EBRI ISSUE BRIEF

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REVISING THE FEDERAL TAX TREATMENT OF EMPLOYER CONTRIBUTIONS TO HEALTH INSURANCE: A CONTINUING DEBATE

The longstanding debate over revising the federal tax treatment of health insurance benefits paid by employers remains unsettled. Legislation that would reduce or eliminate the federal tax exemption of employer health insurance contributions has been introduced in Congress and referred to Committee.1/ The Congress may take action on these proposals during this legislative session; if not, similar proposals to reduce tax preferences for employer health insurance contributions are likely to re-emerge in the future.

Limiting tax preferences for employer health insurance contributions has been advocated by two groups: those seeking new revenue sources to reduce federal deficits, and those seeking to control inflation in health care costs. Both groups see the revision of tax preferences for health insurance as an opportunity to garner additional federal revenue, reduce inflationary pressure on health care costs, or both.

This issue brief describes the arguments for altering the current tax treatment of employer contributions to health insurance, as well as the arguments against these proposals. The Issue Brief first analyzes three major issues that have not generally been addressed: (1) The effect of reduced tax preferences on the generosity of health insurance benefits provided by employer group health plans and the use of health care services; (2) the impact on employer costs; and (3) the effect on the rate and distribution of health insurance coverage among workers and their families. Then, the two most common issues are reviewed: (1) the effect on federal tax revenues and the distribution of the federal tax burden; and (2) the effectiveness of tax policy in containing further inflation in health care costs in the context of total public and private spending for personal health care services.

Background: Employer-Provided Health Insurance Coverage and Benefit Growth

Three-quarters of all workers, and nearly 90 percent of all full-time full-year workers, participated in an employer group health insurance plan in 1979. 2/ As a result of the widespread coverage of dependents in employer group plans, more than 60 percent of the total civilian population were covered

by an employer group health plan that year. Nearly 93 percent of those persons received an employer contribution to their coverage.

Several factors have encouraged the growth of employer group health insurance among workers and their families. Scale economies associated with insuring larger employee groups have encouraged the inclusion of lower-income, part-time and seasonal workers in employer group plans. The growth of real marginal tax rates since 1960 has raised the demand for the tax-exempt employee benefits, including employer contributions to health insurance coverage. At the same time, the cost of individually purchased health insurance relative to the cost of employer group coverage has risen as preferred risks (prime-age, working adults and their families) have been absorbed into employer group plans. As a result of these factors, employer group health insurance has become the primary source of private health insurance coverage in the United States. In 1979, more than 82 percent of all persons with private health insurance were covered by an employer group plan.

Since 1965, employer contributions to health insurance as a share of total compensation has doubled. This growth has alarmed some who see the growth of health insurance benefits as an erosion of the tax base, and as a threat to the public sector's ability to finance government programs. In addition, growth of employer contributions to health insurance has become popularly equated with the emergence of "generous" health insurance coverage, a corresponding reduction in insured consumers' out-of-pocket health care costs, and increasing stimulus to inflation in health care costs.

At a conceptual level, the growth of employer contributions as a share of compensation can be disaggregated into several components. These include: (1) growth in the share of all workers covered by an employer group health plan, as well as the growth of dependents coverage under these plans; (2) inflation in health care costs that has persistently exceeded increases in average compensation levels; (3) increases in private insurance costs, including the effects of cost-shifting by public-sector insurance programs; and, (4) the enhancement of benefits provided by employer group plans. Although much of the data necessary to measure these components has not been compiled, it is possible to evaluate the contribution of inflation to growth of employer contributions to health insurance.

The growth of real employer contributions to health insurance, (that is, contributions adjusted for the increase in medical care prices in excess of general inflation) is presented in Table 1. Since 1970, real employer contributions -- including growth in the proportion of workers and their dependents covered by employer group plans, insurance costs and benefit enhancement -- have grown at an average annual rate of 5.2 percent (Column 4). The real growth of employer contributions, however, slowed consistently between 1975 and 1982 (Column 5); between 1975 and 1982, real employer contributions to health insurance grew at an average annual rate of less than 3.1 percent (Column 4). Employer adjustments for inflation in health care costs, by comparison, have risen at an average rate of more than 12 percent annually since 1970 (Column 2). Since 1975, the inflation adjustment component of employer contributions to health insurance has accelerated, showing an

abrupt and unusually large increase in 1981: 16.1 percent. This continued into 1982, when more than 14 percent of all employer contributions to health insurance as a share of total compensation reflected the increase in health service prices relative to 1965 levels (Column 3).

