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Issue BRIEF

Employment-Based Health Benefits and Taxation: Implications of Efforts to Reduce the Deficit and National Debt

By Paul Fronstin, Employee Benefit Research Institute

HEALTH INSURANCE THE BIGGEST TAX EXPENDITURE: The tax preference associated with employment-based health coverage is the largest tax expenditure in the U.S. budget, accounting for $1.1 trillion in foregone tax revenue during 2012–2016. In contrast, retirement plans account for about $700 billion in foregone tax revenue and the mortgage interest deduction accounts for about $600 billion. This makes the tax treatment of health coverage an almost inescapable target.

DEBT COMMISSION TARGETS HEALTH BENEFITS: President Obama's bipartisan National Commission on Fiscal Responsibility and Reform proposed changes that would achieve $4 trillion in deficit reduction by 2020 and reduce the debt to 30 percent of GDP by 2040. As part of the proposal, the commission would reduce the preferential tax treatment of employment-based health benefits as it applies to workers, first by capping, then freezing, phasing down, and ultimately eliminating them. The Commission does not recommend any changes to the employer deduction as a business expense.

PPACA: The Affordable Care Act changes the playing field in that workers will no longer need to rely on their employer to obtain health coverage. Workers will benefit from a number of insurance market reforms, such as guaranteed issue, modified community rating, subsidies, and increased choice of health plan.

REACTION BY INCOME: If the favorable tax treatment of workers' health benefits is eliminated, they would face an increase in taxes and some would question the value of keeping the coverage. Lowest-income workers would find the new health exchanges more advantageous than employment-based health benefits , while high-income workers likely would not. For example: For single coverage among policyholders regardless of age at 150 percent of the federal poverty level (FPL) in 2014 would save an average of about $800 by moving from employment-based coverage to a health insurance exchange; workers at 200 percent of FPL would come out about even between employment-based coverage and the insurance exchange; and those above 250 percent of FPL would have to pay more for coverage in the exchange than employment-based coverage if their employer did not give them any portion of the employer share of the premium.

MESSAGE TO EMPLOYERS: The number of workers who might prefer an insurance exchange over employment-based coverage depends upon not only the relative premium in each option and income levels, but the number of workers by income. About 41 percent of workers are in families with income between 133 percent and 400 percent of the federal poverty level, accounting for 65 million workers. Even if only a fraction of these workers preferred an insurance exchange over employment-based coverage, it would send a clear message to employers that millions of workers no longer valued the benefit. If employers found that workers no longer valued the coverage, they might stop offering health coverage. Predicting how this might play out by firm size, industry, worker earnings, geographic region, among other things, is highly uncertain.

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Introduction

The United States is facing severe financial issues. The federal budget ran a deficit in 36 of the years between 1971 and 2010, increasing the debt held by the public from $300 billion to $9 trillion.[1] The debt as a percentage of gross domestic product (GDP) increased from 28 percent in 1971 to 62 percent in 2010.[2]

Overall debt is about currently $14 trillion when intragovernmental holdings, such as the Social Security and Medicare trust funds, are considered.

Under current law, the Congressional Budget Office (CBO) projects that debt as a percentage of GDP will reach 74 percent by 2030 and 84 percent by 2040 (Figure 1). More realistically, the CBO projects that debt as a percentage of GDP will reach 100 percent in 2023 and 200 percent in 2037, when changes to current law are incorporated. Known as the "alternative fiscal scenario," the CBO assumes the following changes will take place to current law: renewal of the 2001/2003 tax cuts on income below $250,000, continued Alternative Minimum Tax (AMT) patches, continuation of the estate tax at 2009 levels, and continued Medicare "doc fixes."

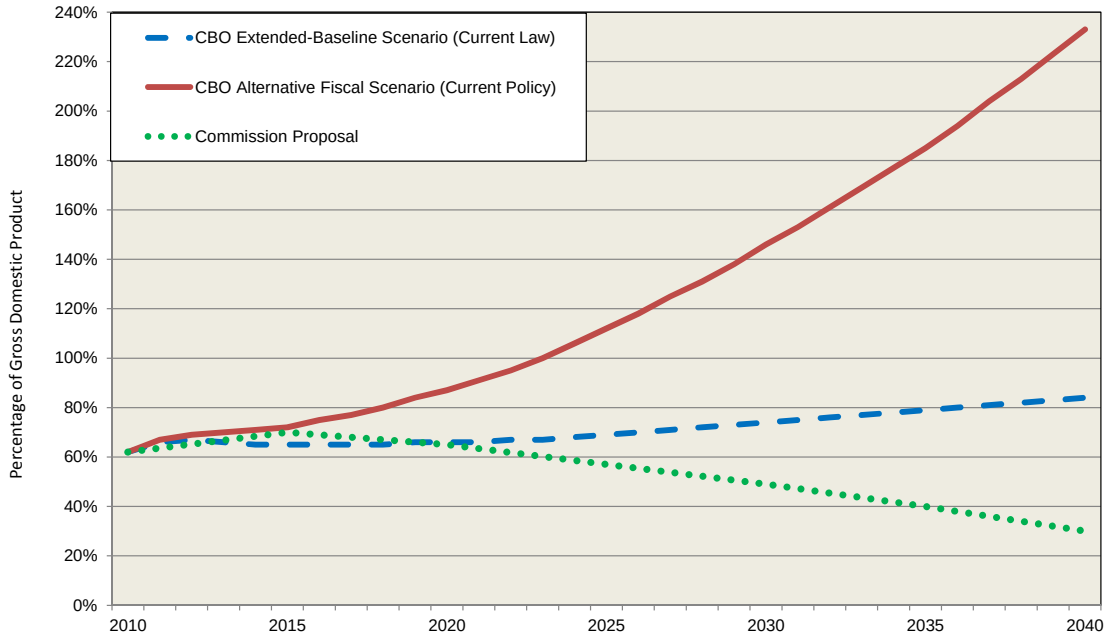
President Obama created the bipartisan National Commission on Fiscal Responsibility and Reform to address the nation's growing debt. The commission was charged with identifying policies to improve the fiscal situation in the medium term and to achieve fiscal sustainability over the long run. The commission released its recommendations in December 2010 and proposed changes that would achieve $4 trillion in deficit reduction by 2020 and reduce the debt to 30 percent of GDP by 2040 (Figure 1).

Among its recommendations, the commission proposes to change the tax treatment of employment-based health benefits. The preferential tax treatment of employment-based health benefits as it applies to workers would first be capped, frozen, phased down, and ultimately eliminated. The commission does not recommend any changes to the employer deduction as a business expense—meaning that workers eventually would pay taxes on the value of the health benefits they receive, while businesses would still be able to deduct the cost of health benefits they provide.

Tax expenditures—foregone government revenue—have been growing and now account for over $1 trillion annually (Figure 2). The Office of Management and Budget estimates that health coverage and health care will account for $184 billion in foregone tax revenue during FY 2012 and $1.1 trillion over 2012–2016, or 17 percent of all foregone tax revenue (Figure 3).[3] The tax preference associated with employment-based health coverage is the largest tax expenditure in the federal budget, making it an almost inescapable target for cuts from both a budgetary and political perspective. In contrast to the $1.1 trillion in foregone tax revenue related to employment-based health coverage, retirement plans account for about $700 billion in forgone tax revenue[4] and the mortgage interest deduction accounts for about $600 billion. According to the Congressional Budget Office (December 2008), income tax revenue would increase $108.1 billion during 2009–2013 if the tax exclusion were limited to the 75th percentile for health premiums and indexed to inflation, and to $205.7 billion if it were replaced with a refundable tax credit equal to 25 percent of the premium.

