# How Capping the Tax Exclusion May Disproportionately Burden Children & Families

By Elise Gould, Economic Policy Institute

## Introduction

Employer contributions to health insurance premiums are excluded (without limit) from workers' taxable income. Proposals to tax all or some of employer-sponsored health premiums have been forwarded as a means of paying for health reform. Although there have been recent calls to dismiss this idea, namely from House Ways and Means Chairman Charles Rangel (Pear 2009), limiting the tax exclusion has found support from other members. Experts at the Senate round-table discussion on May 11 urged senators to limit the tax exclusion (Leonhardt 2009), and Senate Finance Chairman Max Baucus has maintained that changing the tax exclusion should be part of the discussion (Yoest 2009).

We should proceed with caution before taxing these benefits as ill-conceived plans could disadvantage particularly vulnerable groups. Previous research has demonstrated that small firms and firms with older workers are more likely to be affected by a tax cap (Gould and Minicozzi 2009a). Workers at small firms are more likely to have high premiums because of the difficulties of securing insurance in small groups (e.g. inadequate risk pooling, high administrative costs). Workers at firms with older workers pay higher premiums, not because of the generosity of their health insurance plan, but because of their perceived or actual higher health costs.

While taxing health premiums to any extent may erode access to employer-sponsored insurance, policymakers should also be wary of changes to the tax treatment that disproportionately weaken families' access to insurance.

This paper examines how proposals to cap the tax exclusion may unintentionally disadvantage another group – those with family plans – a subject yet to be discussed in the public discourse. The decision of where to set the cap needs to take into account the relative likelihood of single and family plan enrollees being directly impacted. While taxing health premiums to any extent may erode access to employer-sponsored insurance, policymakers should also be wary of changes to the tax treatment that disproportionately weaken families' access to insurance. At the very least, reform should create a level playing field.

One goal of health reform should be to strengthen the coverage children and families currently enjoy through the employer market and provide affordable alternatives to those left out. This analysis explains the current tax treatment of health premiums, documents the recent policy proposals to change the tax treatment, discusses the relative premium levels and growth of single and family plans, charts out who would be most affected by a tax cap now and in the future, and makes policy recommendations to better protect families and particularly children from further losses in employer-sponsored health insurance.

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## Background

The employer-sponsored health insurance industry in the United States did not flourish until the middle of the 20th century. During World War II, employers offered health benefits as a way to attract workers when the National War Labor Board froze wages.

In 1954, Congress amended the Internal Revenue Code to clarify and expand a 1943 administrative tax ruling that granted tax exempt status to employers' contributions for their employees' group medical and hospitalization premiums. Excluding premium contributions from taxable income made one dollar worth of health insurance less expensive to provide than one dollar worth of wages. Furthermore, laws passed in late 1970s and 1980s denoted by Section 125 of the Internal Revenue code allows employee contributions to be excluded when their employer has a qualifying 125 plan (often called cafeteria plans).

This combination of tax exemptions encourages the use of employer-sponsored health insurance (ESI). In general, the tax exemption – effectively a government subsidy – reduced after-tax insurance premiums enough to encourage even the healthiest employees to enroll. In this way, sustainable risk pools were formed and group policies became more attractive to insurance companies.

Over the latter half of the 20th century, employer-sponsored health insurance became increasingly popular. Workers have grown to rely on employers to provide health insurance, and employers have used it as a tool to attract and retain the best workers and improve the health of their workforce.

## Recent proposals to alter the tax treatment of premiums

Over the last several years, there have been many proposals to change the tax treatment of ESI premiums, including a considerable number of bipartisan proposals in the 1990s. Policymakers have advocated for a wide range of solutions including elimination of all or a portion of the exclusion and conversion of the current exclusion into credits for purchase of insurance through employers or on the individual market. These include proposals by House Majority Leader Dick Armey (R-TX) and Pete Stark (D-CA) in 1999, and Reps. Jim McCrery (R-LA) and Jim McDermott (D-WA) in 2000. In addition, Stuart Butler from Heritage Foundation and David Kendall from the Progressive Policy Institute made policy recommendations along these lines during the same period.

