Limiting the Tax Exclusion of Employer-Sponsored Health Insurance Premiums: Revenue Potential and Distributional Consequences

Timely Analysis of Immediate Health Policy Issues

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Lisa Clemans-Cope, Stephen Zuckerman, and Dean Resnick

Summary

Serious efforts to forge a budget agreement in 2013 will increase the likelihood that lawmakers will seek changes to tax provisions in order to raise revenue. The exclusion of employer-sponsored health insurance premiums and medical benefits from taxable income could be a target, since this exclusion reduced federal tax revenues by $268 billion in 2011 alone—by far the largest federal tax expenditure. Moreover, the exclusion disproportionately subsidizes those with higher incomes. Yet proposals to change the tax exclusion of employer-sponsored insurance have provoked intense debate.

In this brief, we provide estimates of the revenue potential and distributional consequences of a new policy option. The policy we analyze here would impose a cap, or dollar limit, on the aggregate cost of employer-sponsored health coverage excluded from income and payroll taxes. The cap would be set at the 75th percentile of the sum of premiums and other medical benefits, and would be indexed, or allowed to grow over time, by a five-year average of the rate of GDP growth. Our goal in choosing the level and indexing for the cap was to select a policy that would make a significant contribution to debt reduction, but would be distributionally equitable. We answer four critical questions related to the 75th percentile cap on the exclusion of premium and medical benefits: What are the estimated new tax revenues related to this policy in 2014 and 2014–2023? How many people would pay higher taxes in each quintile of income? How much would taxes increase for those paying higher taxes? And, what are the characteristics of employers whose employees are likely to pay higher taxes?

We show that the 75th percentile tax cap would produce $264.0 billion in new income and payroll tax revenues over the coming decade while still preserving 93 percent of the tax subsidies available under the current policy. Across all tax units, 15.7 percent would pay higher taxes under the 75th percentile cap on the exclusion of premium and medical benefits in 2014, with this share increasing to 20.0 percent by 2023. Although tax units across the entire income distribution would experience some tax increases, these increases are considerably smaller and less prevalent at lower income levels. The policy change would affect public-sector employees to a greater extent than private-sector employees. In addition, among private-sector employees, those in the financial services/real estate or professional services industries would be affected to a greater extent, while employees in other industries such as the retail industry, would be affected to a lesser extent. Establishments with a union presence have only a modestly higher share of employees with premiums above the 75th percentile premium, compared to the average across all establishments.

Introduction

Serious efforts to forge a budget agreement in 2013 will increase the likelihood that lawmakers will seek changes to tax provisions in order to raise revenue. The exclusion of employer-sponsored health insurance premiums and medical benefits from taxation could be a target. This exclusion reduced federal tax revenues by $268 billion in 2011 alone—by far the largest federal tax expenditure. Because it reduces taxable income, the exclusion benefits taxpayers in higher tax brackets more than those facing lower tax rates.[1] And, since higher-income individuals are much more likely than lower-income individuals to have employer-sponsored insurance, higher-income individuals are much more likely to receive this tax subsidy.[2] Moreover, due to the continuing shift in compensation from wages and salaries to medical benefits, even if total compensation grows at the same rate as GDP, over time both income and payroll taxes would decrease substantially as a share of GDP.[3] This could have serious adverse consequences for programs funded primarily by payroll taxes, particularly Social Security and Part A of the Medicare program.[4] Yet proposals to limit the tax exclusion of employer-sponsored insurance have provoked intense debate.

Affordable Care Act's Excise Tax on the Highest Employer-Sponsored Insurance Premiums and Benefits

A modest limitation of the tax exclusion of employer insurance is included in the Affordable Care Act (ACA).[5] Beginning in 2018, the ACA imposes a 40 percent excise tax on employer-sponsored plans that exceed a threshold aggregate cost. This provision taxes the amount that the plan's aggregate cost exceeds the threshold defined under the ACA. Aggregate cost is defined broadly to include employer-paid premiums, tax-free employee premium contributions, reimbursements under a flexible spending account

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for medical expenses, health reimbursement arrangements (HRA), employer contributions to a health savings account (HSA), and supplementary health insurance coverage, excluding dental and vision coverage. In 2018, the threshold aggregate cost is tentatively set at $10,200 for a policy covering one person and $27,500 for a policy covering more than one person. The threshold will receive a one-time upward adjustment to the degree that the costs of the Federal Employees' Health Benefit Plan Blue Cross/Blue Shield standard premiums rise more than 55 percent between 2010 and 2018. Starting in 2020, the thresholds will increase by the consumer price index for urban consumers (the CPI-U). The thresholds will be adjusted for variation in plan costs caused by the age and sex of enrollees. In addition, increased thresholds will be set for retirees and employees covered under employer plans in certain high-risk industries (e.g., police officers, firefighters).[6]

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that the ACA's provision will increase government revenue by $11 billion in fiscal year 2018 and $111 billion during the five fiscal years (2018 to 2022) when the excise tax is in effect.[7] The JCT estimates that less than 20 percent of the revenue produced by such a provision would come from direct imposition of the excise tax on those with high-cost plans.[8] The vast majority of revenues result from a shift in compensation away from medical benefits to taxable wages, as employers offer lower-premium plans to avoid paying the new excise tax. While the ACA's high-cost excise tax raises significant revenue, additional policies addressing the tax exclusion of these medical benefits could provide additional revenue and make the current tax exclusion less regressive overall.

