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Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employers and Workers

By Paul Fronstin, EBRI

EXECUTIVE SUMMARY

HEALTH CARE TAX CAP—With health reform a major priority of the new 111th Congress and President Barack Obama, this *Issue Brief* examines the administrative and implementation issues that arise from one of the major reform proposals: *Capping* the exclusion of employment-based health coverage from workers' taxable income.

CURRENT TAX TREATMENT—The amount that employers contribute toward workers' health coverage is generally excluded, without limit, from workers' taxable income. In addition, workers whose employers sponsor flexible spending accounts are able to pay out-of-pocket expenses with pretax dollars. Employers can also make available a premium conversion arrangement, which allows workers to pay their share of the premium for employment-based coverage with pretax dollars.

TAX CAP RECOMMENDATIONS—In 2005, a presidential advisory board concluded that limiting the amount of tax-preferred health coverage could lower overall private-sector health spending. The panel recommended a cap on the amount of employment-based health coverage individuals can exclude from their income tax, as a way to reduce health spending. In his 2008 "Call to Action" for health care reform, Sen. Max Baucus (D-MT), chairman of the Senate Finance Committee, states 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."

IMPLEMENTING A TAX CAP—While a tax cap on health coverage sounds simple, for many employers, it could be difficult to administer and results would vary by employer based on the type of health benefit plan, the size and demographics of their work force, and even where the workers live. The change would be especially difficult for self-insured employers that do not pay insurance premiums, since they would have to set the "premium equivalent" for each worker. This would not only be costly for employers, depending upon the requirements set out by law, but could also create fairness and tax issues for many affected workers.

ADMINISTRATIVE COSTS—For self-insured employers, calculating insurance premium costs under a tax cap could be done fairly easily using the COBRA premium. However, whether self-insured employers would be able to use the least costly method to determine the value of coverage would have to be determined by law and/or regulations.

THE SEC. 89 EXPERIENCE—Sec. 89 of the Tax Reform Act of 1986, which attempted to make employee benefits more standard and fair, became so controversial that it was repealed by Congress in 1989—in part because the regulations created regulatory burdens that were so complicated and costly as to be unworkable. Similarly, valuation calculations under a health coverage tax cap could become overly burdensome if the lessons from Sec. 89 are not heeded.

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Introduction

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 income tax exclusion for workers or creating a tax credit both for persons with employment-based health coverage and those in the non-group (individual) market.

President Reagan was the first to propose a tax cap (Aaron and Burman, 2008). 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 health tax credit proposals by 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, and Miller, 2002).

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.[1] Most recently, in November 2008, Sen. Max Baucus (D-MT) released his vision for health reform; in the last section of his proposal, Baucus states 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."[2] Baucus rules 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, saying it would "disrupt" employment-based benefits, but he does suggest more targeted reforms, such as a tax cap.

From both a budgetary and political perspective, the tax preference associated with employment-based health coverage is an almost inescapable target. So-called "tax expenditure" estimates of the current tax exclusion on health benefits—government revenue foregone due to its tax treatment—are large and vary depending upon the source of the estimate. During FY 2009, the congressional Joint Committee on Taxation (2008) estimates that $147 billion was not collected in tax revenue due to the tax treatment of health coverage and health care. It also predicts that $799 billion would not be collected in tax revenue over 2008–2012.

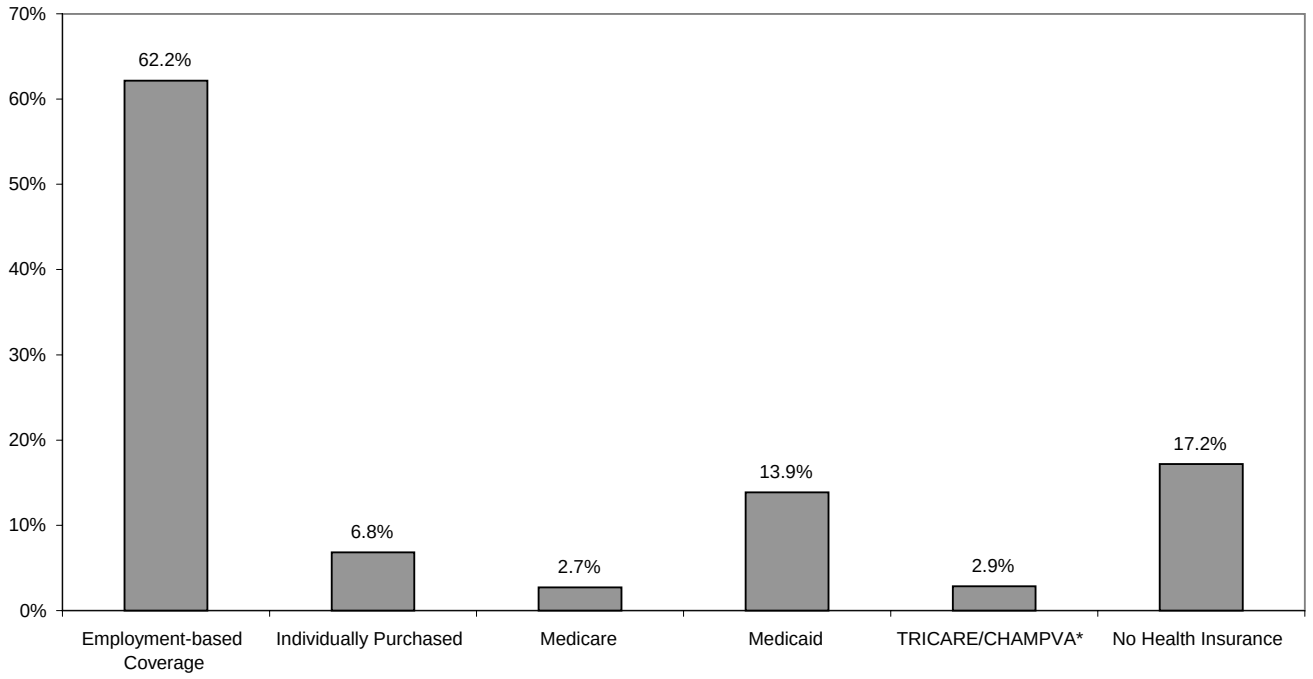
In contrast, the White House Office of Management and Budget estimates that health coverage and health care will account for $174 billion in foregone tax revenue during FY 2009 and $835 billion over 2008–2012. According to the Congressional Budget Office (2008), income tax revenue would increase $108.1 billion during 2009–2013 if the tax exclusion were limited to the 75th percentile for health premiums and indexed to inflation, and $205.7 billion if it were replaced with a refundable tax credit equal to 25 percent of the premium.

Because employment-based health coverage is by far the most common source of health coverage in the United States (Figure 1), proposals to change the way health coverage is taxed could have far-reaching implications for employment-based health coverage, including not only traditional designs but the viability of many of the newer "consumer-driven" health plan designs that use a combination of flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs). The proposals also raise questions about the cost and challenges to employers—as the sponsors of job-based health benefits—of administrating a change in the tax treatment of health coverage.

