The Tax Exclusion for Employer-Provided Health Insurance: Issues for Congress

-name redacted-
Specialist in Aging and Income Security

January 4, 2011

Congressional Research Service
7-....
www.crs.gov
RL34767

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

Employer-provided health insurance is excluded from the determination of employees' federal income taxes, resulting in significant tax savings for many workers. Comparable exclusions apply to federal employment taxes and to state income and employment taxes. Because employment-based health insurance covers three-fifths of the population under the age of 65, the exclusions also result in considerable revenue loss to the government. Ending them could raise several hundred billion dollars a year, depending on exactly what is repealed and how workers and employers adjust. Some see this revenue as a source for financing health care reform without explicitly raising taxes.

The federal income tax exclusion—the focus of this report—is criticized for several reasons. Because it reduces the after-tax cost of insurance in ways that are not transparent, it likely results in people with insurance obtaining more coverage than they otherwise would. Not being explicitly capped or limited, it does little to restrict the generosity of the insurance or annual premium increases. These attributes contribute to what some economists argue is a welfare (or efficiency) loss from excess health insurance for those with coverage and also contribute to rising health care costs and spending. In addition, the income tax exclusion often is criticized because it gives greater tax savings to higher income individuals and families, an outcome that strikes many observers as wasteful and inequitable.

These arguments about the exclusion merit careful consideration, as President Obama's Commission on Fiscal Responsibility and Reform include the tax exclusion as a recommendation for reducing the deficit. However, the arguments involve complex issues, and other points and perspectives might be taken into account. The welfare loss may be difficult to gauge considering how consumers react to higher cost-sharing. Determining alternative tax benefits that would not adversely affect people with high costs to replace the exclusion could be challenging. The larger tax savings to higher-income people might not be an inequitable subsidy, but only a consequence of the proper treatment of losses under a progressive income tax.

The income tax exclusion has been in the tax code more than 50 years, and its repeal could have unintended consequences. For example, unless exceptions were made, repeal would also terminate the exclusion for employer-paid disability insurance, health care flexible spending accounts, and other benefits some consider useful.

The exclusion and regulatory decisions in the 1940s sometimes are said to be the reason why employer-paid coverage is the predominant form of private health insurance in the United States. There is something to this argument, but there are other reasons why employment-based insurance arose and why it remains attractive. These reasons make it difficult to predict the effect of ending the exclusion on the future of employment-based insurance, a major policy issue.

Contents

Appendixes

Contacts

Introduction

Under current law, employer-provided health insurance coverage is excluded from employees' income for determining their federal income taxes.[1] Exclusions also apply to federal employment taxes (Social Security, Medicare, and unemployment taxes) and to state income and payroll taxes as well. Considering the average cost of employment-based insurance, now around $4,750 a year for single coverage and $12,700 for family coverage, these exclusions result in significant tax savings for many workers.[2]

Because employment-based health insurance covers more than three-fifths of the population under the age of 65, the exclusions also result in considerable revenue loss to the government. Ending the exclusions could raise several hundred billion dollars a year, depending on exactly what would be repealed and how workers and employers adjust.[3] Revenue effects of this magnitude make the exclusions a tempting target for policy makers and other advocates who seek to raise revenues without explicitly raising tax rates.

The federal income tax exclusion—the focus of this report—has been targeted for other reasons as well. Because it reduces the after-tax cost of insurance to the worker in ways that are not transparent, it likely results in people with insurance obtaining more coverage than they otherwise would. Not being explicitly capped or limited in some other manner, it does little to restrict the generosity of the insurance or annual premium increases. These attributes contribute to what many economists argue is a welfare (or efficiency) loss from excess health insurance for those with coverage. These attributes also contribute to rising health care costs and spending throughout the country.

In addition, the federal income tax exclusion often is criticized as unfair because the workers' tax savings depend on their marginal tax rate. High-income workers generally have greater savings than middle-income workers, and the latter usually have more than low-income workers.[4] When

[1] An exclusion allows an item of income to be left out of tax calculations. Terms such as exclusion, deduction, and credits are shown in the federal income tax formula that appears in the **Appendix**.

[2] *Employer Health Benefits: 2008 Annual Survey*. The Kaiser Family Foundation and Health Research and Educational Trust, p. 14. Employers typically pay on average 84% of the cost of single coverage and 73% of the cost of family coverage (p. 72); it is these shares to which the tax exclusion applies, assuming employees pay their share with after-tax dollars.

[3] In March 2007, the Joint Committee on Taxation estimated that the Administration's proposal to terminate the federal income and Social Security and Medicare exclusion for employer coverage, the tax deduction for self-employed taxpayers, and the itemized deduction for individuals not enrolled in Medicare would increase revenues by $1,228.3 billion over the FY2009-FY2012 period, an average of more than $300 billion a year. Tax expenditure estimates (which unlike revenue estimates do not include the effects of behavioral responses) of the exclusions alone typically are smaller. On July 30, 2008, the Joint Committee on Taxation estimated calendar year 2007 tax expenditures for the employer coverage exclusion to have been $143.3 billion for the federal income tax and $100.7 billion for FICA (Social Security and Medicare) taxes. *Tax Expenditures for Health Care*, JCX-66A-08. Also see Thomas M. Selden and Bradley M. Gray, "Tax Subsidies for Employer-Related Health Insurance: Estimates for 2006," *Health Affairs*, v. 25 no. 6 (November/December 2006), pp. 1568-1579.

[4] The marginal tax rate is the rate that applies to the last dollar of income received by a taxpayer. Often it is the same as the statutory tax rate that applies to the highest band of taxable income for the taxpayer. For married couples filing joint returns for 2008, the statutory tax rate for taxable incomes not exceeding $16,050 is 10%, whereas the rate for taxable incomes over $357,700 is 35%. An exclusion reduces the income that is taxed at the highest rate; thus the tax savings on an exclusion of $1,000 generally would be $100 (i.e., $1,000 x .10) for someone in the lowest tax bracket and $350 (i.e., $1,000 x .35) for someone in the highest bracket.

these tax savings are viewed simply as an economic subsidy, this pattern strikes many people as wasteful and inequitable.

These three assertions about the income tax exclusion—that the revenues could help to reduce the deficit, that it contributes to inefficiency and rising health care costs, and that higher-income taxpayers unfairly get greater tax savings—are the principal arguments put forth for repeal. Each is discussed in this report. Before turning to them, however, the report discusses the scope and origins of the exclusion, both of which are more complex than is generally recognized. The income tax exclusion has been in the tax code for more than 50 years, and its repeal could have unintended consequences unless policy makers understand what transactions it covers and what role it has had in the development of employment-based insurance. A discussion of the scope and origins will also reveal some of the uncertainties repeal would raise for both tax and health care policy.

