

Changes to the Tax Exclusion of Employer-Sponsored Health Insurance Premiums: A Potential Source of Financing for Health Reform

Timely Analysis of Immediate Health Policy Issues

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Summary

One of the challenges that Congress will face as it considers major health reform legislation this year will be identifying the necessary financing. Many have suggested that reducing or eliminating the tax exclusion of employer-sponsored health insurance (ESI) could generate significant additional tax revenue to fund expansions in health insurance coverage. In this paper, we discuss the revenue and distributional consequences of several policy options that would alter the ESI tax exclusion. We focus on two specific policy design elements: (1) a cap, or dollar limit, on the amount of employer-sponsored health insurance premiums excluded from taxable income; and (2) an index that determines how this cap might grow over time. We present first year (2010) and 10-year (2010-2019) revenue estimates for all options and distributional impacts in 2019 for selected options. The distributional impacts include income and payroll taxes even though payroll tax revenue would not be available to fund health reform, because any decreases in benefits resulting from the tax changes would eventually return to workers as higher wages that would be subject to both types of taxes.

Even the policy option generating the least estimated revenue—capping the ESI premium exclusion at the 75th percentile of premiums and indexing by medical expenses—would generate \$62 billion in new income tax revenue over 10 years relative to current law, but maintain the vast majority (97 percent) of the tax subsidy from the current ESI exclusion. This policy change would increase taxes for only 14 percent of tax units in 2019. Alternatively, indexing a 75th percentile cap more slowly over time would generate considerably more income tax revenue—\$224 billion using a GDP index—but would increase taxes for almost 40 percent of tax units in 2019. Because high-income households are more likely to have ESI, each of the policies modeled would increase taxes for relatively fewer lower-and middle-income tax units compared with those in the top two income quintiles.

Setting the cap on the exclusion at the median of ESI premiums would generate about twice as much tax revenue in the first year as applying a cap set at the 75th percentile

of premiums. Over time, however, the relative revenue gains would depend on how the cap is indexed. If the cap is indexed to grow more slowly than medical expenditures, a 75th percentile cap would increase revenues by only between 16 percent and 34 percent less over 10 years than a median cap.

In 2010, under every policy option examined, affected tax units in each income quintile would see their after-tax income fall less than 1 percent. However, the burden would increase over time because projected ESI premiums grow faster than the caps. Some reform options would increase average federal taxes substantially by 2019, but the average percentage changes in after-tax income would be relatively modest for most income quintiles and most index options. For example, imposing a 75th percentile cap indexed by GDP growth would increase federal taxes by an average of \$550 in 2019 for affected tax units in the lowest income quintile—reducing after-tax income by an average of 3.9 percent. Those in the top income quintile would experience an average reduction in after-tax income of 0.7 percent—about \$1,920 in 2019. Much of the additional tax paid by lower-and middle-income tax units would come from payroll taxes. Retaining the exclusion for payroll taxes would make the reform more progressive but would forgo substantial additional funding for Social Security and Medicare.

Our analysis shows that limiting the ESI tax exclusion could be an important component of financing health reform. The extent of the impact on overall health care costs depends, in part, on whether this causes employees to demand plans that are less expensive in order to keep their premium under a cap, or whether employees are likely to accept a plan with a higher premium even if some portion of the premium is taxed. Any effects on cost growth would likely be modest, given that the vast majority of the current tax exclusion would remain in place. In any case, limiting the tax exclusion would not only provide funding for health reform but would also mitigate the huge inequities built into the current treatment of employer contributions to premiums.



Introduction

One of the challenges that Congress will face as it considers major health reform legislation this year will be identifying the necessary financing. The Obama Administration wants health reform to be “deficit neutral,” but financing proposals have thus far fallen short of the estimated costs of comprehensive reform.¹ Many have suggested that changes to the tax exclusion of employer-sponsored health insurance (ESI) could generate significant additional tax revenues that Congress could use to fund significant expansions in health insurance coverage. In this paper, we discuss the revenue potential and distributional consequences of several policy options that would alter the ESI exclusion.

The federal tax code subsidizes the purchase of ESI by excluding from federal income and payroll taxes premiums paid on employees’ behalf.² This exclusion reduced federal tax revenues by an estimated \$246 billion in 2007, making it by far the largest single subsidy in the tax code.³ Most Americans under the age of 65 get their health insurance through an employer—partly because of these generous tax subsidies, but perhaps more importantly, because ESI promotes risk sharing across employee groups. Many people feel that national health reform should leave ESI coverage largely untouched; thus, the policy maker’s mantra for this reform effort is “if you like the coverage that you have, you can keep it.”

This paper compares the tax revenue and distributional effects of alternative approaches to limiting the current federal tax exclusion for ESI coverage.⁴ We focus on two specific policy design elements: (1) imposing a cap, or dollar limit, on the amount of the premiums for employer-sponsored health coverage excludable from taxable income, that is, “capping” the exclusion, and (2) allowing the cap to grow over time, that is, “indexing” the cap.⁵ We present one-year and ten-year revenue estimates for all options and distributional impacts for selected options. Estimates

of individual income tax and payroll tax revenue are presented separately and in aggregate. Payroll tax revenue is typically targeted to finance Social Security and Medicare and, therefore, would not be available to fund health reform. However, we include payroll taxes in this analysis for two reasons. First, if employers would respond either by dropping their offer of ESI or by decreasing premiums by the amount that falls above a cap, these decreases in non-taxed benefits would eventually get passed back to employees as higher wages, subject to both income and payroll taxes. Second, the payroll tax falls more heavily on those with lower incomes; omitting the impact of increases in payroll tax in the distributional analyses would be misleading. We conclude with a discussion of design and implementation issues policymakers should consider when modifying the current ESI tax exclusion.