This *Issue Brief* examines the administrative and implementation issues that arise with *capping* the exclusion of employment-based health coverage from workers' taxable income, which is likely to be at the center of the upcoming national debate on overhauling the U.S. health coverage system, a top priority of both the new Democratic majority in Congress and President Barack Obama. It first summarizes the current tax treatment of health coverage. It discusses reasons why there is interest in changing the tax treatment of health coverage. It then discusses implementation issues for employers and implications for workers and retirees. Lessons from the repeal of Sec. 89 of the Tax Reform Act of 1986 (TRA '86) are also discussed, since that experience relates to regulations valuing health coverage.

This *Issue Brief* only examines *capping the tax exclusion* of employment-based health coverage from workers taxable income. It does not examine changing the *deductibility* of health coverage and health benefits as a business expense for employers. It also does not address *tax credits* or past proposals to provide a tax break to individuals who purchase health insurance directly from an insurance company. See Fronstin (2006), Fronstin and Salisbury (2007) and

Figure 1
Sources of Health Insurance Coverage, Individuals Under Age 65, 2007



Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2008 Supplement.
Note: Details add to more than 100 percent because individuals may receive coverage from more than one source.
* TRICARE (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active-duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

the references within those papers for a more detailed treatment of issues related to leveling the tax-treatment playing field between employment-based health benefits and non-group insurance and the impact on pooling and the future of employment-based health coverage. This report also does not address implementation issues involving the Internal Revenue Service (IRS).[3]

Current Tax Treatment of Health Coverage

The tax treatment of health coverage in the United States has been written into the Internal Revenue 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 (NWLB) froze wages during the war, employers sought ways to get around the wage controls in order to attract scarce workers (Helms, 2008). In 1943, the NWLB ruled that employer contributions to insurance did not count as wages, and thus did not increase taxable income to workers, 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 (Shiels 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 Helms (2008), the NWLB mimicked 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 toward 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 counted as employee income. Lyke (2008) goes so far as the 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 and Helman, 2003; Fronstin, 2007).

Currently, employers that are subject to taxes can deduct from taxable income the cost of providing health coverage as a business expense. This means that whatever an employer spends on health insurance or health coverage 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 income when they chose 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 they should therefore 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 2009.[4] 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).

With respect to workers (including the self-employed), the amount that employers contribute toward health coverage is generally excluded, without limit, from taxable income. In addition, workers whose employers sponsor 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. 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.

Individuals are able to deduct from taxable income contributions they make to a health savings account (HSA), if they have health coverage with a deductible of at least $1,150 for individual coverage or $2,300 for family coverage. In order to make tax-free contributions to an HSA, the health plan must also impose a $5,800 maximum out-of-pocket limit for individual coverage, and a $11,600 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 $3,000 for individual coverage and $5,950 for family coverage. Those age 55 and older can make "catch-up" contributions to an HSA as well. In 2009, 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.

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.

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

In November 2005, the President's Advisory Panel on Federal Tax Reform released a long list of recommendations to fundamentally change the federal tax code.[5] As part of the recommendations, the Panel concluded that limiting the amount of health coverage that an individual could receive on a tax-preferred basis could lower overall private-sector health spending. The Panel recommended capping the exclusion of employment-based health coverage from income, as doing so could reduce health spending.

The theory behind capping the health exclusion rests on the assumption that, because of the tax-preferred status of employment-based health coverage, workers prefer health coverage over cash wages—and because of this preference for health coverage, they are "over-insured" and therefore use more health care services than they otherwise would. The theory holds that workers over-insure because health insurance premiums are not included in taxable income, but out-of-pocket spending on health care services is usually not deductible from taxable income. As a result, workers prefer comprehensive coverage with low cost-sharing. Ultimately, it is argued that low cost-sharing—the ability to pay out-of-pocket spending with pre-tax dollars—leads to overuse of health care services, which drives up insurance premiums and makes coverage less affordable, especially for lower-income workers.

The Panel was mixed in its assessment of whether the tax exclusion is good or bad. On the one hand, the Panel suggested that the tax exclusion is costly and has a negative impact on the market for health care. On the other hand, the Panel concluded 1) the immediate elimination of the tax exclusion for employment-based health coverage would adversely affect many Americans, and 2) several members felt that the tax code should provide an incentive for individuals to have health coverage. Also, the Panel recognized that the employment-based health coverage system reduces transactions costs, may lower premiums for some people who otherwise could not afford health coverage, and

may lead to a greater percentage of the population with coverage. Yet, prominent in the Panel's recommendation were changes in the way health coverage is taxed.

In terms of specific recommendations, the Panel recommended that limits be imposed on the degree to which employees could receive health coverage on a tax-preferred basis. The Panel recommended that (in 2006) the exclusion from income be limited to $5,000 for employee-only coverage, and $11,500 for family coverage. It also recommended that employer spending on health coverage continue to be deductible as a business expense.

Sen. Baucus, as mentioned above, suggests consideration for "capping the amount of health insurance premiums that can be excluded from employee wages for income and payroll tax purposes." He goes on to mention limiting or capping the tax exclusion based on the value of health coverage and/or based on a person's income. He also proposes an exclusion available on a sliding scale and based on income. Otherwise, Baucus offers no details on employer implementation of such a proposal or its effect.

Implementing a Tax Cap: Implications for Employers

On the surface, capping the tax exclusion for health coverage sounds like a straightforward proposition. Employers would be required to report the premium or cost of health coverage on workers' W-2 statements, and workers with coverage valued above the cap would pay taxes on the value of the coverage above the level of the cap. Employers would continue to offer health coverage and workers would continue to get their coverage through their employer. Workers whose cost for coverage is below the cap would see no changes, while workers whose cost for coverage was above the cap would see a change.

Those with a choice of health plan would either 1) pay the tax on the excess value of coverage, or 2) choose a less costly health plan to avoid the tax on health insurance premiums above the cap. Workers above the cap but without a choice of health plan would either 1) pay the tax on the excess value of coverage, or 2) demand that their employers reduce premiums, which would happen by buying down health coverage to a less comprehensive benefits package. Overall, about one-half of employees in firms that offer health coverage currently work for an employer that offers only one plan, and among the one-half working for an employer offering two or more plans, not all of those workers are necessarily eligible for all of the health plans.[6]

Whether the cap on the value of coverage takes the form of a uniform cap or varies by income, as long as employers are required to report the value of coverage on workers' W-2 form, the implications of such a requirement will vary by employer. Employers that offer health coverage finance those benefits in one of two ways: those that purchase health insurance from an insurance company (so-called "fully insured" plans) and those that provide health coverage directly to employees ("self-insured" plans). Overall, 45 percent of workers currently are covered by a fully insured plan and 55 percent are covered by a self-insured plan.[7]

Fully Insured Plans: In a fully insured plan, the employer pays a premium per employee to the insurance company, and the insurance company is the risk bearer, meaning it has to assume the risk of providing health coverage for insured events. In fully insured arrangements, premiums vary across employers based on employer size, employee population characteristics, and health care use. Premiums can also change over time within the same employer simply because of changes to the demographics of the employed group. However, employers are charged the same premium for each employee despite the fact that the employer is likely to employ workers of different characteristics and health care use. Employers with a disproportionate share of older workers will pay higher premiums than an employer with younger workers for the same health plan, but within each employer, the insurer will charge a uniform premium for each employee or dependent covered.

