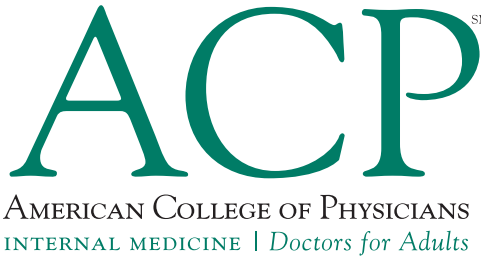

Reforming the Tax Exclusion for Health Insurance

American College of Physicians
A Policy Monograph
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A Policy Monograph of the American College of Physicians

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Executive Summary

Health insurance reform is a costly endeavor. Even after implementing delivery system reforms that may reduce costs in the long run, the cost of improving access to health care coverage is significant. Policymakers are searching for offsets to fund health care reform and some are looking to cap or end tax exclusions for employer-sponsored health insurance (ESI) to help pay for the immense cost of a comprehensive initiative (1, 2). In addition to the potential tax revenues to be gained, limiting the tax exclusion of ESI would address the disparities in tax savings among income groups due to graduated income tax rates, lack of benefit for those who are not offered ESI, the incentive to purchase overly generous insurance, and job lock that forces people to remain in a position to maintain health coverage. Because the exclusion disproportionately benefits higher-income workers and because of the enormous cost of the tax exclusion, many stakeholders have expressed support for altering the current system by capping or reducing the amount of coverage that is excluded from taxable income, by phasing out the exclusion for higher-income people or some other means. Groups as diverse as the AARP and the American Medical Association have called for either capping or eliminating the exclusion in an effort to fund more equitable benefits to those who need it most and to fund comprehensive health reform (3, 4). According to the Congressional Budget Office (CBO), capping the exclusion (at the 75th percentile for health insurance premiums) would save $108.1 billion from 2009 to 2013 (5).

The American College of Physicians is the largest medical specialty society in the United States, with over 129,000 physician and medical student members. In the ACP paper *Achieving Affordable Health Insurance Coverage for All Within Seven Years*, the College recommends a framework for comprehensive reform of the nation's health care system that focuses on expanding coverage and making the delivery system more efficient (6). Because of the College's commitment to reducing the number of uninsured and improving the nation's health care infrastructure, **ACP supports modifications to the current income tax exclusion for ESI if savings are directed to expanding coverage and strengthening the health care system.** The College believes that although eliminating the tax exclusion for ESI would make more funds available for comprehensive health care reform, it could also dramatically undermine the existing employer-based insurance system. ACP supports capping the tax exclusion to help provide funding for a comprehensive health care reform initiative. However, such modifications cannot exist in isolation. Any funds saved through the change should be directed toward expanding health coverage to the uninsured. In addition, incentives should be established to induce employers to continue offering health insurance to their employees. Changes to the tax exclusion must be made in a way that is not detrimental to low-income people and protections should be established so consumers do not see their benefits decrease because of health status, firm size, or medical expenses. Further, any modifications to the existing tax benefit should ensure that individuals can purchase sufficient health insurance that includes a core set of benefits.

ACP has reviewed the benefits and negative aspects of changing the current income tax exclusion and recommends the following:

Recommendation 1: A cap on the existing income tax exclusion for employer-sponsored health insurance should be established as part of overall health care reform that provides guaranteed, affordable, sufficient, and portable coverage to all Americans, without regard to health status, employment, or location.

Recommendation 2: A cap on the existing income tax exclusion for health insurance should be implemented in a way that will not create incentives for employers to drop coverage.

Recommendation 3: A cap on the income tax exclusion should be set at an initial level, and updated annually, to balance several priorities: providing fair treatment to low- and moderate-income workers, creating incentives for individuals to be prudent purchasers of health insurance plans, providing for reasonable growth in level of the cap—such as to reflect increases in health insurance premiums—while creating incentives for cost-effectiveness, reducing incentives for downward pressure on health benefits that could lead to underinsurance, and generating sufficient revenue to help pay for affordable health insurance coverage for all Americans.

Recommendation 4: Changes to the current income tax exclusion for ESI should recognize variations in the health status of covered individuals and regional variations in the costs of providing medical care, health insurance benefits related to collective bargaining contracts, and the experience rating of employers offering coverage.

Background

Roughly 160 million Americans (about two thirds of the U.S. population under age 65) receive health insurance benefits through their employer (7, 8, 9). Employer-sponsored health insurance (ESI) has a number of advantages over insurance acquired through other means (10). Employees form a natural group for spreading risk and obtaining economies of scale. Employers, hoping to control costs while maintaining benefits, are able to compel insurers to implement innovative delivery methods and quality care efforts. Administrative efficiencies derive from collecting premiums through employee pay (11).