Limited to these topics, the report does not address all issues that might be raised about the exclusion. A comprehensive analysis would be difficult because of limited knowledge about who actually pays for employer-provided health insurance and how workers value insurance at different ages and income levels. While there is general understanding about these matters—it is reasonable to assume that much of the employer contribution is actually borne by workers through reduced wages—that is unlikely to be sufficient, and could be misleading, for drawing conclusions applicable to the diversity of employment arrangements throughout the country. For legislation, differences among types of employers (by size and industry, for example) and types of workers (by gender, family status, and income) often are important.

Scope of the Exclusion

The statutory provision allowing an income tax exclusion for employer-provided health insurance is short but complex. It covers more than health insurance (and health plans that often are described as insurance) and applies to most but not all workers, including members of the workers' families. How other forms of coverage would be affected by repeal of the exclusion for health insurance might be considered. In order to understand the tax issue the exclusion resolves, it should be considered along with another exclusion applying to benefits.

When employees receive something of value from their employer, the general presumption under an income tax is that it will be taxable. Whether taxes will actually be paid depends on the deductions and credits a taxpayer might claim, but at least the starting position is that whatever is received should be taken into account for the purpose of determining an employee's tax liability.

This rule is reflected in Section 61(a) of the Internal Revenue Code, which provides that all forms of income from whatever source are taxable unless there is an express exception. With respect to employer-provided health insurance, there are two exceptions that are relevant, an exclusion for coverage and an exclusion for benefits received. These exceptions reflect two different tax questions that arise with this insurance, whether the provision of coverage by itself should be taxable (regardless of whether the taxpayer actually uses insurance benefits) and whether the insurance benefits used should be taxable (regardless of whether the taxpayer paid for the coverage). Proposals to end the exclusion for employer-provided health insurance involve the former question and not the latter, but there are interactions that might be noted. In addition, because the exclusion for coverage applies to more than health insurance as it is commonly

understood, this section of the report also discusses whether it might be appropriate to retain the exclusion for some purposes.

Coverage

The exclusion for coverage can be found in Section 106(a) of the Code:

> General rule—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

The provision allows employees to exclude (that is, leave out of their income tax calculations) employer-paid premiums or contributions to a trust or other fund for their accident or health plan. There is an equivalent exclusion for employment taxes elsewhere in the Code that pertains to both employees and the employer.[5] The term *accident or health plan* includes not only health insurance but also accidental death and dismemberment insurance, short-term and long-term disability coverage, and coverage through reimbursement arrangements such as health care flexible spending accounts (FSAs) and health reimbursement accounts (HRAs).

Although usually described as an employee exclusion, the provision applies as well to coverage of a spouse and dependents of the employee, whether prior to or after the latter's death. Coverage of former employees is also included.

The exclusion applies to both insured and self-insured plans. An insured plan typically involves the purchase of coverage from a commercial carrier, while under a self-insured plan the employer retains the financial risk.[6] In addition, the exclusion applies to coverage employees obtain separately in the individual insurance market, provided employers pay the premiums directly (list-billing) or reimburse employees under a secure arrangement that does not allow reimbursements to be diverted to another purpose. Individual market insurance is not common with this exclusion.

Finally, the exclusion applies to employee-paid premiums under premium conversion plans. Under these arrangements, which must be set up by employers, employees reduce their taxable wages in exchange for their employers using the money to pay health insurance. From an accounting perspective, the premiums are no longer considered to be paid by the employees.[7]

Section 106(a) does not apply to self-employed individuals because they are not considered employees under the Code.[8] However, under current law, they can obtain roughly the same income tax savings from the above-the-line deduction authorized under Section 162(l).

[5] Section 3121(a)(2) for Social Security and Medicare taxes and Section 3306(b)(2) for federal unemployment taxes.

[6] In many self-insured health plans, the employer purchases stop-loss insurance to insure against unexpected large losses.

[7] Premium conversion plans are allowed under cafeteria plan provisions in Section 125.

[8] Self-employed individuals include sole proprietors, general partners in a partnership, limited partners who receive guaranteed payments, and individuals who receive wages from S-corporations in which they are more than 2% shareholders.

Benefits

Exclusions for benefits received can be found in Sections 105(b) and 104(a)(3). Section 105(b) allows taxpayers to exclude benefits they receive from employer-financed accident or health plans. It applies to benefits for their spouse or dependents as well. The exclusion is limited to expenses for medical care as defined in Section 213(d), except to the extent they were claimed as an itemized deduction in a prior year.[9] Thus, the exclusion does not apply to disability benefits attributable to employer payments since these benefits need not be spent on medical care.

In contrast, Section 104(a)(3) allows taxpayers to exclude amounts received through accident or health plans *except for* amounts financed by an employer. The taxpayers themselves might pay for this insurance, but that is not necessary; the only requirement is that the employer not pay. The exclusion here is not limited to expenses for medical care, as is the exclusion in Section 105(b). Thus, it might include disability benefits.

Section 104(a)(3) applies to individual and group policies, including employment-based plans. If both employers and employees pay for the coverage, the benefits might have to be apportioned to determine their tax treatment. This is not necessary for medical expenses from health insurance, which would be excluded under either Section 105(b) or Section 104(a)(3). However, disability benefits attributable to employer payments would be taxable since they are not covered by Section 105(b). Those attributable to employee payments would be exempt under Section 104(a)(3).

Self-insured plans covering highly compensated employees must comply with nondiscrimination rules. If they do not, the Section 105(b) exclusion may be limited for these employees. The nondiscrimination rules do not apply to insured plans.

Self-employed people are covered by Section 104(a)(3), not Section 105(b).

Some Policy Issues

If Section 106(a) were repealed, employer-paid coverage under accident and health plans would become taxable to employees for the federal income tax. States would likely adopt the same treatment, as they do for most income tax provisions. Repealing 106(a) would not by itself end the exclusions for employment taxes, but most proposals would abolish those as well, if only to obtain additional revenue for to help reduce the federal deficit.

However, repealing Section 106(a) would also affect disability insurance and health care reimbursement arrangements, among other employer benefit plans. These possible changes have not received much attention, and they might not be what is intended. Consideration might be given to retaining the exclusion for these benefits, though, as will be seen, doing so may raise other complications.

Employer-paid disability insurance may be needed to prevent the adverse selection that occurs when employees purchase coverage themselves. When left to individual choice, people who think

[9] Section 213(d) defines medical care broadly, including amounts paid "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." Internal Revenue Service publication 502, *Medical and Dental Expenses*, provides further guidance.

they might become disabled are more likely to purchase insurance than those who do not; this drives up premiums as insurers adjust for their anticipated cost. Employment-paid disability insurance may also be needed to provide coverage to workers who will need but would fail to purchase it. Many people underestimate the likelihood of becoming disabled during their working years or do not think about the issue at all.