Small employers that offer health benefits are typically fully insured, meaning they purchase health insurance for their employees directly from an insurance company. In 2008, 88 percent of workers in firms with three–199 employees were in fully insured plans.[8] Because these employers purchase health insurance for their employees and pay a clearly identifiable premium to an insurer, fully insured employers would only have to report the premium on an employee's annual W-2 form to the IRS. Premiums that are paid directly to insurers are known long before employers must file W-2 forms, and premiums are the same for all employees in the company with the same health plan. Smaller firms are typically located in one office or region (if they are on the large side of small). Even if there were multiple locations with different benefit plans and premiums, as long as the employer was paying premiums to an insurance company, it would be relatively easy to report the premium to a payroll company to include on employee W-2s.

Employers that offer fully insured health plans would also need to report the premium to a payroll company to include on employee W-2s, even if that employer operated in multiple locations. Large employers would bear a slightly higher administrative cost than smaller employers if more than one fully insured plan was offered, since reportable information would vary according to the health plan.

Self-Insured Plans: In a self-insured plan, instead of purchasing health insurance from an insurance company and paying the insurer a per-employee premium, the employer acts as its own insurer. In the simplest form, the employer uses the money that it would have paid the insurance company and instead directly pays health care claims

to providers. Self-insured plans often contract with an insurance company or other third party to administer the plan, but the employer bears the risk associated with offering health coverage. Self-insured employers do not pay premiums to an insurance company.

Self-insured employers tend to be large. In 2008, 89 percent of workers employed in firms with 5,000 or more employees were in self-insured plans.[9] Unlike fully insured plans, self-insured plans would have to determine the "value" of health benefits were they required to report it for income tax purposes, since there are no premiums to easily identify the per-employee cost.

The "Value" of Self-Insured Health Benefits

Under a self-insured arrangement, employers do not purchase insurance from an insurance company and do not pay premiums to such a third party.[10] Instead, the employer provides health coverage or a health "benefit" program to its employees. Some employees use the coverage while others do not. While employers can *create* the equivalent of a premium in a self-insured arrangement, determining the "premium equivalent" for each employee may be costly, depending upon the requirements set out by law.

Self-insured employers tend to be large and often have workers not only in multiple locations, but across geographic regions throughout the United States. Even when an employer offers a uniform program across all locations and geographic regions, the cost of coverage or "premium equivalent" will vary across locations and geographic regions because the cost of health care services is not uniform across the United States. Also, large employers often offer multiple self-insured health plans to different classes of workers. Coverage may vary for management and rank-and-file, and coverage may vary by occupation or even hours of work.

The least-costly way for a self-insured employer to calculate the premium equivalent would be to use the COBRA[11] premium. For each plan, the employer would estimate the anticipated claims for the upcoming year. Estimates could be generated in-house or the employer could hire an actuary. The estimates on anticipated claims would then be used to derive the average cost of coverage per worker based on the various ways employers allocate spending, in order to come up with the premium-equivalent for employee-only coverage and family-coverage, employee+1, and employee+spouse if the employer used those categories in its benefits design as well.[12]

Whether self-insured employers would be able to use the simplest method to determine the premium equivalent would be determined by legislation and/or regulations. Sec. 89 of the Tax Reform Act of 1986 (TRA '86) was repealed by Congress in November 1989 because the regulations created a complicated and administratively costly burden for employers to comply with the law (see section below for more information on Sec. 89). In fact, Sec. 89 required that employers value benefits based upon the coverage *received* rather than the coverage *made available.*

Valuation calculations could become burdensome if lessons from the repeal of Sec. 89 are not heeded. Laws and/or regulations may make the calculation of the premium-equivalent so burdensome that the cost of complying with a coverage valuation mandate for the purposes of worker compliance with a tax cap may outweigh any benefits, creating another Sec. 89-type scenario. For example, rules and regulations may require that employers calculate a premium equivalent for each worker based upon his or her unique characteristics, such as age, health status, geographic region, benefits package, family status, etc. In other words, the value of the coverage would be lower for lower-risk individuals than it is for higher-risk individuals. Congress may instead allow employers to use COBRA premiums or domestic partner premiums to value coverage, or Congress could be silent on how the value of health coverage is determined, which would mean employers would either have to wait for regulations to be written and released, or they would seek IRS letters of determination—both fairly long and complicated processes. In the absence of any formal law, regulation or guidance, employers would likely use COBRA premiums (less the 2 percent administrative fee) or domestic partner premiums.

Self-insured employers would have to report the value of health coverage on workers' W-2 forms, which by law is required to be furnished—properly addressed and postmarked—by January 31 each year. It is highly unlikely that self-insured employers would know their total costs for health coverage soon enough after the end of the calendar year in time to report it on a W-2 form, but they do know COBRA premiums and the cost of domestic partner benefits. The reason self-insured employers wouldn't know the true cost for health coverage at the end of the plan year is because health claims are often not filed immediately by providers and workers, and even if they are filed quickly and processed quickly (also unlikely), it takes time to collect and analyze the claims data. As a result, self-insured employers likely would have to *estimate* their health coverage costs, if they are allowed to do so by law and regulations. Questions would also arise regarding employer incentives to artificially reallocate the cost of health coverage from high-cost locations to low-cost areas, and the allocation rules needed for tax caps may be complex and difficult to enforce (Congressional Budget Office, 1994).

In addition to offering health coverage, larger employers frequently offer on-site worker health programs. These programs can take the form of on-site clinics with doctors and/or nurses; employee assistance programs that provide mental health benefits, flu shots, fitness centers, smoking cessation programs; and other health promotion, disease prevention, and disease management programs. Some employers even offer incentives for healthy behavior by providing direct payments to an account for those who follow good health practices (as defined by the employer).

Questions would arise regarding how to include the value of on-site clinics and on-site programs. Would the cost of the programs be apportioned to *all* employees and their dependents, or only those that used the programs? Or would the cost of these programs be exempt from the tax cap calculation? And if they were exempt, would that give an undue advantage from a tax perspective to workers in larger firms at the expense of workers in smaller firms where these benefits are less prevalent?

Questions would also arise regarding contributions to tax-advantaged savings and spending accounts, such as FSAs, HSAs, and HRAs. FSAs are always self-insured, even when offered by a small employer. Workers may be below the cap in terms of health insurance coverage, but their contributions to a FSA or HSA may put them above the cap if those contributions were counted toward the cap. Employers currently report worker contributions to an FSA on W-2 statements, but HRA contributions would have to be included in the premium equivalent.