Employer-sponsored insurance is subsidized through the tax system. Although most people pay federal and state taxes on wages, employer contributions for employee health insurance are excluded from worker's taxable income. Employees also can exclude from taxable income payments for their share of health insurance premiums if their employer offers a Section 125 " cafeteria plan," also known as a Flexible Spending Account (FSA), that allows employees to elect benefits on a pretax basis (12). The exclusion is applied to federal and state income and payroll taxes.

The tax treatment for ESI results in a significant cost to the federal government. In 2007, the exclusion amounted to $246 billion in foregone income and payroll tax revenue (13). This policy results in substantial savings for employees who are covered by ESI. For instance, if an employer provides $5000 worth of insurance benefits for an employee in the 28% tax bracket, that employee benefits from a $1400 income tax break (14).

Self-employed individuals are permitted to make an "above-the-line" income tax deduction from their adjusted gross income for health insurance premiums. Other tax-favored health insurance expenses include employee and employer contributions to health savings accounts. Such contributions are excluded from payroll and income taxation (15). Taxpayers who pay qualified medical expenses that are more than 7.5% of their adjusted gross income can claim the expenses above this amount as itemized federal income tax deductions (16).

Although a number of rulings and laws helped establish the foundation of employer-provided health insurance, the explicit tax exclusion for ESI is stated

in Section 106(a) of the Internal Revenue Code. Enacted in 1954, the new status made ESI more affordable and may have led to a move from individual insurance policies to group coverage (17). In addition, employers began offering ESI to compete in tight labor markets and to ensure the health and productivity of their workforce (18).

Proponents of the current law believe that the tax exclusion for ESI has facilitated risk pooling that dampens price fluctuations, made acquiring insurance a simple process for employees, and has led to a shift away from the volatile, expensive, and unstable individual insurance market (19, 20, 21). Supporters also note that the exclusion and IRS nondiscrimination policy helps ensure that firms who offer certain health benefits to high-wage workers are required to offer similar coverage to low-wage workers (22). Some labor unions maintain support of the current exclusion because it can be used as a collective bargaining tool (23).

Although this favorable tax status has facilitated the proliferation of ESI and has helped provide affordable insurance to those who would otherwise not have access to it, a number of economists and health care experts have criticized the tax exclusion and have called for reform. Criticism of the favorable tax status is not rooted in any particular ideology; although the idea was originally posed by conservatives in the 1980s, a number of liberal and consumer-focused groups have also supported modifications to the tax exclusion as a way to fund universal health care (24). Critics note that the exclusion is not needs-based and that the amount of the tax break does not depend on the type of health insurance plan (25). Critics also raise concern that the benefit is regressive because higher-income earners (who are also more likely to have access to ESI) benefit more from the exclusion than lower-income workers (26). There is also concern that the subsidy incentivizes employers and consumers to purchase costly, overly generous insurance (so-called Cadillac coverage) that they may not need. In addition, individuals who do not receive insurance from an employer do not receive the same favorable tax exclusion and must purchase insurance with after-tax income (27).

Proposals to cap or otherwise change the tax exclusion for health insurance

President's Advisory Panel on Federal Tax Reform

In 2005, President Bush convened an expert panel to review the tax code and make recommendations on how the code could be changed to make it more "simple, fair, and pro-growth."(28) Chaired by former Senators Connie Mack and John Breaux, the panel advised, among other things, that the tax exclusion for employer-sponsored health insurance be capped at $11,500 for family coverage and $5,000 for single plans. The cap would be indexed for inflation to the Consumer Price Index. Both employer and worker contributions toward employer-provided dental, disability, and other benefits would be taxable. Additionally, a new tax deduction for those without access to ESI would be created for the purchase of individual insurance coverage. The individual insurance deduction would also be capped at $11,500 for family plans and $5,000 for single plans. Tax-advantaged accounts like HSAs and FSAs would be combined into a single account called the "Save for Family" account (29).

The Panel advised against total elimination of the tax exclusion. Although the Panel found that the exclusion has led to overspending on health insurance, it recommended capping the exclusion in an effort to maintain the framework of the current system while also reducing health spending (30).

President Bush Budget Request

President Bush's FY2009 budget request included a proposal to replace the current tax exclusion for health insurance with a standard above-the-line deduction of $7,500 for single plans and $15,000 for family plans. The deduction would be applied to either ESI or individual insurance coverage. Employer spending for ESI would be taxable income for federal income and payroll taxes. Additionally, the amount of the deduction would be adjusted annually on the basis of the Consumer Price Index. A Lewin Group analysis found that the proposal would reduce the number of uninsured in 2009 by about 9.2 million people. The analysis also determined that families would see an average after-tax saving of about $732. The proposal maintains a structure that benefits higher-income earners; 70% of the tax reduction would go to families with incomes above $50,000 a year and 20% of the savings would go to the uninsured. The Lewin analysis states that in 2009, the federal deficit would be reduced by $61.8 billion under the proposal (31).