Of course, employers could purchase disability coverage for all employees even if the exclusion were repealed; while the coverage would be taxable, the benefits would then be exempt under Section 104(a)(3). However, many employees would likely object to being taxed for coverage they would not choose in exchange for receiving tax-free benefits most will not need.

For disability insurance, unlike health insurance, there are few proposals for alternative tax subsidies to encourage people to purchase coverage. An expanded tax deduction or a tax credit might provide some of the same incentive as the exclusion for employer-paid coverage, though neither would likely overcome the adverse selection problem.

Health care reimbursement arrangements allow employees to pay out-of-pocket medical expenses (deductibles, copayments, and things not covered by insurance) on a pre-tax basis. The most common form is a health care FSA, though some employers offer HRAs.[10] Most health care FSAs are funded through salary reduction agreements under which employees agree to receive lower take-home pay in exchange for benefits, though others are funded at least in part by employers. Either way, Section 106(a) applies.[11]

Health care FSAs are popular with employees who have families or otherwise anticipate having lots of medical and dental bills. They can help families manage their expenses and cash flow. Employers find them useful for helping employees deal with rising health care costs and for getting them to accept insurance with higher deductibles and copayments as well as restrictions on certain services and products. Although the Section 106(a) exclusion raises many of the same equity and efficiency concerns for FSAs as it does for health insurance, retaining it for FSAs might be justified as a way to hold down rising premiums, arguably the greater problem.[12]

At the same time, retaining the exclusion for these arrangements could raise technical and enforcement issues. If FSAs and HRAs retained tax preferences but insurance did not, over time it is likely the former would expand and the latter would contract, at least in terms of covered benefits if not cost. In effect, FSAs and HRAs would assume some of the functions now borne by insurance. This would counteract some of the anticipated effects of ending the exclusion. It would also result in disparate treatment for small employers, who often cannot establish FSAs due to statutory nondiscrimination requirements.

[10] For information on health care FSAs, HRAs, as well as health savings accounts (HSAs) and medical savings accounts (MSAs), see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by (name redacted).

[11] Although salary reduction agreements are allowed under the cafeteria plan provisions of Section 125, health care benefits under an FSA are exempt under Section 106(a) because they are technically considered to be provided by the employer.

[12] In the FY2008 and FY2009 budgets, President Bush proposed using Health Savings Accounts (HSAs) to serve some of these functions. However, there are a number of unresolved policy issues regarding HSAs, and they remain controversial.

Similar issues might arise with respect to the health care employers provide with on-site doctors and nurses and through wellness programs. If Section 106(a) were repealed, coverage for some of these services might become taxable, discouraging their use.[13] This would not further what some observers think is a useful way to improve workers' health. If instead they were not taxable, however, over time they would likely expand, replacing some of the services now covered by insurance. Attempting to delineate the line between what should be taxable and what should be exempt could be challenging.

Origins

The origins of the tax exclusion for employer-provided health insurance have become part of the debate over whether the exclusion should be repealed. To some, initial determinations about a narrow tax issue, coupled with contemporaneous regulatory decisions, account for the predominance of employer-provided coverage in the United States. However, the history of the exclusion is not unambiguous in this respect, and it reveals concerns about tax policy questions that remain today.

Section 106 was enacted in 1954 as part of a comprehensive revision of the Internal Revenue Code. At the time, it consisted only of what later became Section 106(a), though the wording has changed several times. Current law subsections (b), (c), and (d), which are not relevant to the present discussion, were added relatively recently.[14]

Prior to 1954, there was no statutory provision that explicitly allowed an exclusion for coverage under employer-provided accident and health insurance. Regulatory rulings shortly after the modern income tax began had conflicting outcomes, first providing that premiums on life, accident and health insurance were considered income to employees but then saying they were not, at least in the case of group life coverage.[15] A 1943 ruling held that an employer contribution for group medical and hospitalization insurance issued by a commercial insurer was exempt income to workers.[16] Since group coverage of this sort had started spreading in the 1930s, the need for resolution had become important. Nonetheless, apparently the distinction between which insurance arrangements qualified for the exclusion and which did not remained unclear.

Employer payments for individual coverage were always taxable prior to 1954. Various rationales were advanced for the different treatment of group plans (or at least certain group plans) and individual insurance. Although the economic value of employer payments for individual insurance could be determined from the premiums individuals were charged, the economic value of group coverage would vary among individuals, perhaps substantially. It was not at all clear—as

[13] Some might initially remain exempt as a working condition or de minimus fringe benefit under Section 132.

[14] Subsections (b) and (d) of Section 106 allow for an exclusion for employer contributions to Medical Savings Accounts and Health Savings Accounts; they were added in 1996 and 2003, respectively. Subsection (c) disallows an exclusion for employer-provided coverage for long-term care provided through flexible spending account or similar arrangement; it was added in 1996 when long-term care premiums and other expenses were explicitly allowed as part of the itemized deduction for medical expenses. For a time, the nondiscrimination provisions for self-insured plans now found in Section 105(h) were included under Section 106.

[15] The initial ruling was in Reg. 45, Art. 33 as revised on April 17, 1919; the later ruling was issued on January 28, 1921. For information on these and other rulings prior to 1954, see "Employer Health or Accident Plans: Taxfree Protection and Proceeds," *The University of Chicago Law Review*, vol. 21 (1953-1954), p 277-286.

[16] Ruling letter August 26, 1943.

it still is not today—how to value coverage for someone who would not be insurable in the individual market. In addition, there was parallel treatment at the time for life insurance: employer coverage for individual life insurance (or life insurance with cash value) was taxable, while group coverage for term insurance was not, at least to a point. Finally, health insurance at the time often included wage continuation payments for periods of illness; since rights for this were forfeited when employment was terminated, it was not clear whether coverage by itself (in contrast to actual receipt of payments) constituted income.

