JOINT ECONOMIC COMMITTEE
ROBERT F. BENNETT, CHAIRMAN DECEMBER 17, 2003

HOW THE TAX EXCLUSION SHAPED TODAY'S PRIVATE HEALTH INSURANCE MARKET

For 60 years, the so-called "tax exclusion" for employer-paid group health insurance has treated the portion of an employee's health insurance premium that is paid by his or her employer as a tax-free benefit. It is not subject to any federal and state income taxes that an employee pays, and it is not reported as income on the employee's W-2 form. Because employer-paid health insurance benefits are not considered taxable wages, they also are not subject to federal payroll taxes imposed on employers and employees. This tax policy helped foster rapid growth of employer-sponsored group health insurance in the United States, but it also created unintended consequences for the structure, cost, and availability of both private health insurance and health care that continue today.

- **The tax exclusion and employer-paid health insurance are intertwined.** Most of the post-World War II expansion of private health insurance involved sales of insurance to employers. Tax policy favored growth of employer-paid group insurance by providing it with strong and consistent advantages through the tax exclusion.

- **The amount of federal revenue not collected due to the tax exclusion is substantial.** Revenue losses attributable to provisions of the tax laws that provide special advantages (so-called "tax expenditures") for private health spending equaled $137 billion in 2002. Tax exclusion benefits for employer plans amounted to $128 billion, or 93 percent of all federal tax expenditures for health care. Other tax advantages for employer-related health benefits amounted to $5 billion. More than three out of five non-elderly Americans are covered by employer-sponsored health benefits plans.

- **The tax exclusion tilts the playing field toward employer-paid group plans.** The exclusion denies equivalent tax benefits to current and potential purchasers of individual insurance and other non-employer forms of group insurance. Individually paid insurance accounts for a very small share of the non-elderly health insurance market (about 5 percent).

- **The tax exclusion raises the overall cost of health insurance and health care.** The exclusion operates like a subsidy that increases demand for more comprehensive insurance and more health care services, reduces the sensitivity of individual consumers to health care costs, and raises health care prices.

- **The tax exclusion results in employers and their insurers making important health care decisions for an individual.** Health plan choices for many workers are effectively limited to whatever an employer offers to them. Nearly four out of ten workers with employer coverage have no choice of health plan. Less than half have a choice of more than two plans.

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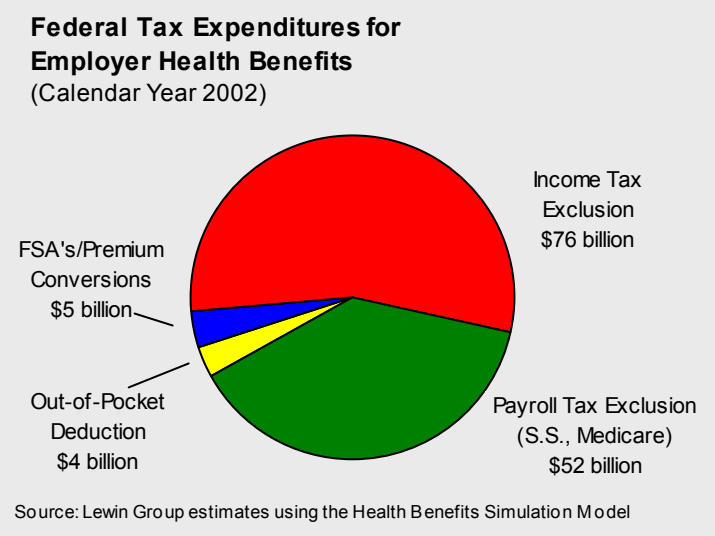
On October 26, 1943, the Internal Revenue Service (IRS) issued a special ruling that confirmed, for the first time, that employees were not required to pay tax on the dollar value of group health insurance premiums paid on their behalf by their corporate employers.[1] The ruling did not explicitly cover union-sponsored health plans, private insurance programs sponsored by other employee associations, other private plans, and employer contributions to the individual health plans of employees. Over the next decade, a number of IRS rulings and court decisions created additional uncertainty over the full scope of the tax exclusion. When Congress codified this area of tax policy in the new Internal Revenue Code in 1954, it provided many employers and unions with even stronger incentives to sponsor group health insurance plans, but the roots of today's exclusion reach back to 1943.