Recent Proposals for Limiting the Tax Exclusion for Employer-Sponsored Health Insurance

Changes to the tax exclusion of employer-sponsored health insurance have repeatedly been recommended as part of a broad-based federal debt-reduction package. Proposals to change the tax exclusions of employer-sponsored insurance have included capping and phasing out the tax exclusion, eliminating the tax exclusion and creating a tax credit, and eliminating the tax exclusion and creating a standard tax deduction for health insurance. Recent proposals in the first category have included the President's September 2011 Plan for Economic Growth and Deficit Reduction,[9] the December 2010 National Commission on Fiscal Responsibility and Reform chaired by Erskine Bowles and Alan Simpson,[10] and the November 2010 Debt Reduction Task Force chaired by Alice Rivlin and Peter Domenici.[11]

New Estimates in this Brief

In this brief, we update our 2009 analysis on this topic[12] and provide estimates of the revenue potential and distributional consequences of a new policy option. This option would impose a cap, or dollar limit, on the aggregate cost of employer-sponsored health coverage excluded from income and payroll taxes.[13] Building on options explored in our previous brief, the new policy modeled in this brief would apply income and payroll taxes to the premiums and medical benefits in excess of a cap set at the 75th percentile of premiums. The cap would be indexed, or allowed to grow over time, by a five-year average of the rate of GDP growth, where the five-year average is used for increased stability.[14] In choosing the level and indexing for the cap, our goal was to choose a policy that would make a significant contribution to debt reduction and would be distributionally equitable. For simplicity in this brief, we refer to the policy estimated as a 75th percentile cap on the exclusion of premium and medical benefits, or a 75th percentile tax cap. To investigate the characteristics of employees who would be affected by a 75th percentile tax cap, we compare the distributions of premiums for private-sector employees with those for state and local government employees. In addition, we examine implications for private-sector employees by industry and union presence. This brief answers four critical questions related to the 75th percentile cap on the exclusion of premium and medical benefits: What are the estimated revenues related to this policy in 2014 and 2014–2023? How many would pay higher taxes in each quintile of income? How much would taxes increase for those paying higher taxes? And, what are the characteristics of employers whose employees are likely to pay higher taxes?

Data and Methods

Estimates from the Tax Policy Microsimulation Model

The Urban-Brookings Tax Policy Center's large-scale microsimulation model produces revenue and distribution estimates of the U.S. federal tax system. The model is similar to those used by the CBO, the JCT, and the Treasury's Office of Tax Analysis (OTA). In these estimates, a tax unit is defined as an individual or a married couple who file a tax return jointly, along with all dependents of that individual or married couple. The baseline estimates represent changes in tax policies embodied in current law over the time period 2014 to 2023. Estimates of tax liability for each tax unit form the basis for estimated changes in government tax revenue resulting from implementation of the 75th percentile cap on the exclusion of premium and medical benefits.[15] The modeling of the 75th percentile tax cap does not include simulation of changes such as changes in benefits offered by employers in response (e.g., a shift in compensation from previously untaxed medical benefits to taxable wages). However, this simplification is likely to have a negligible effect on results. Since the 75th percentile tax cap affects both income and payroll taxes, the change in tax burden does not depend on whether the policy results in newly taxable medical benefits or a shift in compensation from previously untaxed medical benefits to taxable wages and salaries. See technical appendix and previously published documentation for more details regarding the tax model and assumptions.[16]

Premium Distribution Estimates

The Agency for Healthcare Research and Quality's (AHRQ's) 2011 Medical Expenditure Panel Survey–Insurance Component (MEPS-IC) is the source of estimates for (1) the number of employees enrolled in health insurance and levels of total health insurance premiums at or above the 75th percentile for employees enrolled in

Exhibit 1: Income and Payroll Tax Revenue Estimates for Repealing Employer-Sponsored Insurance Premium and Medical Benefit Exclusion and Limiting the Exclusion at the 75th Percentile Cap for Income and Payroll Tax Purposes for Calendar Years 2014–2023 ($ billions)

Baseline and Proposal[a]	First Year	Last Year	Total over 10 Years
	2014	2023	2014–2023
Total Baseline Value of the Exclusion of Employer-Sponsored Insurance Premiums and Medical Benefitsfor Income and Payroll Tax[b]	271.5	474.7	3,646.8
Federal Income Tax	163.9	292.1	2,237.7
Payroll Tax	107.6	182.6	1,409.2
Total Value of Limiting Exclusion of Employer-Sponsored Insurance Premiums and Medical Benefits at 75th Percentile of 2013 Distributions for Income and Payroll Tax Purposes, Indexing Limits by 5-Year Average of Growth Rate of GDP[b, c]	15.6	38.4	264.0
Federal Income Tax Changes	9.5	23.5	161.9
Payroll Tax Changes	6.2	14.9	102.1

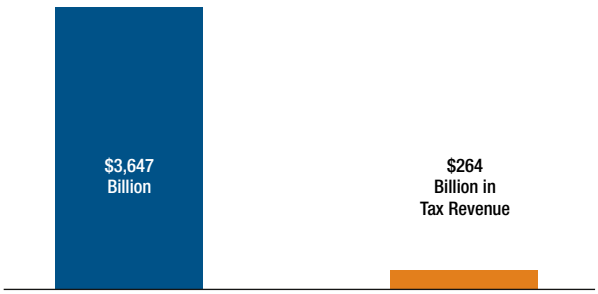
Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0412-8).

[a] Baseline is current law. See text for further detail.

[b] Employer-sponsored insurance premiums and medical benefit exclusion includes the combined exclusion of both employer contributions and employee contributions via section 125 plans (i.e., "cafeteria plans") for employer-sponsored health insurance premiums, dental and vision insurance premiums, and health saving account and medical flexible spending arrangement contributions. Modeled without behavioral change; see text for further detail.

