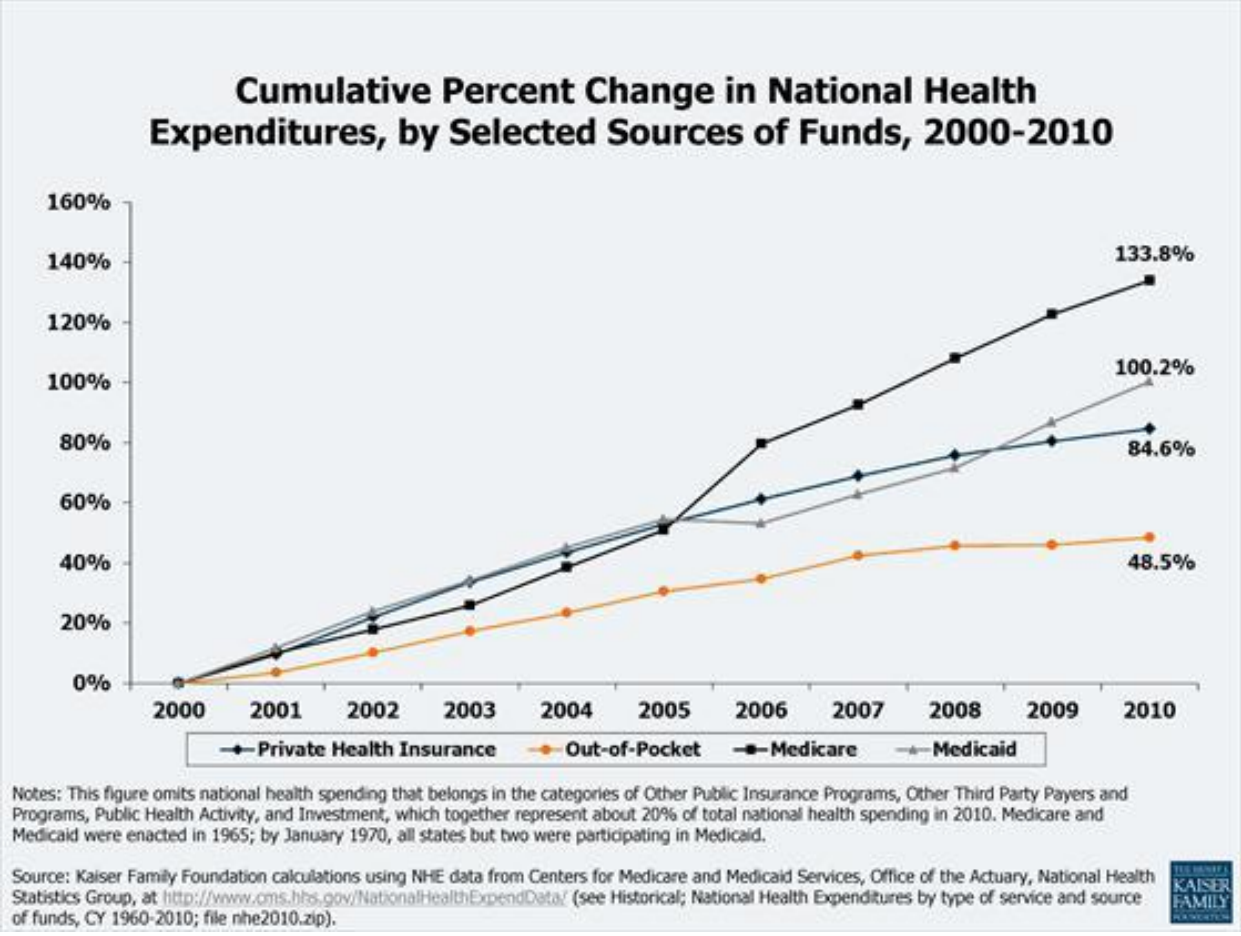
Reforming the Employer-Sponsored Insurance Tax Exclusion