ERIC Member Response to Premium Disclosure Bill

The ERISA Industry Committee (ERIC), a nonprofit association representing the employee benefits and compensation interests of America's major employers, recently polled its members' reaction to a discussion draft of legislation proposed by Sens. Baucus, Enzi, Nelson, Grassley and Wyden [13] that would require employers to disclose health plan premiums on workers' W-2 forms. There was consensus among respondents of ERIC members, as stated in a letter to the senators:[14]

- "The requirements would likely be unnecessarily burdensome in that they would require that employers conform the statements they already offer employees describing their total compensation to a specific timetable and mode of computation."
- "Companies often coordinate communications to employees with enrollment periods during which employees elect plan participation options. As a result, the prescribed timetable may even be counterproductive if the time of year that employees make decisions about their health care coverage options does not align with the time of year that they see their W-2 statements."
- "It is unlikely that disclosing this information in the manner mandated would have significant impact on beneficiaries' health care decision making. Employees already receive information concerning their benefit plans in the form of Summary Plan Descriptions (SPDs) as well as other voluntary information from their employers. The problem is getting workers to read information they already receive, not necessarily in getting employers to provide it."
- "There is no evidence to support the premise, upon which this policy proposal is based, that an employer's benefit cost-sharing is interchangeable with wages and that health care dollars spent by employers would otherwise go to increasing workers' salaries."

The ERIC letter goes into more detail on this last point and also includes examples of the specific feedback received from its members.

HSA contributions, however, create an entirely different issue. Employers would report their HSA contributions but they would be unable to report worker contributions, unless the plan facilitated employee contributions through a Sec. 125 plan. Unlike an FSA, workers are free to make contributions to an HSA without using payroll deduction. Any worker contributions made directly to an HSA would be outside the knowledge of the employer, who would be unable to report such contributions.

If employers were required to withhold taxes on the expected taxable income that is imputed based on the value of coverage and tax cap, much like they are required to withhold taxes on the fair market value of domestic partner benefits (see below for more information on domestic partner benefits), the taxes withheld would not take into account worker contributions to an HSA. This would make tax planning more difficult for workers, as they may have to either increase the amount of income tax withheld from their paycheck or start to pay estimated taxes in order to avoid any tax penalties.

Finally, not all employers use the *calendar* year as the *plan* year. This would cause complications in valuing the coverage, as coverage could and often does change from one plan year to the next. Employers would have to determine the value of coverage for each portion of the plan year and aggregate the value for reporting purposes.

Domestic Partner Benefits: Some employers already calculate the value of health coverage in self-insured health plans for worker income tax purposes. While the cost of health coverage for workers and their dependents are excluded from workers' taxable income, employers that offer domestic partner benefits are required to impute the "fair market value" (FMV) of that coverage when it is provided to non-dependent domestic partners and their children, because health coverage for domestic partners and their dependents is not excluded from worker taxable income.[15]

The imputed FMV is reported on workers' pay stubs, and the imputed income is treated as taxable wages and reported on workers' W-2 forms. Employers also must withhold income taxes on the value of those benefits, as well as Social Security and Medicare taxes.

The IRS has interpreted the FMV as the cost of group coverage, not the cost of comparable nongroup coverage. Through a series of private letter rulings, the IRS has also ruled that the FMV is not based on use of the coverage or on the benefits received under the plan, but rather on the amount that an individual would have to pay for the particular coverage. Fully insured employers can use the difference in the cost of coverage between employee-only coverage and family coverage in determining fair market value. Self-insured employers often use COBRA premiums (less the 2 percent administrative fee) in determining the FMV.

While it may seem straightforward for employers to price domestic partner coverage, not all employers follow the same practice. In some cases, employers treat domestic partner benefits as family coverage. In the case of family coverage, the imputed income is based on the difference between family coverage and employee-only coverage (assuming no other dependents). In other cases where it is only the worker and the domestic partner, employers charge the domestic partner the rate for employee-only coverage and imputed income is based on the full employee-only coverage rate.

Other than private letter rulings,[16] the IRS has refused to issue any guidance on determining the FMV and has refused to dispute or approve of this approach.[17]

Retiree Coverage: Many retirees (and their surviving spouses) receive health coverage through former employers. The employer-paid portion of the premium for this coverage is not counted as taxable income to the retiree. The implementation of a tax cap raises the question of whether retiree health coverage provided to former employees and their dependents would also be subject to the cap.

The administrative issues in determining the value of the coverage would apply as described above. Employers that offer retiree health coverage are disproportionately large and offer self-insured plans, therefore the issues regarding how to value the coverage are highly relevant for these employers. In addition, there are additional administrative issues that need to be considered: For instance, employers do not have to provide W-2 forms to retirees; therefore, the reporting mechanism would need to be addressed. Employers could use the existing 1099-R form to report the value of coverage to retirees, which would add a new cost to employers. Furthermore, employers would not be able to withhold additional taxes for retirees with coverage above the tax cap. Retirees would either need to pay estimated taxes or they would pay the entire additional tax bill associated with the coverage at the time they file their taxes. This raises a question regarding tax penalties for retirees who underpay their taxes.

Another issue arises regarding valuation of the coverage. Many employers group retirees and their dependents into the "active worker" risk pool. The addition of a tax cap may drive employers to separate active workers and retirees into separate risk pools. This would benefit active workers (who are lower-cost than retirees) and may be the goal of employers because of concerns with worker recruitment and retention. It would almost certainly disadvantage retirees, as the cost of their retiree health benefit would go up.

Means Testing: Sen. Baucus mentions the possibility of capping the exclusion from income only for higher-income individuals. When caps were put in place for defined benefit pension plans under the guise of nondiscrimination rules, the result was an explosion of new nonqualified plans, which many employers created in order to make up for the lost benefit for higher-income workers. Similarly, if the income tax exclusion for the cost of health coverage were capped, employers might seek ways to restore the coverage through some sort of new nonqualified vehicle. This would defeat the purpose of capping the exclusion if the goal is to lower the cost of health coverage.

Implications for Workers and Retirees

A primary goal of capping the tax exclusion of employment-based health coverage is to reduce the cost of health care and therefore health coverage. The expectation is that workers would choose or ask employers to offer health plans that are valued at or below the cap in order to avoid paying taxes on excess health coverage. In order to reduce the value of health coverage, employers could offer less comprehensive coverage, and workers and their families would use fewer health care services as a result.

How coverage is valued will affect workers differently, depending on a number of factors. Furthermore, the goal of reducing the number of people covered by so-called "Cadillac" health plans may have the unanticipated consequence of creating equity issues regarding who bears the burden of the tax on excess health coverage and what it really means to have "excess" health coverage.