Undesirable Consequences of the Current Tax Exclusion

The current tax exclusion is regressive. Because it reduces taxable income, the exclusion is worth more to taxpayers in higher tax brackets than to those facing lower tax rates.⁶ Not taxing a \$10,000 premium, for example, saves a taxpayer in the 35 percent top tax bracket \$3,500 but reduces the tax bill for someone in the 15 percent tax bracket by just \$1,500. In addition, the value of the tax exclusion is greater for those with higher incomes, who tend to have jobs with richer benefits, and smaller for lower-income employees, who are much less likely to have ESI coverage.⁷ Thus, the current tax exclusion disproportionately subsidizes those with higher incomes.

The current tax exclusion can contribute to high and accelerating health care costs. Although wages and benefits trade off, at least in the long run, employees tend to view the selection of an ESI plan as independent from their wages. Insulation from the full costs of health care—and the lack of transparency in the trade-off

between wages and benefits—may drive up overall health care costs by spurring greater demand for health insurance that combines benefits, networks, and management features in more expensive ways than employers and employees might otherwise demand.⁸ This can drive up overall health care costs.

The current tax exclusion reduces federal government revenues substantially, and these losses may grow over time.⁹ The ESI exclusion will reduce federal tax revenues by an estimated \$3.5 trillion between 2010 and 2019.¹⁰ In fact, the revenue loss could be substantially more if employee compensation shifts substantially from wages and salaries to employer contributions for health insurance premiums, as recent simulations suggest. Holahan et al. (2009) estimate that employers’ premium contributions will increase from 9.8 percent of total compensation in 2009 to 15.3 percent in 2019; as a result, taxable compensation will decrease as a share of total compensation.¹¹ Thus, even if total compensation grows at the same rate as GDP, both income and payroll taxes would decrease substantially as a share of GDP.¹² This could have serious adverse consequences for programs funded primarily by payroll taxes, particularly Social Security’s Old-Age, Survivors, and Disability Insurance (OASDI) program and Medicare’s Hospital Insurance (HI) program.

Options for Limiting the Tax Exclusion for Employer-Sponsored Health Insurance

Before considering the effects of changes in the ESI tax exclusion, we show tax expenditures associated with the current ESI tax exclusion and projected expenditures over the next decade to provide a baseline against which to compare reform options. We model eight options for limiting the ESI tax exclusion using two different initial exclusion caps and four different indexing options:

- A cap on the amount of the ESI premium that is excludable from taxable income,¹³ set at one of two levels:
 - › the median (i.e. the 50th percentile) ESI premiums for single coverage, single-plus-one coverage, and family coverage in 2009,¹⁴ or
 - › the 75th percentile of ESI premiums for single coverage, single-plus-one coverage, and family coverage in 2009.¹⁵

These caps were chosen as examples of where a cap might be set. Other options for a cap might include different points in the ESI premium distribution (for example, the 90th percentile) or a specific premium from a nationwide health plan, such as the Federal Employees Health Benefits Plan (FEHBP).¹⁶

- An index rate at which the cap is assumed to grow over time, using one of four rates:
 - › no growth, or “unindexed,”
 - › the rate of overall price inflation defined by the Consumer Price Index (CPI),
 - › the rate of overall growth in the economy defined by Gross Domestic Product (GDP) growth,¹⁷ or
 - › the rate of medical expense growth, defined by the growth rate of National Health Expenditures (NHE).¹⁸

The last three approaches were presented as options for indexing a tax exclusion cap by the Senate Finance Committee.¹⁹

Methods

The estimates in this paper come from the Urban-Brookings Tax Policy Center Microsimulation Model.²⁰ For a nationally representative sample of tax units, the tax model calculates tax liability under current law and under alternative policy options. A tax unit is an individual or married couple who files an income tax return—or would file if their income were high enough—

plus their dependents.²¹ Calculations of tax liability for each tax unit form the basis for estimated changes in government tax revenue resulting from implementation of each policy alternative.²² The primary data source for the tax model is the 2004 Public Use File (PUF) produced by the Statistics of Income Division (SOI) of the Internal Revenue Service (IRS). Health insurance coverage for 2004 from the March 2005 Current Population Survey (CPS) Annual Social and Economic Supplement was statistically matched to the SOI by common characteristics in the datasets. Premiums are benchmarked to the average reflected in the Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) 2004 data.²³

We age the data to represent the demographic, income, tax, health, health expenditure, and employment characteristics of the civilian, non-institutionalized population of the United States from 2010 to 2019. The population and patterns of health insurance coverage of the United States in years 2010 to 2019 are based on projections from the Census Bureau.²⁴ Wages are grown from 2010 to 2019 using forecasts developed by the Congressional Budget Office.²⁵ Premiums are calculated for each year based on medical expenditures, and thus “grow” by the rate of medical expense growth²⁶ and changes in coverage.²⁷ For policy options involving a cap on the amount of the ESI premium that is excludable from taxable income, the cap is applied to employees based on the ESI coverage type chosen in 2004 (i.e. single, single-plus-one, or family), regardless of family structure or tax filing status. We assume that the health insurance choices of households and employers do not respond to changes in the cost of health insurance.²⁸ All dollars are reported in 2009 terms.

Tax Revenues Collected In the First Year (2010) and over 10 Years (2010-2019)

Currently, the exclusion generates tax expenditures estimated to be \$240

billion in 2010 and \$3.5 trillion over 10 years (see table 1). Income taxes account for about two-thirds of the total—\$145 billion in 2010 and \$2.2 trillion over 10 years. Thus eliminating the ESI exclusion entirely could generate substantial tax revenues relative to the estimated cost of achieving healthcare reform. However, this could also weaken the employer-based insurance system by removing the current subsidies for coverage.

