

**Statement for the  
Senate Finance Committee**

***“Health Benefits in the Tax Code: The Right Incentives?”***

July 31, 2008  
215 Dirksen Senate Office Building

**Submitted by:**

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Mr. Chairman and Members of the Committee:

The nonpartisan Employee Benefit Research Institute (EBRI) focuses on health and retirement benefits and has done extensive analysis on tax treatment of employment-based health insurance. EBRI, a nonpartisan research institute, does not take policy positions and does not lobby. Its research is available online at [www.ebri.org](http://www.ebri.org) Paul Fronstin is director of the Health Research and Education Program at EBRI. Dallas Salisbury is president and CEO of EBRI.

One of the most common statements of economists, when it comes to health insurance, is that “there are no employer dollars involved, since in the absence of the health insurance being provided, the worker would be paid in added salary or wages.” We must respectfully disagree with this statement as it applies to the individual, even were it to apply to all covered workers as a group, in terms of aggregate funds. Even then, adjustments would occur over the very long term, not immediately or in even the short term of a decade. Consider Congress itself, where the annual salary increases are determined with little or no consideration of what is being spent on employee health insurance. Consider the individual at the minimum wage, or others, who have health insurance added by their employer. Employer decisions on whether or not to provide benefits are generally made for the full workforce, relative to total cost, and not on a micro- or individual-worker basis. Large employers that self-insure know that the actual cost of providing the benefit varies widely across workers as a function of health status, age, etc.

EBRI’s most recent analysis of the topic of today’s hearing was published in the September 2007 *EBRI Issue Brief*, no. 309: “Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System?” The co-authors are Paul Fronstin and Dallas Salisbury of EBRI. Full text is available online at [www.ebri.org/pdf/briefspdf/EBRI\\_IB\\_09-20074.pdf](http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-20074.pdf)

### **Highlights**

- Proposals to change the way in which health benefits are taxed have far-reaching implications for employer health plan design. They also affect the viability of employment-based health benefits generally and raise questions regarding the future of the employment-based health benefits system.
- Currently, employers can deduct from corporate taxable income the cost of providing health benefits as a business expense.
- With respect to workers, the amount that employers contribute towards health benefits is excluded, without limit, from workers’ taxable income. Employers can also make available a premium conversion arrangement as part of the FSA or as part of a cafeteria plan, which allows workers to pay their share of the premium for employment-based health benefits with pretax dollars.
- For individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of AGI, and only the amount that exceeds 7.5 percent of AGI is deductible. This deduction is allowed only when an individual itemizes deductions on his or her tax return, and it is not widely used.
- Comprehensive tax reform as it affects health insurance and health care costs could mean the end of employment-based health benefits. Were the current tax treatment of health benefits replaced with some form of a broad-based tax credit or tax cap that was available either in the employment-based system or the non-group market, healthy workers would opt out of employment-based coverage for the non-group market.

- To the degree that young and healthy workers leave the employment-based system, workers remaining in the system will be disproportionately older and unhealthy, which will drive up premiums in the system. As premiums increase, the youngest/healthiest workers will move to the non-group market, leaving relatively older/less healthy workers in the employment-based system, which will continue to drive up premiums for employer coverage. This phenomenon is known as the “death spiral” because it means the death of employment-based health benefits as a result of continued and increased adverse selection. Were the employment-based system go into the death spiral, employers could eventually drop coverage.

## **Introduction**

Proposals to change the way health benefits and health care costs are treated under the tax code have one thing in common—they would eliminate the current preferential tax treatment for employment-based health benefits and replace it with some form of a flat tax credit or tax deduction for all taxpayers with qualifying private health insurance. From both a budgetary and political perspective, the tax treatment of employment-based health benefits is an almost inescapable target. Tax-favored employment-based health benefits accounted for \$145.3 billion in foregone income tax revenue and \$100.7 billion in foregone FICA tax revenue in 2007.<sup>1</sup> Foregone income tax revenue is predicted to amount to \$628.5 billion over the five-year period from 2007–2011.<sup>2</sup> The tax proposals have far-reaching implications for employer health plan design, including the viability of many of the newer consumer-driven health plans that use health reimbursement arrangements (HRAs) or health savings accounts (HSAs) to increase worker engagement and payment responsibility relative to employer payments. The tax proposals also affect the viability of employment-based health benefits generally and raise questions regarding the future of the employment-based health benefits system.