Healthy America Act

Introduced by Senators Ron Wyden (D-OR) and Bob Bennett (R-UT), the Healthy America Act would replace the existing tax exclusion for health insurance with a fixed-income tax deduction for coverage. Deduction levels are limited to $6,025 for individuals and $15,210 plus $2,000 per dependent (32). The deduction is phased out for upper-income people and phased in for low-income workers. Those who do not pay income tax are eligible for a subsidy. In addition, employers would be required to increase an employee's wages by the average contribution they have made to the employee for health coverage. Payment for the minimum level of coverage would be a part of the individual's tax liability. State-based Health Help Agencies would approve plans, facilitate enrollment, and channel premium payments from the Federal government to health insurers. The exclusion for tax-advantaged accounts, such as FSAs, generally would be eliminated or reduced. Limits on contributions to HSAs also would be established (33). The Congressional Budget Office and the Joint Committee on Taxation have concluded that the Healthy America Act would be budget-neutral in 2014 (34).

John McCain Health Proposal

The health care proposal of 2008 Presidential candidate Senator John McCain (R-AZ) also sought to replace the current income tax exclusion. Instead of a deduction, a refundable tax credit of $2,500 for individuals and $5,000 for families would be made available to purchase insurance. The current payroll tax exclusion for Social Security and Medicare would be maintained. The credit would be updated on the basis of the Consumer Price Index. A Lewin Group analysis of the McCain proposal states that the plan would incentivize individual insurance and that ESI would be reduced. The analysis also found that the number of uninsured would decrease to about 21.1 million, assuming 48.9 million persons are uninsured (35).

Senator Max Baucus's Call to Action white paper

Senate Finance Committee Chairman Max Baucus (D-MT) has stated in his "Call to Action" white paper that reform to the existing ESI exclusion should be considered but that complete elimination of the benefit should be avoided because it would lead to a drastic undermining of the current ESI system (36). While Baucus offers little detail about how the system should be changed, he does suggest that the current benefit could be capped on the basis of the value of benefits, the employee's income, or a combination of the two. Effectively, capping the benefit on the basis of a person's income would amount to a means testing of the exclusion, because higher-income people would see their benefits capped whereas lower-income people would get the full tax advantage (37).

Concerns regarding the tax exclusion for health care

The exclusion disproportionately benefits higher-income people

The benefit an employee derives from the tax exclusion depends not only on the amount spent on health insurance premiums but also on the taxpayer's marginal tax rate. Because of this, higher income earners who pay more taxes receive a larger tax benefit from the exclusion than low-income earners. As noted, an employee in the 28% tax bracket whose employer provides $5000 worth of insurance would receive an income tax break of $1400. However, an employee in the 15% tax bracket would receive a tax break of only $750 for the same $5000 insurance.

The regressive aspect of the subsidy is only relevant to the income tax exclusion, not the Social Security or FICA contribution when combined with an earner's payment to Medicare. Lower-income individuals see a modestly higher benefit from the Medicare and Social Security tax exemptions, at least in the short run (38). Most employees yield 6.2% of their income to Social Security and 1.45% to Medicare (39). Their employer also pays equal amounts for a total of 15.30%. Self-employed people pay the combined rate. The level of income that is taxed by Social Security is capped by a number that is adjusted on an annual basis. In 2009, all income above $106,800 is not subject to the 12.4% Social Security assessment. There is no limit on maximum taxable earnings for Medicare. An individual earning an income under the $106,800 cap would receive a larger benefit from the payroll tax exclusion than an individual earning an income that is over the cap. Therefore, although the payroll tax exclusion benefits lower-income earners more than people with higher incomes, the overall benefit remains higher for those in the upper-income tax brackets because the payroll tax advantage is less significant.

Proponents of maintaining the tax exclusion argue that younger, healthier workers, who are likely to receive less pay, participate in health insurance primarily because the tax benefits subsidize their coverage. Their participation is necessary to spread risk and limit the high premiums that would occur if a disproportionate number of sick patients purchase ESI (40). The funding that employers contribute to their employees' insurance coverage helps make comprehensive coverage affordable, especially to low-income employees (41). Similarly, low-income earners benefit because the exclusion is a higher percentage of their income than higher-income employees. Supporters also note that setting an income threshold to cap or eliminate tax benefits would be a politically difficult task and would disproportionately affect those in certain areas of the country (42).