In the 2000s, there has been a renewed interest in changing the tax treatment of ESI premiums. A summary of recent plans and cap/deduction/credit amounts are detailed in Table 1. In November 2005, the President's Advisory Panel on Federal Tax Reform recommended several changes to the tax treatment of health insurance. The Panel set a cap on the tax exclusion at $5,000 for individual plans and $11,500 for family plans.

In Senator John McCain's presidential campaign, he proposed eliminating the tax exclusion and replacing it with a tax credit for purchase in either the employer or non-group insurance market. The credit proposed was $2,500 for single plans and $5,000 for family plans. President Bush's budget for FY2009 replaced the tax exclusion with a deduction:

$7,500 and $15,000 for single and family plans, respectively. The Wyden-Bennett proposal also replaces the exclusion with a deduction, though it includes provisions which account for family income and number of children. The deduction proposed in their plan is $6,015 for single plans and $15,210 for family plans.

**Table 1.** Proposals to Change the Tax Treatment of Employer-Sponsored Health Insurance Premiums

| Proposal | Type | Single | Family | Family/Single |
|---|---|---|---|---|
| Wyden-Bennett Plan (2009)[a] | Deduction | $6,025 | $15,210 | 2.5 |
| Bush Budget (FY2009) | Deduction | $7,500 | $15,000 | 2.0 |
| McCain Campaign Proposal (2008) | Credit | $2,500 | $5,000 | 2.0 |
| The President's Tax Reform Panel (2005) | Cap | $5,000 | $11,500 | 2.3 |

[a] Wyden-Bennett includes a phase-in/-out component. For single plans, phase-in occurs between 100-400% poverty with phase-out at $62,500. For family plans, phase-in occurs between 100-400% of poverty, and phases out at $124,000. With joint filers with more than one child, the value of the family deduction increases by $1,000 for each child.

**Sources:** Park (2008); Burman et al (2007); Buchmueller et al (2008); Fronstin (2009).

An obvious research question is how well do these parameters meet the needs of children and families? The first place to look to answer this question is the prices of ESI premiums for single and family plans. The next section of this article reviews the costs of premiums in the employer market.

## Single and Family Plan Premiums, 1999-2008

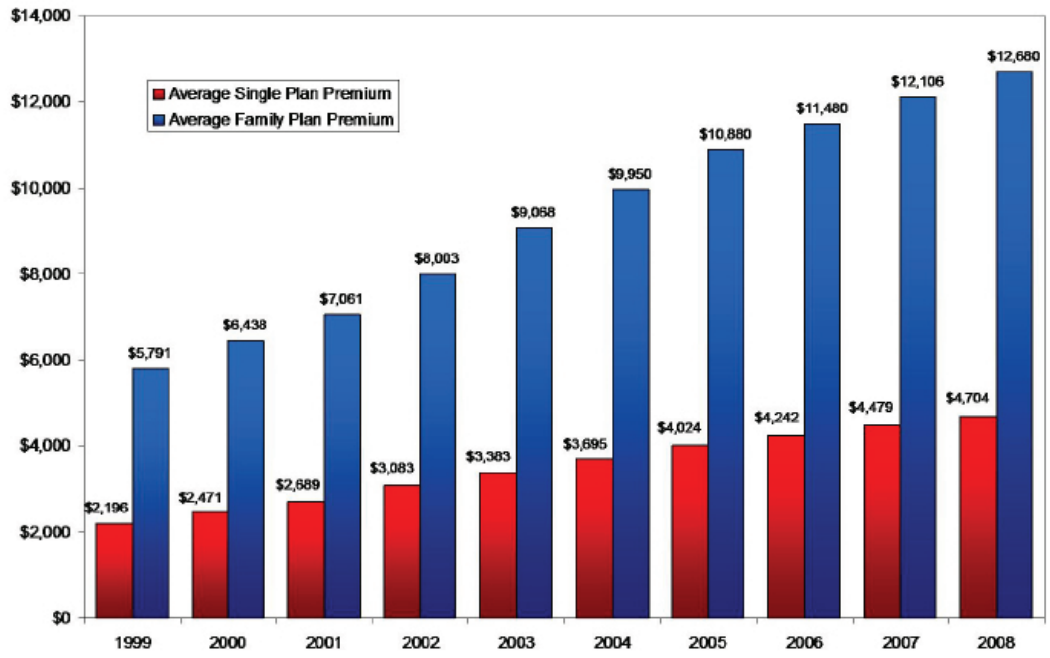
In 2008, total single plan premiums for employer-sponsored health insurance were $4,704 and total family plan premiums were $12,680, as shown in Figure 1 (Kaiser/HRET 2008). From 1999 to 2008, single plan premiums increased by over 114% while family plan premiums increased by 119%. Both rose three and a half times faster than workers' earnings and over four times faster than overall inflation (Kaiser/HRET 2008). The ratio of family to single plans remained relatively constant over the entire period between 2.6 to 2.7.