Figure 1

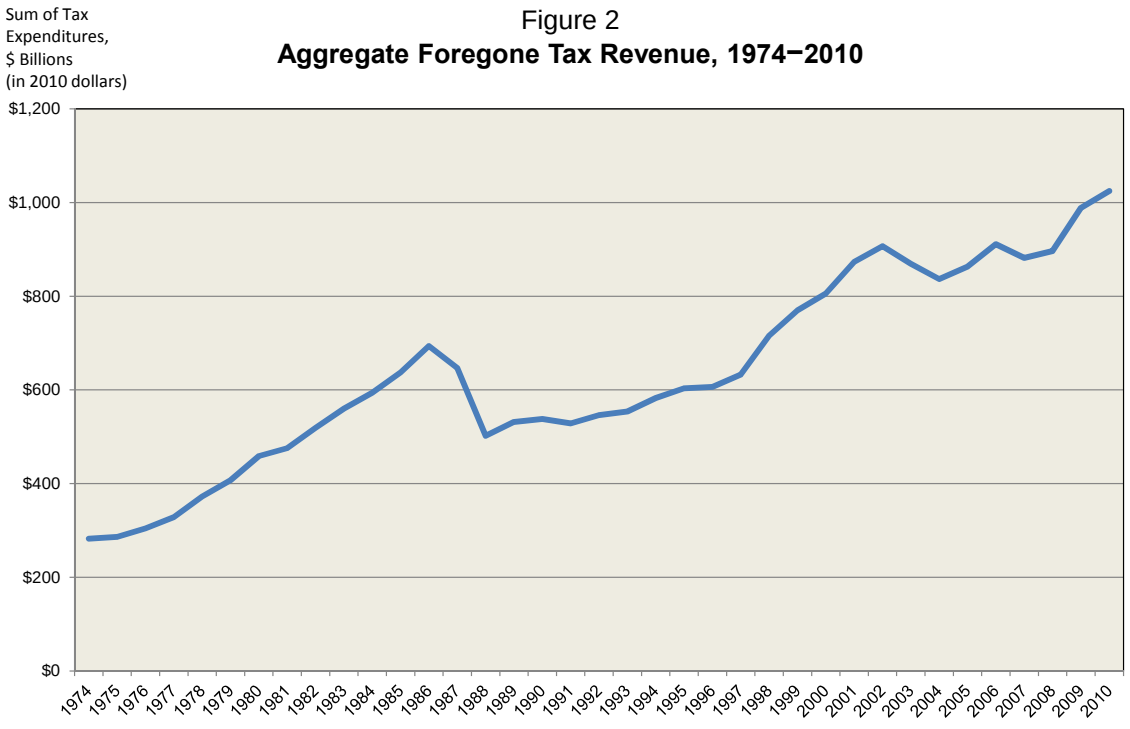
Debt* as a Percentage of Gross Domestic Product (GDP)



Source: Figure A-2 in http://www.cbo.gov/ftpdocs/115xx/doc11579/LTBO-2010data.xls and Figure 1 in www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf
* Debt held by the public.

Figure 2

Aggregate Foregone Tax Revenue, 1974–2010



Source: GAO analysis of OMB, *Analytical Perspectives,* Budget of the United States Government, Fiscal Years 1976–2012.
Note: Summing tax expenditure estimates does not take into account interactions between individual provisions. Additionally, revenue loss estimates include the effect of certain tax credits on receipts only and not the effect of the credits on outlays.

Figure 3

Select* Income Tax Expenditures Ranked By Total Fiscal Year 2012–2016 Projected Revenue Effect

($ Millions)

	2012	2012–2016	2012–2016 Distribution
Total	$1,100,980	$6,465,800	100%
Exclusion of employer contributions for medical insurance premiums and medical care	184,460	1,071,210	17%
Deductibility of mortgage interest or owner occupied homes	98,550	609,180	9%
Step-up basis of capital gains at death	61,480	357,080	6%
401(k) plans	67,590	356,260	6%
Exclusion of net imputed rental income	50,640	302,600	5%
Deductibility of nonbusiness State and local taxes other than on owner-occupied homes	48,640	292,290	5%
Accelerated depreciation of machinery and equipment (normal tax method)	24,450	269,680	4%
Capital gains (except agriculture, timber, iron ore, and coal)	38,490	256,280	4%
Deductibility of charitable contributions, other than education and health	43,110	248,930	4%
Employer plans	45,230	245,970	4%
Exclusion of interest on public purpose State and local bonds	36,960	230,440	4%
Captal gains exclusion on home sales	35,200	216,820	3%
Deferral of income from controlled foreign corporations (normal tax method)	42,000	212,840	3%
Deductible of state and local property tax on owner-occupied homes	24,910	142,290	2%
Exclusion of interest on life insurance savings	22,680	129,060	2%
Social security benefits for retired workers	21,830	129,040	2%
Keogh plans	17,070	103,880	2%
Exception from passive loss rules for $25000 of rental loss	13,110	83,750	1%
Deduction for U.S. production activities	14,630	82,000	1%
Individual Retirement Accounts	15,610	80,490	1%
Exlcusion of benefits and allowances to armed forces personnel	13,710	65,500	1%
Deductibility of medical expenses	10,010	60,020	1%
Child credit	10,580	49,200	1%
Earned income tax credit	8,500	45,060	1%
Social Security benefits for disabled workers	7,510	41,240	1%
Exclusion of workers' compensation benefits	7,410	40,940	1%
Self-employed medical insurance premiums	6,690	38,840	1%
Credit for low-income housing investments	6,290	36,070	1%
Expensing of research and experimentation expenditures (normal tax method)	5,770	35,080	1%

Source: White House FY 2012 Budget, Table 17-3, www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/receipts.pdf

* Tax expenditures listed only if it accounts for at least 1 percent of total tax expenditures during 2012–2016 period.

Employment-based health coverage is by far the most common source of health coverage in the United States. In 2009, 59 percent of the population under age 65 had health coverage through an employer, or about 156 million of the 265 million people under age 65 (Figure 4). The Patient Protection and Affordable Care Act (PPACA) enacted March 23, 2010, and the Health Care and Education Reconciliation Act (HCERA) enacted March 30, 2010, include incentives for employers to continue to be the primary source of health coverage in the United States. According to the Congressional Budget Office, PPACA would have very little impact on the number of individuals with employment-based health benefits. It projects that 162 million people would be covered by employment-based health benefits in 2019 without health reform and 158 million with health reform (Figure 5).

However, proposals to change the way health coverage is *taxed* could have far-reaching implications for the number of people with employment-based health coverage, other forms of health coverage, the future of the employment-based health coverage system, and government tax collections. The purpose of this *Issue Brief* is to examine the implications of changing the tax treatment of employment-based health coverage. The next section discusses the current tax treatment of health coverage. Various proposals to change the tax treatment of health coverage are then presented. The implications of changing the tax treatment are then discussed in the context of health reform.