Opponents of the current exclusion argue that it undermines the progressive tax structure since the tax exclusion disproportionately benefits higher-income people (43). Other critics say that because 80% of the uninsured pay income taxes, these typically low-wage earners effectively subsidize the income taxbenefits of high-wage earners (44). Lastly, employers with a high number of low-income workers may be less likely to offer health insurance because their employees are subject to less of a tax advantage. Because the tax benefit is so low for this group, low-income earners are less likely to demand this benefit from their employer (45). Higher-income people are also more likely to have access to ESI. One study found that about 22% of individuals in the bottom income quintile had employer-sponsored insurance, whereas about 86% of those in the highest income quintile had ESI (46). The CBO has stated that one of the advantages to limiting the tax exclusion on higher-income earners is that it will dissuade companies from providing special comprehensive health packages to top executives (47).

The tax exclusion is only available to those who receive group coverage through their employer

As previously noted, the 7% of people who purchase insurance in the individual market are not able to exclude their contributions from taxable income. They are able to deduct the amount of qualified medical expenses they incur over 7.5% of adjusted gross income. Only the portion of contribution above the 7.5% threshold is deducted. However, this deduction is claimed by only about 7% of tax filers. This may be because of the limited number of people who reach the 7.5% threshold and because most people file standard deductions (48). Higher-income people may not qualify because their percentage of income related to health expenses may not reach the threshold (49). Whereas self-employed individuals are able to file an income tax deduction for health insurance premiums, payroll taxes are not subject to the same treatment and the self-employed must pay the full payroll tax (50). In addition, the income tax benefit does not aid low-income people who do not pay income taxes.

Supporters of the current law argue that employer-sponsored insurance is necessary to pool risk and mitigate adverse selection. Groups of employees serve as natural pools of individuals connected for a primary reason other than to purchase health insurance. Because of this inherent diversity, adverse selection can be mitigated, whereas in a pool created solely to purchase insurance, as in a state high-risk pool, costs tend to be higher because sicker patients are enrolled (51). Further, the tax preference for ESI ensures that sick individuals aren't exposed to the volatile and sometimes inaccessible individual insurance market (52). Proponents of the current exclusion maintain that the inequities regarding those with very low incomes can be addressed without drastically altering the tax code. For instance, the National Association of Health Underwriters (NAHU) suggests that a credit similar to the Earned Income Tax Credit be distributed to qualifying low-income people in an effort to make the current exclusion more equitable and progressive (53). Further, inequities in the tax status of the self-employed can be mitigated by permitting these persons to deduct health insurance payments at a level similar to that of corporations. Finally, the premiums for people covered by individual market insurance could be deducted as medical expenses.

Opponents believe that the tax code should be changed so that those purchasing ESI or individual market coverage are doing so on a level playing field. Individual market insurance often has higher cost-sharing, which may make enrollees more sensitive to health care costs and therefore more prudent buyers.

Overuse of benefits

Many proponents of changing the existing tax advantages for ESI argue that the tax exclusion incentivizes employers to purchase overly generous health insurance for their employees regardless of whether they need it. Employees are unaware of the expense (and the lost wages that offset the insurance benefit) because the amount of the tax exclusion is not apparent. Employer-sponsored insurance is maintained because it is assumed that employees prefer health benefits over equivalent cash wages. Fiscally, the purchase of excessive insurance means less tax revenue. Some observers argue that overly comprehensive insurance with low out-of-pocket spending raises the overall cost of insurance and increases the number of uninsured who are unable to afford coverage (54, 55). People are more likely to purchase generous insurance to insulate against high market rates for health services.

Over the past 20 years, the dominant forms of health insurance have transitioned from permissive fee-for-service plans to restrictive health maintenance organization plans to less restrictive preferred provider organizations. So-called consumer-directed plans, such as high-deductible health plans paired with health savings accounts, are becoming an increasing segment of ESI plans. Evidence suggests that fee-for-service style plans contributed to the excessive amount of insurance and that recent moves to restrictive forms of coverage have helped to temper overuse of services (56). There is considerable evidence that imposing high deductibles on enrollees leads to less use of health care services and lower costs. The transition from volume-based fee-for-service payment in the private insurance market occurred largely because of employers' desire to limit the growing cost of health care benefits. In this regard, more restrictive health insurance plans serve as a check on the uncapped tax exclusion (57). Gatekeeping policies that limit an enrollee's ability to see a specialist and plans that charge enrollees more to receive care from out-of-network providers are examples of how employer-sponsored insurance essentially acts as a limit on the tax exclusion benefit.