Private health insurance benefits in the United States have traditionally been generous. Coverage of hospital care, in particular, has involved little cost-sharing on the part of insured consumers. Federal tax

TABLE 1

Inflationary and Real Components of Employer Contributions to Group Health Insurance Benefits, Selected Years 1965-1982

	Nominal Employer Contributions as a Percent of Compensation	Inflation Adjustment as a Percent of Compensation 1/		Real Benefits and Insurance Cost as a Percent of Compensation	
		Amount	Percent of Contribution	Amount	Percent of Contribution
	(1)	(2)	(3)	(4)	(5)
1965	1.5	-	-	1.5	100.0 2/
1970	1.9	0.1	5.3	1.8	94.7
1975	2.7	0.2	7.4	2.5	92.6
1976	2.8	0.3	10.7	2.5	89.3
1977	3.0	0.3	10.0	2.7	90.0
1978	3.0	0.3	10.0	2.7	90.0
1979	3.0	0.3	10.0	2.7	90.0
1980	3.1	0.3	9.7	2.8	90.3
1981	3.1	0.5	16.1	2.6	83.9
1982	3.5	0.4	14.3	3.1	88.6
Average Annual Growth:					
1970-1982	5.2	12.2	8.6	4.6	-0.6
1975-1982	3.8	10.4	9.9	3.1	-0.6
1980-1982	6.3	15.5	21.4	5.2	-0.9

Source: EBRI estimates from National Income and Product Accounts, U.S. Department of Commerce.

1/ Estimate is based on levels of a fixed-weight price index for personal health care expenditures between 1965 and 1981 constructed by the Division of National Cost Estimates, Health Care Financing Administration, U.S. Department of Health and Human Services. Values of the index are unpublished.

2/ Because base prices are assumed at the 1965 level, all employer contributions to health insurance are allocated to real benefits for 1965.

policy has not discouraged the emergence of generous health insurance plans. At the same time, econometric studies suggest that tax policy has been a relatively minor contributor to the development and growth of these plans. 3/ Nonetheless, both advocates and critics of changing federal tax policy toward employer group health insurance anticipate considerable response to the taxation of either all or part of employer contributions.

Effect on the Generosity of Health Insurance Benefits

The most common argument used in support of taxing all or some employer contributions to health insurance is the potential effect on the generosity of employer group plan benefits. Advocates of a tax "cap" that would limit the tax exemption of employer contributions contend that the tax-exempt status of employer contributions encourages first-dollar coverage of hospital and physician care and broad coverage of discretionary services (regular dental and vision care, for example). They cite the scarce literature on the relationship between insurance prices and the amount of cost-sharing that emerges in individual health insurance coverage, and the relatively abundant literature on the relationship between greater cost-sharing and lower health care utilization and cost. Based on this literature, advocates of revising the tax treatment of employer contributions contend that tax-exempt employer contributions discourage cost-sharing in employer group plans. As a result, health care utilization and costs are greater. Removal of tax exemptions, they conclude, will encourage less complete coverage and lower utilization of health care services. Lower utilization will, in turn, reduce aggregate health care costs and ultimately dampen inflation in health care prices.

Opponents of reduced tax preferences for employer health insurance contributions claim that this argument ignores the complexity of the health services market. They argue that rational consumers are unlikely to reduce coverage for the particular service category -- hospital care -- that drives health care cost inflation. Other service categories -- primary physician coverage, preventive service coverage and routine vision and dental care -- they contend, are more vulnerable than hospital coverage to tax policy that would increase the price of health insurance to consumers. The cost of these services, however, has risen much more slowly than the cost of hospital care. They conclude that a tax cap , if at all successful, is likely to be an inefficient way to contain inflation in health care costs.

These arguments have not been satisfactorily resolved; neither position is based on a substantial body of research. In seeking to break the deadlock, other arguments that might support revising the tax treatment of employer health insurance contributions must be considered.