Ryan Hill *August 2, 2012*

Health reform efforts in the United States have recently focused on two troubling and related problems: the rapidly increasing costs of medical care and the lack of health insurance for up to 50 million individuals. The Obama administration has focused almost exclusively on expanding coverage to all Americans through government provision of insurance through larger Medicaid enrollments and subsidized private insurance. Despite the claim of "affordable care" in the title of his signature health law, the reform includes very few specific provisions that tackle rapidly increasing medical spending. Since 1970, health care costs per capita have grown an average 2.4 percentage points faster than the GDP. The share of economic activity devoted to health care now represents 17.9% of GDP, up from 7.2% in 1970.[i] Figure 1 shows that these alarming trends have only gotten worse in the past decade. One of the most likely causes of rapidly increasing costs is built into the culture and policies of American health care: employer-sponsored insurance (ESI) and its accompanying tax exclusion. This paper will examine the positives and negatives of the ESI tax exclusion, the possibilities for reform, the potential revenue from removing or limiting the exclusion, and the political challenges to reform.



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History of Employer-Sponsored Insurance

Just under half of all Americans - 149.8 million people – are covered by some form of health insurance provided by an employer. The figure is even higher for under-65 adults, with almost 60% covered by ESI. This group is covered by a variety of plan types from traditional insurance to managed care schemes such as HMOs and PPOs. Only 6% of adults are covered by a health plan that they purchased on the individual market.[ii] The prominence of employer provided insurance has only developed in the past 70 years. During World War II, Congress passed the Stabilization Act of 1942 which included anti-profiteering wage controls on most American businesses. With wages frozen, firms began offering health benefits to entice the most competitive employees and efficiently compensate the labor market. Even after the wage controls ended, offering company health insurance continued as a useful fringe benefit to attract workers into large companies. Since the benefits were not technically considered wages, there was some uncertainty as to how the premiums paid for by employers should be treated in the tax code. In 1954, Congress amended the tax code by including Section 106(a), which stated: "General rule – Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan."[iii] This law created what has become known as the employer-sponsored insurance (ESI) tax exclusion, which affirms that all health benefits provided by an employer, including premiums paid directly from the company, are exempt from income and payroll taxes.

The tax exclusion has given a significant built-in preference for employer health insurance plans over any other type of coverage. If an individual wants to purchase insurance on the private market, she will pay the premium with income that has already been taxed between 10% and 35% of earnings. If she enrolls in a plan through her employer, the ESI exclusion ensures that the premium would be paid directly without any reductions for income taxes. If the plans are of relative value, the individual will rationally opt to choose the employer plan. It should be noted that self-employed individuals can receive the full ESI exclusion. There is also an itemized deduction available to any individual who pays for medical expenses out of pocket if the cost is greater than 7.5% of earned income and greater than the standard deduction. The use of itemized deductions is rare, and only about 7% of all filed returns claim the medical expense deduction.[iv] Both Republicans and Democrats have supported policies that foster an individual market for health insurance, but the ESI exclusion provides enough advantage to employer plans that individual plans are still rare.

Pros of Employer-Sponsored Insurance

Undoubtedly, the rise of employer-sponsored health plans during and after World War II dramatically increased the number of Americans that had access to health insurance. In 1940, only about 20% of the population was covered by some form of health insurance; by 1960, that figure had increased to 75% of the country.[v] Employer plans are convenient to enroll in and remain the most affordable plan for most people, due in part to the tax exclusion.

ESI plans also help resolve the market failure of adverse selection associated with insurance pools. Since every individual has different health needs and risks, some enrollees in an insurance pool will cost more to cover than they pay in premiums, and others will pay more in premiums than they will receive in care. In an individual market, insurance pools can be unsustainable because the healthier individuals will refuse to pay a high average premium and drop out of the market. Unless there is some mechanism to keep them in the pool (such as an individual mandate) the market will experience an upward spiral of increasing premiums that will

leave only the least healthy individuals in the pool. Large firms and unions that offer health insurance act as a built in pooling mechanism since the firm is the payer for all employees. Most companies do not give their employees the option of opting out of health coverage in return for higher wages, so there is little incentive to decline the insurance. The advantage of automatic pooling is most prevalent in very large firms with many employees. Small businesses often do not employ enough people to spread health risks and maintain a sustainable insurance pool.