The Tax Exclusion and Employer-Sponsored Health Insurance Grew Up Together

Although all forms of private health insurance increased after World War II, most of this expansion occurred through sales of insurance to employers. For six decades, tax policy helped shape the private health insurance market by providing subsidies to employer-sponsored group insurance in the form of the tax exclusion.[2]

Proponents of the tax exclusion for employer-provided health insurance contend that it provides the financial incentives that hold our employer-based, private health insurance system together and sustain a market-based alternative to the government-controlled health care models of many other countries.[3] Funneling tax benefits through employers makes the after-tax cost of employer-financed health insurance more affordable. Additionally, there are relative efficiencies in the marketing and administration (and perhaps the risk pooling) of health insurance plans sold to larger employers as opposed to individual purchasers. However, economists Mark Pauly and Bradley Herring recently observed that, apart from tax considerations, the relative advantages of the employer group market, compared to the individual insurance market, are overstated. Their research discovered that much less risk segmentation occurs in the individual market, and less risk pooling occurs in the employer market, than is commonly assumed. They concluded that the real problem behind higher costs for individual health insurance is the higher administrative and marketing costs in a thin nongroup market that lacks persistent purchasers.

Figure 1:



Federal Tax Benefits for Private Health Spending Equaled $137 Billion in 2002

All but a tiny amount of "tax expenditures" for health care spending are due to the tax exclusion (Figure 1).[4] Federal tax expenditures for employer-provided health benefits represent the potential revenue that is not collected by the government when the dollar value of those benefits is excluded from employees' federal income taxes ($76 billion) and from their federal employment taxes such as those for Social Security and Medicare ($52 billion). Many employees also take advantage of two other tax benefits that supplement their employer's health plan

coverage. Flexible spending accounts (FSAs) allow employees to set aside pre-tax money each year for out-of-pocket health expenses. Premium conversion arrangements under Section 125 of the Internal Revenue Code (sometimes called "cafeteria plans") allow employees to pay with pre-tax dollars their share of premiums for employer-sponsored coverage. The latter two tax benefits amounted to $5 billion in 2002.

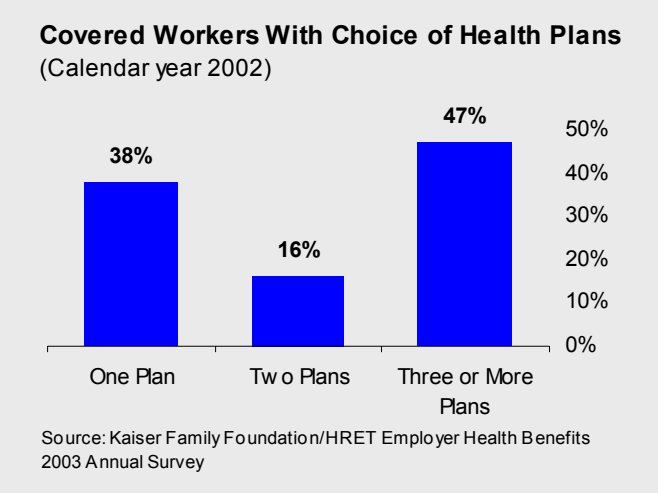
The Tax Exclusion Inhibits Competitive Alternatives to Employer-Sponsored Group Insurance

The tax exclusion favors employer group plans over other forms of private insurance. While it lowers the after-tax price of employer-paid health benefits, it does not provide equivalent tax benefits to potential purchasers of individual insurance and non-employer-based group coverage. By 2001, just under two-thirds of the non-elderly population was enrolled in employer-sponsored plans while roughly 5 percent were enrolled in private individual plans (recent estimates for the latter range from 3.6 percent to 6.6 percent). The powerful economic incentives of the tax exclusion caused the market for health insurance to develop very differently than markets for most other types of personal insurance. For example, automobile and homeowners insurance policies are purchased by individuals, not employers. Life insurance is more evenly divided between individual (60 percent of all life insurance in force) and employer group coverage.

The Tax Exclusion Leaves Key Decisions with Third Parties and Limited Individual Choice

The party that controls the money for health insurance gets to write many of the rules for how it is used. Under the tax exclusion, the employer pays for its employees' health insurance and, accordingly, makes most of the important choices as the primary "customer" for insurers, doctors, and other medical providers. Many employers, particularly those in small- to medium-sized firms, find it difficult to offer even a limited number of health plan choices to their workers. Nearly four out of ten workers offered employer coverage have no choice of health plan, and less than half (47 percent) have a choice of more than two plans (Figure 2). Even then, a choice of plans may simply mean a choice of slightly different products offered by the same insurer.