In the last column of Table 1, the relative value of cap/deduction/credit is listed. In both the FY 2009 Bush budget and the McCain campaign proposals, the value set for family plans was merely twice that of single plans. The Wyden-Bennett Plan reflects a 2.5 to 1 ratio between family and single plans, and the Tax Reform Panel falls somewhere in between. This highlights a key weakness in all of these options: they do not accurately reflect the relative prices of single and family plans. Family plan premiums in 2008 were 2.7 times higher than single plan premiums.

Those with family plans will see a higher share of their premiums taxed than their single counterparts.

What this means is that attempts to change the tax treatment while assuming anything less than a 2.7 relative ratio of prices will disproportionately affect family plans over single plans. That is, on average, the cap/deduction/credit in recent proposals is more favorable towards (disproportionately advantages or disadvantages to a lesser degree) single plans over family plans. And, those with family plans will see a higher share of their premiums taxed than

**Figure 1:** Single and Family Employer-Sponsored Health Insurance Premiums




**Source:** Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008

their single counterparts. Capretta (2007) argues that anything less than setting the level in accordance with actual premium amounts will "induce the breakup of many family insurance arrangements, with spouses enrolling in separate coverage and parents enrolling children in public insurance to avoid paying premiums" above the deduction or cap amount.

Another way this disadvantage can play out is through a reduction in the quality of insurance offered to families. In reference to a comparable proposal to alter the tax treatment, Dorn (2007) posits that "employers may lower the generosity of the benefits they provide to conform to the 'official' deduction." He suggests that such conformity will lead to fewer covered benefits and higher out-of-pocket costs for family plans relative to single plans.

One thing to keep in mind when using average total premiums to analyze relative differences in which groups would be more affected is that changing the tax treatment only affects the tax preferred portion of the premium and not the total premium. As noted previously, the employer contribution is not subject to taxation as is the majority of employee contributions, but not all. Therefore, it is important to explore the issue further and examine only the tax-preferred portion of the premium when looking at the relative affects among family and single plan holders. First, however, we turn to coverage rates among the under-65 population to uncover how trends in coverage have affected adults and children differently.

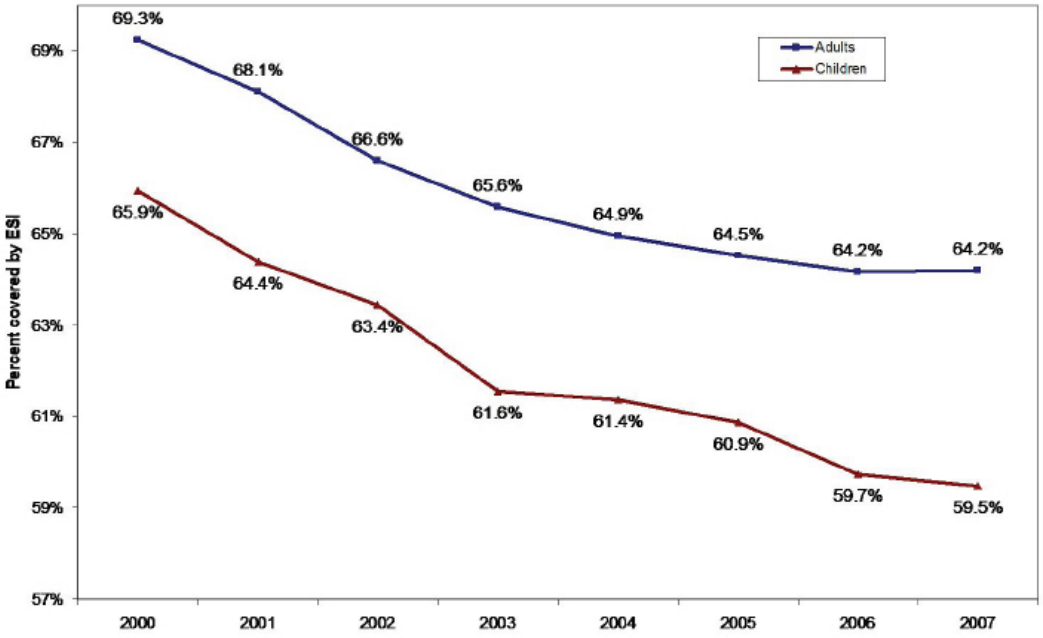
## Children display lower rates and larger declines in coverage