The enactment of Section 106 provided a basis for excluding employer payments for individual insurance and certain other coverage such as union plans.[17] It also clarified a number of other points, though other ambiguities remained.[18]

Sections 104(a)(3) and 105(b) were also enacted as part of the 1954 Code and have remained largely unchanged since. The predecessor to Section 104(a)(3) can be traced back to the Revenue Act of 1918, when it was added to clarify that amounts received through accident or health insurance or from workmen's compensation acts would be exempt. Under that provision as well as the successor Section 22(b)(5) of the 1939 Code, the exclusion was limited to amounts received through accident and health "insurance," which included commercially insured arrangements but not most private employer or employee association plans. Benefits from private employer plans were sometimes exempt when they were established pursuant to state law. Further uncertainty about the definition of "insurance" arose from the 1952 Seventh Circuit decision in *Epmeier v. U.S.*, which applied the term to a self-insured plan paying benefits based upon salary and length of employment, that is, a form of wage continuation.[19]

The 1954 Code clarified these issues by carrying over the language in Section 22(b)(5) of the 1939 Code to present law Section 104(a)(3) and adding a new section, 105(b), that provided an exemption for benefits from self-insured plans. The legislation allowed a limited exemption for wage replacement benefits in Section 105(d), but this was repealed by the Tax Reform Act of 1976.

Debate Over Consequences

By removing much of the uncertainty about these tax questions, the 1954 Code furthered the growth of group insurance. Not only did the statutory exclusion reduce the effective price of insurance, but it made coverage easier to obtain as employers, having clearer guidance, became more willing to establish plans. One study shows how the change both increased the amount of coverage obtained and engendered a shift from individual to group policies.[20]

---

[17] The exclusion for individual coverage is based on language in the House and Senate reports on the legislation. Individual coverage still had to be provided through plans.

[18] For example, the scope of the term "plan" remained unclear. "Taxation of Employee Accident and Health Plans Before and Under the 1954 Code," *Yale Law Journal*, vol. 64 (1954-1955) p. 222-247.

[19] One reason for the complexity and uncertainty prior to 1954 was that it was not unusual for health insurance at that time to have wage continuation benefits. Although arguably these could be exempt if the taxpayer had purchased the insurance with after-tax earnings, an exemption did not appear justified when the employer paid for the coverage, particularly if that were excluded from taxation as well. Since wages from working were taxable, the argument goes, why should continuation wages from *not* working be exempt?

[20] Melissa A. Thomasson, "The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance," *The American Economic Review*, vol. 93, no. 4 (September 2003) pp. 1373-1382.

Even before 1954, however, group insurance coverage had been expanding. One reason for this is that the Stabilization Act of 1942, which otherwise imposed strict limits on wage increases, expressly exempted insurance and pension benefits.[21] Employers eager to attract workers in a tight labor market expanded their benefit plans instead. In addition, the National Labor Relations Board in 1948 held that fringe benefits could be covered under collective bargaining agreements; this furthered the growth of union plans.[22]

To some observers, these tax changes and regulatory decisions largely explain the predominance of employment-based insurance in the United States. Coming at a time of dramatic growth in the number of people with insurance, the policies were both a response to changes in how insurance was provided and the cause of their perpetuation.[23] In retrospect, it might seem that a handful of legal developments, each of which was aimed at resolving a narrow issue, was responsible for both the way in which a majority of the population now finances its health care and the problems associated with it.

There is something to be said for this argument. At the very least, it shows that tax policies currently at issue were largely shaped during a particular period in history, responding to what were perceived to be the needs at that time. An implication might be that current policies should be reviewed in light of today's needs, and that further changes might now be appropriate.

At the same time, the historical argument about the importance of tax and regulatory policies may be overstated. Enrollment in group plans expanded steadily from 1939 onwards, starting prior to the tax ruling and regulatory changes mentioned above and increasing roughly in tandem with increases in enrollments in individual policies.[24] If employment-based insurance supplanted individual market coverage, it was not evident at the time.

Moreover, other forces possibly contributed to the rise of employment-based insurance. According to one analysis, a range of influential groups—doctors, hospitals, insurers, and employers—saw it as a way of achieving their own goals while simultaneously reducing pressure for a government solution in the form of compulsory social insurance. The latter had been advocated by some during the years before World War Two.[25]

More important, the historical argument does not explain why employment-based insurance has persisted as the predominant form of coverage for people under the age of 65. Although the proportion of this age group covered under employment plans has declined somewhat in recent years, it is still about the same as it was 20 years ago.

---

[21] P.L. 729 of the 77th Congress, 56 Stat. 765, Section 10.

[22] The NLRB rulings were the subject of two federal court cases, *Inland Steel Company v. NLRB* 170 F. 2d 247 and *W.W. Cross and Company v. NLRB* 174 F. 2d 875. The NLRB order in the former case dealt with retirement and pension plans though it made passing reference to insurance. The order in the latter case dealt with group accident and health insurance.

[23] The proportion of the population with hospitalization insurance increased from 10% in 1940 to 71% in 1957. By 1954, around half the population had group coverage. Herman M. Somers and Anne R. Somers, "Private Health Insurance," *California Law Review*, vol. 46 (1958), pp. 376 and 378.

[24] The President's Commission on the Health Needs of the Nation, *Building America's Health*, Financing a Health Program for America, vol. 4. Washington, 1953. Table 11.6.

[25] Jacob S. Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States*, Cambridge (2002), p. 219.

Much of the recent decline has occurred in smaller businesses, where the principal problem has less to do with financing, let alone the tax benefits, than with lack of access to stable insurance pools in which risk and administrative costs are spread over large numbers of participants.

Employers are not legally required to provide health insurance to their workers, let alone pay for it. There is little doubt they do so partly because of tax advantages from the Section 106(a) exclusion. It is uncertain how much employers gain from the exclusion except from reductions in employment taxes, but even if they gained nothing directly they would likely provide coverage in order to give their workers tax savings. In a competitive labor market, workers' tax savings on one form of compensation might allow employers to reduce other forms.

However, it is likely that employers provide health insurance for other reasons as well. One is that insurance is an attractive benefit to most workers, both for the coverage it provides and for the time it saves them in shopping for policies on their own. Given these preferences, when other employers competing for the same workers offer health insurance, it is difficult for one employer not to do so. Second, employers have an economic interest in healthy workers and, to some extent, workers' healthy families. According to some studies, healthy workers are more productive. These advantages are more likely to be found in large firms employing higher-skilled workers; they diminish as firm size shrinks and skill levels decline.[26] But even if employers could readily dismiss ill employees and replace them with others, there would be turnover costs.

For these reasons, whether employer-provided coverage would erode if the exclusion were repealed cannot be forecast with any certainty, particularly given the diversity of employment arrangements in the country. Much would depend on the availability of alternative tax benefits that might replace the exclusion as well as whether these would be linked to attempts to create stable insurance pools. Regardless of how the exclusion came to be part of the tax code, these present factors are likely to be more significant.

The future of employment-based insurance was one of the most important issues in health care reform. Considering its dominant role in providing coverage for people under the age of 65, changes to the insurance, whether intentional or not, ought not be taken lightly. Most employment-based insurance is thought to have larger and more stable risk pools than individual market insurance, and barring improvements in the latter some would oppose policies that might threaten the former.[27] Some would argue that one of the first decisions to be made about reform is whether employment-based insurance should be strengthened, weakened, or left alone, and that decisions about the tax exclusion should be based upon that choice.