Limiting the amount of the ESI premium that is excludable from taxable income would affect far fewer taxpayers and generate far less revenue than completely removing the exclusion. If the tax exclusion were capped at the median premium level, half of those with ESI would not face increased taxes. Those whose premiums fall above the median would owe tax on the amount by which their premium exceeds the median premium; they would not be taxed on the full value of their premium. Because everyone would still receive an exclusion up to the median premium level, the revenue generated would be far smaller than doing away with the exclusion altogether. Relative to setting the cap at median premium level, setting the cap at the 75th percentile of premiums would affect an even smaller share of the premium (the amount of the premium that exceeds the 75th percentile) for a smaller share of enrollees (the 25 percent who pay the highest premiums).

While a cap could reduce revenue relative to removing the exclusion entirely, it would still generate enough income tax revenue to provide significant potential funding for health care reform. An unindexed cap set at the median premium could generate \$13 billion dollars in income taxes in 2010, similar to the amount that would be generated using the CPI to index the cap.²⁹ Using GDP growth to index the cap would raise \$17 billion in income taxes in 2010, while applying a medical expenditures index would only draw in \$8 billion in 2010. In 2010, for any given indexing option, setting the cap at the 75th percentile of ESI would generate

Table 1. Income and Payroll Tax Revenue for Various Reforms of the ESI Exclusion in 2010 and 2010-2019

		First Year Tax Revenue in Billions \$, 2010			10 Year Tax Revenue in Billions \$, 2010-2019		
		Income tax	Payroll tax	Total	Income tax	Payroll tax	Total
Value of current ESI tax exclusion		\$145	\$96	\$240	\$2,242	\$1,297	\$3,539
Reforms of ESI tax exclusion							
Index	Initial cap						
Unindexed							
	Median	\$13	\$9	\$22	\$722	\$421	\$1,142
	75th percentile	\$7	\$5	\$12	\$608	\$354	\$962
CPI							
	Median	\$13	\$9	\$22	\$576	\$337	\$914
	75th percentile	\$7	\$4	\$11	\$456	\$266	\$722
GDP							
	Median	\$10	\$7	\$17	\$341	\$199	\$541
	75th percentile	\$5	\$3	\$8	\$224	\$130	\$354
Medical Expenses							
	Median	\$8	\$5	\$13	\$133	\$77	\$210
	75th percentile	\$4	\$2	\$6	\$62	\$35	\$97

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-1).

Notes: Baseline is current law. See text for reform option descriptions and the median and 75th percentile of premiums for single coverage, single-plus-one coverage, and family coverage.

about half as much tax revenue as setting the cap at the median.

Regardless of the initial level of the cap, more restrictive indexing (i.e., no indexing or indexing based on the CPI or GDP) means that, over time, the cap would affect an increasing share of the premium for a growing share of taxpayers. In contrast, if indexed by medical expenses, the cap and the premium would move together over time. This means that the share of the premium exceeding the tax exclusion and the share of taxpayers subject to additional taxes would remain steady. As a result, indexing the cap on the tax exclusion by medical expenses would lead to the slowest growth in revenues relative to the other indices.³⁰

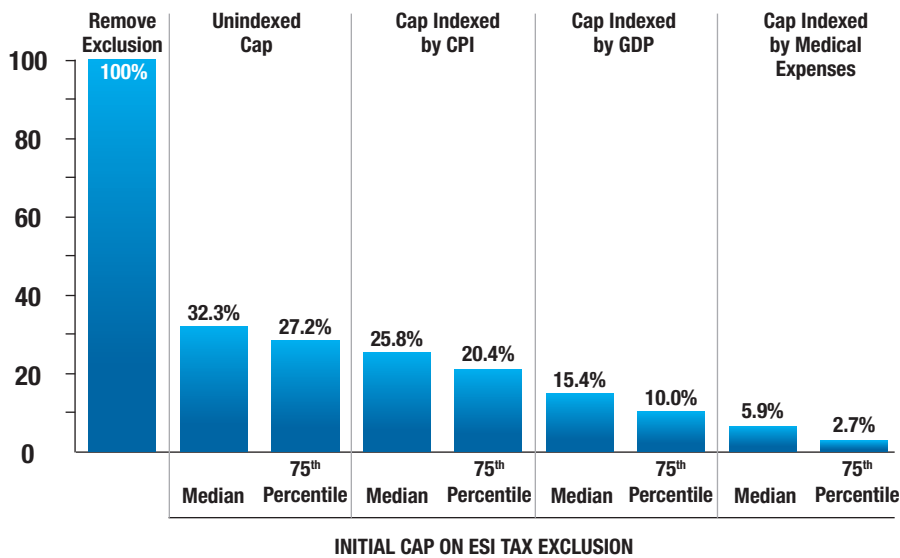
The level of the cap and the index chosen interact in their effects on the

amount of revenue raised over time. When the index grows more slowly than premiums, the difference in revenue raised over time between a median and a 75th percentile cap is smaller. When the index is less restrictive, the choice of the initial level of the cap matters more. For example, under an unindexed cap, shifting from a median cap on ESI to a cap at the 75th percentile would reduce income tax revenue by 16 percent over 10 years.³¹ At the other extreme, indexing at the same rate at which premiums are assumed to grow, a cap at the 75th percentile of premiums would decrease income tax revenue by about 53 percent relative to a median premium cap on the ESI exclusion.