[c] Exclusion limits vary by policy type—employee, employee-plus-one, or family. The 75th percentile value is based on the distributions of total employer-sponsored insurance premiums, dental and vision premiums, plus health saving account and medical flexible spending arrangement contributions (as opposed to the distribution of exclusion) among individuals with some exclusion with the relevant policy type in 2013. The 75th percentile of ESI and medical benefits for employee, employee-plus-one, and family policy distributions in 2013 is $6,600, $12,700, and $18,150, respectively. The applicable exclusion limits are the 75th percentile values indexed by the compounded year-to-year growth rate defined as the five-year average of GDP growth rate, and rounded to the nearest $50. For example, the limit for family policy in 2016 is $19,950, which is the 75th percentile value of the ESI and medical benefit distribution in 2013 ($18,150) indexed by the five-year average GDP growth rate between 2009 and 2013 (2.33%), the five-year average GDP growth rate between 2010 and 2014 (3.42%) and the five-year average GDP growth rate between 2011 and 2015 (3.99%) ($18,150 x 1.0233 x 1.0342 x 1.0399 = $19,975) and rounded to the nearest $50.

Exhibit 2: The 75th Percentile Tax Cap Policy Leaves In Place 93 Percent of Tax Subsidies from the Current Exclusion over 10 Years, 2014-2023



Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0412-8).

private-sector establishments, by firm size, and, in state and local governments, by number of employees in 2011; and (2) the number of employees at private-sector establishments enrolled in health insurance. To estimate the distribution of private-sector premiums by employer characteristics, we used a methodology combining information in the published summaries from the 2011 MEPS-IC and the premium distributions observed in the 2011 Kaiser/HRET Employer Survey microdata. See technical appendix for further detail on this methodology.

Results

Tax Revenues Collected in the First Year (2014) and over 10 Years (2014–2023)

Currently, the exclusion of employer-sponsored health insurance premiums and medical benefits generates tax expenditures estimated to be $271.5 billion in 2014 and $3.6 trillion over the 10-year period from 2014 to 2023 (see Exhibit 1).[17] Income taxes account for nearly two-thirds of the total—$163.9 billion in 2014 and $2.2 trillion over 10 years. Limiting the amount of the premiums and medical benefits[18] excludable from income and payroll taxes would affect far fewer taxpayers and generate far less revenue than completely removing the exclusion.

In the first year, the policy to limit the exclusion of premiums and medical benefits as described above would generate tax revenues estimated to be $15.6 billion in 2014 and $264.0 billion over 10 years, with income taxes consistently accounting for just under two-thirds of total tax revenues. Thus, the 75th percentile cap on income and payroll taxes, indexed by GDP, would leave 94 percent of the current tax subsidies in place in 2014, falling to 92 percent in 2023. In aggregate, over the 10-year period 2014–2023, the 75th percentile cap policy would leave 93 percent of the full value of the tax exclusion in place (Exhibit 2).

Exhibit 3: Distribution of Federal Tax Change by Income Percentile In 2014 and 2023, Limiting the Exclusion of Employer-Sponsored Insurance Premiums and Medical Benefits at 75th Percentile of 2013 Distributions for Income and Payroll Tax Purposes, indexing limits by 5-year average of growth rate of GDP

Income Quintile[b, c]	2014[a] Tax Units with Tax Increases[d]		2023 Tax Units with Tax Increases[d]	
	Percentage of Tax Units with a Tax Increase in 2014	Average Change in Federal Income Tax Among Tax Units with a Tax Increase in 2014	Percentage of Tax Units with a Tax Increase in 2023	Average Change in Federal Income Tax Among Tax Units with a Tax Increase in 2023
All	15.7	$633	20.0	$1,133
Lowest Quintile	3.3	$284	5.7	$636
Second Quintile	10.7	$503	13.4	$873
Middle Quintile	17.5	$544	21.5	$914
Fourth Quintile	25.1	$619	31.2	$1,147
Top Quintile	32.6	$840	39.5	$1,544

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0412-8ED). 29/1/2013

[a] Calendar year. Baseline is current law. See notes to exhibit 1 for more detail on the policy modeled.

[b] Includes both filing and nonfiling units but excludes those that are dependents of other tax units. Income is defined as "cash income"; for detail, see http://www.taxpolicycenter.org/TaxModel/income.cfm. Tax units with negative cash income are excluded from the lowest income class but are included in the totals.

[c] The income percentile classes 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 breaks are (in 2012 dollars): 20%, $27,797; 40%, $48,516; 60%, $76,595; 80%, $113,780; 90%, $181,697; 99%, $657,697.

[d] Includes tax units with a change in federal tax burden of $10 or more in absolute value.

The Distribution of Tax Increases by Income in 2014 and 2023

Distribution of tax increases and the size of the tax increases are driven primarily by those with higher incomes, who are much more likely to have employer-sponsored coverage and have higher effective marginal tax rates compared to those with lower incomes. Among employees with employer-sponsored coverage, those with higher incomes are also likely to have more expensive coverage compared to those with lower incomes, which would also tend to result in higher tax increases under the 75th percentile tax cap for those with higher incomes.

How Many Would Pay Higher Taxes?

Across all tax units in 2014, 15.7 percent would pay higher taxes under the 75th percentile cap on the exclusion of premium and medical benefits (Exhibit 3). Across income quintiles, this increases from 3.3 percent for those in the lowest quintile, 10.7 percent in the second quintile, 17.5 percent in the middle quintile, 25.1 percent in the fourth quintile, and 32.6 percent in the highest quintile of income.[19] In 2023, as a result of the caps being indexed at a slower rate than premium and medical benefit growth rates, 20.0 percent of all tax units would pay higher taxes, increasing across quintiles of income from 5.7 percent for those in the lowest quintile, 13.4 percent in the second quintile, 21.5 percent in the middle quintile, 31.2 percent in the fourth quintile, and 39.5 percent in the highest quintile of income.

How Much Would Taxes Increase for those Paying Higher Taxes?