[26] Ellen O'Brien, Employers' "Benefits from Workers' Health Insurance." *The Milbank Quarterly*, vol. 81 no. 1 (2003), pp. 5-40. The article puts forth a business case for employer-provided health insurance and summarizes a number of relevant studies. Also see Paul Fronstin and Ray Werntz, "The 'Business Case' for Investing in Employee Health: A Review of the Literature and Employer Self-Assessment." *Issue Brief no. 267*, Employee Benefit Research Institute (EBRI), March 2004.

[27] However, some analyses argue that there is considerable risk pooling in the individual market, even where it is largely unregulated. Mark V. Pauly and Bradley Herring, "Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market," *Health Affairs*, vol. 26, no. 3 (2007), pp. 770-779.

Excess Insurance

One criticism of the exclusion for employer-provided health insurance is that it reduces the after-tax cost of insurance to workers in ways that are not transparent, likely resulting in their obtaining more coverage than they otherwise would. Not being explicitly capped or limited in some other manner, it does little to restrict the generosity of the insurance or annual premium increases. The exclusion thus contributes to what some economists consider an excess of insurance coverage and a significant welfare (or efficiency) loss for insured individuals and society as a whole.[28] How repealing the exclusion would affect this welfare loss is a complicated question, however, depending on how consumers react to higher cost-sharing. It could be challenging to determine alternative tax benefits to replace the exclusion without adversely affecting people with high costs.

The welfare loss from excess insurance, particularly insurance with low deductibles and copayments, occurs because people pay more for health care services than they would if everyone assumed more of the cost themselves.[29] This outcome is caused partly by the increased demand attributable to insurance (people generally use more services when they have coverage because their effective price at the time of service drops) and partly by the increase in market prices for services due to higher aggregate demand. Increased market prices in turn encourage people to purchase more insurance in order to avoid or minimize the additional financial risk from higher prices.

Low deductibles and copayments reduce the financial risk insured people face, and this welfare gain must be offset against the losses described above. Even taking this into account, estimates of the net welfare loss from health insurance indicated that it could be a large sum. In an article on this issue in 1973, Martin Feldstein estimated that raising the coinsurance rate from one-third to two-thirds of private hospital expenditures could have saved $4 billion a year out of a base of $12.6 billion in 1969.[30] A later revision of Feldstein's work in a 1991 study estimated that the net welfare loss from excess health insurance could have been $109.3 billion in 1984 dollars, assuming that insurance induces a large increase in gross prices and consumers place large marginal value on medical spending. Assuming constant prices and high marginal valuation, the estimate would still have been $33.4 billion. These figures obviously would be much higher in today's dollars.[31]

Health insurance and health care have changed since the 1980s, and some of the excesses at that time might have been attributable to unrestricted fee-for-service plans that no longer are common.

---

[28] The term *excess health insurance* may sound inappropriate when there is widespread concern about the growing number of people who are uninsured. However, the argument pertains to people with coverage, not without it. One reason that some people do not obtain insurance is that excess coverage increases the cost for everyone.

[29] Ibid. To some observers, the country has serious problems of both excess insurance and growing numbers of uninsured.

[30] Martin S. Feldstein, The Welfare Loss of Excess Health Insurance, *Journal of Political Economy*, vol. 81 (March/April 1973), pp. 251-280.

[31] Roger Feldman and Bryan Dowd, "A New Estimate of the Welfare Loss of Excess Health Insurance," *The American Economic Review*, vol. 81, no. 1 (March 1991), pp. 297-301. For other work on the concept of excess health insurance see Mark V. Pauly, Taxation, Health Insurance, and the Market Failure in the medical Economy, *Journal of Economic Literature*, vol. 24 (June 1986), pp. 629-675 and Thomas Rice, *The Economics of Health Reconsidered*, Chicago, Health Administration Press, 1998, pp. 82-91.

In 1988, 73% of workers with employment-based coverage were enrolled in conventional insurance plans while in 2007 only 3% were. In the latter year, 57% were enrolled in preferred-provider organization (PPO) plans and 21% in health maintenance organizations (HMOs); in 1988, only 27% were enrolled in either.[32] Today it is not unusual for health plans both to control utilization directly (requiring approval by gatekeepers for access to specialists, for example) and to limit providers' charges as a condition of their participating in a network. In these respects, employment-based health insurance is subject to restrictions even though the tax exclusion itself is not.

Nonetheless, for the most part employment-based insurance does not have high deductibles. In 2007, more than 80% of workers in HMOs did not have *any* general annual deductible, which was also the case for just under 30% of workers in PPO plans and more than 50% of workers in point-of-service (POS) plans. For those with a general annual deductible, the average amounts for single coverage were only $401 in HMOs, $461 for PPO plans, and $621 for POS plans. Although the average deductible in high-deductible plans with savings options was $1,729, only 5% of covered workers were in these plans.[33] (Enrollees in all of these plans would likely have had copayments for most services.)

Whether moving to higher insurance cost sharing would reduce health care spending is not at issue; notwithstanding measurement difficulties, economic theory, actuarial experience, and empirical studies all indicate that it does. Probably the most frequently cited research demonstrating this point is the RAND Health Insurance Experiment (HIE), a carefully designed study of nearly 6,000 people between 1974 and 1982. Among other things, the study showed that per capita expenses for patients with a 95% coinsurance requirement for outpatient services were 31% lower than those for patients without cost-sharing. Reductions were also present but somewhat smaller for patients with lower coinsurance requirements, as they were for those with deductible policies. Reductions occurred for a broad range of conditions, especially for ambulatory care but also for hospitalizations.[34]

More debatable is what effect reductions in spending have on individuals' health, which could affect measures of the welfare loss. A common reading of the RAND HIE is that the health outcomes of those with high cost sharing were not different from those having conventional coverage, with several exceptions.[35] (The exceptions included high blood pressure and vision imperfections in adults and anemia in children.)[36] Although more health problems might have arisen for the high cost sharing group had the experiment continued longer, there is no way to prove or disprove this now.

---

[32] *Employer Health Benefits: 2007 Annual Survey*. The Kaiser Family Foundation and Health Research and Educational Trust. p. 63.

[33] *Employer Health Benefits: 2007 Annual Survey*, pp. 63 and 87. Savings options associated with the high deductible plans were either health savings accounts or health reimbursement accounts. Coinsurance requirements of the different plans are difficult to summarize here; for information, see pp. 87-122.

[34] Willard G. Manning, et al. "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *The American Economic Review*, vol. 77, no. 3, June 1987. p. 258.

