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Issue Brief

Progressive or Regressive? A Second Look at the Tax Exemption for Employer-Sponsored Health Insurance Premiums

Cathy Schoen, Kristof Stremikis, Sara Collins, and Karen Davis
The Commonwealth Fund

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For more information about this study, please contact:

Cathy Schoen, M.S.
Senior Vice President
Research & Evaluation
The Commonwealth Fund
E-mail cs@cmwf.org

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ABSTRACT: The major argument for capping the exemption of health insurance benefits from income tax is that doing so will generate significant revenue that can be used to finance an expansion of health coverage. This analysis finds that given the state of insurance markets and current variations in premiums, limiting the current exemption could adversely affect individuals who are already at high risk of losing their health coverage. Evidence suggests that capping the exemption for employment-based health insurance could disproportionately affect workers in small firms, older workers, and wage-earners in industries with high expected claims costs. To avoid putting many families at increased health and financial risk, and to avoid undermining employer-sponsored group coverage, any consideration of a cap would have to be combined with coverage for all, changes in insurance market rules, and shared responsibility for financing.

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OVERVIEW

Eliminating or capping the exemption, or exclusion, of employer-based health insurance from personal and Social Security taxes has often been described as progressive tax policy, and as one way to raise revenue for an expansion of coverage.[1] This issue brief assesses some of the implications of proposals to change the tax treatment of employer-sponsored health plans by reviewing current sources of variation in insurance premiums. It also uses recent data on the benefits of the current income-based tax exemption in order to examine the tax incidence effect—the change in tax as a share of income—of eliminating the exemption.

Our analysis finds that given the state of insurance markets and present variations in premiums, limiting the current exemption could adversely affect individuals who are already at high risk of losing their health coverage. Evidence

suggests that capping the exemption for employment-based health insurance could disproportionately affect workers in small firms, older workers, and wage-earners in high-risk industries (those with high expected claims costs, such as farming and construction). Without adjusting for cost of living, such a cap would also disproportionately affect those working in high-cost geographic areas.

Claims that the current tax treatment of health insurance benefits is regressive are typically based on changes in absolute tax dollars rather than changes in tax rates. In economics, tax increases are defined as "progressive" if they represent a greater share of income for higher-income households. Defined as a share of income, the value of the current tax exemption is larger for low- and middle-income households with employer-provided coverage than for high-income households. Elimination of the exemption would thus introduce a much greater increase in federal tax liability for households with incomes below $50,000 than for those with incomes above $200,000, and increase the tax rate of lower-income households with employer coverage *more* than those higher-income households. Therefore, a cap on the tax exemption of health benefits would represent a regressive—not progressive—change in tax policy.

CAPPING THE EXEMPTION: REVENUE FOR FINANCING A COVERAGE EXPANSION

The major argument for capping the exemption of health insurance benefits from income tax is that doing so will generate significant revenue that can be used to finance an expansion of health coverage. The Congressional Budget Office (CBO) estimates that the existing personal income and payroll tax exemptions for employee health benefits resulted in $246 billion of forgone federal revenue in 2007.[2] These exemptions translate into tax savings that are divided among workers and their employers. Projections by the CBO and congressional Joint Committee on Taxation show that workers with employment-based health benefits will save roughly $145 billion to $175 billion in individual income taxes in FY2009, while both employees and businesses will save approximately $100 billion in payroll tax.[3] Five-year (2008–12) estimates of uncollected revenue run from $799 billion to $835 billion.

The CBO further estimates that limiting the exemption for employer-provided health benefits to the 75th percentile of health insurance premiums, and indexing the cap to inflation, would save $452.1 billion over the 10-year period 2009–18.[4] In examining a range of potential revenue sources in the context of comprehensive health reform, a recent Commonwealth Fund report analyzed the revenue effect of capping the tax exemption at the premium level of a nationwide benchmark health plan offered to everyone within a national health insurance exchange implemented along with broad insurance market reforms (e.g., community rating and pooling of health risks).[5] Taxing health benefits in excess of the benchmark plan premiums of $3,000 for single coverage and $9,000 for family coverage was projected to generate $344 billion over the 2010–2019 period. Phasing down the tax exemption for workers with incomes between $250,000 and $500,000 and eliminating the exemption above $500,000 were projected to generate $24 billion during that same period.