There are a number of reasons why health insurance premiums in a fully insured plan or the value of health coverage in a self-insured plan would be above the tax cap that are completely independent of the comprehensiveness of the coverage. The cost of health coverage is known to vary with firm size, employee health status, average age of the group of employees, and geographic region. To the degree that individuals face higher taxes as a result of these factors, the principle of "horizontal" equity is violated (Congressional Budget Office, 1994).[18]

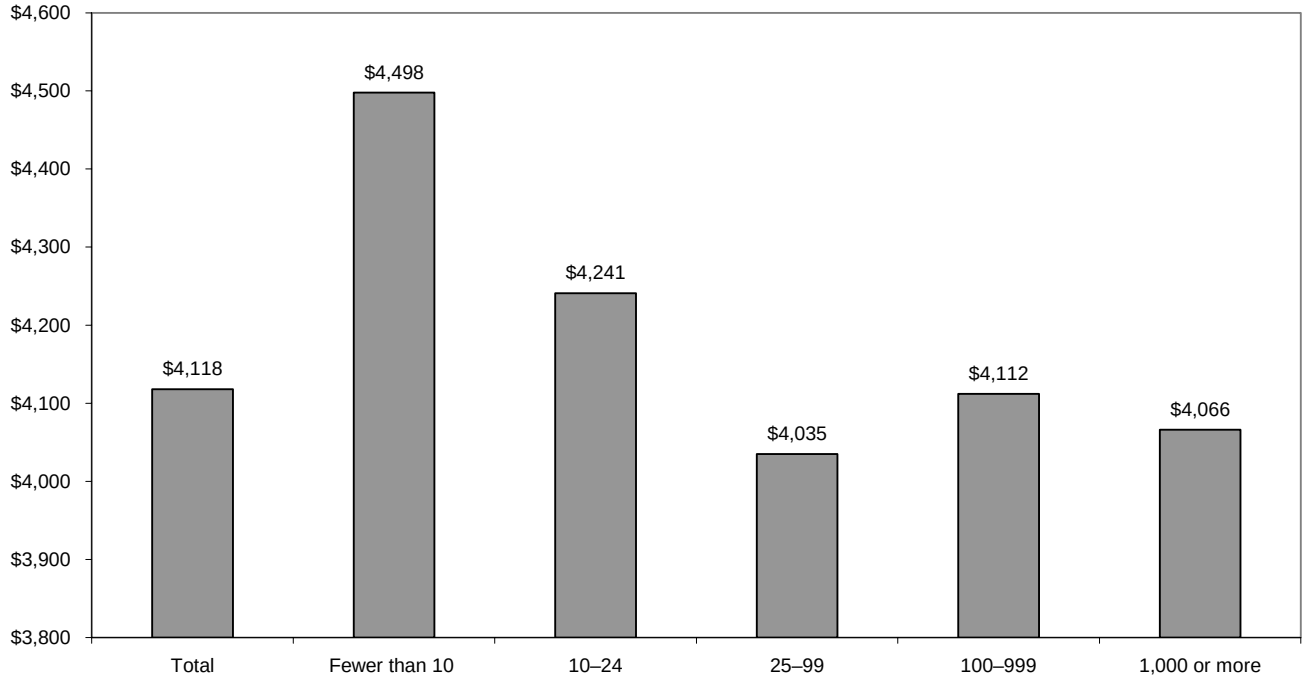
Questions Raised by Employers and Others: Implementation Challenges

A number of individuals interviewed for this report and/or peer reviewers raised implementation questions and concerns that they hope would be addressed if the federal government pursues a tax cap on health coverage. These questions are not meant to be exhaustive, but are listed here solely to illustrate logistical problems facing plan administrators. Some are more relevant to the debate than others, but they represent the kind of troublesome logistical details that may need to be addressed if a tax cap on health coverage were to work as planned. They are directly quoted below without attribution.

- "Deal-breaker is actual claim costs. We cannot report from the insurance companies the actual costs by employee to the W-2. We have too fragmented of a system to do this and [it] fails to recognize the insurance aspect of pooling risk."
- "It might be administratively easier to repeal the deductibility of health care costs of the employer."
- "In taxing the value of health care benefits: The employer-paid value premium or COBRA-like premium is relatively easy to report. The question is under a Sec. 125 plan: How would you treat salary deferral elections, since under the tax code it is classified as employer [money]—yet employees feel it is their premium money?"
- "The January deadline for W-2 reporting would be a challenge with coverage changes that occur in December. The reporting lag would make it difficult to complete calculations of the excess value in order to strictly comply. For example, someone who gets married and drops dental coverage in December would see a different amount of taxable income. Although imputed income under life insurance can be affected by a December pay change, the amount can be automated easily in the payroll system."
- "There is a timing issue in that the cost for a year for a self-insured plan is not known until well after the end of the year."
- "There are often special arrangements for lay-offs or early retirement windows.
- How would the employer reflect health incentives, such as additional payments to an account for those who follow good health practices?"
- "Those in high-cost groups would lose the ability to use an FSA, while those in low-cost groups might not."
- "In terms of risk pools—some employers pool actives and retirees in the same pool, while others separate them. Same goes for wage versus salary. By the very risk pool [they wind up in], employees could be taxed significantly differently. I know of an employer that offers a PPO and HSA plans. The selection is older, higher-cost employees elect the PPO, and thus the premium rates are materially higher for the under-25 employees who enroll in it."
- "Some employers offer premiums by pay grade—again, another level of complexity for administration."
- "Restricting the employer-cost deduction for health care is a deal-breaker. Employers would likely switch to [all] compensation to achieve a full tax deduction. We cannot afford to forgo 30–35 percent of a tax deduction [for health benefits] while it is fully available under pay."
- "Do you feel a tax break leads to over use of health care in general? Yes—for the FSA program with the use-it-or-lose-it. But this is negligible compared to the total program. Do employees even understand the pre-tax nature of premiums under a Sec. 125 plan? Would you get a medical treatment twice merely because of the tax break? I would concede employees buy up coverage using pre-tax dollars, which leaves them more take-home pay and the opportunity to avoid paying at the time of service. The 100 percent-plan [coverage] design enables employees to disengage from health care purchasing. But I do not feel the pre-tax nature encourages more usage at the time of the service when it comes out of the bank account of the employee—regardless of the pre- vs. post-tax nature."
- "With small employers, premiums are usually age-banded. This would add a complexity of reporting employee-specific premiums, which disadvantages older workers of small employers compared to [those of] large employers."
- "In terms of taxing the benefit, we need to address the employee deferrals of FSAs and HSAs. Is that an employer-provided value, or pre-tax aspect of the employee?"
- "Taxing it may drive employers to separate the risk pools of actives and retirees. It benefits actives to have a lower cost (to attract and retain), while older retirees who have limited tax advantages today could see higher tax rates. How might we address social benefits such as Medicare and Medicaid? Are they considered already taxed due to FICA taxes, or is it considered a benefit provided?"
- "How much flexibility will employers have in calculating the cost of coverage by the types of health plans, such as not only employee-only and family coverage, but employee+1 and employee+spouse?"
- "The January deadline for W-2 reporting would be a challenge with coverage changes that occur in December. The reporting lag would make it difficult to complete calculations of the excess value in order to strictly comply."

Firm Size: The cost of providing health coverage varies by firm size. Small employers pay more than large employers for identical health coverage. Small employers tend to provide less comprehensive coverage than large employers and even when they do, they pay more on average than large employers. In 2006, employers with fewer than 10 employees paid $4,498 for employee-only coverage, whereas employers with 1,000 or more employees paid $4,066 on average (Figure 2). Smaller employers face higher costs for coverage than larger employers because they do not have the same purchasing power as larger employers, and smaller employers do not realize the same economies of scale in the purchasing of health coverage. As a result, workers employed at small firms would be more likely to pay taxes on excess health coverage than workers at larger firms, even when the actual health insurance coverage is the same. The difference in cost of coverage may be solely due to firm size and may have nothing to do with the comprehensiveness of the coverage.