[35] See for example the statement in John F. Cogan et al., *Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System*, Washington, American Enterprise Institute, 2005, p. 16.

[36] Kathleen N. Lohr et al., "Use of Medical Care in the RAND Health Insurance Experiment," *Medical Care*, vol. 24, no. 9, September 1986. pp. S72-S87.

However, the similarity in outcomes for participants in the HIE did not occur because individuals with high cost sharing chose to forgo only services of limited clinical value. Instead, it reflected a beneficial reduction in harmful medical services that offset a detrimental reduction in useful services. Bad care and good care were both forgone, resulting in outcomes similar to those having conventional coverage. Today there may be more effective treatments for chronic diseases that higher cost sharing would place at risk, and formerly untreatable or acute illnesses may now be considered chronic and subject to treatment.[37]

A critical question here is whether greater cost sharing can be combined with other reforms so that individuals reduce their spending but maintain or even increase effective care. Possible changes include reducing or eliminating cost sharing for services likely to impart high value, providing better information and helping people use it, and making prices for services and products more available and transparent. Some steps have already been taken in these directions (in consumer-driven health care plans, for example), though it is too early to tell how far they will spread and whether they will make a significant difference.

Some Policy Issues

Ending the tax exclusion could be helpful in reducing health care spending. Because the exclusion reduces the net price of insurance, it likely encourages workers to obtain more coverage than otherwise; since it is uncapped, tax savings and the incentive to purchase more coverage grow unchecked as the cost of insurance rises. In contrast, while an alternative tax benefit such as an expanded tax deduction or a refundable tax credit might have no effect on the former problem (since it too would reduce the net price of coverage), it could provide a brake on the latter, depending on how it is designed.

For example, President George W. Bush proposed terminating the exclusion and replacing it with a standard deduction for health insurance (SDHI) of $7,500 for self-only coverage or $15,000 for family coverage. The Joint Committee on Taxation has estimated that adoption of the SDHI coupled with other parts of the proposal would result in a net revenue increase of over $440 billion from FY2009 through FY2018. The increase would occur largely because the SDHI would be indexed to changes in the Consumer Price Index (CPI) while the exclusion it replaces would have grown at the higher rate for health insurance costs. The reduced tax savings from the change presumably would affect the amount of coverage purchased.[38]

However, it may be somewhat speculative to assume that a reduction in tax savings from indexing alternative benefits to the CPI would materialize to the extent envisioned. If large savings were to occur in the out-years, the reduction in spending they encourage might lead to calls for Congress to adjust the limits.[39] It may also be speculative whether ending the exclusion

[37] Michael E. Chernew and Joseph P. Newhouse, "What Does the RAND Health Insurance Experiment Tell Us About the Impact of Patient Cost Sharing on Health Outcomes?" *American Journal of Managed Care*, vol. 14, no. 7 (July 2008) p. 412. The authors state that "the RAND findings should not be used to justify higher cost sharing across the board."

[38] *Description of Revenue Provisions Contained in the President's Fiscal Year 2009 Budget Proposal*. Joint Committee on Taxation (March 2008), JCS-1-08, p. 317. The $440 billion estimate also reflects other parts of the proposal: repeal the health insurance deduction for self-employed taxpayers and the itemized deduction for people not enrolled in Medicare. A footnote states that the "estimate is very preliminary and subject to change upon clarification of the proposal. Many of the details of the President's health proposals are unspecified."

[39] Of the $440 billion estimate cited above, nearly 70% occurs in the last three fiscal years, 2016 through 2018, and (continued...)

would also encourage more effective care. One possibility is that a deduction or credit would be allowed only if the insurance had incentives to this effect. Another is that if the cost of insurance exceeds what could be claimed as a deduction or taken into account as a credit people would become more cost-conscious and concerned about effectiveness. Whether these things would occur is unknown, however.

There are other issues with potentially ending the exclusion that merit attention. For one thing, in replacing the exclusion with a capped deduction or credit (for example, the $7,500 and $15,000 figures in the President's proposal), it is not immediately clear where to set the cap. Setting it too low might erode needed insurance benefits for some people; if many were affected, the level might not be sustainable. Setting it too high may lock in current welfare losses, delaying significant savings for years to come. (The same dilemma applies to proposals to cap the exclusion rather than replace it with a deduction or credit.)

The issue is complicated by the wide range of health care costs throughout the country. As analysis by the Congressional Budget Office shows health care spending per capita in 2004 varied from approximately $4,000 in Utah to $6,700 in Massachusetts. Although differences in spending reflect more than price differentials (they are also influenced by differences in health status, preferences, and other matters), the magnitude of the differences suggests price disparities might not be inconsequential.[40] Even if they were, spending may be the better indicator for setting a cap unless it is plausible to assume that usage can be reduced in high cost areas. A study by Milliman of 14 major metropolitan areas shows similar spending differences.[41]

In addition, health care costs vary among people with employment-based insurance regardless of where they live. In 2005, median health care spending was $2,525 for people aged 55 through 64 and $623 for those aged 25 through 34. For women aged 25 through 64 with this insurance, median spending was $1,086, whereas for men it was $530. People aged 25 through 64 with this insurance who reported being in fair health had median expenditures of $3,777, while those who reported being in very good health had median expenditures of $893.[42]

To the extent that health insurance reflects these differences, its cost will vary. The largest differentials might occur among small employer plans, particularly in states where there are few restrictions on premium variations in insured plans. (At the same time, small employers might drop coverage that becomes too expensive, which large employers would be unlikely to do.) Workers who incur very high costs might have illnesses or injuries that require them to leave their jobs, reducing the differentials, though sometimes the high cost person is a family member.

Conceivably, tax limits on insurance costs might be adjusted to compensate for some of these differences. For example, the ceiling on a deduction or credit (or the cap on the exclusion) could be set higher for people aged 55 through 64. Alternatively, high cost people might be allowed an additional deduction based upon some portion of their income (similar to the current itemized

(...continued)

28% occurs in the last year alone.

[40] Congressional Budget Office, *Geographic Variation in Health Care Spending*, February, 2008, pp. 1 and 10.

[41] *2008 Milliman Medical Index*, p. 4.

[42] The estimates were done by CRS using the Medical Expenditure Panel Survey. Reflecting the high cost of people with serious health care needs, the mean expenditure for people reporting being in fair health was $11,294, whereas for people reporting very good health it was $2,342.

deduction, though here not limited to itemizers). However, these variations would add complexity, and they might perpetuate differentials that ideally should be reduced.