Estimates of the number of individuals who are covered by an overly comprehensive plan are limited. However, President Bush's FY2009 budget proposal estimated that in 2009, about 75% to 80% of filers would have insurance plans that are below the $7,500/$15,000 thresholds. Those with plans valued above the thresholds would pay taxes on the amount exceeding the threshold. Over time, fewer people would fall under the threshold because health care costs would probably increase faster than the rate of inflation (58). A study authored by Elise Gould and Alexandra Minicozzi found that the number of people with insurance contributions in excess of $5,000 for single plans and $11,500 for family or plus-one plans (plan thresholds based on 2005 recommendations of the President's Advisory Panel on Federal Tax Reform) is substantial. The study found that among private establishments, 19.5% of single-plan enrollees and 41.1% of family-plan enrollees would have tax-preferred contributions over the cap.

Although the level of benefits contributes to the cost of the insurance package, other factors, such as geography, health status, health plan choice, and size of employer, affect the cost of insurance for firms and employees. The location of the plan plays a significant part in the cost of coverage. Health insurance plan costs can vary dramatically depending on where a person purchases insurance. One study reviewed the average premium cost of Medigap plans (private supplemental insurance plans available to Medicare beneficiaries) with the same level of benefits in each state and found considerable differences. For instance, a Medigap Plan C product has an average premium of $1204 in New York, whereas the same plan has an average premium of $2,589 in Connecticut.

Annual premiums for family coverage can also vary significantly by region, from $12,252 in the South to $13,656 in the Northeast. Although research on geographical differences in private health insurance costs is limited, extensive evidence shows that wide geographic disparities in spending per beneficiary and use exist in the Medicare fee-for-service program (59). Other studies show that areas with significant hospital consolidation are more likely to negotiate for higher rates from private insurers, which may translate to higher premiums for the consumer (60). In addition, Federal Employee Health Benefit Program PPO plans paid higher hospital and physician rates in areas with less HMO capitation plan penetration (61).

Health insurance costs can differ significantly in other ways. Firm size is a major indicator of the purchaser's premium burden. Small employers pay more than large employers for health insurance and often provide less comprehensive coverage (still at a higher cost than for large employers) to their employees (62). Smaller firms lack the negotiating power of larger firms and cannot exploit economies of scale. For instance, according to 2006 data, firms with fewer than 10 employees had an average total employee-only premium of $4,498; firms with 1,000 or more employees had an average premium of $4,066. However, some evidence suggests that the disparities between large and small firms may not be drastic. One study found that single-plan enrollees employed by a small firm were more likely to have insurance that would exceed the $5,000 tax exclusion cap. For family insurance plan enrollees, larger firms with more than 1,000 employees had a higher percentage of workers who would exceed the cap, but there was little variation among the different-sized firms (63). Further, employer surveys regarding health care costs for 2008 show that small employers actually had lower average costs for family plans than large employers and similar costs for single plans (64).

Another significant factor in determining health insurance costs is the health status and age of the group. Generally, firms with a high number of older workers have higher health care premiums regardless of the benefits package. After controlling for comprehensiveness of benefits, the study by Gould and Minicozzi found that firms with the highest share of workers over age 50 would have the largest number of employees that exceeded the $5,000/11,500 cap (65). Health insurers are known to charge higher rates on similar products to firms with higher-than-expected expenses. Therefore, if the tax benefits for health insurance were capped, employees in firms with a high proportion of older employees would pay additional taxes.

The NAHU, a proponent of the current system, stresses that about half of those covered under ESI only have a single plan choice available to them; therefore, they are unable to decide between an overly generous health plan and one that is more restrictive. Additionally, employees may not be able to influence what type of plan option is made available to them even if they support purchasing a cheaper, more restrictive form of health coverage (66).

Some argue that initially the cap on tax exclusion for health insurance would not reduce participation in excessively comprehensive health plans. The outcome depends on how the employee values the health insurance and the expected tax liability they face under the cap. As insurance premium growth exceeds overall inflation, the effect of the cap may lead more people to enroll in lower-cost plans, but according to the Employee Benefit Research Institute, such a result may take years (67). The CBO has also stated that the incentive to push for less comprehensive benefits would occur over time (68).

The tax exclusion is not portable

Some critics of the tax exclusion argue that employer-sponsored insurance forces employees to remain at their job in an effort to maintain health insurance. In addition, those who switch jobs or are laid off are usually severed from their health insurance coverage, which leads to disruptions in care. Although laws like the Health Insurance Portability and Accountability Act and the COBRA program are intended to improve portability, health insurance remains expensive for those who do not receive ESI. Instances of job lock—when an employee remains in a job solely to maintain such benefits as health care—are not uncommon. According to one study, 27% of adults reported that they had remained in a job they otherwise would have left so they could maintain health insurance (69). Proposals to reform the tax exclusion and replace it with either a deduction or refundable credits would improve portability and potentially reduce job lock. The current exclusion makes it difficult for someone who may find a less-expensive plan in the individual market to leave the ESI plan because they would lose the tax advantage.