Impact on Employer Costs

Employer group health plans typically cover most if not all employees of the firm. In spite of potentially wide variations in the health care risks represented by different employees, broad participation in the plan is achieved by keeping the price of coverage to employees low. Survey data on plan

provisions between 1977 and 1980 indicate that more than 80 percent of all plan participants make no contribution to coverage under the plan; more than 60 percent make no contribution for dependents' coverage. 4/

The pooling of risks within employer group plans can generate significant cross-subsidies among employees who participate in the plan. Low-risk employees (for example, men, young employees and those with no history of chronic illness or impairment) receive benefits from the plan that may be considerably lower than the employer's average plan cost. Conversely, higher-risk employees (for example, women, older employees or employees with chronic health problems) receive benefits in excess of the employer's average plan costs. Because low-risk employees pay little or none of the costs of the plan, however, they are indifferent to their subsidization of higher-risk participants in the health plan.

Taxation of employer contributions to health insurance would raise the costs of coverage to participants in employer group health plans. Low (that is, stringent) levels of a tax cap on employer contributions would encourage low-risk employees to reduce their after-tax health care costs by seeking less complete or narrower health insurance coverage. The exit of low-risk participants from existing plans (that is, adverse selection) raises the average risk that plan-stayers represent. As a result, the average cost of the plan rises.

Employers who have objected to the proposed taxation of contributions to health insurance contributions expect taxation to significantly raise their costs of providing health insurance benefits. Increased employer costs might result in several ways. First, employer tax liability under FICA would rise. Increased employer payments to FICA, however, are partly offset by the deduction of FICA payments from corporation income tax.

Second, employers anticipate that workers will respond to taxation of health insurance contributions by demanding higher wages or greater levels of other tax-exempt benefits in an effort to maintain pre-tax compensation levels. The adverse selection of low-risk employees from existing plans, moreover, may generate a second-round increase in employee demand for greater pre-tax compensation. As low-risk plan participants exit from the "standard" plan, the average cost of the plan -- and employer contributions for the remaining participants -- would rise. Employers are likely to be under substantial pressure from employees who benefit from generous plan coverage to continue to offer that coverage. At the same time, equivalent compensation for employees who leave generous plans would rise with increases in the average cost of the "standard" coverage.

Finally, because of pressure from some employees to offer less expensive alternative health insurance coverage, employers foresee increased administrative costs as well as the loss of some scale economies in their group plan benefits. Fragmenting existing employer group plans into a number of smaller plans may increase insurance costs for smaller employers, or reduce the coverage employers are able to provide at current contribution levels.

Impact on the Rate of Health Insurance Coverage

A potentially important problem that arises in the context of higher employer and employee costs for health insurance is the possibility that some employees would lose health insurance coverage altogether. Increases in the employer costs of providing coverage to marginal workers -- part-time or seasonal workers, and workers who are laid off -- suggest increases in the rate at which these workers and their dependents might be excluded from coverage.

To investigate the problem of coverage loss among some workers, EBRI performed a simulation of the rates of health coverage that might emerge among the currently insured population in the absence of an employer contribution. This simulation mimics the situation that might arise if employer contributions were fully taxable. The results indicate that fewer than half of all persons living in households with annual income less than $15,000 (in 1979) would have had private health insurance coverage in the absence of a tax-exempt employer contribution. In addition, periods of unemployment would have had a more significant impact on insurance coverage; even moderate periods of unemployment (12 weeks or less) generate very long lapses in health insurance coverage among individuals and their dependents when re-employment does not provide an employer contribution to health insurance. These factors, together with the significance of family composition in determining private health insurance coverage in the absence of an employer contribution, imply that current tax policy has probably raised "normal" rates of health insurance coverage throughout the population, despite perverse economic and demographic trends.

Impact on Tax Revenue and Burden

Estimates of the tax revenues that might result from the taxation of employer contributions to health insurance have attracted considerable attention. These estimates typically are high and, based on assumptions of continued growth in employer contributions, rise significantly over the next few years. These federal revenue projections vary significantly depending upon the assumptions used and the level of taxation proposed.

The primary assumptions behind projected federal revenue gains from the taxation of employer contributions include: (1) the cost of health insurance coverage, (2) the rate of employer contributions as a percent of cost, and (3) the rate and distribution of health insurance coverage among worker households. The cost factor used for projecting health insurance premiums is an actuarial estimate that rises somewhat faster than projected growth in the medical care component of the Consumer Price Index. The rate of employer contributions as a percent of cost, and the rate and distribution of health insurance coverage, are both assumed to rise slowly after a tax cap is imposed.