Although any of these options would generate many billions of additional tax revenue, each option would recover

only a small share of the current ESI exclusion (figure 1) and would likely disrupt the employer-based system only marginally. Even the most aggressive option—an unindexed median cap—would recover only about a third of the revenue lost because of the current ESI exclusion. A 75th percentile cap indexed by GDP would yield \$224 billion in income tax revenue over 10 years, but leave 90 percent of the current tax subsidies in place. Imposing a 75th percentile cap indexed by medical expenses would recoup only 3 percent of the current ESI exclusion over 10 years. But even under this modest option, income tax revenues would still increase by \$62 billion over 10 years, and each of the alternatives would face fewer risks than doing away with the exclusion altogether.

Figure 1. Share of ESI Tax Exclusion Subsidies Recovered from Selected Policy Options, 2010-2019



Source: Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-1).

The Distribution of Tax Increases by Income in 2019

How many would pay higher taxes?

Removing the exclusion would increase income and payroll taxes for virtually all tax units with ESI by the end of the 10 year period. Across all tax units—with or without ESI coverage, 43 percent would face increased taxes in 2019 due to removing the exclusion (table 2, top panel).³² Regardless of the index chosen and even with an initial cap set at the 75th percentile, nearly everyone with ESI would pay higher taxes in 2019.³³ A smaller share of the lower-income tax units have ESI coverage, so they would be much less likely to pay higher taxes compared with those in the higher quintiles of income. For example, removing the exclusion would increase taxes for just 14 percent of tax units in the lowest quintile in 2019. But taxes would increase for 31 percent in the second quintile, 56 percent in the middle quintile, and more than 60 percent of those in the two highest quintiles. These shares are similar whether the cap is unindexed

or indexed by CPI or GDP growth. However, far fewer tax units would experience a tax increase when the 75th percentile of premium is indexed by medical expenses: only 14 percent of tax units with ESI would pay higher taxes in 2019 and the effects across income quintiles would range from 4 percent of poorest tax units to 24 percent of the richest.

How much would taxes increase for those paying higher taxes?

Among tax units with a tax increase, there is wide variation in the estimated average change in 2019 federal income and payroll taxes across quintiles of income and across reform options (table 2, middle panel).³⁴ If the entire exclusion were to be removed, tax units with tax increases would pay, on average, between \$3,780 more for those in the lowest quintile of income and \$9,670 more for those in the highest quintile of income in 2019.³⁵ However, this option may seem too potentially disruptive to ESI coverage. Under the other options, tax units paying higher taxes in the lowest quintile of income would pay, on average, between \$190 (with a 75th percentile cap indexed by

medical expenses) and \$1,450 (with an unindexed 75th percentile cap) more in federal taxes.³⁶ Those in the middle quintile of income tax units would pay, on average, between \$380 and \$2,340 more. Those with a tax increase in the top quintile of income tax units would see an increase in federal taxes of, on average, between \$960 and \$4,350. The upward trend in the average tax increases across the income quintiles clearly illustrates that the biggest benefits of the current tax exclusion have been accruing to those with the highest incomes. But, even after limiting the ESI exclusion, the remaining exclusion would still disproportionately benefit those with higher incomes.

How would after-tax incomes be affected?

Measuring income and payroll tax increases relative to a tax unit's ability-to-pay gives a better sense of the burden they impose. In 2010, after-tax income for those with a tax increase would fall less than 1 percent for each quintile of income under every policy option with a cap (data not shown). The impact, however, would increase over time. Although these reform options can cause fairly substantial average federal tax increases in 2019, the average percentage changes in after-tax income would be relatively modest for most income quintiles and most options with an indexed cap (table 2, lower panel). If we impose a 75th percentile cap indexed by GDP growth, tax units with a tax increase in the lowest quintile of income would have after-tax income reduced by an average of 3.9 percent. Those in the top income quintile would experience an average reduction in after-tax income of 0.7 percent. Indexing by medical expenses would decrease average after-tax income for those with a tax increase by 1.3 percent for those in the lowest income quintile and by 0.4 percent for those in the highest income quintile in 2019. However, under an unindexed cap and a cap indexed by CPI—the strictest indexing constraints—those with tax increases in the lowest income quintile would experience larger reductions in after-tax

income of 10.3 percent and 7.4 percent in 2019, respectively. Those in the other income quintiles would generally experience a smaller change in their after-tax incomes.

Other Policy Design Issues

The primary goals of changing the ESI exclusion would be raising revenues to finance health care reform, mitigating the huge inequities in the current policy, and providing incentives that

might limit health care spending. Attaining those goals requires not just capping the ESI exclusion but also constraining other tax subsidies for health spending. To that end, policy makers need to count all forms of tax-advantaged employer health benefits

Table 2. Distribution of Income and Payroll Tax Change by Income Percentile for Various Reforms of the ESI Exclusion, 2019

Income by quintile ^{1,2}	Remove current ESI tax exclusion	Initial Cap on ESI Exclusion at the 75th Percentile of Premium			
		Indexing Option			
		Unindexed	CPI	GDP	Medical expenses
Percent of tax units with tax increase in 2019³					
Lowest quintile	14.0 %	13.6 %	13.3 %	11.7 %	4.3 %
Second quintile	31.2	31.1	30.6	27.4	9.5
Middle quintile	55.5	55.4	54.5	49.4	18.3
Fourth quintile	64.5	64.5	63.3	58.5	22.4
Top quintile	65.3	65.3	64.3	59.9	23.9
All	42.6	42.4	41.7	38.1	14.3
Average change in federal income and payroll tax among tax units with tax increase in 2019⁴					
Lowest quintile	\$3,780	\$1,450	\$1,050	\$550	\$190
Second quintile	\$4,500	\$1,960	\$1,470	\$810	\$320
Middle quintile	\$5,460	\$2,340	\$1,760	\$980	\$380
Fourth quintile	\$7,560	\$3,340	\$2,540	\$1,430	\$650
Top quintile	\$9,670	\$4,350	\$3,320	\$1,920	\$960
All	\$6,670	\$2,930	\$2,220	\$1,260	\$570
Percent change in after-tax income among tax units with tax increase in 2019⁵					
Lowest quintile	-26.8 %	-10.3 %	-7.4 %	-3.9 %	-1.3 %
Second quintile	-13.4	-5.9	-4.4	-2.4	-1.0
Middle quintile	-9.7	-4.2	-3.1	-1.7	-0.7
Fourth quintile	-8.1	-3.6	-2.7	-1.5	-0.7
Top quintile	-3.7	-1.7	-1.3	-0.7	-0.4
All	-8.6	-3.8	-2.9	-1.6	-0.7