## **Current Tax Treatment of Health Insurance**

The tax treatment of health benefits has been formed in the tax code through a series of laws and rulings that date back to the 1920s. Currently, employers can deduct from corporate taxable income the cost of providing health benefits as a business expense. This means that whatever an employer spends on health insurance or health benefits on behalf of workers is considered a business expense just as wages and salaries are a business expense. In other words, employers get the same deduction in calculating taxable business income when they choose to provide compensation in the form of health benefits as they would were they to provide compensation in the form of wages and salaries and should therefore be indifferent from an income tax point of view between providing health benefits or cash wages.

Employers do however get a break on payroll taxes when compensation is provided in the form of health benefits instead of wages and salaries. They do not pay the 6.2 percent payroll tax for Social Security for workers whose incomes are below the Social Security wage base, which was set at \$102,000 in 2008. They also do not pay the 1.45 percent payroll tax for Medicare for all levels of wages.

With respect to employees (including the self-employed), the amount that employers contribute towards health benefits and health insurance is generally excluded, without limit, from workers’ taxable income. In addition, workers whose employers sponsor flexible spending accounts (FSAs) are able to pay for out-of-pocket health care expenses with pretax dollars

through the FSA, meaning they are not taxed on the amount of money that is put into the FSA. Employers can also make available a premium conversion arrangement as part of the FSA or as part of a cafeteria plan, which allows workers to pay their share of the premium for employment-based health benefits with pretax dollars. Workers also do not pay income tax on employer contributions to FSA's and HRA's.

Individuals are able to deduct from taxable income contributions made to a health savings account (HSA) if they have health insurance with a minimum deductible of at least \$1,100 for individual coverage or \$2,200 for family coverage. In order to make tax-free contributions to an HSA, the health plan must also impose a maximum \$5,800 out-of-pocket limit for individual coverage, and an \$11,200 limit for family coverage. Deductibles can be as high as the out-of-pocket maximum, which would mean there would be no cost sharing above the deductible, though there are exceptions for plans that include benefits for out-of-network providers. There are other restrictions as well. Regardless of who contributes to the account, annual contributions are tax-free to the individual who owns the account, up to a limit of \$2,900 for individual coverage and \$5,800 for family coverage. Persons ages 55 and older are allowed to make "catch-up" contributions as well. In 2008, a \$900 catch-up contribution was allowed, and is being phased in to \$1,000 by 2009.<sup>3</sup> Unspent balances in an HSA grow tax-free, and distributions from an HSA are tax-free when used for qualified medical expenses and certain premiums.

For individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of AGI, and only the amount that exceeds 7.5 percent of AGI is deductible. This deduction is allowed only when an individual itemizes deductions on his or her tax return, and it is not widely used. The standard deduction is larger than the sum of itemized deductions for most taxpayers, and most do not have deductible medical expenses that exceed 7.5 percent of AGI. In 2001, about one-third of all individual income tax returns had itemized deductions, but only 17 percent of these claimed a medical expense deduction, accounting for about 6 percent of all tax returns.<sup>4</sup> There is one exception to the 7.5 percent AGI rule, however. Contributions to an HSA are fully deductible from taxable income and are not subject to the 7.5 percent AGI threshold.

### **Issues With Changing the Tax Treatment of Health Benefits**

Comprehensive tax reform as it affects health insurance and health care costs could mean the end of employment-based health benefits. Were the current tax treatment of health benefits replaced with some form of a broad-based tax credit or tax cap that was available either in the employment-based system or the non-group market, healthy workers would opt out of employment-based coverage for the non-group market.

Insurers may respond to a broad-based tax credit, for example, by designing health plans to attract the young and/or healthy and the uninsured. They may advertise the fact that certain health plans will be "free" in the sense that the tax credit would cover or more than cover the premium. The availability of these plans will be a draw to young and healthy workers with employment-based health benefits. If young workers leave employment-based health benefits for the individual market, the employment-based system will suffer from adverse selection that pushes up the cost of the employment-based coverage and employers will rethink their role in providing health benefits.

To the degree that young and healthy workers are able to and do in fact leave the employment-based system, workers remaining in the employment-based system will be

disproportionately older and unhealthy, which will drive up premiums in the employment-based system. The employment-based system will then be in a vicious cycle. As premiums increase, the youngest/healthiest workers will move to the non-group market, leaving relatively older/less healthy workers in the employment-based system, which will continue to drive up premiums for employer coverage. This phenomenon is known as the “death spiral” because it means the death of employment-based health benefits as a result of continued and increased adverse selection.

Were the employment-based system go into the death spiral, employers could eventually drop coverage. Coverage would be dropped for a number of reasons. Employers offer health benefits primarily to be competitive in the labor market.<sup>5</sup> Health benefits are by far the most valued benefit in the workplace<sup>6</sup> and employers offer them to recruit and retain workers. If workers dropped health benefits and instead found coverage on their own in the non-group market, employers would stop offering coverage because they perceived that workers did not value coverage.