Figure 2:



When employers struggle to make one-size-fits-all health insurance decisions for many different employees, mismatches between individual preferences and options available at the group level are likely. According to one recent survey of workers receiving employer coverage, fewer than half (48 percent) trust their employer to design a health plan that will provide the coverage they need.[5]

Employer-based health insurance arrangements tend to focus more on shorter-term cost considerations and less on longer-term quality and continuity of care concerns. Employees who do not personally own and control their health insurance remain more subject to disruptions and shifts in coverage when they switch (or lose) jobs or when their employer decides to change carriers. Although the tax exclusion does not explicitly prevent employees and other health care consumers from purchasing health insurance and/or health care through other means, such purchases are more expensive because they cannot take advantage of the tax-free discount available for equivalent insurance coverage purchased by an employer. Even when employers provide flexible spending

account options to help employees to finance a portion of their out-of-pocket health spending on a tax-advantaged basis, employers rather than employees make the initial key decisions (whether or not to offer an FSA benefit and what will be the maximum amount that an eligible employee may earmark for tax-advantaged health spending in a given calendar year).

The Tax Exclusion Increases the Overall Cost of Health Care and Health Insurance

The tax exclusion provides employers and employees with a substantial "discount" – equal to an employee's marginal income tax rate plus the payroll tax rate – on the cost of employer-provided health insurance. This discount encourages employers to offer health insurance as a form of compensation; employers offset most (if not all) of the insurance costs by lowering the cash compensation that they offer. The tax exclusion similarly encourages employees to accept employer-provided health insurance even though they must also accept lower wages and salaries. The tax exclusion thus increases the provision (and cost) of employer-provided health insurance while reducing the amount of cash compensation that employees could direct to out-of-pocket spending on health care or to spending on other goods and services.

Some workers might prefer to receive higher wages in return for bearing more of their health care costs. These workers would have higher incomes and pay lower insurance premiums. In return, they would incur higher out-of-pocket costs for deductibles, co-payments, and uncovered services. They would face a greater likelihood of drawing on their personal savings to pay for health care, and they would be less likely to consume as many health care services. The tax exclusion strongly discourages such choices: workers preferring less insurance coverage would have to forfeit the tax benefits available for greater insurance coverage. The tax exclusion thus encourages greater spending on health insurance.

Employer-provided health insurance also hides the full costs of health care decisions and fosters the illusion that "someone else" is paying for one's care. It disconnects consumption decisions from payment responsibilities. The tax exclusion reduces consumers' incentives to seek out prices and other health information that would facilitate cost-effective decisions.

Because the tax exclusion offers an uncapped tax benefit to employers and employees, it grows in step with each additional dollar spent on employer-provided coverage. Those open-ended financial incentives encourage the purchase of more comprehensive (and more expensive) levels of insurance coverage that extend well beyond protection against major or infrequent risks and prepay the costs of services that would otherwise be paid for with after-tax dollars. The tax exclusion also discourages the purchase of insurance coverage with more extensive controls on costs.

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Individuals with more comprehensive health insurance coverage tend to spend more money on health care. Insurance lowers the net cost of health services at the time a patient decides to purchase care. As the share of health spending that is covered by insurance (i.e., the portion not paid out-of-pocket by an insured patient as "coinsurance") increases, the so-called "moral hazard" effect of insurance coverage increases, too. Moral hazard occurs whenever the quantity of insurance that individuals obtain alters their behavior that affects their expected losses. Moral hazard squanders scarce resources by encouraging individuals to spend more on health care instead of on other goods and services that would be more valuable (absent insurance considerations).