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-1).

Notes: Baseline is current law. See text for reform option descriptions and the 75th percentile of premiums for single coverage, single-plus-one coverage, and family coverage.

(1) Cash income is a more comprehensive measure of income than adjusted gross income (AGI). For example, cash income includes such items as untaxed social security and pension benefits, unrealized capital gains, tax-exempt employee benefits, and tax-exempt interest. For this analysis, tax units with negative cash income are excluded from the lowest income class but are included in the totals. For a more detailed description of cash income, see <http://www.taxpolicycenter.org/TaxModel/income.cfm>

(2) The cash income quintiles (fifths of the distribution) used in this table are based on the income distribution for the entire population and contain an equal number of people, not tax units. The top income for each quintile is (in 2009 dollars): 20%, \$22,005; 40%, \$41,316; 60%, \$74,736; and 80%, \$128,774.

(3) Includes both filing and non-filing tax units but excludes those that are dependents of other tax units.

(4) Average change in federal tax includes changes in individual and corporate income tax, payroll taxes for Social Security and Medicare, and the estate tax.

(5) After-tax income is cash income less: individual income tax net of refundable credits; corporate income tax; payroll taxes (Social Security and Medicare); and estate tax. The calculation of percent change in after-tax income assumes that after-tax income is distributed uniformly within each quintile. If actual incomes within a quintile are positively skewed, the percentage change in after-tax income will be somewhat higher for the average unit.

towards the cap and impose standards about the benefits a policy must have to qualify for any tax exclusion. Specifically,

- Policymakers would have to change other tax subsidies for health care. Several health-related employer benefits, such as tax-free contributions to Flexible Spending Accounts (FSAs)³⁷ should either (1) be eliminated or (2) reduced in value, dollar-for-dollar, so that the amount paid for premiums and these tax-free contributions would not exceed the cap on the ESI tax exclusion. Otherwise, health benefits formerly covered under the health plan with a capped premium would be shifted to coverage under other tax-advantaged means; this would reduce the tax revenue and potential cost containment effects of a change in the ESI tax exclusion.³⁸
- Policymakers would need to require that any plan qualifying for the ESI tax exclusion satisfy minimum benefit standards to prevent employers from offering limited coverage options that would allow workers to game the system. For example, firms would not be allowed to offer plans that couples with two ESI offers could use to “build” a coverage package that would get around the cap on the tax exclusion.³⁹ Otherwise, the revenue and cost containment effects of scaling back the ESI tax exclusion would be reduced.

In addition to these fundamental aspects to changes in the tax exclusion policy, policymakers may want to consider several other issues.

Allow the ESI exclusion to vary by household income.

Even under the policy alternative that generates the least tax revenue, some tax units with lower incomes would face substantial tax increases. Policymakers could consider several policy design options that would further concentrate the tax increases on higher income individuals and families. An option proposed by Jonathan Gruber would implement a “progressive cap,”⁴⁰ which would retain the full ESI

exclusion for lower-income employees but cap the income tax exclusion at the median premium level for those with middle and higher incomes. The highest income employees would get no income tax exclusion.

Another approach to lessen the tax impact among lower- and middle-income tax units would impose a cap on the ESI tax exclusion only for income taxes, while maintaining the full exclusion for payroll taxes. Since income taxes are more progressive than payroll taxes (i.e., lower-income individuals and families pay a larger share of their income in payroll taxes than higher-income households) lower-income households would benefit relatively more from a payroll tax exclusion than from an income tax exclusion. Without the additional payroll tax revenues, the revenue gain from any particular policy option would decrease by more than one-third, but income tax revenues available to finance health reform would remain largely unchanged.

Allow the cap to vary by geographic area.

Implementing a fixed-dollar cap for all geographic areas would effectively make the tax exclusion more generous in some places than in others, since premiums vary geographically. Such variation may arise because of differences in the underlying costs of health care inputs (e.g., salaries and rents) or variation in medical practice styles and market conditions. Allowing full geographic variation in the cap on the tax exclusion might, however, subsidize less efficient areas to a greater degree relative to more efficient areas.⁴¹ Improving equity may trade off against improving efficiency, and policymakers would have to balance the two competing aims. Choosing higher percentiles for the cap would diminish this concern in the near term, regardless of the indexing option chosen, by reducing the share of the premium exposed to taxation and effectively limiting the potential inequities associated with geographic variation. However, this approach would also reduce revenue gains.

Allow the cap to vary by the risk status and size of the employer group.