Among tax units with a tax increase, the average estimated change in 2014 taxes would be $633, with the amount increasing with quintiles of income, from an average of $284 for those in the lowest quintile, $503 in the second quintile, $544 in the middle quintile, $619 in the fourth quintile, and $840 in the highest quintile of income (Exhibit 3). After 10 years of real growth in wages, premiums, and medical benefits, the estimated average change in 2023 taxes increases across quintiles of income, from $636 for those in the lowest quintile, $873 in the second quintile, $914 in the middle quintile, $1,147 in the fourth quintile, and $1,544 in the highest quintile of income.

How Does the Choice of Indexing of the Cap Affect Revenues Over Time?

In the 75th percentile tax cap policy we analyze here, we chose GDP as the index for the cap. Regardless of the choice of initial level of the cap, an alternative index that is less restrictive, such as indexing by the growth in premiums and medical benefits, would lead to slower growth in tax revenues over time. An alternative index that is more restrictive, such as CPI, would lead to more rapid growth in tax revenues over time. The GDP indexing that we chose is in the middle.[20]

The initial level of the cap and the indexing of the cap interact in their effects on the amount of revenue raised over time. Previous research demonstrated that if the index grows more slowly than premiums, the difference in revenue raised over time between a median and a 75th percentile cap is diminished. However, if the index chosen is less restrictive, the choice of the initial level of the cap has a larger effect on revenues over time. For example, indexing at the same rate at which premiums are assumed to grow, an initial cap at the 75th percentile of premiums would decrease income and payroll tax revenue by about 54 percent relative to revenues with an initial cap set at the median premium.[21]

Exhibit 4: Number of Employees Enrolled in Health Insurance and Levels of Total Health Insurance Premium at the 75th Percentiles for Employees Enrolled in Private Sector Establishments by Firm Size and in State and Local Governments by Number of Employees, in 2011

	Employees Enrolled in their Employer's Offer of Insurance in 2011 (In Millions)[A]	75th Percentile Premium (in $2011)[B]		
		Employee-Only Coverage	Employee-Plus-One Coverage	Family Coverage
All Private-Sector Establishments	**54.8**	**$6,100**	**$12,000**	**$18,000**
Fewer than 50 Employees	9.5	$6,200 *	$13,000 *	$17,000
50 or More Employees	45.3	$6,100	$12,000	$18,000
State Government	**3.6**	**$6,828 *^**	**$12,540 ***	**$16,944**
Local Government by Total Number of Employees	**9.2**	**NA**	**NA**	**NA**
Fewer than 250 Employees	1.4	$7,044 *^	$14,645 *^	$18,924 *
250–999 Employees	23.0	$7,260 *^	$14,328 *^	$18,768 *
1,000–4,999 Employees	2.6	$7,212 *^	$13,284 *^	$18,768 *
5,000–9,999 Employees	1.0	$7,098 *^	$12,900 *	$17,700
10,000 or More Employees	2.0	$6,780 *^	$12,288 *	$17,040

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2011 Medical Expenditure Panel Survey-Insurance Component. Table III.G.1 Premium distributions (in dollars) for employees enrolled in single, employee-plus-one, and family coverage at the 75th percentile through State and local government jobs by government type: United States, 2011

NA = not available in the published data

[a] Number of all employees that are enrolled in health insurance through state and local government jobs that offer health insurance, by government type and size and census division, United States, 2011, based on MEPS-IC Table III.B.1, Table III.B.2, and Table III.B.2.b.

[b] Total premium includes employer and employee contributions.

* Indicates cells that are above the 75th percentile of all private-sector establishment premiums in 2011 by policy type: employee-only, employee-plus-one, or family.

^ Indicates cells that are more than 10% higher than the 75th percentile of all private-sector establishment premiums in 2011 by policy type.

While the current income tax exclusion disproportionately subsidizes those with higher incomes, the dollar amount of the tax exclusion represents a larger share of after-tax income (defined as cash income minus individual income tax net of refundable credits, corporate income tax, Social Security and Medicare payroll taxes, and estate tax) for those with lower incomes.[22] Accordingly, for those paying higher taxes, the proposed policy decreases after-tax income by a greater percentage than for those with lower incomes. However, even for the 3.3 percent in the lowest quintile of income who pay higher taxes in 2014, the reduction in after-tax income is less than 3 percent. For the 5.7 percent in the lowest quintile of income who pay higher taxes in 2023, the reduction in after-tax income is less than 5 percent (data not shown).[23]

How Does the Choice of Indexing of the Cap Affect the Distribution of Tax Increases Over Time?

In previous analysis of similar policies to limit the tax exclusion of premiums and medical benefits, we found that a similar *share of tax units* faced increased taxes regardless of the index chosen for the cap—provided that the index was more restrictive than the rate of premium growth. However, the choice of indexing has a large effect on the *average tax increase* for those facing a tax increase. For example, for a policy similar to the one proposed in this brief, switching indexing of the cap from GDP to CPI would roughly double the average tax increases over a 10-year period for those facing a tax increase for all quintiles of income.[25]

The 75th Percentile Premium is Higher for Employees in State and Local Government Coverage Compared to Private-Sector Coverage

To shed more light on the types of employees that would be affected by this policy change, we draw inferences from the 2011 MEPS-IC data.[24] Exhibit 4 compares employment and premiums for private-sector employees (by firm size) to those for public-sector state and local government employees (data are not available for public-sector federal government employees). In particular, we examine the distributions of premiums among these groups of employees to determine whether state and local government employees had premiums above the 75th percentile premiums of private-sector employment. In 2011, driven by the relatively large size of the private sector, the number of employees enrolled in health insurance coverage offered by their employer was much greater among private-sector employees (about 55 million) than among state government employees (4 million) or local government employees (9 million).