As workers leave the employment-based system for the non-group market and drive up premiums in the employment-based system, employers will find coverage less and less affordable and will eventually drop that coverage. Third, employers are already concerned about the rising cost of health benefits and some are looking for an excuse to drop those benefits.<sup>7</sup> Equalizing the tax treatment of employment-based health benefits and non-group insurance may be the excuse employers use to drop health benefits altogether. Small employers would likely be the first to drop benefits because they struggle with affordability more than large employers. However, large employers have also been struggling with the cost of health benefits, and while they are generally hesitant to drop benefits if their workers will have a difficult time getting coverage in the non-group market, employers are always looking for a competitive edge, and it only takes one large employer to drop health benefits in order to trigger a movement of large employers away from health benefits.

Employers may drop benefits because of the additional administrative costs related to valuing the benefit. Under proposals to change the tax treatment of health benefits, employers will be required to value health benefits and report the value of health benefits as imputed income. While the details of how employers would be able to value health benefits would likely be worked out in regulations, employers may have some choices to make when it comes to valuation, and these choices would likely affect workers and the value they place on employment-based health benefits.

Employers provide health benefits either by purchasing a fully-insured health plan from an insurer, or by self-insuring. Groups that are fully insured pay an insurer a per-person premium, with an average price that varies by employee population characteristics and health care use. Self-insured employers typically divide the total cost of the health plan by the number of covered employees to derive an average “premium equivalent.” This premium equivalent is used to determine COBRA premiums in a self-insured setting. If employers were required to value health benefits for employee income and tax purposes, the current method that employers use to value premiums would be beneficial to some workers but not to others.

It is clear from employer experience with COBRA that the method used to value premiums is beneficial for some workers but not to others. Employers are allowed to require that COBRA beneficiaries pay 102 percent of the premium for COBRA coverage. Because workers are generally required to pay the full premium on an after-tax basis (as opposed to paying a portion of the premium on a pre-tax basis while at work), there is a self-selection issue regarding who takes COBRA. Employers have found that COBRA beneficiaries incur on average about

50 percent more health care expenses than the average population or insured workers.<sup>8</sup> This self-selection occurs because COBRA beneficiaries tend to be older, less healthy workers who continue coverage because COBRA premiums (even at 102 percent on an after-tax basis) are more affordable than premiums for comparable insurance in the non-group market.

Under a self-insured health plan there is no premium: Employers pay claims as they are incurred. If employers had to value health benefits for tax purposes, would they value the benefit at the average COBRA equivalent premium, or would each worker be assigned a value corresponding with his or her actual or expected use of health care services? Is the value of health benefits lower for lower-risk individuals than it is for higher-risk individuals? If the value of the benefit is determined by health risk, higher-risk individuals would be assigned a higher value for health benefits, and, all else equal, would pay higher taxes associated with the value of the benefits that is above the exclusion cap. If the value of the benefit is not associated with risk, but instead valued at the community rate, higher-risk individuals would benefit because they would, on average, use more health care services than the average value of the benefit. The method used to determine the value of the health benefit may drive adverse selection. If the average premium was used to value the benefit, lower-risk individuals would likely opt out of the plan in order to seek less costly health insurance on their own. As mentioned above, when lower-risk individuals leave the insurance pool, the average cost of insurance rises for everyone who remains in the pool. The process would continue until only higher-risk individuals remained in the pool, making the insurance plan unsustainable.

Valuing the benefit would also be complicated for employers operating in multiple locations. Employers with sites in different states could face multiple valuations because the cost of the benefit package could vary in different geographical regions for a number of reasons. The underlying prices for health care service may be higher in one part of the country over another, or demographic differences in different parts of the country for the same employer may affect the valuation of health benefits.

### **Would Tax Credits Be Effective in Expanding Coverage?**

Tax credits have been on the radar scope of policymakers even before President Clinton proposed comprehensive reform to the health insurance system.<sup>9</sup> Unsuccessful tax credit bills were introduced by both Democrats and Republicans, and in some cases, bills were co-sponsored by both. Cunningham (2002) describes what has become the “joint custody” of tax credits among Democrats and Republicans.<sup>10</sup> Sen. Lloyd Bentsen (D-TX) was a principal architect of the unsuccessful health insurance tax credits enacted during the first Bush administration in 1991. In 1999, House majority leader Dick Armey (R-TX) and ranking Ways and Means Democrat Pete Stark (D-CA) jointly endorsed tax credits on the opinion page of the Washington Post, but the proposal did not go anywhere.<sup>11</sup> Also in 1999, Stuart Butler of the conservative Heritage Foundation and David Kendall of the (Democratic) Progressive Policy Institute made a joint proposal, as did Reps. Jim McCrery (R-LA) and Jim McDermott (D-WA) in 2000.<sup>12</sup>