Figure 2
Average Total Employee-Only Premium at Private-Sector Establishments, by Firm Size, 2006



Source: www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2006/tic1.htm

Geographic Region: Where employees live and/or work also has an impact on the cost of coverage independent of the comprehensiveness of the health plan. For example, health plans offer Medigap plans, which are health plans that Medicare beneficiaries use to supplement Medicare; these plans have been standardized, which means a Medicare beneficiary purchasing Medigap Plan C in one state will have the same exact coverage as a Medicare beneficiary purchasing Medigap Plan C in a different state. However, while the *coverage* may be standardized, the *premiums* for Medigap Plan C vary considerably by state. For example, in 2005, the average premium for Plan C in New York was $1,204, while in neighboring Connecticut it was more than twice as high at $2,589 (Figure 3). And state averages masks an even wider variation in premiums that cannot be accounted for by any difference in the comprehensiveness of the coverage. At the extremes, Plan C premiums varied across the United States from $651 to $9,798,[19] even though plan coverage is the same nationwide.

Medigap premiums are not useful for evaluating the monetary impact of a tax cap, but they are useful for illustrating the fact that premiums vary substantially even when the coverage does not. It would be more useful to compare premiums for active workers and their dependents, but the premium data would need to control for the comprehensiveness of the coverage in order to be meaningful. Recently released data on premium variation (which do not control for the comprehensiveness of coverage) do show wide variation in premiums. When grouping states by the

four major geographic regions, it can be seen that premiums for family coverage range from an average low of $12,252 to an average high of $13,656 (Figure 4).

Figure 3
Average Medigap Plan C Premiums, by State, 2005

Alabama	$1,786
Alaska	1,062
Arizona	1,750
Arkansas	2,199
California	1,820
Colorado	1,582
Connecticut	2,589
Delaware	1,899
District of Columbia	1,571
Florida	2,224
Georgia	1,791
Hawaii	1,620
Idaho	2,058
Illinois	1,566
Indiana	1,676
Iowa	1,497
Kansas	1,666
Kentucky	1,678
Louisiana	1,948
Maine	1,926
Maryland	1,864
Michigan	1,955
Mississippi	1,554
Missouri	1,788
Montana	1,399
Nebraska	1,649
Nevada	1,851
New Hampshire	1,606
New Jersey	1,759
New Mexico	1,685
New York	1,204
North Carolina	1,634
North Dakota	1,510
Ohio	1,975
Oklahoma	1,666
Oregon	1,519
Pennsylvania	1,727
Rhode Island	1,807
South Carolina	1,663
South Dakota	1,543
Tennessee	1,705
Texas	1,813
Utah	1,432
Vermont	1,685
Virginia	1,484
Washington	1,993
West Virginia	1,744
Wyoming	1,638

Source: www.weissratings.com/News/Ins_Medigap/20050830medigap.pdf

The effects of a tax cap have a lot to do with the level at which the cap is set, and would also be affected by how fast the cap is allowed to grow over time. If a tax cap was set at the national average premium of $12,680, then people in the northeast and Midwest parts of the United States would be more likely to be above the tax cap and disproportionately affected by it. The additional tax for people in the northeast would range from $98 per year for those in the 10 percent tax bracket to $342 for people in the 35 percent tax bracket. Among those in the Midwest, individuals in the 10 percent tax bracket would pay an additional $13 in taxes, while those in the 35 percent tax bracket would pay an additional $45. Individuals in the South and West would be much less likely to pay additional taxes by virtue of the lower cost of health benefits in their regions.

If the tax cap was set high enough such that individuals in all regions were on average above it, there would still be wide variation in the amount of additional taxes incurred because of geographic variation rather than due to any differences in comprehensiveness of the benefits. If the tax cap was set at a lower level, additional tax payments would be higher on average and more individuals would be incur additional taxes. For example, if the tax cap were set at $11,000, additional taxes would be higher in the northeast and Midwest than if the tax cap were set at $12,260, and it would trigger additional taxes for individuals in the South and West.

The real issue is that there would be disparities in the additional tax incurred by individuals simply because of differences in premiums by geographic regions. Individuals in the 10 percent tax bracket in the West would incur an additional $135 in taxes, while those in the northeast would incur $266 in additional taxes. Similarly, individuals in the 28 percent tax bracket would incur an additional $744 in taxes, while those in the west would incur an additional $378 in taxes. In addition, these additional tax estimates are only for federal income taxes. These additional tax estimates do not take into account any additional payroll taxes or state and local taxes that may be incurred.

The geographic differences are significant not just because of the way they affect individuals living in different parts of the country, but because they could affect workers employed in the same firm differently. For example, if a self-insured employer with multiple locations throughout the country that offers uniform coverage is required to take into account any geographic differences in the cost of providing health coverage in its valuation of coverage, workers within the same tax bracket but in different locations in the company would either pay different amounts in additional taxes if all are above the tax cap, or some workers would pay additional taxes while others do not—even when covered by the same health coverage simply because of where they work.

The use of the four major geographic regions should not imply that geographic region differences are small. Use of these regions masks important variation in the coverage as shown with the Medigap premiums above. Figure 5 presents data on average total employee-only premiums for "exclusive-provider plans"[1] by firm size and state. These plans are a good proxy for how a tax cap may affect employees differently by geographic region because variation in the coverage offered is relatively small. Overall, premiums vary from $3,036 in Idaho to $4,768 in Delaware, a 57 percent difference. In establishments with fewer than 50 employees, premiums varied by more than 100 percent, with a premium of $2,401 in Kentucky and $5,184 in Texas, whereas among larger employers, premiums varied by 56 percent, ranging from $3,162 in Nevada to $4,947 in West Virginia.

While individuals may incur higher taxes simply because of where they live or work, it is well known that the provision of health care costs more in certain parts of the country than in others. A tax cap that was uniform regardless of geographic region might put pressure on high-cost regions to bring their costs more in line with more-efficient regions.

Figure 4
Impact of Tax Cap Due to Variation in Premiums by Geographic Region, 2008

	$12,680 Tax Cap				
	Average	Northeast	Midwest	South	West
Total Cost	$12,680	$13,656	$12,809	$12,252	$12,351
Tax Cap	12,680	12,680	12,680	12,680	12,680
Excess Health Benefits		976	129	0	0
Tax on Health Benefits					
10% tax bracket		98	13		
15% tax bracket		146	19		
25% tax bracket		244	32		
28% tax bracket		273	36		
33% tax bracket		322	43		
35% tax bracket		342	45		
	$11,000 Tax Cap				
	Average	Northeast	Midwest	South	West
Total Cost	$12,680	$13,656	$12,809	$12,252	$12,351
Tax Cap	11,000	11,000	11,000	11,000	11,000
Excess Health Benefits		2,656	1,809	1,252	1,351
Tax on Health Benefits					
10% tax bracket		266	181	125	135
15% tax bracket		398	271	188	203
25% tax bracket		664	452	313	338
28% tax bracket		744	507	351	378
33% tax bracket		876	597	413	446
35% tax bracket		930	633	438	473

Source of premium estimates: Exhibit 1.3 in http://ehbs.kff.org/pdf/7790.pdf

Group Composition: Premiums may be over the tax cap not because of the comprehensiveness of insurance but instead because of the composition of the group an individual belongs to. Insurers can and often do charge higher premiums for the same benefits package to groups with higher-than-expected expenses than to groups with lower-than-expected expenses. This could translate into workers in one firm paying higher taxes because their premium is above the tax cap simply because workers employed in that firm were less healthy or older than the average group. Hence, two workers in the same industry, in the same city, with the same health coverage could pay different taxes on the benefits (with one incurring a tax increase and the other not seeing any change in taxes) simply because of the health status of the workers at the firm. Similarly, two workers in the same city with the same health coverage could pay different taxes on the coverage simply because one is in a high-cost industry (like construction) while the other is in a low-cost industry.