Ending the exclusion would also raise the question of what amount should be included in employees' income for tax purposes. An average premium (for example, the COBRA premium) has been suggested.[43] However, the economic value of group health insurance varies widely among workers, as was recognized in debates over the exclusion prior to its codification in 1954 (see the discussion above in the "Origins" section). The value of insurance to a young, healthy worker is likely far less than the value to an older worker in poor health, or who perhaps has a family member in poor health. It would seem unfair to require both workers to recognize the same additional amount in the income on which they must pay taxes. Age-based variations might seem more equitable, but the opposite might be true if the younger worker had poor health and the older worker were in good health. Moreover, if the total amount of the employer contribution had to be recognized, small increases for young workers would mean very large increases for older workers, likely to provoke their opposition to the policy change.

Determining a fair allocation of the employer contribution that workers should recognize could become complex. For example, some might think that income should be taken into consideration. Income often increases with age, so older workers arguably could afford the larger tax obligation. However, average incomes increase only until the late middle ages; then they start to decline just when health care expenses rise more sharply.[44] In addition, some research suggests that some older workers already pay for their higher health care costs through lower wages.[45] To the extent this is true, it might not seem appropriate to increase the amount of the employer contribution older workers must recognize.

The current exclusion avoids all of these technical issues; everything is just left out of the tax calculations. To some observers, this is a virtue. At the same time, while the simplicity of omission has obvious attractions, it does not show variations in the allocation of tax subsidies that some would consider important. Differences in the amount of subsidy by age, geography, and health condition might seem inappropriate to some. Ending the exclusion would improve transparency and allow these difference to be assessed and debated. At the same time, it might create new controversies that divert attention from other health care issues.

Tax Equity

Two equity issues arise with respect to the tax exclusion of employer-provided coverage. One is how people with employer-provided coverage are treated for tax purposes compared to otherwise similar people who have coverage purchased in the individual market. The other is how people with employer-provided coverage are treated at different income levels. The former issue, which

[43] Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272), employers with 20 or more employees must offer separated employees the option of continuing the employer's health plan coverage for a temporary period. Employers may be charged up to 102% of the total premium for this coverage.

[44] *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, U.S. Census Bureau, Current Population Reports P60-233 (August 2007), Table 1, p. 5. Median income increased from $30,937 for householders ages 15 through 24 to $64,874 for householders aged 45 to 54; it then declined for those aged 55 to 64, in part because they were no longer in the labor force.

[45] Louise Sheiner. *Health Care Costs, Wages, and Aging.* Finance and Economics Discussion Series. Federal Reserve Board, 1999.

is addressed first, is easier to analyze, and there is an obvious solution to what some people consider a problem. The latter issue is more complicated than is usually recognized and may defy simple solutions.

The tax exclusion sometimes is criticized for providing tax savings when employers pay for the insurance, while coverage purchased in the individual market generally has no tax savings. To some, this creates an unwarranted distortion in the insurance markets. In their view, it is not obvious why health insurance, which is essentially a personal matter, should be tied to one's job. It is argued that the tie limits workers' health plan choices and penalizes workers who might be able to work more productively elsewhere.

Under current law, there are two provisions that provide tax savings to people who purchase insurance in the individual market. One is the 100% deduction allowed self-employed taxpayers who buy policies for themselves and their family members; this applies only to a small number of people, less than 3% of all who file returns.[46] The other is the itemized deduction for unreimbursed medical expenses, which is available only to taxpayers who itemize their deductions and only to the extent the expenses exceed 7.5% of their adjusted gross income. For most taxpayers, the standard deduction is larger than the sum of their potential itemized deductions, and of those who itemize, most do not have extensive unreimbursed medical expenses. In 2005, about 35% of all returns had itemized deductions, and of these, less than 21% (about 7% of all returns) claimed the medical expense deduction. Most people who purchase insurance in the individual market cannot claim either of these deductions.

This imbalance in individuals' tax savings could largely be remedied by allowing an above-the-line deduction for premiums that is available to everyone without employer-provided coverage. This type of deduction, which could be claimed whether or not one itemized, might be a standard deduction like President George W. Bush proposed or limited to premiums actually paid; in the latter case, the income tax savings to individuals would be approximately the same as those from the exclusion for equivalently-priced employer-provided insurance.[47] The income tax deduction just described would not provide savings from the exclusion for employment taxes, but an additional deduction might be allowed people with employment income for that purpose.

Some might oppose this solution since employer-provided insurance generally has broader and more stable risk pooling; in their view, this should be protected and rewarded despite the apparent inequity in tax savings.

The second tax equity issue is how people with employer-provided coverage are treated at different income levels. Income tax savings from the exclusion for employer provided health insurance depend on taxpayers' marginal tax rates. For low-income taxpayers, the savings on federal income taxes might be 10% or as little as none, depending on their income. In 2008, for

[46] IRS data for tax year 2005. The health insurance deduction for self-employed taxpayers is claimed on about 3% of all returns. In addition to being self-employed, the taxpayer must meet a number of additional conditions. The deduction cannot exceed the net profit and any other earned income from the business under which the plan is established, less deductions taken for certain retirement plans and for one-half the self-employment tax. It is not available for any month in which the taxpayer or the taxpayer's spouse is *eligible* to participate in a subsidized employment-based health plan (i.e., one in which the employer pays part of the cost). These restrictions prevent taxpayers with little net income from their business (which is not uncommon for a new business) from deducting much if any of their insurance payments.

[47] The savings would be the same if the employer paid for all the coverage or the workers could pay their share with pre-tax dollars under a premium conversion arrangement.

example, single tax filers generally will not have a regular tax liability until their income exceeds $8,950, the sum of their standard deduction and personal exemption. Until their income exceeds $16,975, their taxable income (the difference between $16,975 and $8,950) would be taxed at 10%. Thus, if single taxpayers with wage income of $13,000 were given employer-paid insurance worth $3,000, their savings from the income tax exclusion would be $300 (i.e., $3,000 x 10%).[48]

For higher-income taxpayers, the income tax savings would be greater. For single filers in the top tax bracket of 35%, the tax savings from the exclusion of $3,000 of coverage would be $1,050, appreciably more than the savings for low-income workers. For middle-income taxpayers in the 15% or 25% brackets, the income tax savings would be $450 or $750, respectively. (In 2008, the 15% bracket for single filers applies to taxable incomes of $8,026 to $32,550; the 25% bracket to taxable incomes of $32,551 to $78,850; and the 35% bracket to taxable incomes over $357,700). Different figures apply to taxpayers filing as married or head of households, but the pattern just described would be the same.

Taxpayers often get additional savings from a parallel exclusion on their state income taxes. Currently, 43 states and the District of Columbia impose taxes on individual incomes. Rates vary from state to state, and while some of the tax savings would be offset by a reduction in the itemized deduction for state income taxes, typically higher income taxpayers would get greater savings.