Premium distributions differed between the private and public sector. The 75th percentile premium for employee-only coverage in particular was considerably higher—more than 10 percent higher—in the public sector than the private sector. In addition, the 75th percentile premium for employee-plus-one and family

Exhibit 5: Estimated Share of Employees with Premiums at or Above the 75th Percentile Premiums of Private-Sector Establishments, by Employer Characteristics and Family Configuration in 2011

	Percentage of Cell at or above the 75th Percentile Private-Sector Premium by Family Configuration[a]		
	Employee-Only Coverage	Employee-Plus-One Coverage	Family Coverage
Share of Private-Sector Employees Enrolled in Health Insurance with Premiums at or above the 75th Percentile by Family Configuration	25.0%	25.0%	25.0%
By Industry Group[b]			
Agriculture/Fishing/Forestry	—	—	—
Mining/Manufacturing	17.6%	16.3%	16.2%
Construction	22.7%	20.2%	18.0%
Utilities/Transportation	19.2%	21.7%	20.4%
Wholesale	22.0%	23.1%	21.4%
Retail	17.1%	20.1%	14.4%
Financial Services/Real Estate	28.9%*	27.8%*	31.7%*
Professional Services	35.4%*	33.9%*	34.8%*
Other Services	19.8%	20.9%	22.9%
Union Presence[b, c]			
Some Union Employees	31.0%*	25.7%*	27.2%*

Source: Urban Institute calculation of estimates based on MEPS-IC 2011 and the Kaiser/HRET 2011 Employer Survey.

[a] Estimated share of employees enrolled at this level of premium or higher among employees enrolled in their employer's offer of insurance; premium distributions based on employees by premium by family configuration in all private establishments in 2011. Premium includes both employer and employee contributions.

[b] Premium distributions by union presence and industry group distributions are informed by published mean and standard errors by those characteristics, and the overall published distributions of private-sector premiums by family configuration. Some industry groupings differed in the MEPS-IC and Kaiser/HRET data, and computation of estimates required additional assumptions; see technical appendix for more detail.

[c] An employee is categorized as being in an establishment with "union presence" if any of the establishment's employees are covered by a collective bargaining agreement.

* indicates cells that are above the 75th percentile of all private-sector establishment premiums in 2011 by family configuration.

— Indicates data were suppressed due to variability of the small sample estimate.

coverage exceeded that of the private-sector for moderate-sized (e.g., under 5,000 employees) local governments. For example, the 75th percentile premium for employee-plus-one coverage across all establishments in the private sector was $12,000, while the 75th percentile premium for employee-plus-one coverage in local governments with fewer than 250 employees was $14,645. Thus, setting a cap on the tax exclusion of premium and medical benefits at the 75th percentile of private-sector premiums, would affect public-sector employees to a greater extent—the 75th percentile premiums for some types of state and local government coverage were higher than the 75th percentile premiums for private-sector coverage.

Financial and Professional Service Industries—and to a Lesser Extent, Unions—Have a Higher Share of Employees with Premiums above the Average 75th Percentile Premium

To further investigate the characteristics of private-sector employees who might be affected by a policy of capping the tax exclusion at the 75th percentile of private-sector premiums, we draw inferences from analysis of a combination of the 2011 MEPS-IC and the 2011 Kaiser/HRET Employer Survey, as described above. In particular, we examine private-sector employees by industry and union presence.[26] For these groups in 2011, Exhibit 5 shows the estimated share with premiums at or above the 75th percentile premiums of private-sector establishments.

Across industries, employees in the combined financial services/real estate industries (over 5 million enrolled employees, or 12 percent of employees enrolled in health insurance through their employer) and the professional services industry (17 million enrolled employees, or 31 percent of employees enrolled in health insurance through their employer) had a higher share of employees with premiums above the 75th percentile premium.[27] In financial services/real estate, the share with this level of premiums was 29 percent for employee-only coverage, 28 percent for employee-plus-one coverage, and 32 percent for family coverage. The share was even greater for professional services at 35 percent for both employee-only coverage and family coverage, and 34 percent for employee-plus-one coverage. Industries whose employees would be least affected by a 75th percentile tax cap include the retail and construction industries.

Of the nearly 55 million employees enrolled in health insurance through their employer, about 10 million (18 percent) are employed at establishments with a union presence (enrollment data not shown). For employee-only coverage, 31 percent of employees in establishments with a union presence had premiums above the 75th percentile premium. For other types of coverage, establishments with a union presence had only a modestly higher share of employees with premiums above the 75th percentile premium—26 percent for employee-plus-one coverage and 27 percent for family coverage.

Conclusions

This brief shows that limiting the tax exclusion for employer-sponsored health insurance beyond the provisions already enacted in the ACA could be a significant source of revenue for the federal government. A cap on the income and payroll tax exclusion set at the 75th percentile of private-sector premiums and indexed by GDP growth would produce $264.0 billion in new income and payroll tax revenues over the coming decade while still preserving 93 percent of the tax subsidies available under the current policy. Across all tax units, 15.7 percent would pay higher taxes under the 75th percentile cap on the exclusion of premium and medical benefits in 2014, with this share increasing to 20.0 percent by 2023. Although tax units across the entire income distribution would experience some tax increases, these increases are considerably smaller and less prevalent at lower-income levels.

Setting the cap at the 75th percentile of premiums would affect public-sector employees to a greater extent, since the 75th percentile premiums for some types of state and local government coverage were higher than the 75th percentile premiums for private-sector coverage. In addition, a closer examination of the characteristics of private-sector employees showed that employees in the financial services/real estate or professional services industries would be affected to a greater extent, while employees in other industries such as the retail industry would be affected to a lesser extent. Establishments with a union presence have only a modestly higher share of employees with premiums above the 75th percentile premium, but the differences are larger for employee-only coverage.