Current Tax Treatment of Health Coverage

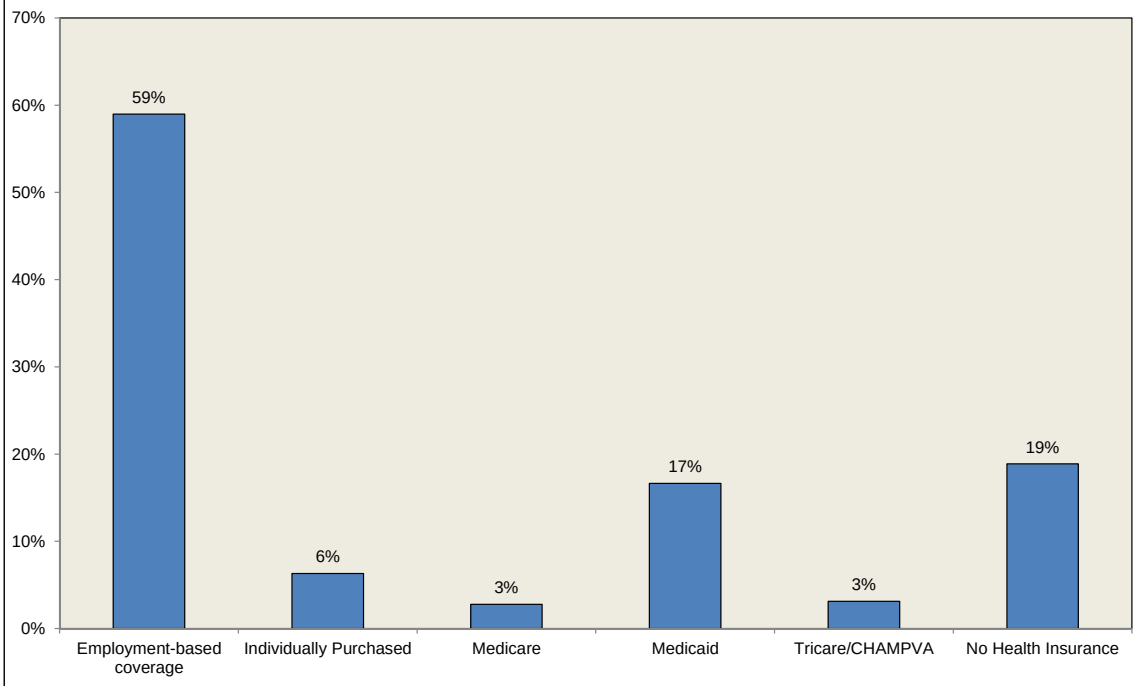
The tax treatment of health coverage has been formed in the tax code through a series of laws and rulings that date back to the 1920s. However, it was during World War II that many employers began to offer health coverage. Because the National War Labor Board froze wages, employers sought ways to get around the wage controls in order to attract scarce workers (Helms 2008). In 1943, the National War Labor Board (NWLB) ruled that employer contributions to insurance did not count as wages, and thus did not increase taxable income and could therefore be offered in addition to wages and salaries. As a result, employers began to offer health coverage to their workers to be competitive in the labor market, and the number of persons with employment-based health coverage started to increase.

It is also often suggested that the tax-preferred status of employment-based health coverage led to the rise in its prevalence and comprehensiveness (Gabel 1999), and that the tax-exempt status of health coverage has encouraged employers to offer it and to provide more comprehensive coverage than they otherwise would have (Sheils and Haught 2004). However, there is still disagreement among historians as to the role of taxation in the growth of employment-based health coverage. According to Helms (2008), the NWLB decision on health benefits mirrored IRS rulings that insurance benefits were not to be treated as taxable income. In contrast, according to Lyke (2008), none of the 1940s ruling addressed the question of whether employer contributions to health coverage should be deductible by the employer. Furthermore, according to Hacker 2002, it was not until the Revenue Act of 1954 that the Internal Revenue Code made it clear (after a number of conflicting IRS rulings prompted Congress to demand a blanket exception), that employer spending on employee health benefits was not to be counted as employee income. Lyke (2008) goes so far as to conclude that the "historical argument about the importance of tax and regulatory policies may be overstated." Regardless of the historical debate, employers today offer health coverage because of their belief that offering it has a positive impact on the overall success of the business (Fronstin 2007) (Fronstin and Helman 2003).

Tax Treatment of Employment-Based Health Coverage for Employers

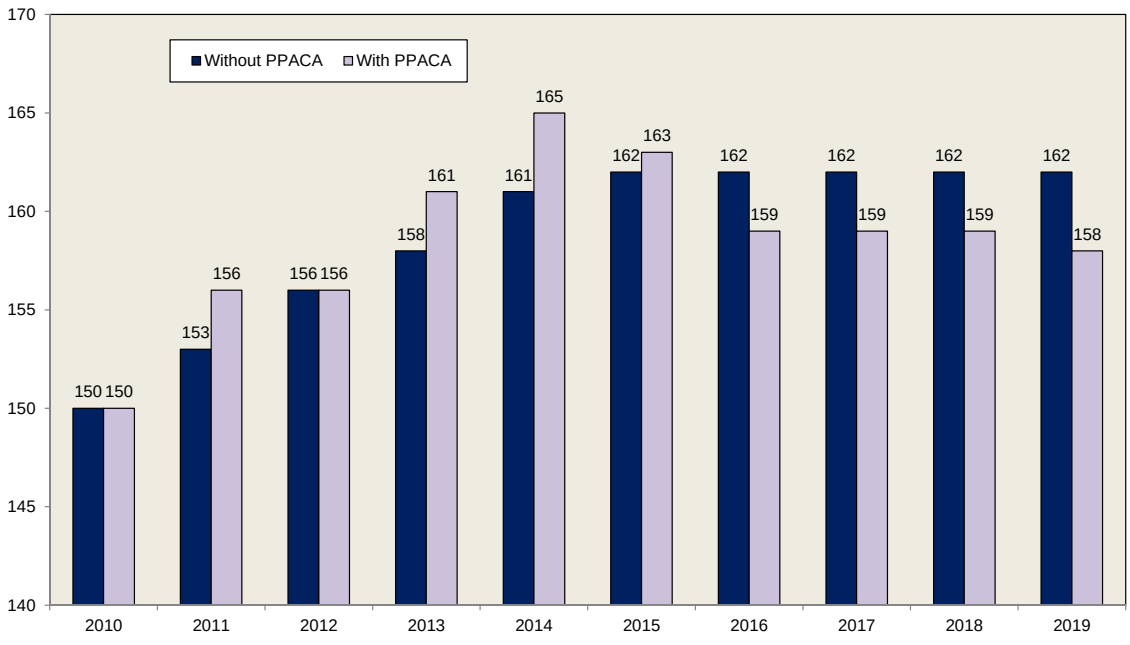
Currently, employers can deduct from taxable income the cost of providing health coverage to workers (and their dependents) as a business expense, just as wages and salaries are a business expense. In other words, employers get the same deduction in calculating taxable income when they chose to provide compensation in

Figure 4
Sources of Health Insurance Coverage, Population Under Age 65, 2009



Source: Employee Benefit Research Institutes estimates from the March 2010 Current Population Survey.