The tax exclusion increases moral hazard by subsidizing the purchase of greater amounts of more comprehensive insurance. The additional dollars devoted to health insurance coverage increase the demand for health care spending. The growth of comprehensive insurance coverage triggered by the tax exclusion has changed the style of health care. It encourages hospitals and physicians to produce more extensive and more expensive health care services. Likewise, it reduces the disincentive for an individual to seek unnecessary care. The additional dollars devoted to health spending also drive up the prices for health services and for health insurance. Even uninsured individuals seeking care must pay higher prices caused by the insurance-driven spending of others. As economist Martin Feldstein once described this cycle of mutually reinforcing behavior, "more insurance increases the price of care, and a higher price of care increases the demand for insurance."[6] Ultimately, the ability of the tax exclusion to improve levels of participation in health insurance coverage becomes quite limited by the rising prices for health care and health insurance that it also creates.[7]

The Tax Exclusion Improves Access to Care for Some Workers, But Leaves Others Behind

Tax advantages for employer-provided group health insurance improve access to more affordable care for workers fortunate enough to work steadily for larger companies with generous health plans. However, many other workers and other individuals lack access to any employer group plan at all, let alone a good one. They include the unemployed, non-working adults, part-time and temporary workers, and full-time workers whose employers do not provide health insurance. Indeed, access to employer-paid health insurance is implicitly tied to one's health status (the ability to show up for work consistently). Moreover, portability of the same insurance coverage remains uncertain during employment transitions (job losses, job changes, job relocations), notwithstanding limited portability provisions of the Health Insurance Portability and Accountability Act of 1996 **(**HIPAA prohibited discrimination on the basis of health status in employer group plans, and it limited the use of preexisting condition restrictions on access to such coverage in a new employer's plan when certain eligible employees switched jobs). Individuals lacking access to employer-provided group coverage must pay for the higher costs of coverage and out-of-pocket care caused by the tax exclusion. If they lack sufficient financial resources to do so, they may end up priced out of the private insurance market entirely.

What about the Next 60 Years?

Over the last decade or so, employer-provided group insurance appears to have reached its maximum limits in covering a large share of the population. In fact, coverage levels have gradually declined from nearly 70 percent of non-elderly Americans in 1987 to just over 61 percent in 2002.[8] Rising premiums for employer group plans are outpacing the ability of tax incentives to keep traditional types of employer group coverage from becoming less affordable. As a result, closing remaining gaps in access to health care, and preventing new ones from expanding, may require more creative approaches than simply adding new layers of tax advantages for group health insurance purchased by third parties.

Employers are increasingly turning away from such cost controls as managed care that attempt to restrict the supply of health care. Instead, they are exploring new ways to contain costs by empowering employees to make more value-conscious health care decisions. Individual workers also are seeking a wider range of health care financing choices. Over the next 60 years, there will need to be consideration of alternatives to the heavy reliance on the tax exclusion and employer-paid group health plans to finance most private health insurance coverage.

Providing more equitable tax treatment of all health insurance purchasers ("tax parity") so that those with employer-based health insurance and those without it would face more similar after-tax prices is one option. Policy tools to achieve a level playing field for otherwise-similar consumers might include

tax credits or full tax deductibility for health insurance spending. Reducing the current scope and scale of the tax exclusion also would level the tax playing field for health spending. Comprehensive tax reform might trade lower overall tax rates for fewer special tax preferences. More incremental measures might include setting fixed caps on tax benefits for health spending or income-relating one's access to them.

The most promising approach involves further expansion of "Consumer-Driven Health Care" plans that rely less on tax subsidies for comprehensive health insurance selected and administered by third-party employers and insurers and more on tax-advantaged personal saving earmarked for health expenses. Consumer-driven health vehicles would reacquaint individuals with the cost and quality of the choices they can manage on their own. Recent congressional approval of liberalized health savings account options in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 should boost their growth.

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Further Reading about the Tax Exclusion

Leonard E. Burman, Corrie E. Uccello, Laura L. Wheaton, and Deborah Kobes, "Tax Incentives for Health Insurance," Discussion Paper no. 12, Urban-Brookings Tax Policy Center, May 2003, http://www.urban.org/UploadedPDF/310791_TPC_DP12.pdf.

Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (Washington: D.C.: U.S. Government Printing Office, March 1994).

Robert B. Helms, "The Tax Treatment of Health Insurance: Early History and Evidence, 1940-1970," in *Empowering Health Care Consumers Through Tax Reform*, Grace-Marie Arnett, ed. Ann Arbor: University of Michigan Press, 1-25, http://www.galen.org/book/chapter1.html.

Mark V. Pauly, "Taxation, Health Insurance, and Market Failure in the Medical Economy," *Journal of Economic Literature* (June 1986): 629-75.