Implementing a fixed-dollar premium cap could also impose tax penalties on the basis of enrollees’ health, generosity of plan benefits, and firm size. Tax increases would fall disproportionately on (1) high-cost enrollee groups if their premiums cover a significant share of their health expenditures and (2) employees of smaller firms whose higher premiums reflect higher administrative “loading” costs rather than richer benefit packages compared to larger firms.⁴² A cap based on actuarial value—in which actuaries value each plans’ covered benefits based on the hypothetical claims of a nationally representative population—might address this concern.⁴³ Although the actuarial-value cap could improve equity, it could also lock in current levels and patterns of health care spending and create additional complexity in the health insurance system.⁴⁴ This inequity arises not from the cap per se, but from the limited ability to spread health care risk across a broad enrollee population, lack of economies of scale in administering and marketing plans, and weak competition in the private marketplace. The most efficient solution is not to adjust the cap, but rather to provide opportunities for greater risk pooling.

Summary and Discussion

Limiting the tax exclusion for ESI premiums could provide a major source of financing for health reform. Even the policy option generating the least revenue—capping the ESI premium exclusion at the 75th percentile of premiums and indexing the cap by medical expenses—would increase tax revenues available for financing health reform by \$62 billion over 10 years relative to current law. These tax increases would come from only 14.3 percent of tax units in 2019. Indexing the cap more slowly over time would generate considerably more revenue: more than three times as much using a GDP index and more than seven times as much using the CPI index. In addition, many more tax units would experience a tax increase with these latter

options—38.1 percent of tax units in 2019 when indexing by GDP growth and 41.7 percent of tax units in 2019 when indexing by the CPI. Each of the policies modeled would, however, increase taxes for relatively fewer lower-and middle-income tax units compared with those in the top two income quintiles.

Setting the cap on the exclusion at the 75th percentile of ESI premiums would generate about half as much additional tax revenue in the first year as applying a cap set at the median premium. Over time, however, the relative revenue gains would depend on how the cap is indexed. If the cap is indexed to grow more slowly than medical expenditures, a 75th percentile cap would reduce revenues by only between 16 percent and 34 percent over 10 years relative to the revenues associated with a median cap.

Much of the additional tax paid by lower-and middle-income tax units would come from payroll taxes, so retaining the exclusion for payroll taxes would make the reform more progressive but at the cost of forgoing potential new funding for Social Security and Medicare. Of course, the current policy collects no payroll taxes on employer-paid premiums; maintaining the exemption for payroll taxes would not make the existing situation worse. The additional income taxes would still provide substantial funds to expand eligibility and subsidize insurance.

Since reductions in after-tax income are generally not large relative to income for the majority of those with ESI, the incentives to seek more limited coverage may be weak.⁴⁵ The extent of the impact on costs depends, in part, on whether limiting the exclusion causes employees to demand plans that impose greater cost sharing or that eliminate less-essential covered benefits in order to keep their premium under a cap, or whether employees are likely to accept a plan with a higher premium even if some portion of the premium is taxed. The difference in the impact on costs occurs because the former would tend to decrease service use (since the increase cost is formulated as an increase in out-of-pocket medical costs experienced by an employee at the time of the service), while the latter would tend not to decrease service use (since the increase in costs is formulated as an increase in household taxes on the premium—removed from health care delivery decisions). Any effects on cost growth would likely be modest, given that the vast majority of the current tax exclusion would remain in place.

Any policy limiting the ESI tax exclusion would change one of the fundamental pillars upon which the current private health insurance system is built and, as such, could create uncertainty about how employer-sponsored coverage might change. Therefore, having guaranteed, affordable, and adequate coverage available for individual purchase would be a critical

complement to modifications in the tax treatment of ESI. This is particularly important given that there would likely be a disproportionate impact of a cap on employees of small firms or employees of firms whose enrollees have high health costs as well as among firms in high-cost geographic areas. Although there could be complicated adjustments to the cap on the tax exclusion, a better approach for health reform would combine limits on the tax exclusion with policies that promote greater risk sharing and competition among insurance plans options in the context of a well-structured health insurance exchange.

This paper shows that limiting the ESI tax exclusion could be an important component of financing health reform and should be considered. Our analysis shows that one of the least aggressive options—a 75th percentile cap indexed by GDP growth—would produce \$224 billion in new income tax revenues over the coming decade while still preserving 90 percent of the tax subsidies available under the current policy. In addition, limiting the exclusion would increase taxes more for high-income than low-income taxpayers. Therefore, in addition to providing a source of funding for health reform and incentives for seeking less expensive coverage, limiting the tax exclusion would mitigate the huge inequities built into the current treatment of employer contributions to premiums.