CONCERNS WITH CAPS: PREMIUM VARIATION BY FIRM SIZE, REGION, AND RISK

While eliminating or limiting the exemption for employer-provided health benefits would generate a significant amount of federal revenue, any change to the current tax policy must be carefully assessed for potential unintended consequences. Employment-related group insurance is currently the primary source of coverage for the under-65 population, insuring two-thirds of working-age adults, and the tax exemption for such coverage has helped support the pooling of health risks and group health insurance.

Some believe that the current exemption should be limited to create incentives for individuals to select less-comprehensive insurance benefits or more cost-effective health plans. The concern is that the tax subsidy for premiums may, at the margin, undermine

incentives to choose higher-value, lower-cost health plans.[6] This view often assumes that health insurance benefits in plans with premium costs that are above the national average are "excessive."

In truth, however, many so-called "gold-plated" health benefit premiums are high only because insurance costs vary according to the size of the firm, the geographic region in which it is located, and the composition of the employer's risk pool.[7] In today's insurance markets, establishing a universal cap will have a disproportionate impact on workers in small firms, high-cost areas, and expensive risk pools.[8]

Firm size. Without economies of scale and the ability to pool risk broadly, small businesses tend to pay higher premiums, despite having less-comprehensive benefits. Recent analysis of Medical Expenditure Panel Survey (MEPS) data for employers, conducted by Paul Fronstin of the Employee Benefit Research Institute (EBRI), shows that the average total premium for employee-only coverage in a business with fewer than 10 workers was $4,498 in 2006, about 10 percent greater than the average premium in firms with more than 1,000 workers (Exhibit 1). Research by Jon Gabel demonstrates that this excess cost is not going toward additional "gold-plated" coverage.[9] Overall, the higher average premiums paid by small businesses typically buy *less*-comprehensive benefit packages with much higher deductibles and cost-sharing. Capping the tax exemption at the "average" premium could thus disproportionately increase taxes for employees of small firms, irrespective of their benefit package.

Geographic location. Premiums also vary by where employees live. Analysis by EBRI's Fronstin of the Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Annual Survey shows that, in 2008, the average total health insurance premium for family coverage in the Northeast was $13,656, while coverage for a family in the South averaged $12,252 (Exhibit 2). Furthermore, premiums for MediGap policies with the same benefits also vary widely—an indication that underlying health care markets and costs, rather than benefit design, are driving premium variations.

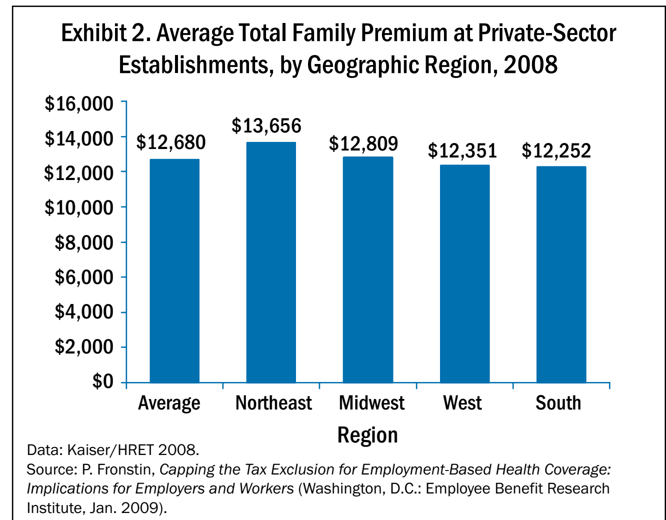


Exhibit 2. Average Total Family Premium at Private-Sector Establishments, by Geographic Region, 2008

Data: Kaiser/HRET 2008.
Source: P. Fronstin, *Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employers and Workers* (Washington, D.C.: Employee Benefit Research Institute, Jan. 2009).

A uniform cap at the national average would thus increase taxes in higher-cost states and regions. Even if policies were put in place to moderate costs in expensive health care markets where there is evidence of inefficient or wasteful care, without adjusting for the cost of living the cap would still disproportionately affect workers living in high-cost areas.