Cons of Employer Sponsored Insurance

Although the rise of employer-sponsored health insurance helped insure millions of previously uncovered Americans, it may also be preventing the final 50 million individuals from receiving coverage today. As mentioned earlier, many individuals struggle to buy their own insurance on the private market because of the steadily increasing costs of health care. This trend can be credited to numerous endogenous and exogenous factors, including the fee-for-service payment structure in Medicare, lack of competition among insurers and care providers, and a general lengthening of life expectancies. But one of the primary culprits is the overuse of medical care caused by the prevalence of traditional insurance offered by employers.

Encourages Overutilization and Spending

Overspending on medical care is created by an economic market failure called moral hazard. This occurs because the true costs of care are shielded from the consumer by a separate payer, the employer. For example, if an individual is covered by a traditional plan offered by her employer, she will have all medical expenses covered by the premiums paid by the company. Therefore, when she is deciding whether to get one extra MRI or choose an expensive surgery over an equally effective round of physical therapy, she does not have to consider the economic costs of her decision. Whichever treatment she chooses, the insurer will pay for it, so she will probably choose to get as much extra care as she can. If she paid her own medical expenses, she would only choose to receive the care that she felt was worth it for the price she was paying. Many health reformers have stated this as the need to "get more skin in the game", or restructure plans so that individuals will have to bear some of the costs of their care. A common method is to attach a deductible or co-payment so that the individual has to pay a portion of their coverage. High deductible plans only offer coverage for catastrophic health expenditures, and all other costs must be covered by the consumer. These plans are often connected to a health savings account (HSA) that allows the consumer to save up for future non-catastrophic medical needs. Unfortunately, most employers have very low deductibles, which encourage moral hazard. As of January 2012, only 13.5 million people were covered in a certified high deductible plan with a health savings account. That percentage is slowly increasing, up from 6.1 million in 2008 and only 1 million in 2005.[vi]

A RAND corporation health insurance experiment correlated high deductibles with decreased health spending. They tracked the health spending patterns of 6,000 people for six years. Half of the subjects were enrolled in a traditional plan with no deductible or co-pay, and the other group had a 95% co-payment for outpatient services. The study showed that per capita expenses were 31% less for those in the cost-sharing plan as compared to those in the traditional plans, and their health outcomes were not adversely affected.[vii]

The tax exclusion offers very little incentive for individuals to enroll in plans with high deductibles or cost sharing. Two studies suggest that eliminating the tax exclusion for premiums could result in a 41-65 percent increase in the coinsurance rate, which could lead to a 9-38 percent reduction in health spending by

the privately insured.[viii] This increase in coinsurance rates would help policymakers accomplish the goal of affordable care and more extensive coverage.

Regressive Tax Treatment

The ESI tax exclusion not only encourages overspending and overuse of medical services, but it is inherently an inequitable structure of the tax code. Public opinion, policy, and political norms suggest that taxes should be somewhat progressive by income. Tax codes at the federal, state, and local level are structured so that higher wage-earners pay higher income, property, capital gains, and luxury taxes. The income tax is very obviously progressive, with low income households paying as little as 10% and high income households paying up to 35%. It is this same graduation of income taxes that makes the ESI exclusion inherently income regressive. If an employer pays $10,000 in health premiums a year for all employees regardless of salary, the high earners will get an effective tax deduction of $3,500 while the low earners will get a smaller exemption of $1,000. Even if the exclusion were equal for all wage earners, upper income workers receive more health benefits on average, and thus benefit more from the exclusion. One study found that 89.6% of workers with incomes over 400% of the federal poverty line were eligible for employer coverage compared to only 39.8% with incomes below the poverty line. Of those that were eligible, 83% of the high income group accepted coverage compared to only 63.5% in the lower bracket.[ix] The federal government is essentially subsidizing the benefits of the upper class with the health insurance exclusion.