Notes

- 1 Orszag, P. "A 'Belt and Suspenders Approach' to Fiscally Responsible Health Reform". Office of Management and Budget Blog. 1 June 2009. <http://www.whitehouse.gov/omb/blog/09/06/01/ABeltandSuspendersApproachtoFiscallyResponsibleHealthReform/>; The Obama administration identified \$635 billion dollars in its Fiscal Year 2010 Budget Proposal it would use as a "reserve fund" for financing health reform over 10 years. Office of Management and Budget. "President Obama's Fiscal 2010 Budget: Transforming and Modernizing America's Health Care System." President's Budget Fact Sheets. Accessed June 15, 2009. http://www.whitehouse.gov/omb/fy2010_key_healthcare/; President Obama also recently identified an additional \$313 billion in new savings from Medicare and Medicaid that would be used to finance reform, bringing the total revenue sources identified by the administration close to \$950 billion. White House Briefing Room. "Paying for Health Reform: \$313 Billion in Additional Savings to Create a Deficit Neutral Plan". Fact Sheet. Accessed June 15, 2009. <http://www.whitehouse.gov/MedicareFactSheetFinal/>; Congress is currently considering a number of financing options, but has yet to come to a consensus on what the key sources of financing health reform will be. Senate Finance Committee. "Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options". Washington, DC. May 20, 2009. <http://finance.senate.gov/sitepages/leg/LEG%202009/051809%20Health%20Care%20Description%20of%20Policy%20Options.pdf>
- 2 In addition, premiums in the non-group health insurance market generally—with the exception of some premiums of the self-employed—are not excluded from income for tax purposes as ESI premiums are. Some see this as unfairly disadvantaging the non-group option.
- 3 See Table 1 from The Joint Committee on Taxation. "Tax Expenditures for Health Care." Publication JCX-66-08. Washington, DC. July 30, 2008. <http://finance.senate.gov/hearings/testimony/2008test/073108ekttest.pdf>. This tax expenditure estimate does not account for behavioral changes, thus it does not imply that removing the exclusion would increase revenues by \$246 billion.
- 4 While revenue estimates typically incorporate behavioral changes that would result from changing the tax provisions, the estimates presented in this analysis do not.
- 5 In this analysis, we do not examine the policy implications of reformulating the ESI exclusion as a tax credit, a voucher, a tax deduction, or some combination, as some have proposed. For a discussion of restructuring options including credits, vouchers and deductions, see Burman, L. "Roundtable on Financing Healthcare Reform". Testimony Before the Senate Committee on Finance. Washington, DC. May 12, 2009. <http://finance.senate.gov/Len%20Burman.pdf> Burman, L. and J. Gruber. "Tax Credits for Health Insurance." Discussion Paper No. 19. Washington, DC: Urban-Brookings Tax Policy Center. June 2005. http://www.taxpolicycenter.org/UploadedPDF/411176_TPC_DiscussionPaper_19.pdf; Pauly, M. and J. Hoff. *Responsible Tax Credits for Health Insurance*. Washington, DC: American Enterprise Institute. 2002. http://www.aei.org/docLib/20021130_71619.pdf
- 6 For a more detailed discussion, see Burman, L., B. Garrett, and S. Khitatrakun. "The Tax Code, Employer-Sponsored Insurance, and the Distribution of Tax Subsidies," in H. Aaron and L. Burman, *Using Taxes to Reform Health Insurance*. Washington, DC: Brookings Institution. 2008.
- 7 Clemans-Cope, L. and B. Garrett. "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005." Issue paper. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. December 2006.
- 8 Pauly M., *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance*, Ann Arbor: University of Michigan Press, January 1998.
- 9 The impact of state taxes would tend to mirror and magnify the federal results, since "state income taxes generally follow federal rules with respect to deductions and exclusions." Kaiser Family Foundation (KFF). "Tax Subsidies for Health Insurance: An Issue Brief." p. 1. Washington, DC: KFF. July 2008. <http://www.kff.org/insurance/upload/7779.pdf>.
- 10 Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-1).
- 11 Holahan, J. B. Garrett, A. Lucas, and I. Headen. "Health Reform: The Cost of Failure." Princeton, NJ: Robert Wood Johnson Foundation. May 21, 2009. <http://www.rwjf.org/files/research/costoffailurefinal.pdf>.
- 12 The Boards Of Trustees, Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds. *2009 Annual Report Of The Boards Of Trustees Of The Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds*. Washington, DC. May 12, 2009. <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf>
- 13 While the exclusion applies only to employer contributions, most employees have access to an Internal Revenue Service Section 125 benefit plan which allows employees to pay their share of the ESI premium on a pretax basis. Thus, our analysis of ESI premiums include both employer and employee contributions.
- 14 The median ESI premiums in 2009 (including both employer and employee contributions) are assumed to be \$5,346 for single coverage, \$9,910 for single-plus-one coverage, and \$12,696 for family coverage.
- 15 The 75th percentile of ESI premiums in 2009 (including both employer and employee contributions) are assumed to be \$5,642 for single coverage, \$11,011 for single-plus-one coverage, and \$13,806 for family coverage.
- 16 Caps based on the FEHBP are included in Senate Finance Committee, Financing Comprehensive Health Reform: Proposed Health System Savings and Revenue Options, May 20, 2009. <http://finance.senate.gov/sitepages/leg/LEG%202009/051809%20Health%20Care%20Description%20of%20Policy%20Options.pdf>
- 17 We use CBO targets for GDP growth. See Congressional Budget Office (CBO). "The Budget and Economic Outlook: Fiscal Years 2009 to 2019." Washington, DC: CBO. January 2009. <http://www.cbo.gov/ftpdocs/99xx/doc9957/01-07-Outlook.pdf>.
- 18 For the growth rate of medical expenses, see Table 2 of Centers for Medicare & Medicaid Services (CMS), Office of the Actuary. "National Health Expenditure Projections, 2008-2018." Washington, DC: CMS. January 2009. <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf>.
- 19 Senate Finance Committee, May 20, 2009.
- 20 For general documentation of the Urban-Brookings Tax Policy Center Microsimulation Model, see Rohaly, J., Carasso, A., and Saleem, M.A. "The Urban-Brookings Tax Policy Center Microsimulation Model: Documentation and Methodology for Version 0304." Washington, DC: Urban-Brookings Tax Policy Center. January, 10 2005. http://www.urban.org/UploadedPDF/411136_documentation.pdf.
- 21 A tax unit may or may not correspond to a family or household. For example, a married couple and their coresident adult children compose a single family but the children would be separate tax units. Similarly, a household might comprise three unrelated individuals, each of whom is a tax unit. The analysis excludes tax units who are dependents on someone else's tax return.
- 22 The model also estimates changes in effective marginal tax rates and in the distribution of tax liabilities. The effective marginal tax rate is the additional tax liability incurred if an individual's income were to increase by a dollar.
- 23 We assume that those with relatively higher premiums are distributed evenly across tax units of different incomes. Thus, to the extent that those with higher premiums tend to be higher income, our analysis may tend to overestimate the increase in federal taxes for those with lower income subsequent to a reform scenario.
- 24 We do this by first growing the data from 2004 to 2007 given actual changes in coverage and population growth between 2004 and 2007, as measured by the CPS, and we make further adjustments to ensure consistency with Census estimates of population growth, by age and gender cells, from 2004 to 2019. See "Table 2a. Projected Population of the United States, by Age and Sex: 2000 to 2050" from U.S. Census Bureau. "U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin." Washington, DC. March 18, 2004. <http://www.census.gov/population/www/projections/usinterimproj/natprojtab02a.pdf>.
- 25 CBO 2009.
- 26 We make the conservative assumption that premiums grow at the rate of medical expense growth. If premium growth exceeds medical expense growth, as it has recently, revenue estimates would be higher than those shown here. In particular, each option would generate more tax revenues and affect more tax if premium growth exceeds the growth in underlying medical expenditures.
- 27 These coverage changes result from projections based on Census data, as noted above, and do not represent simulated behavioral responses to a particular policy option.
- 28 Thus, if under current law an employer offers an ESI benefit with a premium exceeding a specified "cap," we assume that the employer would offer the same ESI benefit after reform, despite any reduction in the tax advantages relative to current law. Similarly, we assume that employees' enrollment in ESI would not respond to changes in cost. To the extent that decreases in ESI premiums or enrollment result in increases in taxable wages—as economic theory suggests—the impacts on tax revenue estimates from omitting behavioral responses are likely to be limited. These simulations exclude possible effects on income of any wage passback resulting from behavioral responses related to premiums or offers.
- 29 Differences in indexing affect revenue estimates in 2010 since we use the index to grow premiums from 2009 to 2010.
- 30 When we index the cap by medical expenses—the same rate we assume for premium growth—revenues accrue solely from population growth (which tends to increase revenue through growth in the number of employees encountering the cap) and employment changes (decrease during the recession and increases during the projected recovery) in the number of employees encountering the cap over the period. For a discussion of employment and coverage projections over the period, see Holahan, J. et al. 2009.