Many employees in groups with higher premiums have traded off wages for more costly medical benefits. As a result, over time, employee compensation has shifted substantially from wages and salaries to medical benefits, and the trend is expected to continue.[28] A policy such as the 75th percentile cap on the income and payroll tax exclusion would cause some employers to shift compensation back to wages and salaries rather than medical benefits. Lower premium benefit designs could entail a combination of higher levels of cost-sharing, tighter utilization management, more limited network offerings, extensively tiered networks (with different cost-sharing levels even for in-network providers)—and, possibly, lower negotiated provider rates. We cannot predict the precise change in the nature of medical benefits offered. We believe the impact would be modest, since the policy leaves the vast majority of the current tax exclusion in place. As a result, the 75th percentile tax cap is not likely to result in a dramatic change in medical benefits, nor a dramatic reduction in the growth of health spending. The main impact of the policy, in addition to the tax revenues, would be to make the current tax exclusion less regressive overall.

To further the goal of making the current tax exclusion less regressive, several policy design options could further concentrate the tax increases on higher-income employees. A policy option modeled by Jonathan Gruber in 2009 would apply a "progressive cap" to the tax exclusion. This policy would retain both the income and the payroll tax exclusions for lower-income employees, cap the income tax exclusion at a specified premium level for middle- and higher-income employees, and completely eliminate the income tax exclusion for those with the highest incomes.[29] More recently, a similar policy retaining the payroll tax exclusion was modeled.[30] Neither policy would protect lower-income employees from the regressivity of payroll taxes if employers respond to the limitation of the current exclusion by shifting compensation from medical benefits to wages. However, since relatively few low-income employees have employer-sponsored insurance (and even fewer have high-premium insurance), and employer coverage for these employees is decreasing over time,[31] we would expect a modest impact on lower-income employees regardless of policy design.

Our analysis of a new policy imposing a 75th percentile cap on the income and payroll tax exclusion shows that limiting the tax exclusion for employer-sponsored insurance could be an important component of a broad-based federal debt-reduction package, while having minimal impacts on those with lower incomes. In addition, although not analyzed explicitly in this brief, the 75th percentile tax cap policy would also result in increased state tax revenues, since state income tax rules generally reflect federal income tax rules with respect to exclusions.[32] Effects on health care cost growth of a 75th percentile tax cap policy are likely to be modest, because the vast majority of the current tax exclusion would remain in place and because the existing excise tax on the highest-cost policies in the ACA is already current law. However, further limiting the tax exclusion would not only provide additional tax revenue to the federal government, but would also mitigate the regressivity of the current treatment of employer contributions to premiums.

Technical Appendix

Estimates from the Tax Policy Microsimulation Model

The tax revenue and distribution estimates in this paper come from the Urban-Brookings Tax Policy Center Microsimulation Model.[33] The model calculates tax liability for a nationally representative sample of tax units, both under the rules that currently exist (current law) and under alternative policy options. A tax unit is an individual or a married couple who files an income tax return—or would file if their income were high enough—plus any dependents.[34] 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.[35] The primary data source for the tax model is the 2004 Public Use File (PUF) produced by the Statistics of Income Division of the Internal Revenue Service. Data from the March 2005 Current Population Survey (CPS) were used to add information not available in PUF.[36] In addition, data from various surveys were used to add detailed information related to consumption, education, health, retirement, and estate tax calculations. In particular, data from the 2005 MEPS-IC; data from the 2007 and 2008 Kaiser/HRET Employer Health Benefits Surveys; and CBO, JCT, and Department of Treasury estimates and projections were used to impute information regarding employer-provided health insurance and medical benefits.

The estimates presented in this brief project changes in tax liability relative to the current law (i.e., tax policies currently scheduled to take effect in each year between 2014 and 2023). Thus, tax provisions legislated under the ACA, including the excise tax on

high-cost employer health insurance premiums, are part of the current law baseline. For purposes of modeling the 75th percentile tax cap, tax units are assumed to keep unchanged their decisions to work, to earn, or how they choose to enroll in health insurance in response to a change in policy, and employers would not change employment decisions or benefits provided. While modeling the 75th percentile tax cap without these "behavioral" responses was implemented for simplicity and clarity, it is likely that this simplification has a negligible effect on results. In particular, assuming that employees' compensation is unchanged, an identical amount of income and payroll tax revenues result whether the 75th percentile tax cap results in employees switching to a plan with a lower premium and medical benefits or results in employees retaining the same plan they have under the current law. That is, the change in tax burden does not depend on whether or not the policy results in newly taxable medical benefits or a shift in compensation from previously untaxed medical benefits to taxable wages and salaries.

In addition, as mentioned in the text, the revenues in Exhibit 1 do not include the revenues associated with the current law high-cost excise tax. If the excise tax were repealed and replaced with the 75th percentile tax cap presented in this paper, the distributional implications would differ to some extent. The impact would depend on the net effects of the following factors: (1) taxpayers' effective tax rate on the portion of benefits potentially subject to high-cost excise tax compared to the effective tax rate on the portion of benefits subject to the proposed cap, (2) the relative thresholds of the excise tax versus the cap, and (3) taxpayers' valuations of different types of compensation and benefits.

Premium Distribution Estimates

For the analysis presented in Exhibit 5, distributional summaries of private-sector premiums by coverage type and employer characteristics and premium distributions by decile by coverage type from the 2011 MEPS-IC data were combined with premium distributions by employer characteristics from the 2011 Kaiser/HRET Survey of Employer Health Benefits. The methodological approach was as follows.

In the Kaiser/HRET data, each firm's reported premiums were replicated according to the number of covered employees represented by each sampled firm. Using a statistical fitting procedure in SAS, we determined that the Kaiser/HRET premium data closely fit a gamma distribution (i.e., predicted quintiles generally fall in 95 percent confidence intervals estimated from actual distribution), particularly when the most extreme premium values (those more than 3.5 standard deviations from the mean) were removed. The means and variances of these gamma distributions of premium by employment characteristic were then benchmarked to the means and variances by employment characteristic provided in the MEPS-IC survey, which draws on a much larger sample compared to the Kaiser/HRET survey. Due to the small sample size, we were unable to compute variances for the agricultural, fish, and forestry industry grouping.