Figure 5
Projected Number of Individuals With Employment-Based Health Benefits, 2010−2019
(millions)



Source: Congressional Budget Office, www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf

the form of health benefits as they do to provide compensation in the form of wages and salaries. Therefore, they should be indifferent from an income tax point of view between providing health coverage or cash wages.

Employers do, however, get a break on payroll taxes when compensation is provided in the form of health coverage 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 $106,800 in 2011. They also do not pay the 1.45 percent payroll tax for Medicare for all levels of wages. Employer savings related to the Social Security and Medicare payroll tax savings accounted for about $73 billion in 2006 (Selden and Gray 2006).

Tax Treatment of Employment-Based Health Coverage for Workers

With respect to workers (including the self-employed), the amount that employers contribute toward health coverage is generally excluded, without limit, from taxable income. Employers can also make available a premium conversion arrangement, which allows workers to pay their share of the premium for employment-based health coverage with pretax dollars. In addition, workers whose employers sponsor flexible spending accounts (FSAs) are able to pay for out-of-pocket health care expenses with pretax dollars, meaning they are not taxed on the amount of money that is put into the FSA.

Individuals are able to deduct from taxable income contributions made to a health savings account (HSA), if they have health insurance with a deductible of at least $1,200 for individual coverage or $2,400 for family coverage. In order to make tax-free contributions to an HSA, the health plan must also impose a $5,950 maximum out-of-pocket limit for individual coverage, and an $11,900 limit for family coverage. There are other restrictions as well. Regardless of who contributes to the account, annual contributions are tax free for the individual who owns the account, up to a limit of $3,050 for individual coverage and $6,150 for family coverage. Those age 55 and older can make "catch-up" contributions to an HSA as well. In 2011, a $1,000 catch-up contribution was allowed. Unused balances in an HSA grow tax free, and distributions from an HSA are tax free when used for qualified medical expenses and certain premiums.

Tax Treatment of Health Insurance Premiums and Health Care Expenses for Individuals

For individuals who do not receive employment-based health coverage, total qualified health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income (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. This deduction is not widely used, because the standard deduction is larger than the sum of itemized health deductions for most taxpayers, and most do not have deductible medical expenses that exceed 7.5 percent of AGI. In 2005, about 35 percent of all individual income tax returns had itemized deductions, but only 21 percent of these claimed a medical expense deduction, accounting for about 7 percent of all tax returns (Lyke 2008). 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.

Excise Tax on High-Cost Health Plans

Starting in 2018, an excise tax on high-cost health plans, the so-called "Cadillac tax," will take effect. A nondeductible 40 percent excise tax will be imposed on the portion of health coverage costs that exceed $10,200 for single coverage and $27,500 for family coverage in 2018. These thresholds will be $1,650 higher for single coverage and $3,450 for family coverage for early retirees and individuals in high-risk professions. Adjustments to the total cost of the plan will be allowed for the age and gender mix of workers. In determining the portion of health coverage costs that are subject to the excise, reimbursements from FSAs and HRAs, and employer contributions to HSAs will also be counted.

The tax burden falls on the issuer of the plan. In the case of fully insured plans, the insurance carrier would be responsible for paying the tax. In the case of self-insured plans, if the employer uses a third-party administrator (TPA) then the TPA would be responsible for paying the tax. If the plan is self-administered, the employer would be responsible for paying the tax. When both a health plan and a stand-alone FSA are offered, the tax would be apportioned to the respective issuers. As such, when an FSA is offered with a fully insured plan, the insurer and the FSA administrator will each be responsible for part of the excise tax. There is an outstanding question regarding whether insurers and TPAs will be able to pass the tax onto employers and workers.

Proposals to Change the Tax Treatment of Employment-Based Health Benefits

Changing the tax treatment of employment-based health coverage has been a policy goal of many Democrats and Republicans since as far back as the 98th Congress, when Ronald Reagan was president. Proposals have generally taken the form of either capping the tax exclusion from income for workers, creating a tax credit for both persons with employment-based health coverage and individuals in the nongroup market, or creating a broad-based tax credit that would displace the tax preference for employment-based coverage.

President Reagan was the first to propose a tax cap (Aaron and Burman 2008) (Chollet 1983) (Employee Benefit Research Institute 1984), tax credit bills have been introduced over the years by 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. Former Sen. Lloyd Bentsen (D-TX) was a principal architect of health insurance tax credits enacted during the first Bush administration in 1991. In 1999, then-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 their proposal went nowhere (Armey and Stark 1999). 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 (Butler and Kendall 1999) (Miller 2000).

In November 2005, the President's Advisory Panel on Federal Tax Reform released a long list of recommendations to fundamentally change the tax code. As part of the recommendations, the panel concluded that limiting the amount of health benefits that an individual could receive on a tax-preferred basis could lower overall spending on health care. The panel recommended capping the exclusion of employment-based health benefits from income, as doing so also could reduce health spending.

The second President Bush twice proposed tax credits as an alternative to the current tax treatment of health coverage, but during the 2007 State of the Union address and subsequent budget proposal for 2008 he proposed a "standard deduction for health insurance" which would act like a tax cap.[5] During the health reform debate leading up to the Patient Protection and Affordable Care Act of 2010 (PPACA), Sen. Max Baucus (D-MT) proposed that "Congress should explore ways to restructure the current tax incentives to encourage more efficient spending on health and to target our tax dollars more effectively and fairly."[6] Baucus ruled out conversion of the current tax treatment of employment-based health coverage to a tax deduction or tax credit as an approach that would go too far as it would "disrupt" employment-based benefits, but he did suggest more targeted reforms, such as a tax cap. Ultimately, it could be argued that the Baucus proposal led to inclusion of the excise tax on high-cost health plans in PPACA.

National Commission on Fiscal Responsibility and Reform

In December 2010, the National Commission on Fiscal Responsibility and Reform released "The Moment of Truth" proposal, which it said would eliminate the deficit by 2035 and reduce the debt to 30 percent of GDP by

2040. The proposal includes a combination of discretionary spending cuts, tax reform, reductions in federal government spending on health care, and changes to the Social Security program and other mandatory government programs.

As part of the proposal to eliminate the deficit and reduce the national debt, the commission proposes fundamental changes to the tax treatment of employment-based health benefits. The illustration presented in the proposal would first cap the exclusion at the 75th percentile of premiums in 2014. The cap would be frozen at that level through 2018. At that point, the exclusion would be gradually phased down and then eliminated by 2038, ending the tax preference on employment-based health benefits that workers have enjoyed since World War II. While the preferential tax treatment for workers is not the primary reason why employers offer health benefits to workers, eliminating the tax preference, especially when combined with the insurance market reforms in PPACA, could have major implications for the future of the employment-based health benefits system.

Other Proposals—There are and there will continue to be new proposals to address the deficit and the debt. Like the Commission proposal, the Heritage Foundation proposal would do away with the preferential tax treatment of employment-based health benefits. It would replace the current tax treatment of health coverage with a uniform, nonrefundable tax credit that individuals and families could use to purchase health coverage either through the work place or directly from an insurer.[7] However, not all proposals to reduce the deficit and the national debt change the tax treatment of health coverage. Both President Obama's budget proposal and House Budget Committee Chairman Rep. Paul Ryan's (R-WI) proposal leave the current tax treatment of health benefits unchanged.

