACA subsidies provide more dollar value to lower-income individuals than to high-income individuals. The new law reduces subsidies on a sliding scale. The premium tax credit, for example, ensures that a household at the poverty level will contribute no more than 2% of household income toward health insurance. This credit declines with income and a household above 4 times the poverty level receives no ACA subsidies.

If an individual employed full-time (meaning at least 30 to 35 hours a week) purchases insurance on an exchange, the value of these subsidies may be offset by penalties payable by the individual's employer as a result of the employer's failure to offer affordable insurance, or failure to offer health insurance at all. In general, the penalties may apply to employers of at least 50 employees.

At the lowest income levels, the value of the exchange subsidies exceeds the sum of (a) the increase in federal income taxes resulting from the loss of the benefit of excluding health insurance from income plus (b) the penalties payable by employers who fail to provide any, or any affordable, insurance. Therefore, at the lowest income levels, the employer and/or the employee come out ahead if the employee purchases insurance from an exchange. At the highest income levels, the relationship is reversed, and it makes more sense to use employer-provided health insurance rather than exchange coverage. A break-even point falls between 2.25 and 3.5 times the poverty level, depending in part on family size. According to Tax Policy Center calculations, it will occur at approximately $80,000 of annual income for a family of four in 2016. This exceeds median household income, which equaled about $50,000 in 2011.

The way in which a lower-income employee and employer share the savings produced by exchange coverage depends upon long-run wage responses. But however the cost savings are shared, an employer should benefit from moving lower-income employees onto exchanges, either via lower costs or the ability to offer higher wages and attract more productive employees. Nondiscrimination provisions prevent employers from achieving this result artlessly. But the rules offer several more subtle escape routes.

For example, subject to final nondiscrimination rules, employers might increase employees' wages and permit them to purchase insurance through a "cafeteria plan" under which insurance prices might be unaffordable for lower-income employees and affordable for higher-income employees. Larger employers might outsource lower-income workers' jobs, for example to smaller employers not subject to the employer penalties. Or employers might move lower-income workers to part-time schedules.

Gamage points out that the phasing out of exchange subsidies as household income increases creates higher marginal tax rates that "stack with" marginal rates created not only by income and payroll taxes but also by phaseout provisions in other social welfare programs such as the earned income tax credit, food stamps and housing vouchers. This may discourage work, or at least over-the-table work. And Gamage joins others in explaining that because the doorway to purchasing exchange insurance for a family closes if one member of the family is offered affordable employer-provided self-only coverage, the ACA also discourages marriage.

Yet the incentives Gamage precisely lays out could prompt future events to proceed in a number of different directions, possibly for a net welfare gain, since the new ACA incentives act upon a second-best system shaped in part by other, pre-existing perverse incentives. For example, what if increasing numbers of small employers, or part-time jobs, decreases unemployment and/or increases productivity, including in the "formal sector," for example among second earners or retirees not prepared to work full-time? What if lower-income workers with exchange coverage provide an initial critical mass that helps strengthen the exchanges through market forces and/or relevant statutory changes? What if the exchanges as a result have sufficient market power to address the primary underlying fiscal issue, which is health cost inflation?

Gamage does not grapple with these broader questions in this paper. Instead, he focuses on the question of how to rehabilitate the health insurance market by removing the perverse incentive wedges created by the combination of the ACA and the employer-provided health insurance exclusion. He supports repeal of the income exclusion and enactment of refundable tax credits commensurate with exchange subsidies. The proposal would not eliminate higher marginal tax rates caused by the ACA because of the phaseout of exchange subsidy benefits. But it would leave employer-provided health insurance with only the non-tax risk-pooling and intermediation advantages that Gamage observes at the top of his paper. It would thus create a fair playing field, sans perverse-incentive tax expenditures that favor one approach over the other, for the government and employers to compete to be the most

efficient provider of health insurance.

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