Mark V. Pauly and Bradley J. Herring, *Pooling Health Insurance Risks* (Washington: AEI Press, 1999.

Edgar A. Peden and Mark S. Freeland, "A Historical Analysis of Medical Spending Growth, 1960-1993," *Health Affairs* 14 (2) (1995): 236-47.

Melissa A. Thomason, "The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance," National Bureau of Economic Research Working Paper no. 7543, Cambridge, Mass., February 2000.

[1] 433CCCH, Federal Tax Service, paragraph 6587. Federal government policy first influenced the formation of employment-based health insurance in a 1942 ruling by the War Labor Board that allowed employers to bypass wage controls during World War II by providing fringe benefits to attract workers.

[2] In years since 1943, more modest federal tax subsidies have also been provided to the self-employed, to employer reimbursement of an employee's purchase of individual coverage, and to individuals with substantial out-of-pocket medical expenses.

[3] Proponents of the tax exclusion worry that eliminating it, or even capping the level of its subsidy, might reduce current levels of private insurance coverage and increase the number of uninsured Americans. See, e.g., Jonathan Gruber, "Taxes and Health Insurance," National Bureau of Economic Research Working Paper no. 8657, December 2001, p. 26.

[4] Tax benefits for health spending represent the second-largest "tax expenditure" in the federal budget, if one compares them to the federal tax benefits for all kinds of private pensions. The White House, *Economic Report of the President* (Washington: D.C.: U.S. Government Printing Office, 2003), p. 192. State tax expenditures for employer health benefits in 2002 amounted to another $15 billion. Lewin Group, "Federal and State Tax Expenditures for Employer Health Benefits Contributions, 2002," (Lewin estimates using the Health Benefits Simulation Model).

[5] Watson Wyatt Worldwide, Maximizing the Return on Health Benefits: 2001 Report on Best Practices in Health Care Vendor Management (Washington: Watson Wyatt Worldwide, 2001).

[6] Martin Feldstein, "The Welfare Loss of Excess Health Insurance," *Journal of Political Economy* 81 (2) (1973): 276-77. In several classic articles in the 1970s, Feldstein and his colleagues demonstrated that generous tax subsidies created excess levels of health insurance coverage. Instead of simply producing greater quantities of health services and improving their quality, those additional tax subsidies imposed net welfare losses (spending more and getting less) amounting to as much as 30 percent of total health insurance spending.

[7] Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (Washington, D.C.: Government Printing Office, March 1994), p. 19.

[8] See Leonard E. Burman, Cori E. Uccello, Laura L. Wheaton, and Deborah Kobes, "Tax Incentives for Health Insurance," Urban-Brookings Tax Policy Center Discussion Paper No. 12, May 2003, p. 3; and Robert J. Mills and Shailesh Eharidari, "Health Insurance Coverage in the United States: 2002," *Current Population Reports*, U.S. Census Bureau, September 2003, http://www.census.gov/prod/2003pubs/p60-223.pdf.

Committee Publications

Recent JEC reports include:

- "How the Tax Exclusion Shaped Today's Private Health Insurance Market," December 17, 2003. Explains the existing tax benefit for employer-paid health insurance and the resulting influence throughout health care.

- "New Insights on the 2000-2001 Economic Slowdown," December 10, 2003. Outlines historical revisions to GDP growth, which now show the economy contracted in the third quarter of 2000.

- "Recent Economic Developments: The Economy and Job Market Strengthen," November 25, 2003. Summarizes recently released gross domestic product (GDP) and employment estimates.

- "Recent Economic Developments: Payrolls Revive, Economic Growth Soars," November 12, 2003. Reviews economic indicators released in the past month and prospects for future economic growth.

- "A Productivity Primer," November 7, 2003. Explains what productivity is, that productivity grew an estimated 8.1% in the 3rd quarter and why productivity growth is good for our economy.

Other JEC reports include:

- "A Tale of Two Employment Surveys," October 14, 2003.
- "Constant Change: A History of Federal Taxes," September 12, 2003.
- "Understanding Today's Deficits," September 9, 2003.

Recent JEC hearings and events include:

- "The Employment Situation," November 7, 2003.
- "Rethinking the Tax Code," November 5, 2003
- "Reshaping the Future of America's Health," October 1, 2003.

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