Improving the economic incentives in the marketplace is reason enough to limit or remove the tax exclusion all together. However, the more politically viable motive for reforming the tax code is to raise revenue that can fund other health reforms. The ESI tax exclusion is the highest expenditure of the Internal Revenue Service in the American tax code. The Joint Committee on Taxation estimated in 2007 that the total cost of the exclusion is $246.1 billion per year. Of the total, $145.3 billion is from income taxes and $100.7 billion is from the Federal Insurance Contributions Act, or common payroll taxes.[x] These figures are simply the total value of the taxes that are excluded from tax filings by individuals and businesses. Repealing Section 106(a) would not necessarily recoup all of this revenue at once, since individuals and firms would change behavior to limit the new tax incidence. However, micro-simulation models of the marketplace have estimated the amount of revenue that could be recovered (as described below).

Reforming the Tax Exclusion

There are many different strategies that have been proposed for reforming the ESI exclusion. A simple repeal of Section 106(a) would make employer-sponsored health plans taxable to employees for the federal income tax. However, section 106(a) also contains the tax exclusion for disability insurance, which would likely be preserved in any reform effort. A full repeal would lead to some unwanted side effects. For example, many employers are switching to more cost-effect high deductible plans and health savings account. Removing the exclusion completely would incidentally hurt employers that are attempting to control costs. On-site doctors and wellness programs would also become taxable, and the federal government should have an interest in continuing to subsidize those initiatives.

Another option for reform is limiting or capping the exclusion at some value of yearly premiums paid. For example, George W. Bush proposed a reform that would replace the exclusion with a standard deduction for health insurance of $7,500 for self-only coverage or $15,000 for family coverage. The JCT estimated that

the proposed cap (coupled with a handful of other reforms in the plan) would result in a net revenue increase of over $440 billion from FY2009 through FY2018.[xi] This method would accomplish many of the goals of reforming employer-sponsored insurance, even if the tax benefit is partially preserved. Companies will be incentivized to limit benefits to keep the premium under the cap. This will result in more companies offering high deductible plans with savings accounts or managing care in a way that will reduce health spending.

A cap or limit on the exclusion is also useful because it is a tax that can generate revenue without being collected directly. If companies reform their health benefits to stay below the standard deduction, the savings will be passed on to employees in the form of higher wages. A portion of these wages can then be recouped as taxable income. A full removal of the exclusion would have even larger revenue effects and it would improve incentives for health spending, but the cap is more politically palatable in a reform effort.

The Urban institute did a comprehensive study of the revenue possibilities of limiting or removing the ESI exclusion. The estimates come from the Urban-Brookings Tax Policy Center Microsimulation Model[xii] (see reference for detailed explanation of methods). They structured the possible reform using two important policy design elements: the initial size of the cap and the method of indexing the future rate of cap growth. They considered two likely possibilities for the size of the initial cap: capping the exclusion at the median premium level or capping it at the 75th percentile of premium rates in the country. Since that cap has to increase over time to stay consistent with economic growth, they suggested four possible indices for increasing the cap in the future: No growth, or "unindexed", CPI (general inflation), GDP growth, and rate of medical expense growth. Any combination of these models is a plausible policy prescription, and the study simulates the possible tax revenues under each combination. The results for the first year revenues and 10-year estimates are shown below in Table 1.

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

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

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-1).
Notes: Baseline is current law. See text for reform option descriptions and the median and 75th percentile of premiums for single coverage, single-plus-one coverage, and family coverage.

An important consideration for the policy model chosen is the size of the tax base that would be affected by the chosen cap and index. A high cap would not affect every employer insurance plan in the country, so only certain individuals would pay more in income taxes. For example, capping the ESI exclusion at the 75th percentile of premiums and indexing by medical expenses would create $62 billion more in income tax revenue over ten years as compared to current law. However, only 3% of tax units would be affected by the tax, so the majority of Americans would maintain the ESI subsidy with no change. The same initial cap with a slower index such as GDP growth would generate more revenue over ten years – up to $224 billion – but approximately 40 percent of the tax base would be affected.[xiii] These types of simulations would be necessary as policy makers consider how much revenue they need to generate, and who will bear the brunt of the new taxes.