Recommendations

Recommendation 1: A cap on the existing income tax exclusion for employer-sponsored health insurance should be established as part of overall health care reform that provides guaranteed, affordable, sufficient, and portable coverage to all Americans, without regard to health status, employment, and location.

Changes to the current tax exclusion for ESI cannot exist in isolation; any modifications must be part of a broader health care reform initiative that increases coverage to the uninsured and reforms the health care delivery system. ACP's paper *Achieving Affordable Health Insurance Coverage for All Within Seven Years* outlines suggestions on how coverage can be expanded by improving access to Medicaid for low-income individuals; providing advance, refundable, and sliding scale tax credits to uninsured working Americans with modest incomes; and permitting subsidy recipients to purchase coverage in group purchasing arrangements based on such models as the Federal Employees Health Benefits Program. In addition, the paper suggests that an expert panel be established to create policy on a core benefits package and how to increase coverage to uninsured higher-income individuals. To achieve universal coverage, individual and employer mandates, and automatic enrollment would be considered. Finally, small employers would have new options to purchase health insurance for their employees (70).

Eliminating the tax exclusion without establishing consumer safeguards or diverting savings to those without health insurance would probably have significantly negative effects on the current health care system. For instance, critics of President Bush's effort to replace the tax exclusion with an above-the-line standard deduction expressed concern that the proposal could lead to precipitous declines in the rate of ESI, which could undermine group insurance and risk spreading and facilitate adverse selection or underinsurance for those remaining in ESI coverage. Additionally, such a change would have little benefit for very low-income individuals who do not have an income tax liability. According to the CBO, even capping the tax exclusion could lead individuals to drop their existing coverage, because the after-tax cost of insurance would rise. In one scenario, the number of uninsured would increase by 3.2 million over 5 years after being subject to a cap on the ESI exclusion (71). Again, providing advance, refundable tax credits to uninsured persons with modest incomes and expanding public programs to insure low-income individuals would help avert coverage decreases that result from changes in the tax status of health insurance.

Recommendation 2: A cap on the existing income tax exclusion for health insurance should be implemented in a way that will not create incentives for employers to drop coverage.

Although a majority of Americans receive health insurance through their work, the percentage of employers who offer health insurance to their employees has declined over the past decade. From 2000–2007, the number of persons under the age of 65 who received ESI dropped by 5.4% (72). Premiums for health insurance have grown exponentially. Since 1999, premiums for employer-sponsored family insurance have risen 120% (73). The share of health insurance as a portion of employee income has greatly increased, from 0.3% in 1948 to 8.3% in 2006 (74). Altering the tax exclusion for health insurance could lead to the end of the employer-based insurance system for a number of reasons (75). Capping the tax benefit could lead employers to limit insurance benefits and force workers into less comprehensive ESI coverage. In addition, some employers may want to drop coverage altogether, especially if an alternative means to finance coverage through a tax credit or subsidy not tied to employment is established (76). As the benefits are capped, healthier workers may look to the individual market, leaving those who remain in ESI group coverage to cope with increased premiums. Elimination of the cap could lead to a major decline in the prevalence of ESI. Elimination of the income tax exclusion for ESI and replacement with a refundable tax credit, as proposed by Senator John McCain (R-AZ), would, according to a Lewin Group analysis, result in 16.1 million workers and their dependents losing ESI coverage (77). Other estimates state that elimination of the tax exclusion would lead to a 17% reduction in the number of employees offered ESI (78).

Despite these concerns, some believe that large employers who have significant bargaining power and lower costs would maintain ESI even if the tax exclusion was capped (79). Small businesses, however, are another matter. Small firms are already at a major disadvantage compared with large firms because they do not have the economies of scale and have relatively higher administrative costs than their larger counterparts; consequently, they incur higher ESI costs. To protect against dramatic changes to the current system, safeguards to maintain coverage, especially for small businesses, should be established to ensure continuity or compel businesses to begin offering ESI. For instance, the CBO offered the possibility that tax credits could be targeted to small businesses with disproportionately low-income workers or to small businesses that do not offer insurance to their employees. Tax credits could be phased out for larger firms (80). Additionally, policymakers could consider releasing advance, refundable tax credits that will promote equity for small firms that may not have a significant tax liability.

Changing the tax exclusion of health insurance may impose complicated administrative requirements for employers, particularly self-insured firms. In a scenario where self-insured plan benefits would be capped, employers would probably have to begin calculating the value of their health benefits for reporting reasons. Because self-insured plans often involve thousands of enrollees in different geographic locations, accurately determining the level of benefits for tax purposes could prove challenging. The least financially burdensome way for self-insured firms to calculate benefits would be to use existing COBRA premiums, which are based on anticipated claims for the coming year (81).