Patient Protection and Affordable Care Act of 2010 (PPACA)

Currently, despite the historical cost increases, employers have in large part maintained access to health coverage through the work place. It has been argued that employers offer coverage primarily to be competitive in the labor market. However, they have been hesitant to drop coverage because there is no alternative to the employment-based system that they consider viable. When considering the implications of eliminating the preferential tax treatment for employment-based coverage, the role of PPACA must be considered.

PPACA changes the playing field in that workers will no longer need to rely on their employer to obtain health coverage. Under PPACA, workers will be able to purchase health insurance directly from a health insurance exchange; however, the key provisions of PPACA are not the exchanges *per se,* but a number of insurance market reforms that are *combined* with the exchanges, such as guaranteed issue, modified community rating, premium and cost-sharing subsidies, and increased choice of health plan. However, in order to be eligible for subsidies, workers must be ineligible for employment-based coverage or where they are eligible, the worker share of the premium must exceed 9.5 percent of their income or the actuarial value of the plan must be below 60 percent.

The role that insurance market reform may play if the preferential tax treatment of employment-based health benefits is eliminated is discussed below in the context of debt reduction. The remainder of this analysis assumes that PPACA is not repealed and that the law is not found to be unconstitutional, as advocated by critics of the law.

Implications of Eliminating the Preferential Tax Treatment of Employment-Based Coverage

Is there a future for the employment-based health benefits system if the value of such health coverage is subject to federal income tax?

To answer this question, we must return to employers' basic reason for offering such coverage. If employers offer it to recruit and retain workers, then they will continue to do so if they think they need to in order to be competitive in the labor market. But perhaps the more important question then is how *workers* will react if the tax treatment of employment-based health coverage is eliminated.

Were the preferential tax treatment of employment-based health coverage eliminated, workers would face an increase in taxes (all else equal). Starting Jan. 1, 2013, employers that issue 250 or more W-2s will be required to report the value of health benefits on the form for calendar year 2012.[8] Employers that issue fewer than 250 W-2 forms will not be required to report the value of health benefits on the form until Jan. 1, 2014.[9] Given that the information on the value of health benefits will already be reported on Form W-2, employers will already be providing enough information to workers to include the value of the benefit on tax returns for purposes of taxation of the benefit.

Once employment-based health benefits are counted as taxable income, workers would start questioning the value of keeping such coverage rather than seeking coverage on their own in the insurance exchange. The real price of employment-based coverage would increase because of its taxation, while the insurance exchange would offer subsidies to individuals in families below 400 percent of the federal poverty line (about $88,000 for a family of four in 2010) (Figure 6).

To give a sense of the degree to which workers might be better off financially in the insurance exchange as compared with employment-based health coverage, the worker portion of the premium must be examined. The worker portion of the premium is the starting point because at this time it is impossible to predict how employers will respond in terms of giving workers a portion of the employer share of the premium if workers were no longer eligible for employment-based health coverage. The worker portion of the premium is projected to be nearly $1,500 for employee-only coverage and about $6,600 for family coverage in 2014 (Figure 7). In order to derive the worker portion of the premium in 2014, it is assumed that the recent gradual increase in the employee share of the premium continues for both employee-only and family coverage (Figure 8) on the premiums shown in Figure 9.

The worker share of the premium is compared with net premiums in the exchange in 2014 in order to give a sense of whether workers would be better off with coverage in the insurance exchange or with employment-based health benefits. It is predicted that, on average, workers will pay about $1,500 out of their own pocket for employee-only coverage in 2014 (Figure 7). Figure 10 shows average premiums after subsidies by income level and age of the policyholder. Some workers will find that the net premium in the health insurance exchange is lower than their share of the premium under an employment-based plan, even when the employer portion of the premium is excluded.

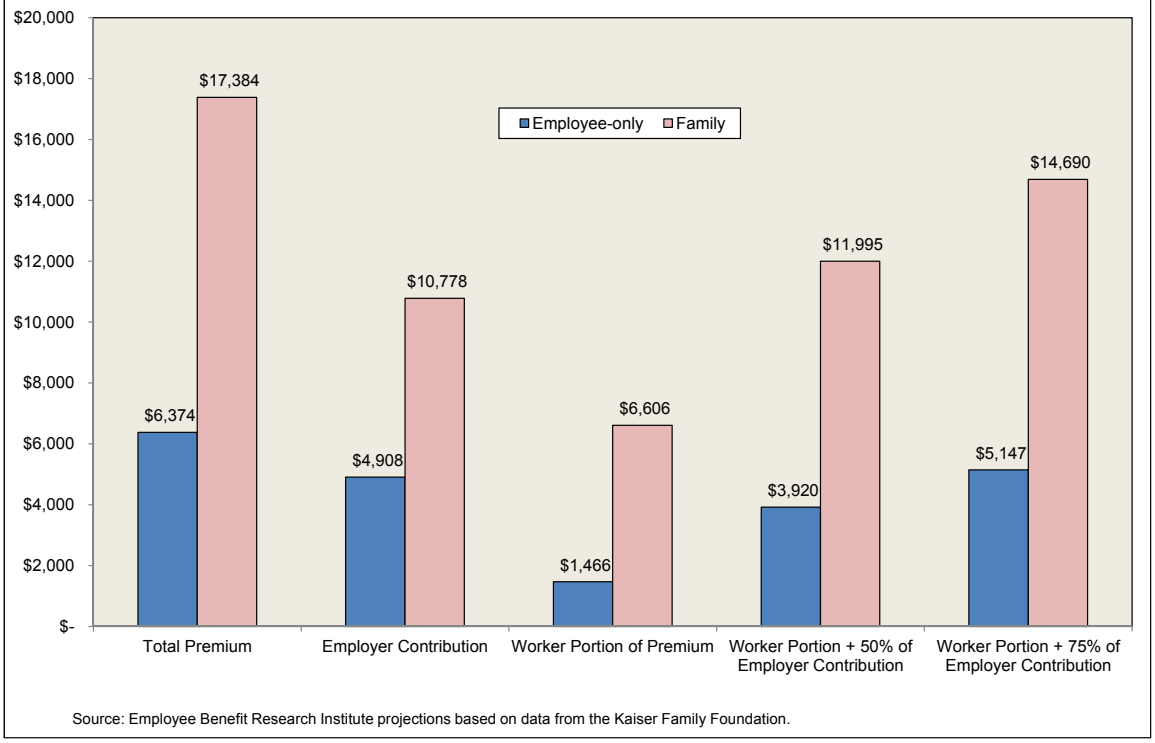
For instance, premiums will average $690 after subsidies for single coverage among policyholders regardless of age at 150 percent of the federal poverty level (FPL) in 2014.[10] Such low-income workers are predicted to pay an average of about $1,500 for employment-based health benefits through payroll deduction. They would therefore save an average of about $800 a year by receiving health coverage through the insurance exchange as compared with employment-based coverage. Workers at 200 percent of FPL would come out about even between employment-based coverage and the insurance exchange. Those above 250 percent of FPL would

Figure 6
Subsidy Levels for Individuals Purchasing Health Coverage in Insurance Exchanges