Although use of these assumptions probably introduces substantial error into the calculation of potential revenues, virtually any other assumptions would be equally hypothetical. The cost of private health

insurance relies, for example, on the package of health benefits offered by employers, reimbursement arrangements made with providers, and the shortfall of Medicaid and Medicare reimbursements relative to provider costs. All of these factors are undergoing dramatic change. Researchers have not developed a method for accurately predicting the effects of these changes on employers' insurance costs; it is clear, however, that they will affect the ultimate yield of a tax on health insurance contributions. While the assumption of slowing rising employer contributions as a share of plan costs may be realistic, the future rate of increase cannot be calculated with any precision given the revision of tax incentives.

Projected federal revenue gains are also highly sensitive to the particular level of taxation proposed. Congressional Budget Office (CBO) projections of potential revenues indicate that a relatively small increase in the level of contributions exempted from federal income and payroll taxes, might produce a significant drop in projected revenues (see Table 2). The sensitivity of these revenue estimates to modest adjustments in the level of the proposed cap reflects the narrow dollar range of employer contributions to health insurance, and the weak relationship between the size of employer health insurance contributions and household income.

TABLE 2

Sensitivity of Projected Federal Revenues to Selected Tax Exclusion Limits, 1983

Proposed Limit Family/Individual Coverage (per month)	Projected Federal Revenue 1/ (in billions)	Increase in Limit (percent)	Decrease in Projected Revenue (percent)
$120/48	$4.6	-	-
135/54	3.7	12.5	19.6
150/60	2.9	11.1	21.6
165/66	2.3	10.0	20.7
180/72	1.8	9.1	21.7

Source: Congress of the United States, "Congressional Budget Office, Containing Medical Care Costs Through Market Forces," (May 1982), p. 35.

1/ Includes revenues from both individual income and Social Security taxation of simulated employer contributions above the exclusion limit in 1983. Social Security tax revenues represent about one-quarter of total projected tax revenues.

Recent survey data reflect the very narrow range of employer contributions to health insurance among participants in employer group plans. Among all plan participants included in the National Medical Care Expenditures Survey, 75 percent of those with an employer contribution to individual coverage received a contribution amount between $100 and $500 in 1977. 5/ The range of employer contributions to family coverage was comparably narrow. Because the level of employer contributions is nearly the same among most plan participants, modest adjustments to the level of the cap can affect a significant proportion of all persons who receive an employer contribution to coverage.

Employer contributions to health insurance, moreover, are broadly distributed across households at most levels of income. In 1979, the rate of coverage among persons with family income above $15,000 was high (73 percent or more) and varied little by income. 6/ More than 90 percent of all persons with employer group coverage, including persons in the very lowest ranges of family income, received an employer contribution to coverage. As a result, the distribution of employer contributions to health insurance coverage is very similar to the distribution of employer group coverage across the population, with little variation in the dollar amount received by households at different levels of income.

The distribution of tax burden that would result from limiting the tax exclusion of employer contributions to health insurance reflects the flat distribution of employer contributions to health insurance over most levels of family income. Employer contributions that are similar at all income levels represent a larger percentage addition to family income at lower levels of income than at higher levels of income. As a result, limiting the exclusion of employer contributions to health insurance tends to place a heavier tax burden on families at lower levels of income. In general, the federal income tax structure is not sufficiently progressive to offset both the distribution of employer contributions and the regressivity of the Social Security tax on earnings.

CBO's estimates of the tax burden that would result from capping the exclusion of employer contributions to health insurance are presented in Table 3. These estimates indicate that the distribution of tax burden across households at all income levels would be only mildly progressive, and regressive at income levels above $30,000. The mild degree of progressivity over very low levels of income is due primarily to lower rates of employer group coverage among low-income persons with relatively fragmented work force participation patterns.

Among households that would be affected by a cap on the exclusion of employer contributions to health insurance, the tax burden would be severely regressive. As a proportion of income, persons at the lowest levels of income (those reporting less than $10,000), would pay more than six times the amount of additional tax than would persons with incomes over $50,000. The regressive impact of taxing employer contributions to health insurance is a major argument against proposals to limit the exclusion of contributions at all but the very

TABLE 3

Distribution of Additional Annual Tax Burden of $1800 Annual Exclusion Limit in Calendar Year 1983, by Household (in dollars) 1/

Annual Household Income 2/	All Households		Households Affected		
	Average Additional Taxes	Percent of Income	Percent Affected by Limit	Average Additional Taxes	Percent of Income 3/
$ 0-10,000	$ 3	0.05	2	$138	2.76
10,001-15,000	14	0.11	9	168	1.34
15,001-20,000	21	0.12	14	147	0.84
20,001-30,000	44	0.18	23	191	0.76
30,001-50,000	88	0.22	33	267	0.68
50,001-100,000	116	0.18	36	323	0.43
Over 100,000	108	0.08	27	403	0.40

Source: Congress of the United States, Congressional Budget Office, Containing Medical Care Costs Through Market Forces" (May 1982), p. 36.