Recommendation 3: A cap on the income tax exclusion should be set at an initial level, and updated annually, to balance several priorities: providing fair treatment to low- and moderate-income workers, creating incentives for individuals to be prudent purchasers of health insurance plans, providing for reasonable growth in level of the cap—such as to reflect increases in health insurance premiums—while creating incentives for cost-effectiveness, reducing incentives for downward pressure on health benefits that could lead to underinsurance, and generating sufficient revenue to help pay for affordable health insurance coverage for all Americans.

The decision on where to set the level of a cap on ESI, and how to update it on an annual basis, will need to balance several important elements, and each of these have an effect on the other as well as on the amount of revenue that can be raised. The tax exclusion has helped facilitate employer-based insurance for millions of Americans. However, because of the progressive income tax structure, the income tax exclusion does not benefit those with little or no income tax liability as much as those in higher tax brackets, or those who do not receive insurance through their employer. Some employers also vary contributions based on income and/or offer better health benefits to executives, thus further exacerbating income-related inequities (82, 83). One way to correct the regressive aspect of the tax exclusion within the framework of comprehensive health care reform is to continue the tax exclusion for low-income workers (in addition to providing some means for subsidized coverage) and tax the benefits of upper-income workers on a sliding scale (84). The cap on the tax exclusion should be set high enough that low- and middle-income individuals who do receive ESI are not negatively affected (85). For instance, income tax payers in the 10% to 28% tax bracket would retain the full tax exclusion for ESI, whereas the cap would be phased in gradually for higher-income filers.

The cap should be adjusted over time to ensure that it does not adversely affect low- and middle-income individuals and is increased to keep pace with growth in health insurance premiums, and to create incentives for individuals to be prudent purchasers of health benefits. The standard deduction proposed by President Bush would have tied the deduction level to the Consumer Price Index (CPI). Because medical costs increase faster than the CPI, lower- and middle-income individuals would see their benefits capped and be forced to pay additional taxes over time. Whereas all but the top 20% of earners would see some tax benefit from the deduction (starting in 2009), all but the lowest income earners would see their insurance capped by 2017. A number of options could be implemented to avert this outcome, such as indexing the cap to the per capita growth in National Health Expenditures or requiring Congress to review the cap amount and update it based on fiscal outlook (86). However, basing the cap on growth in National Health Expenditures could encourage health care inflation and reduce the incentives for individuals to be prudent purchasers of insurance benefits. The method used to update the cap on the ESI tax exclusion greatly affects who will have their benefits capped and how much revenue will be raised. For instance, if the cap were indexed to the CPI, it would save about $850 billion over 10 years. Adjusting the cap to annual health cost increases would generate $165 billion in savings over the same period (87).

Efforts to eliminate the current tax exclusion for health insurance and replace it with a standard deduction would do little to improve the health insurance status of low-income people who are most likely to be uninsured. The standard deduction has essentially the same tax benefit to the taxpayer as the current exclusion, so establishing a standard deduction would continue to disproportionately benefit higher-income earners (88). Changing the current exclusion may also endanger the IRS nondiscrimination rule that requires employers to offer similar health benefits to all workers regardless of income if they want to qualify for the tax subsidy (89). Should the tax exclusion be capped, savings should be targeted to uninsured low-income individuals, preferably in the form of progressive, advanced, refundable tax credits for insurance, and pooling mechanisms with adequate consumer safeguards should be established (90, 91).

A cap on ESI could lead to downward pressure on health benefits, leading to underinsurance, unless coupled with safeguards to ensure that all insurers provide recommended core benefits. One of the dangers of setting a cap too low

is that insurers may offer plans that provide insufficient coverage but have low cost sharing so enrollees avert having to pay taxes above the cap. A similar experience occurred with the health earned income tax credit, which provided a small tax credit to low-income parents to purchase health coverage for their children (92). Insurers offered plans at a price that was below the level of the credit but offered miniscule benefits—some plans restricted payment to extremely low limits (e.g., $50 per day for a hospitalization) or covered only specific diseases (93). ACP has recommended that an expert panel be formed to recommend a core set of benefits that all insurers would be encouraged to provide. Once such an expert panel has determined the core set of benefits, the cap on tax exclusions should be reset (or established) at a level that ensures such a benefit package is affordable. Determining a core set of benefits is essential to ensuring that public funds are used in an efficient and effective manner (94).

Policymakers also should consider maintaining the current payroll tax exclusion because the tax burden would disproportionately affect those with low incomes and would result in a tax increase for employers, and savings from the cap would be directed to the Social Security and Medicare trust funds, rather than funding health care system overhaul (95).