Similarly, within a firm, if health coverage is valued at the same level for all workers, younger healthier workers may incur additional taxes if the firm pays high premiums simply because it employs a disproportionate share of older, less-healthy workers.

Implications for Retirees: If retiree health benefits were subject to the tax cap, retirees would be much more likely to incur higher taxes than active workers. Retirees are older and less healthy than the average worker. As recently as 2006, the average annual premium for single-person pre-Medicare-eligible retiree health benefits was more than $6,600, with employers paying an average of $3,900 per retiree. Employer contributions are excluded from a retiree's taxable income, but retiree contributions are made on an after-tax (out-of-pocket) basis and are deductible from taxable income only to the degree they meet the 7.5 percent AGI rule, as discussed above.[20] In contrast, the average employee-only premium in 2006 was $4,242.[21] Premiums for retirees are higher than active worker premiums because they are older and use more health care services than the typical younger active worker. A uniform tax cap across workers and retirees would mean that a disproportionate number of retirees would be above the tax cap simply because of their age and health status. However, any tax cap applicable to retirees will be mitigated by the fact that only the employer portion of the premium would be subject to the tax cap because the retiree portion of the premium is not deductible from retiree taxable income unless they meet the 7.5 percent AGI rule discussed above.

Figure 5

Average Total Employee-Only Premium for Exclusive-Provider Plans* at Private-Sector Establishments, by Firm Size and State, 2006

	Total	Under 50 Employees	50 or More Employees
United States	$3,976	$4,147	$3,912
New England:			
Connecticut	4,128	3,725	4,249
Maine	4,525	4,362	4,636
Massachusetts	4,511	4,947	4,359
New Hampshire	4,732	4,675	4,767
Rhode Island	4,471	4,687	4,344
Vermont	4,637	4,491	4,695
Middle Atlantic:			
New Jersey	4,382	4,022	4,578
New York	4,215	4,522	4,036
Pennsylvania	4,196	4,391	4,128
East North Central:			
Illinois	3,726	4,250	3,592
Indiana	4,041	3,696	4,095
Michigan	4,291	4,125	4,376
Ohio	4,170	4,739	3,950
Wisconsin	4,301	4,268	4,315
West North Central:			
Iowa	4,223	3,937	4,352
Kansas	4,089	4,116	4,081
Minnesota	4,331	4,286	4,347
Missouri	4,103	4,086	4,109
Nebraska	4,054	3,144	4,403
North Dakota	3,922	4,044	3,778
South Dakota	3,963	3,957	3,964
South Atlantic:			
Delaware	4,768	5,081	4,678
District of Columbia	4,201	4,269	4,184
Florida	3,982	4,240	3,910
Georgia	3,768	3,730	3,782
Maryland	3,969	4,135	3,864
North Carolina	3,637	4,625	3,310
South Carolina	4,436	5,031	4,311
Virginia	3,788	4,101	3,631
West Virginia	4,731	4,267	4,947
East South Central:			
Alabama	4,123	3,504	4,334
Kentucky	3,692	2,401	4,183
Mississippi	4,196	4,953	4,006
Tennessee	3,877	3,450	3,970
West South Central:			
Arkansas	3,840	3,724	3,865
Louisiana	3,735	3,876	3,674
Oklahoma	3,984	4,734	3,721
Texas	4,014	5,184	3,700
Mountain:			
Arizona	4,082	3,842	4,159
Colorado	3,763	3,987	3,659
Idaho	3,036	2,799	3,223
Montana	3,977	4,033	3,893
Nevada	3,178	3,251	3,162
New Mexico	4,011	4,351	3,846
Utah	3,356	3,088	3,430
Wyoming	4,640	4,617	4,649
Pacific:			
Alaska	3,756	5,065	3,489
California	3,703	3,762	3,679
Hawaii	3,422	3,660	3,278
Oregon	4,009	3,825	4,069
Washington	4,040	3,950	4,073

Source: www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2006/tiic1a.htm

* Enrollees and covered dependents must go to providers associated with the plan for all nonemergency care in order for the costs to be covered. Most health maintenance organizations (HMOs), individual practice associations (IPAs), and the exclusive provider organizations (EPOs) are exclusive-provider plans.

Lessons from the Tax Reform Act of 1986: Sec. 89

The Tax Reform Act of 1986 (TRA '86) made dramatic changes in employee benefits both through the numerous provisions directly affecting benefits and through the overall reduction in individual tax rates (Employee Benefit Research Institute, 1986). The changes were intended to produce more comparable employee benefit coverage of rank–and-file employees and of highly compensated employees. Sec. 89 of the TRA tightened nondiscrimination rules with a goal of reducing tax-favored benefits for higher paid employees.[22]

For testing purposes, each variation in coverage, employee or employer contributions, deductibles and copayments, created a benefit plan that had to be tested separately. For example, a plan that offered employee-only and family coverage and two different deductibles was actually treated as four different plans for testing, under the law. Employers were *required* to conduct the nondiscrimination tests based on the actual health coverage that workers received, rather than on the coverage that was made available to them.

Employers had two ways to prove that their plans did not discriminate:

- *80 Percent Coverage Test:* A plan passed this test if 80 percent of the employees who were not highly compensated actually received coverage.
- *Eligibility and Benefits Tests:* A plan passed this test if the employer showed that the plan passed each of the three following tests:
  - ✓ *90 Percent–50 Percent Eligibility Test:* Ninety percent of the non-highly compensated employees had to be eligible for benefits at least 50 percent as valuable as benefits for highly compensated employees.
  - ✓ *50 Percent Eligibility Test:* At least 50 percent of non-highly compensated employees had to be eligible for a benefit under the plan, or the percentage of eligible highly compensated employees was no higher than the percentage of eligible non-highly compensated employees.
  - ✓ *75 Percent Benefits Test:* Non-highly compensated employees had to actually receive an average benefit at least 75 percent as valuable as the average benefit for highly compensated employees.

Cafeteria plans (in which employees may choose their own benefits structure within overall cost limits) were tested like any other plan. Each option in the cafeteria plan was considered a separate plan for testing purposes.

If employers did not comply with Sec. 89, their workers would incur taxes on the excess value of coverage. Billions were reportedly spent by employers building the administrative systems to comply with the law. Some employers actually found it easier to increase wages to compensate for the loss in employees' income, as increasing wages was less expensive than bearing the administrative costs of going through the rigorous IRS tests required under Sec. 89.