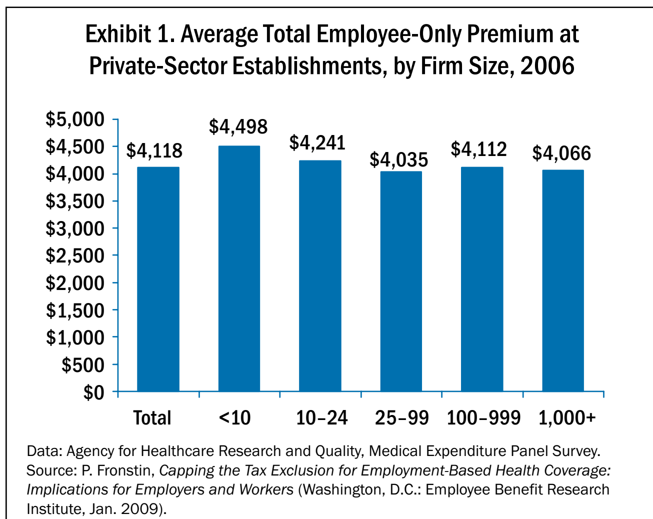


Exhibit 1. Average Total Employee-Only Premium at Private-Sector Establishments, by Firm Size, 2006

Data: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.
Source: P. Fronstin, *Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employers and Workers* (Washington, D.C.: Employee Benefit Research Institute, Jan. 2009).

Risk pool. The composition of an employer's risk pool is directly correlated with the employees' coverage premium. Through the process of medical underwriting, insurance companies charge higher premiums to groups with larger expected claims costs, resulting in premiums that vary by age and health.[10] Individuals

employed by a firm where workers are sicker or older than the norm, or where all workers face higher health risks, are likely to face higher premiums than individuals insured in a lower-risk group. A non-targeted cap on the employer-provided health benefits exemption would result in additional taxes for workers in high-cost groups, even though their benefits may be equivalent to, or worse than, those received by their counterparts in lower-cost groups.

Without substantial market reforms, a uniform cap would have the unintended consequence of differentially taxing benefits for workers in small firms, old and high-risk groups, and high-cost geographic areas. Although it would be possible to adjust for some of these factors, the technical challenge of varying limits in the tax code and the complications encountered while attempting to value health benefits under now-repealed Section 89 of the Tax Reform Act of 1986 may give policymakers pause.[11]

REGRESSIVE CONSEQUENCES OF ELIMINATING THE CURRENT EXEMPTION

Eliminating the current tax exemption for employer-provided health benefits would also have important, often overlooked regressive consequences for low- and middle-income individuals and families. While the average tax subsidy for health benefits in absolute dollars is larger for workers higher on the income ladder, the subsidy amounts to nearly 10 percent of after-tax income for very low-wage workers and only 1 percent of after-tax income for workers earning more than $200,000 a year (Exhibits 3 and 4).[12] Although it is true that low-income workers are far less likely than high-income workers to have employment-based health insurance, the value of the current tax treatment is high as a share of income for low- and middle-wage workers that have such health benefits.[13] Further, tax changes in the context of health reform that requires employers to provide health insurance to workers or contribute to a fund would result in nearly all workers receiving coverage from their employers.

Employers typically pay the same premium for health insurance for all eligible workers, irrespective of income level, although payments vary based on whether the plan is for single or family coverage. Over the past decade, premiums have generally increased far faster than wages.[14] As a result, employer payments for health insurance premiums represent a substantial share of total compensation for low-and middle-income employees and a much lower share for upper-income employees and corporate executives.[15] Thus, the federal tax exemption for employer-paid premiums is of particular value to low-wage and middle-income workers and their families.