Recommendation 4: Changes to the current income tax exclusion for ESI should recognize variations in the health status of covered individuals and regional variations in the costs of providing medical care, health insurance benefits related to collective bargaining contracts, and the experience rating of employers offering coverage.

Critics of eliminating or capping the tax exclusion have expressed concern that it would push individuals out of ESI. A modification could create an incentive for some to purchase insurance elsewhere, such as in the volatile individual market—where experience rating rules and lack of guaranteed issue requirements in most states place a heavy burden on such vulnerable individuals as the sick and aged. Although health insurance premiums vary because of comprehensiveness of benefits, they are also dramatically affected by health status of the group and the cost of providing medical care in the plan's area. Policymakers should keep this distinction in mind when reforming the tax exclusion to ensure that vulnerable people are not unjustly taxed and that healthy people are not given an extra incentive to leave the group insurance plan to purchase a less comprehensive plan in the individual market.

It is likely that some employers would reduce the comprehensiveness of ESI benefits when faced with a cap or would stop offering ESI altogether. Others who are more cost-sensitive may forego insurance coverage (96). This impact would be mitigated by mandating that larger employers provide health insurance coverage or pay into a pool to provide coverage for uninsured persons (pay or play), as recommended by ACP. To protect individuals, federal or state entities might consider establishing pooling arrangements and consumer protections, such as community rating, guaranteed issue and renewability, and portability, to ensure that those entering the individual market are adequately covered (97). Advance, refundable tax credits could be distributed to those who qualify. For those who remain in ESI, a potential way to cap the exclusion in a less punitive way is to index it on the basis of age (98). Because firms with a high number of older employees typically pay higher premiums, increasing the tax exclusion cap for older workers (or setting it on the basis of the average age of all employees in the firm) may help preserve the tax benefit for those who incur higher costs. In addition, providing a separate tax deduction or additional credit for those

with high medical costs (similar to the itemized medical expenses deduction currently in place) may help preserve the benefit for sicker individuals (99).

Collective bargaining agreements often include relatively generous health benefits for union members. Insured workers in firms with higher union penetration are often more likely to exceed a tax exclusion cap of $5,000 for single plans and $11,500 for family plans. According to Gould and Minicozzi, half of employees in firms that are 40% to 59% unionized would see their health insurance benefits exceed the cap (100). Collective bargaining agreements should be grandfathered to ensure that health benefits for relevant unionized workers are not affected by a tax exclusion cap. Once the contract has terminated, the cap on the tax exclusion for ESI will be applied to any new collective bargaining agreements.

Another concern is the variation in the costs of medical care in different parts of the country. Some of this variation may be tied to practice expense. For instance, some expenses related to physician practice expense may be out of the practitioner's control. Office space costs in Manhattan, for example, would be considerably higher than those in rural Missouri. Medicare uses the Geographic Practice Cost Indexes adjustment to compensate for differences in physician inputs, such as practice cost, physician work, and malpractice (101). A uniform cap for the entire country could help force excessive costs downward (102) but would also unfairly disadvantage people in areas where medical costs are highest. One possibility would be to adjust a cap on tax exclusions for ESI and/or tax credits to purchase health coverage to reflect geographic variations based on the Geographic Practice Cost Indexes used by Medicare (103). Another potential way to adjust a cap for cost of living is to establish regional caps. Under such a scenario, the tax exclusion cap on employer-provided health insurance purchased in New England would be higher because health insurance is more expensive in that region; conversely, the cap would be lower in the South, where health insurance costs are lower (104, 105). Basing a cap on such regional differences results in a more generous cap for areas of the country that have higher health care expenditures without producing commensurate better health outcomes, while providing a less generous cap for areas of the country with lower expenditures and equal or better outcomes, thereby exacerbating unwarranted variations in health care quality and cost of care.

Conclusion

The tax exclusion for employer-sponsored insurance has helped millions of Americans obtain affordable health insurance through their workplace. However, the current system disproportionately benefits upper-income people and does not benefit low-income people who do not owe income taxes, the self-employed, and people with individual market insurance. A comprehensive health care reform initiative will be expensive, and one way to at least partially fund such an effort is to cap the tax exclusion for employer-sponsored health insurance. Savings from the cap could be directed toward insuring those who do not have insurance coverage. Implementing a cap would need to be done in a way that considers the needs of low-income people who have ESI and should reflect variations in insurance costs due to firm size, health status, and practice expense. Finally, a cap should be coupled with reforms to ensure that a core set of benefits is affordable.

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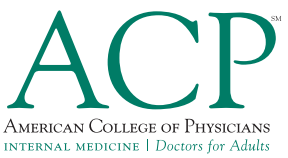

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