In 2007, 64.2% of non-elderly adults had employer-sponsored health insurance, down 5.1 percentage points from 69.3% in 2000 (see Figure 2). In 2007, the ESI coverage rate among children was only 59.5%, nearly 10 percentage points

lower than the adults. In addition, children experienced even larger declines in coverage. Their coverage rate fell 6.4 percentage points or 25% faster than the declines among adults.

Overall, there is a fairly significant gap between the coverage rates of children and adults and that gap has widened in recent years. This worsening access to ESI, particularly among children, should be factored in to any health policy proposal. The ESI losses among children did not translate into a one-for-one rise in the uninsurance rate as the strength of public insurance such Medicaid and State Children's Health Insurance Program (SCHIP) kept many children from becoming otherwise uninsured.

**Figure 2:** Trends in Employer-Sponsored Health Insurance for Adults (18-64 years old) and Children (under 18 years old), 2000-2007




**Source:** Author's analysis of the March Current Population Survey, 2001-2008

## Case Study: 2005 Tax Reform Panel Cap

To best assess how families might be disproportionately affected by a cap on the tax exclusion, it is required to examine data which separates out the tax preferred premium from the total premium. The Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) allows for such analysis. In this section, we examine a recent well-know proposal to cap the tax exclusion and look at how many single and family plans would be directly impacted.

In 2005, President Bush established a bipartisan panel to recommend reforms which would make the tax code "simpler, fairer, and more pro-growth." In its final report, the President's Advisory Panel on Federal Tax Reform, (heretofore called the Tax Reform Panel) recommended substantially changing the tax subsidy for employment-based health insurance by setting a limit on the premium amount that could be excluded from an individual's taxable income.

In November 2005, the Tax Reform Panel recommended several changes to the tax treatment of health insurance. The most prominent recommendation was to set a cap on the income and payroll tax exclusion for employer and employee

contributions to health insurance premiums. Thus premiums in excess of the fixed dollar limit (which varies by type of coverage) would be included in taxable income and subject to payroll taxes. The Panel set the exclusion limit at the average cost of health coverage in 2006, indexed by the CPI-U. In 2006, the proposed maximum exclusion was $5,000 for individual plans and $11,500 for family plans including employee-plus-one plans. Using the MEPS-IC, we estimate how many people would be directly affected by this proposal in the first year and over a 10 year horizon.

**Table 2.** Percent of Employees and Mean Dollars Affected by Plan Type, 2006

| | Single Plans | Family Plans | Plus One Plans |
|---|---|---|---|
| Cap Amount | 5,000 | 11,500 | 11,500 |
| Percent of Enrolled Employees Affected | 23.3% | **40.4%** | 8.2% |
| Mean Dollars Affected | 1,279 | 2,750 | 2,071 |

**Source:** Gould and Minicozzi (2009). Calculations based off of tabulations provided by the Agency for Health Care Research and Quality using data from the Medical Expenditure Panel Survey Insurance Component

As shown in Table 2, the Tax Reform Panel's cap would directly affect 40% of employees in family plans, 9% in plus one plans, and 23% in single health insurance plans. As before, we can determined the relative cap values as 11,500 to 5,000 or 2.3 to 1 whereas the ratio of total premiums was 2.7 to 1. Given this discrepancy between 2.3 and 2.7, it is not surprising that a much higher share of family plans are impacted than single plans. Family plan enrollees are over 70% more likely to be directly affected than single plans.