³¹ The 16-percent reduction equals one minus the ratio of \$608 billion to \$722 billion. Other percentages are calculated in a similar manner.

³² We also explored the distributional impacts of options with the cap set at the median premium. A table containing these results are available from the authors upon request.

³³ Eliminating the exclusion entirely would affect relatively more tax units in 2010 (47.3 percent) than in 2019 (42.6 percent). In contrast, options that cap the exclusion generally affect more units over time. For example, with an unindexed 75th percentile cap, 24.6 percent of tax units pay higher taxes in 2010 compared to 42.4 percent in 2019.

³⁴ It is important to recognize that the 2019 dollar values reported here would be associated with wages and premiums that would result after 10 years of real growth. The amount of taxes that would be paid in 2010, among those with tax increases, would be far lower.

³⁵ Each number reported is computed as the ratio of the average change in federal income and payroll taxes across all tax units in a quintile (data not shown) divided by the share of tax units that will experience a tax increase (the top panel of Table 2), rounded to the nearest \$10.

³⁶ In 2010 the tax increase is far less. Under the options with an indexed cap, among those with a tax increase, tax units in the lowest quintile of income

would pay, on average, between \$50 (with a 75th percentile cap indexed by medical expenses) and \$70 (with an unindexed 75th percentile cap) more in federal taxes (data not shown).

³⁷ Other tax subsidies include tax-free employee contributions to premiums (under Internal Revenue Service Section 125 benefit plan which allows an employee to pay their share of the ESI premium on a pretax basis), tax-free contributions to Health Savings Accounts (HSAs), and other employer health benefits, including dental, vision, prescription drug, and employer clinics.

³⁸ For a detailed discussion, see Van de Water, P. "Limiting the Tax Exclusion for Employer-Sponsored Insurance Can Help Pay for Health Reform." Washington, DC: Center on Budget and Policy Priorities. June 2, 2009. <http://www.cbpp.org/files/6-2-09health.pdf>. Our simulations assume that Congress would also eliminate or cap the current deduction of non-group health insurance premiums (purchased directly in the individual market) from income taxes for self-employed individuals in a manner identical to the proposed treatment of ESI premiums.

³⁹ Republican Senator Judd Gregg proposed minimal standards (including preventative care and coverage for major illnesses) in combination with a cap in the ESI tax exclusion, by Republican Senator Judd Gregg. Gregg, J. "Better health care: balancing better options." *Politico*. June 1, 2009. <http://www.politico.com/news/stories/0509/23147.html>.

Minimum standards were endorsed in the context of comprehensive health insurance reform by President Obama in a letter to Senators Edward Kennedy and Max Baucus. Obama, B. Washington, DC: The White House. June 3, 2009. http://www.whitehouse.gov/the_press_office/Letter-from-President-Obama-to-Chairmen-Edward-M-Kennedy-and-Max-Baucus/

⁴⁰ Cohn, J. "Tax My Health Benefits. Please." *The New Republic*. March 17, 2009.

⁴¹ We recognize that geographic variation in the cap may not be feasible because Congressional tax committees have been unwilling to introduce geographic variation into the tax code.

⁴² Administrative "loading" costs include the costs of administering and marketing health insurance plans. Congressional Research Service. *Costs and Effects of Extending Health Insurance Coverage*. Washington, DC: U.S. Government Printing Office. 1988.

⁴³ Dorn, S. "Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible?" Washington, DC: Urban Institute. June 2009.

⁴⁴ Van de Water 2009.

⁴⁵ Reductions in the growth in health care costs could also result from limiting the amount of tax-free health care spending currently flowing through FSAs, HRAs and HSAs.

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