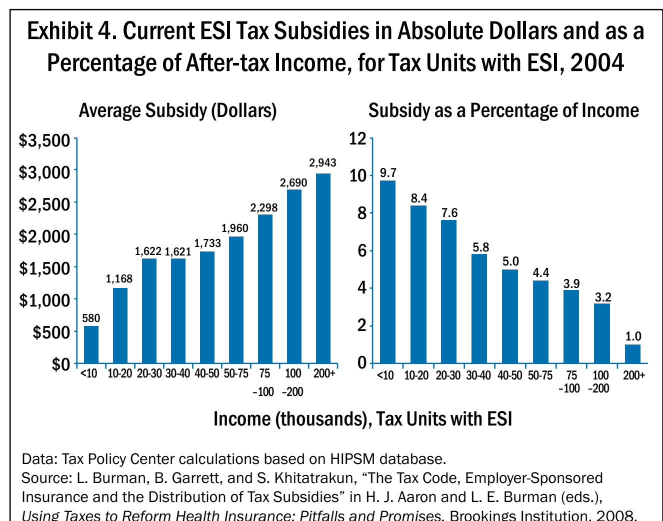
Currently, premium payments for employer-sponsored plans are exempt from Social Security taxes as well as federal income taxes. This exemption is especially valuable to low- and middle-income employees, because all of their income is subject to Social Security taxes. As of 2009, employees pay a

Exhibit 3. ESI Tax Subsidies in Absolute Dollars and as a Percentage of After-tax Income, for Tax Units with ESI, 2004

Income	Average Subsidy	Subsidy as a Percentage of After-Tax Income
Less than $10,000	$580	9.7%
$10,000–$20,000	$1,168	8.4%
$20,000–$30,000	$1,622	7.6%
$30,000–$40,000	$1,621	5.8%
$40,000–$50,000	$1,733	5.0%
$50,000–$75,000	$1,960	4.4%
$75,000–$100,000	$2,298	3.9%
$100,000–$200,000	$2,690	3.2%
$200,000 and over	$2,943	1.0%
All	$1,945	3.5%

Data: Tax Policy Center calculations based on HIPSM database.
Source: L. Burman, B. Garrett, and S. Khitatrakun, "The Tax Code, Employer-Sponsored Insurance and the Distribution of Tax Subsidies," in H. J. Aaron and L. E. Burman (eds.), *Using Taxes to Reform Health Insurance: Pitfalls and Promises,* Brookings Institution, 2008.

Exhibit 4. Current ESI Tax Subsidies in Absolute Dollars and as a Percentage of After-tax Income, for Tax Units with ESI, 2004



Data: Tax Policy Center calculations based on HIPSM database.
Source: L. Burman, B. Garrett, and S. Khitatrakun, "The Tax Code, Employer-Sponsored Insurance and the Distribution of Tax Subsidies" in H. J. Aaron and L. E. Burman (eds.), *Using Taxes to Reform Health Insurance: Pitfalls and Promises,* Brookings Institution, 2008.

6.2 percent FICA tax for Social Security and employers pay an additional 6.2 percent on incomes up to $106,800. Employees with incomes below this threshold would therefore pay additional FICA tax (as well as additional income tax) on employer-paid premium amounts if these were not exempt.

Eliminating the health benefits exemption would substantially increase federal tax liability for those lower- and middle-income families who receive health benefits through their jobs. Preliminary analysis by the Urban Institute and Brookings Institution indicates that workers with employer-sponsored insurance who earn between $30,000 and $40,000 per year would see total federal tax increases of 48 percent. Eliminating the exemption for workers with employer-provided health benefits who earn between $40,000 and $50,000 and between $50,000 and $75,000 would increase tax liability by 28 percent and 20 percent, respectively (Exhibit 5).

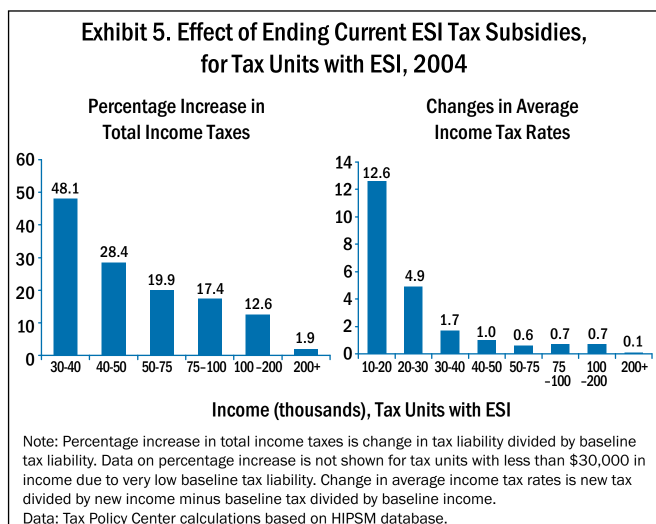


Exhibit 5. Effect of Ending Current ESI Tax Subsidies, for Tax Units with ESI, 2004