This picture is complicated by tax savings from the exclusion for employment taxes. Medicare taxes of 1.85% of wages (considering just the employee's share) apply to workers regardless of income; thus all would be affected equally by an exclusion for insurance worth $3,000. For Social Security taxes, however, the exclusion benefits low and middle-income workers but not those with wages above $102,000, the wage base ceiling in 2008. The exclusion would save the former 6.2% (considering just the employee's share), or $186 for $3,000 worth of insurance.

Employment taxes aside, the figures above show that middle income taxpayers generally benefit more from the exclusion than low income taxpayers, and that high income taxpayers generally benefit more than those with middle incomes. When these tax savings are viewed purely as an economic subsidy, this pattern seems unfair if not wasteful. It is unlikely that an insurance subsidy program using appropriated funds would be designed in this manner.

The equity problems are likely to be exacerbated in several respects. For one thing, higher-income workers are more likely to be eligible for employer-provided health insurance. One study showed that 89.6% of workers with family incomes above 400% of the federal poverty level were eligible for employer coverage in contrast to 39.8% of workers with incomes below the poverty level in 2005.[49] The same study also showed that 83% of those eligible in the higher-income group actually accepted coverage, compared with 63.5% of those eligible in the lower-income group. Where these patterns occur, the disparities in tax savings based on the $3,000 figure in the discussion above would understate differences among income groups.

[48] A full-time employee working 2,000 hours a year at the new national minimum wage of $6.55 an hour would earn $13,100 for the year.

[49] Lisa Clemans-Cope et al., *Changes in Employees' Health Insurance Coverage 2001-2005*, issue paper, Kaiser Commission on Medicaid and the Uninsured, 2006.

Moreover, higher-income taxpayers may benefit more from the exclusion if their employment-based insurance on average provides greater economic benefits than identical coverage provides lower-income taxpayers. As described in the previous section, income on average increases with age, at least until the late middle ages, and age usually is associated with higher health care expenditures.

The preceding analysis is not the only way of looking at the tax equity issue. To some extent, the tax savings shown above might not be an inequitable subsidy but only a consequence of the proper treatment of losses under a progressive income tax. In a progressive tax system, when gains are taxed at higher and higher rates depending on income, then it is conceptually appropriate to deduct losses at those same rates. To the extent that health insurance is viewed as a method of smoothing losses over time and individuals, then the greater tax savings for higher income people from the exclusion would not be inappropriate or, for that matter, unfair.

The argument about progressivity would have greater force if health insurance covered only catastrophic expenditures that everyone would clearly see as losses (for example, hospitalization for accidents or heart attacks). However, since a portion of its cost is for anticipated expenditures for routine care, not all of the exclusion can be associated with a loss of this nature.[50]

The root issue is whether health care is like other forms of personal consumption. On reflection, many people might conclude that it is not. Health care takes time, provides no personal pleasure, and, most important, usually is designed to return patients to a condition prior to an accident or illness that no one would choose to have had. Absent the latter, it does not result in gratification or enhancement of one's well being.[51]

On the other hand, health insurance, which is the subject of the exclusion, provides additional value because people recognize they cannot predict their health with certainty and worry that they might not be able to afford care when they need it. It buys peace of mind as well as services. In this respect, insurance may be like other forms of personal consumption in that it is not directly associated with a loss that should be recognized under an income tax.

Because it is difficult to determine what portion of an insurance premium merits treatment as a tax loss, it is challenging to think of what might be an appropriate remedy. The issue is compounded by the diversity of insurance arrangements and uncertainty about the extent to which particular workers ultimately bear the cost of employer-provided coverage.

Conclusion

There is much to be said for moving toward a health care financing system that is more transparent, equitable, and efficient. Given the extraordinary complexity of American health care

[50] The distinction between catastrophic and routine expenses is not always an indication of what might be a deductible loss. Some high expenditures are voluntary (for example, childbirth of a planned baby), whereas some routine expenditures are incurred only to forestall losses (for example, statin drugs).

[51] This was the argument put forth in a once well-known article by William D. Andrews, "Personal Deductions in an Ideal Income Tax," *Harvard Law Review*, vol. 86 (1972), p. 309. For a more recent discussion, see Jay A. Soled, "Taxation of Employer-Provided Coverage: Inclusion, Timing, and Policy Issues," *Virginia Tax Review*, vol. 15 (1995-1996), p. 447.

and increasing concerns about rising costs and the growing numbers of uninsured, new policy approaches are widely being given careful consideration.

Whether ending the exclusion should be part of these approaches depends on what the replacement policies are. Problems attributable to the exclusion might also occur with new measures, or other problems could arise. It is difficult to evaluate one step without knowing the other. Given the origin of the exclusion, it would not be inappropriate to consider revisions in light of today's problems. However, one might move carefully before dismantling a policy that has been in place for more than 50 years.

Some policymakers appear to be interested in the exclusion primarily to reduce the federal deficit. However, if the *sole* objective were to raise revenues, it might be simpler just to increase taxes generally. For many people who currently have employment-based insurance—over three-fifths of the population under the age of 65—the mathematical effect might be roughly the same, at least for income taxes. For people under the age of 65 paying for other private insurance, an offsetting deduction could provide tax equity. People under the age of 65 with other public insurance might not be affected, considering that their income often is too low to be taxed.

Nonetheless, some argue that the exclusion should be ended not to raise money but to improve efficiency and limit costs and spending. In the absence of alternative proposals to achieve these goals, termination might be appropriate.

A principal policy decision appears to be whether to maintain and possibly strengthen the employment-based system of health care. If that is the goal, then maintaining the exclusion might be appropriate since it is unclear what the effects of termination would be over time. If instead the goal were to move towards individual market insurance or an expansion of public coverage, then ending the exclusion should be given greater consideration.

Appendix. Federal Income Tax Formula

The general formula for calculating federal income taxes appears below. The list omits some steps, such as prepayments (from withholding and estimated payments) and the alternative minimum tax.

1. Gross income (everything counted for tax purposes)
2. *Minus* deductions (or adjustments) for determining adjusted gross income (AGI)—"above the line deductions"
3. *Equals* AGI
4. *Minus* greater of standard or itemized deductions
5. *Minus* personal and dependency exemptions
6. *Equals* taxable income
7. *Times* tax rate
8. *Equals* tax on taxable income (i.e., "regular tax liability")
9. *Minus* credits
10. *Equals* final tax liability

Author Contact Information

(name redacted)
Specialist in Aging and Income Security
/redacted/@crs.loc.gov, 7-....

Acknowledgments

This report was originally written by (name redacted) who left CRS in July 2009.