Income Level	Premium as a Percentage of Income
Up to 133% FPL	2% of income
133%−150% FPL	3−4% of income
150%−200% FPL	4−6.3% of income
200%−250% FPL	6.3−8.05% of income
250%−300% FPL	8.05−9.5% of income
300%−400% FPL	9.5% of income

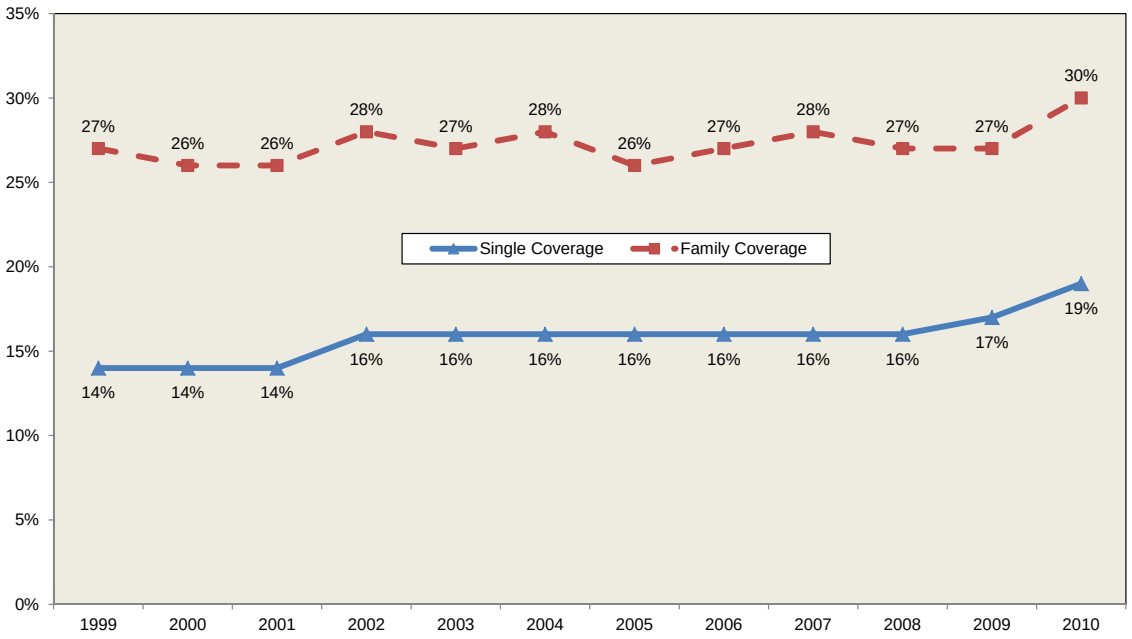
Source: PPACA.
* Federal poverty level.

Figure 7
Worker and Employer Portion of the Premium, 2014



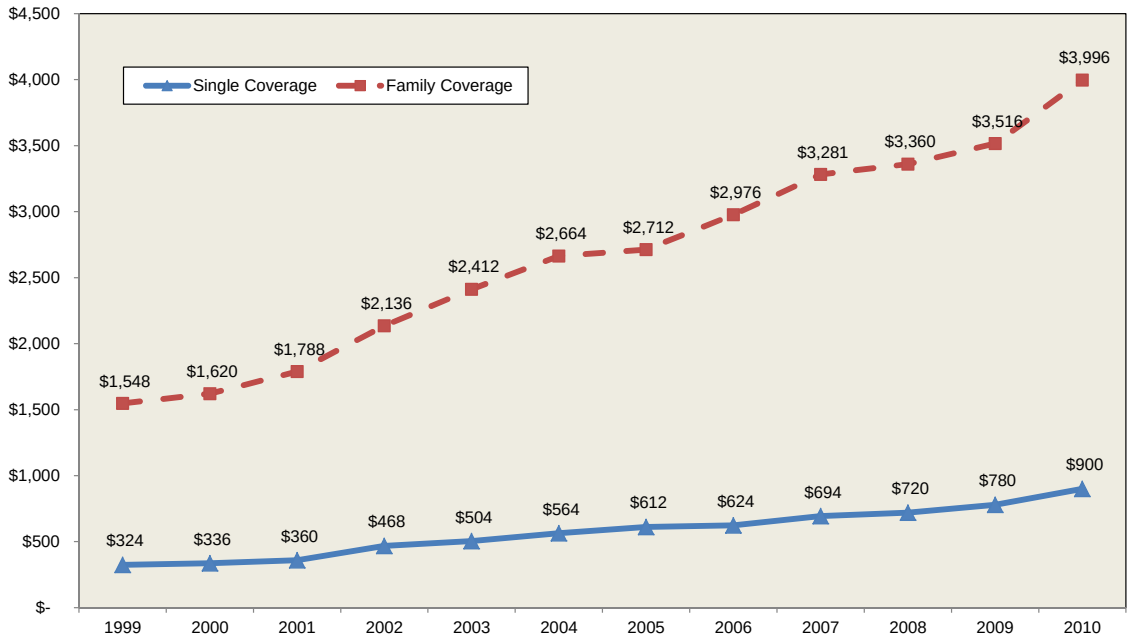
Source: Employee Benefit Research Institute projections based on data from the Kaiser Family Foundation.

Figure 8
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999–2010



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

Figure 9
Average Annual Worker Premium Contributions Paid by Covered Workers for Single and Family Coverage, 1999–2010



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

Figure 10

Premiums for Health Insurance Coverage in an Insurance Exchange, Silver Plan Coverage With 70 Percent Actuarial Value, by Income and Age of Policy Holder, 2014

Single Adult		Age of Policy Holder							
Federal Poverty Level	Projected Income	25	30	35	40	45	50	55	60
150%	$17,258	$690	$690	$690	$690	$690	$690	$690	$690
200%	23,011	1,450	1,450	1,450	1,450	1,450	1,450	1,450	1,450
250%	28,763	2,315	2,315	2,315	2,315	2,315	2,315	2,315	2,315
300%	34,516	3,279	3,279	3,279	3,279	3,279	3,279	3,279	3,279
400%	46,021	3,391	3,440	3,962	4,372	4,372	4,372	4,372	4,372
Family of Four		Age of Policy Holder							
Federal Poverty Level	Projected Income	25	30	35	40	45	50	55	60
150%	$35,137	$1,405	$1,405	$1,405	$1,405	$1,405	$1,405	$1,405	$1,405
200%	46,850	2,952	2,952	2,952	2,952	2,952	2,952	2,952	2,952
250%	58,562	4,714	4,714	4,714	4,714	4,714	4,714	4,714	4,714
300%	70,275	6,676	6,676	6,676	6,676	6,676	6,676	6,676	6,676
400%	93,700	8,901	8,901	8,901	8,901	8,901	8,901	8,901	8,901

Source: Kaiser Family Foundation, http://healthreform.kff.org/SubsidyCalculator.aspx

have to pay more for coverage in the exchange than employment-based coverage if their employer did not give them any portion of the employer share of the premium.