Note: Percentage increase in total income taxes is change in tax liability divided by baseline tax liability. Data on percentage increase is not shown for tax units with less than $30,000 in income due to very low baseline tax liability. Change in average income tax rates is new tax divided by new income minus baseline tax divided by baseline income.
Data: Tax Policy Center calculations based on HIPSM database.

The resulting total change in average federal income tax rates—defined as (after-repeal tax liability)/(after-repeal income) – (baseline tax liability)/(baseline income)—would also be greater for low-wage workers who have employer-paid health benefits. The average income tax rates are projected to increase by 5 percent to 13 percent of income for families with incomes below $30,000 (12.6 percent below $20,000) and 1 percent to 2 percent for families with incomes between $30,000 and $50,000. Meanwhile, those with incomes in excess of $200,000 will see an average change in tax rates of only 0.1 percent.

CONCLUSION: COSTS AND CONSEQUENCES

Changes to the federal income tax treatment of health insurance benefits were a feature of many leading health reform bills in the 110th Congress and are likely to continue to be proposed in the 111th.[16] While modifications may bring significant increases in federal revenue that could be used for coverage expansion, any change to the current tax policy must be carefully targeted.

As shown in this brief, high premiums are not an indication that insurance coverage is excessive or that a plan is "gold-plated." Moreover, it was shown that establishing a universal cap on the tax exemption for health benefits would have a disproportionate impact on workers in small firms, high-cost areas, and expensive risk pools. To avoid putting sicker, older, and low- or modest-income families at increased health and financial risk, and to avoid potentially undermining current employer-sponsored pooled-risk group coverage, any consideration of a cap would have to be combined with coverage for all, changes in insurance market rules, and shared responsibility for financing. In the context of market rules that require community rating and broadly pooled risk, a cap pegged to a benchmark-quality health plan could potentially avoid disproportionately increasing taxes on employees working for small businesses or on employee groups with a higher health risk. And by requiring employers either to provide health coverage or to contribute to an insurance trust, the risk that a cap might unravel financial support for health benefits could be avoided.

Still, this source of revenue for financing a coverage expansion would continue to be more regressive that other potential sources. Even with the implementation of comprehensive insurance reform, it would be important to recognize that changing the current tax treatment of employer-provided health benefits will have consequences for low-income individuals and families. Viewed from the perspective of tax increases as a share of income, eliminating the tax

exemption for employee health benefits would be a regressive—not progressive—tax policy change. The current exemption represents a larger tax break as a percentage of income for low-income households with employer coverage and a smaller tax break for higher-income households. Eliminating it would thus increase the tax burden on low-income households, as a percentage of income and as a percentage of current tax liability, more than it would for higher-income households.

Notes

[1] B. Lyke, *The Tax Exclusion for Employer-Provided Health Insurance: Policy Issues Regarding the Repeal Debate* (Washington, D.C.: Congressional Research Service, Nov. 2008), p. 2.

[2] Congressional Budget Office, *Budget Options, Volume 1: Health Care* (Washington, D.C.: CBO, Dec. 2008), p. 23.

[3] U.S. Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2008–2012* (Washington, D.C.: U.S. Government Printing Office, Oct. 2008); CBO, *Budget Options,* ibid.

[4] CBO, *Budget Options*, 2008, p. 24.

[5] Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

[6] B. Lyke, *Tax Exclusion,* 2008, p. 12.

[7] P. Fronstin, *Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employers and Workers,* (Washington, D.C.: Employee Benefit Research Institute, Jan. 2009), p. 11.

[8] Insurance companies, for example, charge higher premiums for industries with greater likelihood of physical injury, safety hazards, or catching infectious diseases.

[9] J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs*, May/June 2006 25(3):832–43; J. Gabel and J. Pickreign, *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees* (New York: The Commonwealth Fund, April 2004).