Creating a standard limit on tax free premium payments would mostly affect upper income workers and avoid lower income workers. This effect can also be assured by only capping the exclusion for income taxes, which are progressive, and leaving the exclusion for payroll taxes, which are generally regressive. A national structure of general limits will also affect families and businesses disproportionately by region, health risks, business size, and other variants. Therefore, the exclusion cap could vary based on geographic area or other characteristics in order to spread out the new tax burden.

A comprehensive health reform should include at the very least a cap if not a full repeal of the employer tax exclusion. The reform would level the playing field for individual insurance plans that are more flexible for individuals and more cost effective. Even employers that continue to offer health benefits will be forced to be more cost-conscious and shift to plans that will improve incentives for sustainable care. However, removing the exclusion may not be the silver bullet to fixing the problems in U.S. health care. A similar reform enacted in Quebec did not lead to immediate positive outcomes. Eliminating their tax exclusion for employer-sponsored *supplemental* insurance (the effects would be slightly different for *primary* health insurance in the American system) led to a decrease of about one-fifth in ESI coverage. Increases in the non-group market enrollment only offset the decrease by about 10-15 percent.[xiv]

Limiting the tax exclusion will and should lead many companies (especially small businesses) to drop coverage for their employees. This will require individuals and families to either move into government coverage or purchase insurance on the individual market. As stated earlier, the individual market struggles to maintain sustainable insurance groups unless there is a pooling mechanism like subsidies or penalties. Fortunately, the potential revenue from capping the exclusion could provide the needed funding for sustainable reforms that would move the uninsured into continuous coverage.

Congress has already attempted to create a framework that will expand coverage for individuals outside of the employer-sponsored market in the Patient Protection and Affordable Care Act (ACA). When the law was passed, it was touted to cover an additional 32 million Americans with quality health insurance.[xv] Half of those would be covered through a new Medicaid expansion, and another large segment through state-run insurance exchanges. The costs of the Medicaid expansion over the next ten years are expected to be $642 billion. The Congressional Budget Office recently re-evaluated the costs of the entire law, which are estimated to be $1,168 billion between 2012 and 2022.[xvi] These staggering costs could be almost completely paid for with an un-indexed median premium cap on the exclusion without any of the other revenue measures enacted in the law.[xvii] As it was written, the ACA will be funded through a bevy of new taxes on insurers, medical innovators, and individuals as well as cuts to physician reimbursements in Medicare. Although the law

currently scores as a net deficit reducer, it will be politically challenging to keep the score positive as reimbursement cuts loom in the future.

Political Constraints to Reform

Reducing the ESI tax exclusion is surprisingly politically neutral. At one point or another, Democratic Senator Max Baucus, President Obama advisor Jason Furman, Republican Congressman Paul Ryan, and former GOP presidential candidate John McCain have all supported limiting the exclusion.[xviii] Both parties recognize that high coverage plans that are typical of the employer market are pushing spending higher. Democrats are primarily concerned with helping those that are left out of the employer market and recognize the opportunities for new tax revenues to fund their reforms. Republicans may be wary of raising taxes on businesses, but also recognize that the market will become more competitive without preferential treatment to certain plans. As the chairman of the Senate Finance Committee, Senator Baucus floated the idea of funding the Affordable Care Act with limits on the ESI exclusion. The plan was quickly scrapped, probably because of the heavy influence of unions on the Democratic Party.[xix] Congress also found it politically challenging to raise taxes directly on consumers or businesses, so they instead created the Health Insurance Excise Tax - commonly known as the Cadillac tax.