Employers would not have to give workers the entire employer portion of the premium to provide a large enough fixed contribution for workers to afford coverage in the insurance exchange. If employers gave workers 60 percent of the employer share of the premium for employee-only coverage, and only 21 percent of the employer share of the premium for family coverage, then all workers below 400 percent of the federal poverty level would be able to cover their full share of the premium in the insurance exchange. Employers in the exchange than employment-based coverage if their employer did not give them any portion of the employer share of the premium.

Employers would not have to give workers the entire employer portion of the premium to provide a large enough fixed contribution for workers to afford coverage in the insurance exchange. If employers gave workers 60 percent of the employer share of the premium for employee-only coverage, and only 21 percent of the employer share of the premium for family coverage, then all workers below 400 percent of the federal poverty level would be able to cover their full share of the premium in the insurance exchange. Employers would still have about $2,000 left over per worker with employee-only coverage and about $8,500 per worker with family coverage to pay the $2,000 penalty for not offering coverage.

What about workers above 400 percent of the federal poverty level? Employers that dropped coverage could increase their compensation on an after-tax basis using part or all of the savings from the employer share of the premium that was not paid out to lower-income workers.

Ultimately, the number of workers who might prefer coverage through an insurance exchange over employment-based coverage depends upon not only the relative premium in each option and income levels, but also the number of workers by income. According to Figure 11, about 41 percent of workers are in families with income between 133 percent and 400 percent of the federal poverty level. They account for 65 million workers. Even if only a fraction of these workers preferred coverage through an insurance exchange, it would send a clear message to employers that millions of workers no longer valued employment-based health benefits.

This analysis assumes that the health insurance exchanges and insurance market reforms enacted in PPACA are not repealed or found to be unconstitutional. If individuals could not buy insurance on their own and benefit from guaranteed issue and subsidies for those under 400 percent of the federal poverty level, it would be unlikely that a significant number of workers would prefer coverage from the insurance exchange over employment-based coverage if the preferential tax treatment was eliminated.

This analysis does not take into account changes in out-of-pocket expenses. The premiums used in the analysis are based on the "silver plan" in the exchange, which is tied to a 70 percent actuarial value. In other words, the plan would cover an average of 70 percent of the covered expenses for a standard population. The movement from employment-based coverage to a silver plan might increase out-of-pocket costs among individuals making such a switch. It has been estimated that, in 2007, a typical employment-based health maintenance organization (HMO) had an actuarial value of 93 percent; a typical employment-based preferred provider organization (PPO) had an actuarial value of 80–84 percent; and a typical employment-based consumer-driven health plan (CDHP) had an actuarial value of 73 percent without an employer contribution to a health savings account (HSA), but 93 percent with a $750 employer contribution (Peterson 2009). However, average actuarial values may be trending lower than those found in 2007. For example, deductibles have not only been increasing but the average rate of increase during 2008–2010 has accelerated compared with rates during 2005–2007 (Figure 12). Furthermore, cost-sharing subsidies will also be available to individuals under

400 percent of FPL purchasing health coverage through an insurance exchange, which could have the effect of reducing cost sharing below what a low income worker would otherwise be subject to in an employment-based plan (Figure 13).

There is also a question of which workers might prefer coverage in the insurance exchange over employment-based benefits. Regardless of the lower premiums, unhealthy workers may prefer employment-based coverage for a number of reasons: They may be wary of higher cost sharing and they may be concerned about leaving the certainty with employment-based coverage for the uncertainty of the insurance exchange.

If workers show a preference for health coverage in an insurance exchange over employment-based coverage, it sends a message to employers that their workers no longer value the health coverage being provided. Employers would then start to ask themselves why they should continue to offer health coverage if workers no longer value it as an employee benefit. At that point, they might simply drop the benefit, which would enable workers to get subsidized coverage in the exchange. Predicting how this might play out by firm size, industry, worker earnings, geographic region, among other things, is highly uncertain.

Tax Cap

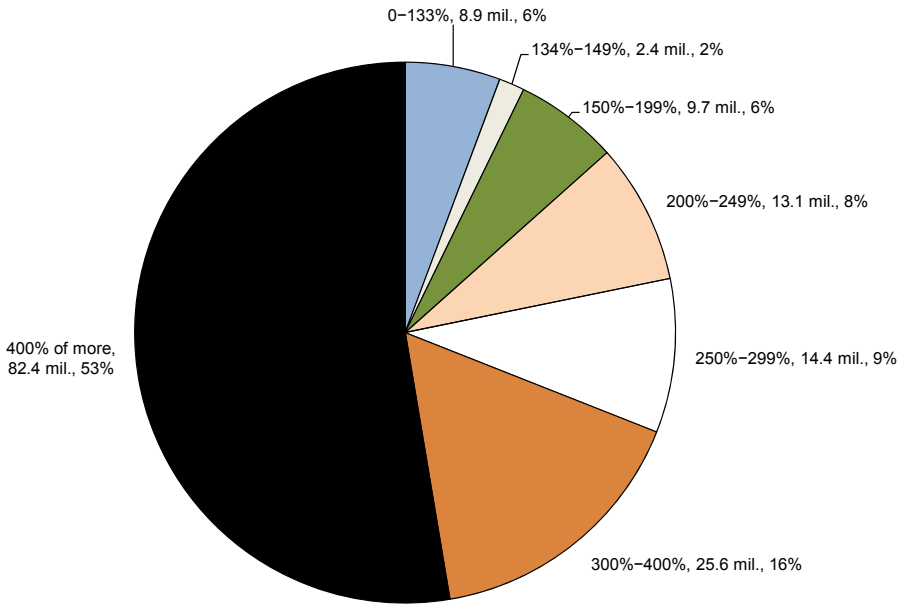
Instead of eliminating the preferential tax treatment of employment-based health coverage, policymakers could chose to use the part of the National Commission on Fiscal Responsibility and Reform proposal that caps the exclusion from worker income. There is precedent for a tax cap, as the excise tax on high-cost health plans is a form of a tax cap. It may also be a more popular option politically than full elimination of the tax preference. A tax cap would also have implications for the future of the employment-based health benefits system.

Workers' preferences for coverage through an insurance exchange and employment-based coverage would vary with how high the cap is set. Preferences could also change over time if the cap is frozen in place, as the National Commission on Fiscal Responsibility and Reform proposes doing for years 2014–2018. The higher the cap is set, the less likely workers would show a preference for coverage in the insurance exchange over employment-based coverage. High cap levels would affect only workers in plans with the highest premiums. Some of these workers are in plans with high premiums because their employer provides a very generous benefit—the kind of benefit that was the target of the excise tax on high-cost health plans. Others are in plans with high premiums because of the makeup of the plan participants, such as plans with a disproportionate number of older workers.

In cases where the plan is above the cap because it provides a very generous benefit, workers would be weighing the additional cost of higher taxes against the possible additional out-of-pocket costs were they to choose a less comprehensive plan or were their employer to provide a less comprehensive plan to help workers avoid the tax. Whether these workers would want to maintain generous benefits would be seen over time, but at some point they might prefer the health plans in the exchanges as they would be able to get a subsidy if in a family below 400 percent of the FPL. It needs to be kept in mind, however, that the subsidies are tied to the cost of the second-lowest-cost silver plan (70 percent actuarial value) in the exchange. As a result, on an apples-to-apples basis, the subsidy for a more generous plan in the exchange might not be high enough relative to a capped tax exclusion to entice a worker to opt out of employment-based coverage, though the cost-sharing subsidies may mitigate this issue for lower-income workers.