A primary issue with a tax credit is whether the tax savings is large enough to induce the uninsured to purchase health insurance. The ability of a tax credit to reduce the uninsured depends heavily on several key design issues, such as the size of the tax credit relative to income and income levels overall. Previous research has shown that for single workers with income at 150 percent of the federal poverty level (FPL), only 48 percent would gain coverage even if the tax credit was set to 79 percent of the premium.<sup>13</sup> In addition, a tax credit equal to the full

amount of the premium would result in only 75 percent of the population of single workers at 150 percent of FPL receiving coverage.

The findings of Thorpe (1999) are reinforced by experiments driven by The Robert Wood Johnson Foundation's Health Care for the Uninsured Program in the late 1980s that were able to reduce premiums for the self-employed and workers in small firms. Despite premium reductions ranging from 9 to 60 percent, with most in the 25 and 50 percent range, no single site in the experiment reached 10 percent of its' target market.<sup>14</sup> Hence, even very generous tax credits may not be large enough for a significant portion of the low income population to purchase health insurance.

## Endnotes

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<sup>1</sup> See Table 1 in <http://www.jct.gov/x-66-08.pdf>.

<sup>2</sup> See Table 3 in <http://www.house.gov/jct/x-32-08.pdf>. This estimate includes the exclusion of employer contributions for health care, health insurance premiums, and long-term care insurance premiums.

<sup>3</sup> Catch-up contributions are not indexed to inflation.

<sup>4</sup> Lyke, Bob. "Tax Benefits for Health Insurance and Expenses: Current Legislation." *CRS Issue Brief for Congress*. Congressional Research Service, Library of Congress, February 23, 2005.

<sup>5</sup> Fronstin, Paul. "The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?" *EBRI Issue Brief* no. 312 (Employee Benefit Research Institute, December 2007).

<sup>6</sup> Helman, Ruth, and Paul Fronstin. "Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey." *EBRI Issue Brief* no. 275 (Employee Benefit Research Institute, November 2004).

<sup>7</sup> Christensen, Rachel, Paul Fronstin, Karl Polzer, and Ray Werntz. "Employer Attitudes And Practices Affecting Health Benefits And The Uninsured" *EBRI Issue Brief* no. 250, October 2002.

<sup>8</sup> See <http://www.cch.com/press/news/2006/20061206h.asp>.

<sup>9</sup> Fronstin, Paul. "Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion." in *Severing the Link Between Health Insurance and Employment*, Dallas L. Salisbury (ed.), (Washington, DC: Employee Benefit Research Institute), 1999.

<sup>10</sup> Cunningham, Robert. "Joint Custody: Bipartisan Interest Expands Scope Of Tax-Credit Proposals." *Health Affairs* Web Exclusive, September 18, 2002.

<sup>11</sup> Arney, Dick, and Pete Stark, "Medical Coverage for All: The Ultimate Congressional Odd Couple Weighs In." *Washington Post*, 18 June 1999.

<sup>12</sup> See Butler, Stuart, M. and David B. Kendall. "Expanding Access and Choice for Health Care Consumers through Tax Reform." *Health Affairs* (Nov/Dec 1999): 45-57. Cunningham, Robert. "Joint Custody: Bipartisan Interest Expands Scope Of Tax-Credit Proposals." *Health Affairs* Web Exclusive, September 18, 2002. Fronstin, Paul. "Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion." in *Severing the Link Between Health Insurance and Employment*, Dallas L. Salisbury (ed.), (Washington, DC: Employee Benefit Research Institute), 1999. Miller, M. "Health Care: A Bolt of Civic Hope," *Atlantic Monthly*, October 2000, [www.theatlantic.com/issues/2000/10/miller.htm](http://www.theatlantic.com/issues/2000/10/miller.htm) (6 August 2002).

<sup>13</sup> Thorpe, Kenneth E. "Changing the Tax Treatment of Health Insurance: Impacts on the Insured and Uninsured." in *Severing the Link Between Health Insurance and Employment*, Dallas L. Salisbury (ed.), (Washington, DC: Employee Benefit Research Institute), 1999.

<sup>14</sup> W. David Helms, Anne K. Gauthier, and Daniel M. Campion. "Mending the Flaws in the Small-Group Market." *Health Affairs*, Summer 1992; 11(2): 7-27.