1/ Includes both federal income tax and the employer's and employee's share of federal payroll taxes. About three-quarters of the tax burden results from federal income tax liability. State and local income taxes are excluded. Estimates assume that taxable excess contributions are ineligible for the medical expense deduction under the federal income tax.
2/ Household income before taxes, but including cash transfer payments (e.g., Social Security benefits) projected to calendar year 1983.
3/ Estimated at the midpoint of the income range.

highest level. The argument for pursuing a high exclusion limit, however, is weak; a high cap would affect only a small proportion of all households and yield very little additional federal revenue.

Tax Policy as a Strategy to Contain Health Care Costs

Employer group insurance that requires little or no cost-sharing by consumers of health care has probably raised the demand for health care services and contributed to inflation in health care costs. Nevertheless, since the mid-1960s, the relative importance of private insurance as a source of demand and inflationary pressure in the health services market has been declining.

Hospital care is the most inflationary component of health care services. Since 1965, the proportion of all hospital care purchased with

private insurance has fallen. Since 1975, moreover, private consumers have paid an increasing share of most health care services, including hospital care, directly out of pocket. Between 1975 and 1982, the real burden of hospital care borne directly by private consumers rose by almost one-half (see Table 4).

TABLE 4

Percentage Distribution of Expenditures for Hospital Care by Source of Payment, Selected Years 1965-1982 1/

	Private				Public		
	Total	Patient Direct Payments	Health Insurance	Other	Total	Medicare and Medicaid	Other
1965	61.2	17.2	41.8	2.2	38.9	--	38.9
1970	47.2	10.0	35.8	1.4	52.9	26.3	26.6
1975	44.7	8.2	35.4	1.1	55.3	31.3	24.0
1978	45.6	8.6	35.8	1.2	54.5	33.6	20.9
1979	46.2	9.9	35.0	1.3	53.8	33.9	19.9
1980 2/	45.9	10.0	33.5	1.5	54.1	35.3	18.8
1981	45.9	11.1	33.4	1.5	54.1	35.5	18.6
1982	46.9	12.1	33.2	1.6	53.1	35.5	17.6

Source: R.M. Gibson and D.R. Waldo, "National Health Expenditures, 1981," _Health Care Financing Review_, 4:1 (September 1982), pp. 24 and 27. R.M. Gibson and D.R. Waldo, "National Health Expenditures, 1980," _Health Care Financing Review_, 3:1 (September 1981), pp. 44-47; and preliminary data from the Health Care Financing Administration, U.S. Department of Health and Human Services.

1/ Total may not add due to rounding.
2/ Based on revised data.

The most important source of expanding coverage and rising health service demand over the last two decades has been the public sector. Since 1967, the public sector has purchased more than a third of all personal health care, and more than half of all hospital care. Most of the growth of public-sector spending for personal health care is attributable to the growth of Medicare and Medicaid spending. In 1982, these programs purchased more than one-third of all hospital care delivered in the United States.

The size of public-sector spending relative to privately insured spending for personal health care is important in considering a revision of federal tax policy toward private health insurance. In legislating the

Medicare and Medicaid programs, Congress established a standard of access to comprehensive health insurance coverage across the population. Federal tax policy that would significantly reduce levels of private health insurance coverage, or jeopardize access to coverage among middle- and low-income persons, promotes inequities between the general population and persons eligible for coverage through the public sector. Federal policy that would reduce eligibility or coverage under Medicare or Medicaid, may be reasonable only if persons who lose public-program benefits can be expected to obtain private-sector health insurance coverage. It is difficult to reconcile reductions in both public-program benefits and private-sector incentives for health insurance coverage in terms of coordinated federal policy.