Sec. 89 ultimately became so controversial that it was repealed in November 1989, before the rules could go into effect. After the regulations were released, employers—especially small employers—found it too onerous and expensive to do the nondiscrimination testing. They were sufficiently motivated that they convinced Congress to repeal the law, something that happens only rarely, particularly in an arcane area like employee benefits. It became clear at the time that neither Congress nor the Treasury Department understood the complexity and expense of demonstrating compliance with the nondiscrimination rules. In fact, Sec. 89 was really a minimal part of a larger statute, and it largely tasked regulatory agencies to essentially create law almost from a blank sheet.

There are a number of lessons that can be learned from the experience from Sec. 89 that are relevant today as policymakers consider a tax cap on employment-based health benefits:

First, a rule intended to increase government revenue can actually cost the government revenue if billions are required to be spent doing the administrative work to comply.

Second, a seemingly simple task such as valuing health coverage actually can be very complex and time-consuming to implement.

Third, policymakers should consider possible unintended consequences in any actions they take regarding enacting and implementing a tax cap.

Conclusion

Changing the tax treatment of health coverage has been proposed repeatedly by policymakers on both sides of the aisle over the last three decades. Proposals have included limiting or eliminating employers' current deduction of health coverage costs as a business expense, as well as changes that would affect workers, such as changing the current tax treatment of health coverage to a tax credit, extending a tax credit to persons purchasing health insurance in the nongroup market, replacing the current tax treatment of health coverage with a standard deduction, and extending that deduction to the nongroup market, and capping the current tax exclusion of employment-based health coverage from workers taxable income.

This report addresses the administrative issues raised by a tax cap: What employers would need to consider if they were required to value health coverage, if the current tax exclusion of employment-based health coverage from workers' taxable income is capped. Employers would be required to report the "value" of health coverage on workers'

annual W-2 statements, and workers with health coverage valued above the cap would pay taxes on the value of the health coverage above the level of the cap.

Some employers (those that purchase health insurance for their employees and pay a premium to an insurer) would only have to report the premium on an employee's W-2 form. But employers offering self-insured plans would have to value the coverage, a very complex process. They might be able to use COBRA premiums to value benefits, which would not necessarily add administrative complexity, as all self-insured employers already calculate COBRA premiums. Employers that offer domestic partner benefits already value coverage for imputed income purposes. However, if employers were required to value coverage based on the coverage *received* rather than the coverage *available* (as was required as part of the TRA '86 until Sec. 89 of that law was repealed), valuing the coverage would become a complicated and administratively costly burden. There are numerous other substantive issues related to FSA, HRAs, HSAs, and retiree health benefits as well.

Workers face a variety of equity issues if the tax exclusion of health coverage were capped. For instance, there are several reasons why the value of health coverage might be above the tax cap, completely independent of the comprehensiveness of coverage: Coverage costs are known to vary with firm size, employee health status, average age of the group of employees, and geographic region. As a result of these factors, some workers may incur higher taxes simply because of where they live, their employers' ability to negotiate premiums, and the composition of the risk pool in which they are insured. Retirees may also be affected simply because of their age or health status.

The tax preference associated with employment-based health coverage is an almost inescapable budgetary and political target, especially as Congress struggles to control massive federal deficits. The Congressional Budget Office recently reported that capping the tax exclusion of employment-based health coverage could increase tax revenues by as much as $108.1 billion during 2009–2013 and $452.1 billion during 2009–2018, if the limit were set at the 75th percentile for health insurance premiums. Different cap levels will have different effects.

Past experience—specifically the controversy over Sec. 89, which led to its repeal by Congress—shows the risk of not carefully anticipating the results of making major changes to the complex (and voluntary) system of employee benefits. Policymakers should be aware of the implications and unanticipated consequences of any change to the tax treatment of health insurance and employment-based health coverage.

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Endnotes

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

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

[3] See Hevener and Kerby (2008) and Holtzblatt (2008) for more information on IRS administrative issues related to health reform.

[4] Employers do not get a tax break on Social Security taxes for workers whose incomes are above the wage base, since the portion of their income that is above the wage base is not subject to the Social Security tax.

[5] Members of the panel can be found at www.taxreformpanel.gov/members.shtml

[6] See Exhibit 4.2 in http://ehbs.kff.org/pdf/7790.pdf

[7] See Exhibit 10.1 in http://ehbs.kff.org/pdf/7790.pdf The percentage of workers in self-insured and fully-insured plans is more relevant than the number of employers that self-insure because self-insured employers often also offer fully-insured plans alongside the self-insured plan and let employees choose which plan to enroll in.

[8] See Exhibit 10.1 in http://ehbs.kff.org/pdf/7790.pdf

[9] See Exhibit 10.1 in http://ehbs.kff.org/pdf/7790.pdf

[10] Most self-insured employers purchase stop-loss coverage, insurance for themselves against large claims made by employees.

[11] COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events. The name stands for the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), which created the program. See *Fundamentals of Employee Benefit Programs, Sixth Edition*, Chapt. 27 (Employee Benefit Research Institute, 2009).

[12] There is no uniform method for allocation claims costs across employees. For example, some employers will determine the employee-only cost of coverage by dividing claims for single employers over the group of single employees. They will determine the family cost of coverage by dividing claims for workers and their dependents over the number of workers with family coverage. Other employers will calculate employee and dependent costs separately and then combine the two to determine the cost of family coverage. Both approaches seem to produce the same effect but the resulting cost of coverage may differ significantly. There is an age bias associated with take-up of coverage. Younger, healthier employees are disproportionately covered as single, and older less healthy employees are disproportionately covered with family coverage. Workers with employee-only coverage in the later approach would have lower premiums than workers with employee-only coverage in the former approach.

[13] See http://bennelson.senate.gov/news/details.cfm?id=304179&&

[14] See www.eric.org/forms/uploadFiles/16E3B0000000A.filename.ERIC_Response_to_W2_Health_Cost_Disclosure_Proposal.pdf

[15] Domestic partners can qualify as a tax dependent and avoid incurring taxes on the value of domestic partner benefits if the partner meets a number of conditions. Also see *EBRI Notes,* "Domestic Partner Benefits: Facts and Background," September 2008, www.ebri.org/pdf/notespdf/EBRI_Notes_09-2008.pdf

[16] See PLRs 19985011, 9717018, 199231062, 199034048, 199111018, 199109060, 200108010, 200339001, and 9603011 for various IRS interpretations related to domestic partner benefits.

[17] See www.icemiller.com/publications/19-ANSWR_Winter2008.pdf

[18] The principle of horizontal equity is violated when income tax changes do not treat people of similar positions equally. See Congressional Budget Office (1994) for a more detailed treatment of how capping the tax exclusion of health benefits improves horizontal equity when measured in terms of income.

[19] www.weissratings.com/News/Ins_Medigap/20050830medigap.pdf

[20] Calculated from Exhibit 4 in www.kff.org/medicare/7603.cfm

[21] See Chart 4 in www.kff.org/insurance/7527/upload/7561.pdf

[22] See Barker (1990) for a more detailed treatment of Sec. 89.

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