The Cadillac Tax is levied on insurance providers and puts a 40% tax on health insurance premiums above $21,000 for families and $8,000 for individuals. Although the tax is collected from insurers, the cost gets passed on to employers and then to consumers. The JCT estimated that the tax would raise $200 billion over the first 10 years. Employers are expected to pare down their high-coverage plans and return the savings to employees through higher wages, which are expected to produce up to $142 billion in additional income tax.[xx] The Cadillac tax is not the ideal way to address the tax preference for employer-sponsored insurance, but it fixes some of the problems built into the system. Employers will have the incentive to adjust plan types so that they will stay under the coverage limit. This should lead to a rise in cost-sharing health plans in the employer market. However, a simple reform of the original tax code would have leveled the playing field more effectively than an additional tax placed on insurers.

Future Reform

Whether the ACA is funded by new excise taxes and Medicare savings or by a reform to the tax exclusion, it does not provide all of the right sustainable policies to improve costs and coverage in the health market. The expansion of the Medicaid program is overly coercive on the states and is another government entitlement that will continue to strain the tenuous fiscal outlook of the country. The program of offering insurance subsidies on federally approved exchanges is a better option, but it still allows government regulators to dictate the coverage requirements of private health insurance.

Another approach to improving the individual market for health insurance is to shift the tax benefits from employers and offer them directly to individuals and families. The government could offer a tax credit for any health insurance purchases directly to the consumer. If the individual wants to maintain the coverage they had under their employer they can do so. But they also have the option of going to the individual market to purchase a plan that meets their health needs and is affordable. The credit would probably be on a sliding scale with higher credits given to low- and middle-income earners, with the credit being phased out for those that are able to purchase their insurance out of pocket. Since many low-income workers are not liable for

income taxes after deductions they would not benefit as much from the tax credit. Therefore, a "defined contribution" subsidy could also be used in place of the tax credit. This would be a set subsidy that could be used to purchase a plan on the individual market. If the family wants to purchase a plan that is cheaper than the subsidy, then they could pocket the savings. If they are inclined to purchase a plan with a higher premium and more generous coverage, then they could pay for the difference out of pocket. This maintains an incentive to shop around for insurance which will inject more competition into the market, further reducing costs. People will have the added advantage of carrying their insurance with them from job to job. With a more mobile and transient society, it is a challenge to maintain effective coverage from job to job, and the individual insurance market can fix that. The government can also incentivize people into plans that are more cost-effective. The tax savings could be directed specifically at health savings account. This will make high deductible plans more attractive and encourage people to save for future health needs.

What stands in the way of reforming the tax exclusion? Limiting or removing the ESI tax exclusion is not by nature a policy problem, it is a political problem. Lawmakers in both parties see it as a responsible reform and a revenue stream for future health reform. Part of the problem is that the exclusion primarily benefits the upper class. Most of the very politically involved business elite will fight to maintain the low taxes on their health insurance. Unions also consider health benefits to be one of their greatest bartering chips in collective bargaining, and will adamantly oppose any effort to remove it. The largest obstacle to reform however is the public perception of employer-sponsored insurance. Americans have never participated in an insurance market that does not tie the consumer to an employer-sponsored plan. Many people appreciate and prefer the plan given by their employer and most do not want to go through the hassle of shopping for an individual policy. Inevitably, the touchstone for any health reform will be this simple guarantee promised by President Obama in 2009: "If you like your health care plan, you can keep your health care plan."[xxi] Even if removing the exclusion will fix cost and coverage problems, it can only be done if some employers drop coverage and people move into the individual market. The Wall Street Journal reported a headline that cited a Deloitte study: "One in 10 Employers to Drop Health Coverage." To a health policy expert, this headline is a sign that policy reform is moving people into more efficient plans which will bend the cost-curve. But for the average voter, the headline gives the premonition of failed reform and an inept health system.

Reform will probably require some shift in the political equilibrium. The current fiscal crisis and clamor for budgetary reform may give lawmakers the political clout to finally push through a bipartisan reform to the tax code. Limiting the ESI exclusion will probably require a comprehensive reform to the tax system. If it is coupled with tax concessions to the upper class and unions, it may be able to pass. Such a reform will reduce health care spending, curb costs, and extend coverage to more Americans.

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