In a few cases, employer industry categories in the Kaiser/HRET data did not match those in the MEPS-IC data, necessitating additional assumptions regarding variance. Specifically, the Kaiser/HRET survey publishes separate means for "professional service" and "other service" firms, but separate variances are not available. To infer these distributional variances, we combined the standard error of the industry's mean reported by MEPS-IC with an estimate of the MEPS-IC's relative design effect by the estimated number of employees. MEPS-IC data include a significant share of employees with unknown union presence at their establishment; due to this lack of data, none of these employees are included in the estimates of employees with union presence.

In addition, the 2011 Kaiser/HRET data do not include premiums for employee-plus-one coverage. In the MEPS-IC, the difference between the standard deviations for employee-plus-one coverage and employee coverage is approximately 64 percent of the difference between the standard deviations for family coverage and employee coverage. We used this estimate to make variance estimates for employee-plus-one coverage according to employer characteristics. Due to the necessity of employing additional assumptions to generate employee-plus-one premium distributions, these estimates are likely to be less reliable.

To compute the national thresholds used in Exhibit 5, we used a modeled distribution rather than reported values to determine the 75th percentile premium threshold levels, because the values reported in the MEPS-IC are substantially altered by rounding to the nearest 100 dollars of premiums. Using the computed thresholds, we calculated the number of employees by employment characteristic and coverage type whose premiums were expected to exceed the threshold.

Endnotes

[1] In simplistic terms, 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. This simple example does not reflect the fact that taxing a $10,000 premium would subject that amount to both income and payroll taxes. In that case, the savings would be based on $10,000/1.0765.

[2] DeNavas-Walt C, Proctor BD and Smith JC. "Income, Poverty, and Health Insurance Coverage in the United States: 2011." Current Population Reports, September. Washington, DC: U.S. Census Bureau, 2012.

[3] 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: Centers for Medicare and Medicaid Services, 2009. http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf.

[4] Social Security's Old-Age, Survivors, and Disability Insurance program and Medicare's Hospital Insurance program.

[5] Patient Protection and Affordable Care Act (H.R. 3590; Public law 111-148), http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.3590:. Health Care and Education Reconciliation Act of 2010 (H.R. 4872; Public law 111-152), http://thomas.loc.gov/cgi-bin/bdquery/z?d111:h.r.04872:.

[6] These increases are $1,650 for a policy covering one person and $3,450 for a policy covering more than one person in 2018.

[7] Congressional Budget Office. "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March. Washington, DC: Congressional Budget Office, 2012. http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf. Previous estimates of revenue can be found in Elmendorf DW, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," Testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, March 30, 2011. Other estimates have also shown that the effect of the excise tax will grow rapidly in subsequent years. The Office of Management and Budget (OMB) estimated that the excise tax will raise $5.7 billion in 2018, $20.3 billion in 2019, $24.4 billion in 2020, $29.4 billion in 2021, and $35.8 billion in 2022. Office of Management and Budget, "Fiscal Year 2013: Analytical Perspectives—Budget of the U.S. Government." Washington, DC: Office of Management and Budget, 2012, p 224. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/spec.pdf.

[8] Joint Committee on Taxation, Letter to the Honorable Joe Courtney, U.S. House of Representatives, December 8, 2009.

[9] In September 2011, the President's Plan for Economic Growth and Deficit Reduction proposed to limit the rate at which higher-income individuals can itemize deductions and other tax preferences to 28 percent of income. Although this would not directly affect the tax exclusion of employer-sponsored insurance, counting the cost of this benefit toward a limit on the reduction of tax liability would effectively reduce the tax exemption. The proposed rule would apply to higher-income taxpayers, defined as individual taxpayers with income over an inflation-adjusted $200,000 (at the 2009 level) and married taxpayers filing a joint return with incomes over $250,000. Altogether, the proposed provision was estimated to result in $410 billion in revenue over a 10-year period. (Office of Management and Budget. "Living within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction." Washington, DC: Office of Management and Budget, 2011. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf.)

[10] In December 2010, the administration's National Commission on Fiscal Responsibility and Reform, chaired by Erskine Bowles and former senator Alan Simpson, proposed that a reduction of the income tax exclusion for employer-provided health insurance be part of a fail-safe plan that would automatically be triggered if legislation were unable to satisfy specified targets for federal funds. In particular, the commission offered an illustrative proposal that, when fully phased in, would cap the tax exclusion at the 75th percentile of premium levels in 2014, with no indexing of the cap through 2018 and a gradual phase-out of the tax exclusion by 2038. The commission also recommended reducing the ACA's excise tax rate to 12 percent, rather than 40 percent. (National Commission on Fiscal Responsibility and Reform. "The Moment of Truth: Report of the National Commission on Fiscal Responsibility and Reform." Washington, DC: The White House, 2010. http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf.)

[11] In November 2010, the Debt Reduction Task Force, chaired by Dr. Alice Rivlin and former senator Peter Domenici, proposed a plan to cap and phase out the tax exclusion. The task force proposal would cap the tax exclusion at the 75th percentile of premiums (including dental and vision coverage) in 2018 and eliminate new contributions to health savings accounts, another tax-free vehicle for health care spending. The cap would be phased out over a 10-year period. For collective bargaining agreements signed prior to the date of enactment, the proposal would not apply over the life of the contract. (The Debt Reduction Task Force, "Restoring America's Future," Washington, DC: Bipartisan Policy Center, 2010. http://bipartisanpolicy.org/projects/debt-initiative/about.)