In practical terms, the size of public spending for personal health care relative to privately insured spending suggests the importance of these programs as independent sources of health care cost inflation. Over the last five years for which data are available, per capita spending for hospital care among Medicare enrollees exceeded per capita spending among the privately insured population by more than 400 percent (see Table 5). While part of the discrepancy in per capita spending for hospital care is the result of differences in the insured populations, at least some of the difference is attributable to hospital practices that have been attuned to Medicare and Medicaid reimbursement policy.

In spite of efforts to curb the burgeoning costs of Medicare and Medicaid, these programs have supported much of the inflation in aggregate health care costs, and in hospital costs in particular. Between 1976 and 1980, the rate of increase in average Medicare and Medicaid spending consistently exceeded the growth of privately insured spending for hospital care. During those years, average hospital costs among Medicare enrollees and Medicaid beneficiaries rose at an average annual rate of 14 and 18 percent, respectively. Average private health insurance costs, by comparison, rose by less than 12 percent, and declined during 1979 and 1980. It is unlikely that these persistent differences between public-sector programs and privately insured consumers in per-capita spending growth reflect quantitative changes in the covered populations.

Federal tax policy that would dampen private-sector demand for health care will probably have little effect on health care inflation as long as Medicare and Medicaid spending continues to rise. Inflation in privately insured spending for hospital care and other health care services has been slowing, possibly in response to adjustments in the coverage provided by employer group plans. Modifying the tax-exempt status of employer contributions to health insurance may accelerate this trend. It is very unlikely, however, that further slowing of privately insured spending for health care can successfully offset inflation in public-sector spending.

TABLE 5

Estimated Amount and Annual Growth of Expenditures for Hospital Care Per Insured Person by Selected Source of Payment, 1976-1980

	Private Health Insurance 1/	Medicare 2/	Medicaid 3/
	(dollars per insured person)		
1976	$122	$486	NA
1977	134	540	NA
1978	149	687	$315
1979	164	772	442
1980	181	926	495
Average, 1976-1980	150	687	417
	(percent annual growth)		
1976	18.4	3.2	NA 4/
1977	9.8	11.1	NA
1978	11.2	27.2	13.6 5/
1979	10.1	12.4	40.3
1980	10.4	19.9	12.0
Average annual growth, 1976-1980	11.9	14.5	18.3

Source: R.M. Gibson and D.R. Waldo, "National Health Expenditures, 1981," Health Care Financing Review, 4:1 (September 1982), pp. 24, 27. R.M. Gibson and D.R. Waldo, "National Health Expenditures, 1980," Health Care Financing Review, 3:1 (September 1981), pp. 44-46. Health Insurance Association of America, Source Book of Health Insurance Data, 1981-1982 (Washington, D.C.), p. 12, U.S. Department of Health and Human Services, Social Security Administration, Social Security Bulletin Annual Statistical Supplement, 1981 (Washington, D.C.), pp. 207, 220.

1/ Private insurance expenditures per person insured for hospital care.
2/ Medicare expenditures per Medicare Part A enrollee.
3/ Medicaid expenditures per Medicaid recipient (unduplicated count) of any personal health care services, including hospital care.
4/ Published figures not available.
5/ Average annual compounded growth between 1975 and 1978.

NOTES

1/ S. 640, introduced as the Reagan administration's bill, would "cap" the level of employer contributions that would be tax exempt; all employer contributions above the cap would be imputed as employee earnings and fully taxed by both the individual income tax and FICA. S. 640 varies the amount of the cap for individual versus family coverage, and adjusts the level of the cap annually by changes in the Consumer Price Index. H.R. 3271, also introduced as S. 1421, would eliminate the exemption of all employer contributions to health insurance as part of comprehensive tax reform. At the same time, this proposal would raise the individual income tax floor for deducting health insurance expenditures to 10 percent of adjusted gross income.

2/ 1979 coverage and employer contribution rates are supported by EBRI tabulations of the May 1980 Current Population Survey.

3/ Recent econometric estimates suggest that the rise in marginal income tax rates between 1970 and 1982 may have accounted for about only 13 percent of the rise in real employer contributions to health insurance over that period.

4/ EBRI tabulations of the Battelle Survey of Employment-Related Health Benefits in Private Nonfarm Business Establishments in the United States (1978) and the Level of Benefits Survey (U.S. Department of Labor, 1980).

5/ G. R. Wilensky and A. K. Taylor, "Tax Expenditures and Health Insurance: Limiting Employer-Paid Premiums," Public Health Reports (July-August, 1982).

6/ EBRI tabulations of the May 1980 Current Population Survey.

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