[10] S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. H. How, and A. L. Holmgren, *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: The Commonwealth Fund, June 2005).

[11] P. Fronstin, *Capping the Tax Exclusion*, 2009, p. 15.

[12] L. E. Burman, B. Garrett, and S. Khitatrakun, "The Tax Code, Employer-Sponsored Insurance and the Distribution of Tax Subsidies," in H. J. Aaron and L. E. Burman (eds.), *Using Taxes to Reform Health Insurance: Pitfalls and Promises* (Washington, D.C.: Brookings Institution, 2008).

[13] The likelihood of having employment-based health insurance increases with income. Analysis of the March Current Population Survey, 2001–2008, by Elise Gould, Economic Policy Institute, in S. R. Collins, "Rising Health Care Costs: Implications and Prospects for U.S. Health Reform," presentation to the Manufacturers Alliance/MAPI Presidents Council Meeting, Nov. 20, 2008.

[14] Commonwealth Fund Commission, *Path to High Performance*, 2009, p. 12.

[15] B. G. Auguste, M. Laboissiere, and L. T. Mendonca, *How Health Care Costs Contribute to Income Disparity in the United States* (San Francisco: McKinsey Global Institute, March 2009).

[16] S. R. Collins, J. L. Nicholson, and S. D. Rustgi, *An Analysis of Leading Congressional Health Care Bills, 2007–2008: Part I, Insurance Coverage*, (New York: The Commonwealth Fund, Jan. 2009).

About the Authors

Cathy Schoen, M.S., is senior vice president for research and evaluation at The Commonwealth Fund and research director for The Commonwealth Fund Commission on a High Performance Health System, overseeing the Commission's Scorecard project and surveys. From 1998 through 2005, she directed the Fund's Task Force on the Future of Health Insurance. She has authored numerous publications on policy issues, insurance, and health system performance (national and international), and coauthored the book *Health and the War on Poverty.* She has also served on many federal and state advisory and Institute of Medicine committees. Ms. Schoen holds an undergraduate degree in economics from Smith College and a graduate degree in economics from Boston College. She can be e-mailed at cs@cmwf.org.

Kristof Stremikis, M.P.P., is research associate for the president of The Commonwealth Fund. Previously, he was a graduate student researcher in the School of Public Health at the University of California, Berkeley, where he evaluated various state, federal, and global health initiatives while providing economic and statistical support to faculty and postdoctoral fellows. He has also served as consultant in the director's office of the California Department of Healthcare Services, where he worked on recommendations for a pay-for-performance system in the Medi-Cal program. Mr. Stremikis holds three undergraduate degrees in economics, political science, and history from the University of Wisconsin at Madison. In May 2008, he received a Master of Public Policy degree from the Goldman School at the University of California, Berkeley. He can be e-mailed at ks@cmwf.org.

Sara R. Collins, Ph.D., is assistant vice president at The Commonwealth Fund. An economist, she is responsible for survey development, research, and policy analysis, as well as program development and management of the Fund's Program on the Future of Health Insurance. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine, Division of Health and Science Policy. Earlier in her career, she was an associate editor at *U.S. News & World Report*, a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. She holds an A.B. in economics from Washington University and a Ph.D. in economics from George Washington University. She can be e-mailed at src@cmwf.org.

Karen Davis, Ph.D., is president of The Commonwealth Fund. She is a nationally recognized economist with a distinguished career in public policy and research. In recognition of her work, Ms. Davis received the 2006 AcademyHealth Distinguished Investigator Award. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, where she also held an appointment as professor of economics. She served as deputy assistant secretary for health policy in the Department of Health and Human Services from 1977 to 1980, and was the first woman to head a U.S. Public Health Service agency. A native of Oklahoma, she received her doctoral degree in economics from Rice University, which recognized her achievements with a Distinguished Alumna Award in 1991. Ms. Davis has published a number of significant books, monographs, and articles on health and social policy issues, including the landmark books *Health Care Cost Containment; Medicare Policy; National Health Insurance: Benefits, Costs, and Consequences;* and *Health and the War on Poverty.* She can be e-mailed at kd@cmwf.org.

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