[12] Clemans-Cope L, Zuckerman S, Williams R. "Changes to the Tax Exclusion of Employer-Sponsored Health Insurance Premiums: A Potential Source of Financing for Health Reform." Washington, DC: The Urban Institute, 2009. Quick Strike Series, June 25. http://www.urban.org/uploadedpdf/411916_tax_exclusion_insurance.pdf.

[13] We considered estimating a new policy capping only income tax exclusions at the 75th percentile, leaving the full payroll tax exclusion to further concentrate the tax increases on higher income employees. However, if employers respond to a new policy by shifting compensation from medical benefits to taxable wages, such a policy would still not protect lower-income employees from the regressivity of payroll taxes.

[14] The applicable exclusion limits are the 75th percentile values indexed by the compounded year-to-year growth rate, defined as the five-year average of GDP growth rate and rounded to the nearest $50.

[15] The model also estimates changes in effective marginal tax rates and changes 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.

[16] The Urban-Brookings Tax Policy Center. Microsimulation Model. September 19, 2012. http://www.taxpolicycenter.org/taxtopics/TPC-Model-Overview-2012.cfm; Rohaly J, Carasso A and Saleem MA. "The Urban-Brookings Tax Policy Center Microsimulation Model: Documentation and Methodology for Version 0304." Washington, DC: The Urban–Brookings Tax Policy Center, 2005. http://www.taxpolicycenter.org/publications/url.cfm?ID=411136.

[17] All estimates in this paper are provided on a calendar-year basis.

[18] Employer-sponsored insurance and medical benefit exclusion includes the combined exclusion of both employer contributions and employee contributions via section 125 plans (i.e., "cafeteria plans") for employer-sponsored health insurance premiums, dental and vision insurance premiums, and health savings account and medical flexible spending arrangement contributions.

[19] The income percentile classes 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 breaks are (in 2012 dollars) 20 percent, $27,797; 40 percent, $48,516; 60 percent, $76,595; 80 percent, $113,780; 90 percent, $181,697; and 99 percent, $657,697. The population includes both filing and nonfiling units but excludes those that are dependents of other tax units. Tax units with negative cash income are excluded from the lowest income class but are included in the totals. For a description of cash income, see http://www.taxpolicycenter.org/TaxModel/income.cfm.

[20] In our previous analysis comparing indexing of caps (Clemans-Cope L, Zuckerman S, Williams R, "Changes to the Tax Exclusion of Employer-Sponsored Health Insurance Premiums," 2009), when the cap is indexed by premium growth or medical expense growth, tax revenues accrue solely from an increasing number of employees encountering the cap due to population growth and employment changes over time.

[21] See Clemans-Cope L, Zuckerman S, Williams R, 2009.

[22] Schoen C, Stremikis K, Collins S, et al. "Progressive or Regressive? A Second Look at the Tax Exemption for Employer-Sponsored Health Insurance Premiums." New York: Commonwealth Fund, 2009. http://www.commonwealthfund.org/Publications/Issue-Briefs/2009/May/Progressive-or-Regressive-A-Second-Look-at-the-Tax-Exemption.aspx.

[23] Since mean income for those with a tax increase in 2014 and 2023 was not readily available, this rough calculation uses the level of income at the midpoint of the income quintile as the denominator, and the average change in tax among tax units with a tax increase in each year as the numerator.

[24] Distributional data on tax-free medical benefits such as HSAs and HRAs were not available for this part of the analysis. The findings in this section presume that the distribution of characteristics for those with premiums above the 75th percentile is the same as for those with premiums plus other tax-free medical benefits above the 75th percentile.

[25] See Clemans-Cope L, Zuckerman S, Williams R, 2009.

[26] AHRQ documentation of union presence in the MEPS-IC data is that "an establishment has a union presence if any of its employees are covered by a collective bargaining agreement" (http://meps.ahrq.gov/survey_comp/ic_ques_glossary.shtml#Unionpresence).

[27] Industry categories used by MEPS-IC follow the NAICS industry categories. See http://meps.ahrq.gov/survey_comp/ic_ques_glossary.shtml#Industrycategories and http://www.census.gov/cgi-bin/sssd/naics/naicsrch. Since some industry groupings differed in the MEPS-IC data compared to the Kaiser/HRET data, some estimates required additional assumptions; see technical appendix for more detail.

[28] 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. Holahan J, Garrett B, Lucas A, et al. "Health Reform: The Cost of Failure." Princeton, NJ: Robert Wood Johnson Foundation, 2009. http://www.rwjf.org/content/rwjf/en/research-publications/find-rwjf-research/2009/05/health-reform.html.

[29] Gruber analysis discussed in Cohn J. "Tax My Health Benefits. Please." New Republic, March 17, 2009. http://www.tnr.com/article/politics/tax-my-health-benefits-please; Transcript, "Hearing of the Senate Committee on Finance— Roundtable Discussion on Comprehensive Health Care Reform." May 12, 2009. http://www.votesmart.org/public-statement/424391/hearing-of-the-senate-committee-on-finance-roundtable-discussion-on-comprehensive-health-care-reform.

[30] Bipartisan Policy Center (BPC). "A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment." Washington, DC: BPC. April 2013. http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405681

[31] Holahan J and Chen V. "Declining Health Insurance in Low-Income Working Families and Small Businesses." Princeton, NJ: Robert Wood Johnson Foundation, 2012. http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf72627.

[32] 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.

[33] For general documentation of the Urban-Brookings Tax Policy Center Microsimulation Model, see Rohaly J, Carasso A and Saleem MA, "The Urban-Brookings Tax Policy Center Microsimulation Model: Documentation and Methodology for Version 0304."

[34] 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.

[35] 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.

[36] In particular, the CPS data are used to replace some fields missing in the PUF, such as the age of the primary and secondary taxpayer and dependents; to obtain information on sources of income not reported on income tax returns, such as welfare benefits; and to create a database of individuals who do not file federal income tax returns.

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