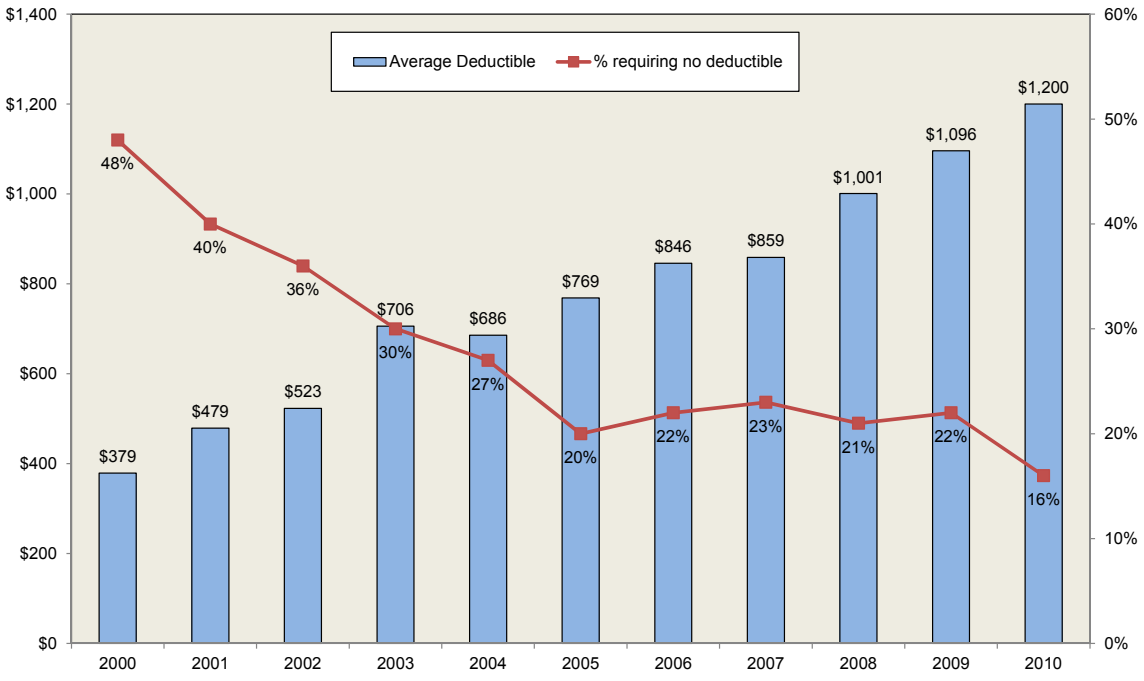
In cases where the plan is above the tax cap because of the composition of the work force, it may make sense to scrap the plan and move to the exchange. These plans are already experience rated (to the degree allowed by state law), which is why premiums are so high. The fact that premiums in the health insurance exchange have limited age rating (and virtually no age rating for workers in families below 400 percent of FPL) and no

Figure 11
Distribution of Population With Employment-Based Health Coverage, by Family Income as a Percentage of Poverty, 2009



Source: Employee Benefit Research Institute estimates from the March 2010 Current Population Survey.

Figure 12
Average PPO Deductible, Employee-Only Coverage, 2000–2010



Source: Mercer.

variation for health status may mean that those premiums would be lower than the premiums in an employment-based group plan with unhealthy enrollees.

Employer Reaction

Employers could react to a change in the tax treatment of employment-based health coverage in a number of ways. Initially, employers may not react to a tax cap or to full elimination of the tax preference for employment-based health benefits. If the change in taxes only affects workers (as opposed to the employer deduction as a business expense), employers might continue to provide health coverage simply because they consider it an important tool for recruitment and retention.

However, in the case of a tax cap, employers might view it as a way to reduce workers' tax burden, by cutting health benefits to reduce premiums to below the tax cap level. In the case of full elimination of the tax preference, employers might also cut health benefits as a way to reduce workers' tax burden. Regardless of the change in the tax preference, if employers cut health benefits by moving to less comprehensive coverage, some workers inevitably would value those benefits less than they had in the past. This could contribute to fewer workers demanding health benefits through the work place, and employers could respond to this lack of demand by dropping benefits entirely.

Figure 13

Cost-Sharing Subsidy Levels for Individuals Purchasing Health Coverage in Insurance Exchanges

Income Level	Actuarial Value
100%-150% FPL	94%
150%−200% FPL	87%
200%−250% FPL	73%
250%−400% FPL	70%

Source: PPACA.
* Federal poverty level.

Conclusion

The tax preference associated with employment-based health coverage is the largest tax expenditure in the budget, making it an almost inescapable target as the United States addresses severe financial issues related to the deficit and the debt. Despite incentives in PPACA for employers to continue to be the primary source of health coverage in the United States, it changes the playing field in that workers will no longer need to rely on their employer to obtain health coverage. As a result, proposals that change the way health coverage is taxed could have far-reaching implications for the number of people with employment-based health coverage, other forms of health coverage, the future of the employment-based health coverage system, and government tax collections.

If workers send employers a message that they preferred to obtain health coverage through an insurance exchange and that employment-based health coverage was no longer a valued employee benefit, either because of the elimination of the preferential tax treatment or because of some type of tax cap or tax reform that reduces the value of employment-based coverage, employers might stop offering it.

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Endnotes

[1] See Table E-1 in www.cbo.gov/ftpdocs/120xx/doc12039/HistoricalTables[1].pdf (last reviewed April 2011). Debt held by the public represents all federal securities held by institutions or individuals outside the U.S. government. Intragovernmental holdings represent U.S. Treasury securities held in accounts which are administered by the U.S. Government, such as the OASI Trust Fund administered by the Social Security Administration.

[2] See Table E-2 in www.cbo.gov\\ftpdocs\\120xx\\doc12039\\HistoricalTables[1].pdf (last reviewed April 2011).

[3] See www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/receipts.pdf (last reviewed April 2011).

[4] Tax expenditures related to retirement plans are different from those related to employment-based health insurance and the mortgage interest deduction. Retirement plans are not excluded from taxable income but are instead tax deferred. As a result, the tax expenditure estimate includes not only lost tax revenue but tax revenue that is collected as a result of an individual receiving income from a retirement plan. For example, in the case of 401(k) plans, tax expenditures would include the taxes lost each year due to contributions, but would subtract out the taxes collected as a result of individuals taking distributions from those plans.

[5] See www.gpoaccess.gov/usbudget/fy08/pdf/budget/hhs.pdf

[6] See http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf

[7] See http://thf_media.s3.amazonaws.com/2011/pdf/sr0091.pdf

[8] See www.irs.gov/pub/irs-drop/n-11-28.pdf

[9] If an employee terminates employment during the year, employers are required to provide a W-2 form within 30 days after the date of receipt of a written request from such employee. Therefore, employers should be in a position to report the value of health coverage on W-2 forms as early as Jan. 2012 for those filing 250 or more forms, and Jan. 2013 for those filing fewer than 250 forms.

[10] Despite the fact that premiums vary with age, the subsidized portion of the premium that individuals under 400 percent of FPL are required to pay does not vary with age in most circumstances.

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