The increase in taxable income caused by the cap is substantial. The average tax-preferred premium for single plans above the cap is $6,279, which translates into an average of $1,279 newly subject to income and payroll taxes. The tax panel recommended subjecting amounts in excess of the cap to both income and payroll taxes. For a taxpayer with 15% marginal tax rate on income (over the range of the premium amount with earnings below Social Security taxable income cap), the newly taxable $1,279 increases tax liability by $290.

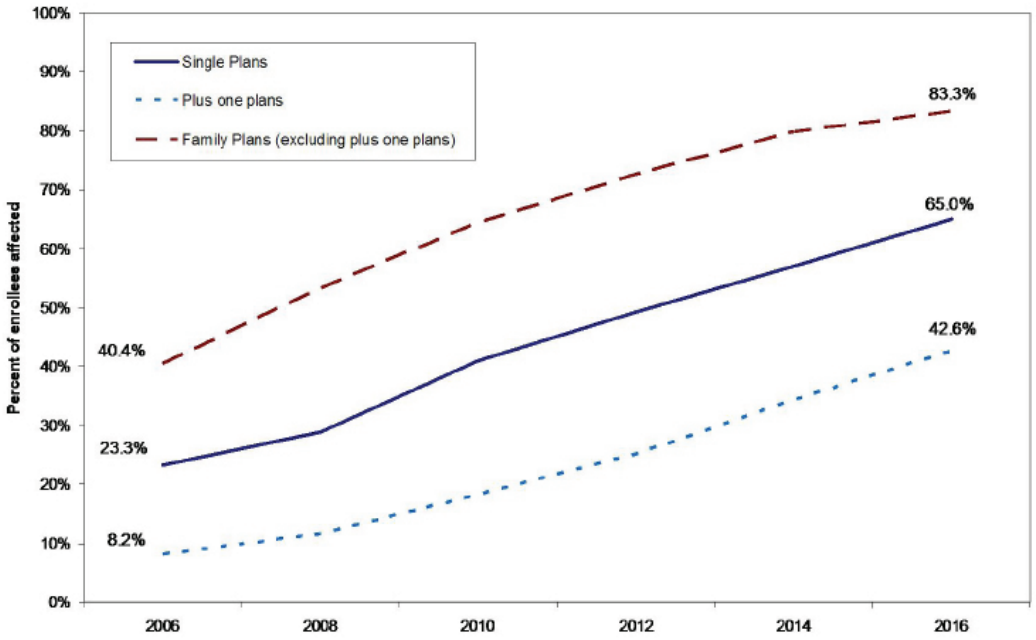
Family and plus one plans are treated equally under the Tax Reform Panel's recommendations, each capped at $11,500. Therefore, it is not surprising that a smaller percentage of plus one plans would be affected. Looking just at family plans above the cap, an average of $2,750 are newly subject to income and payroll taxes. For a taxpayer with a 15% marginal tax rate, this translates into $210 new payroll tax contributions and $413 new income tax contributions for a total of $623 increase in total tax liability.

Family plan enrollees are over 70% more likely to be directly affected than single plans.

So, in this simplified example with comparable marginal tax rates, single plan enrollees would be required to pay $290 more in taxes whereas family plan enrollees would have an increase of $623 in total tax liability. Families would have to pay over twice the amount of single plans because the cap value did not accurately reflect the relative cost of those plans. Coupled with the increase in tax liability is the fact that more family plans are impacted (40.4% vs. 23.3%) and it is clear that family plans are being disproportionately disadvantaged by the Tax Reform Panel recommendations.

In addition, it is important to remember that the ratio of the recommended cap values was 2.3, far higher than the 2.0 ratio that was proposed in the form of a credit by McCain's campaign or as a deduction in the FY2009 budget. Family plans would obviously have been even further disadvantaged under those scenarios.

**Figure 3:** Projected Percent of Enrolled Employees Affected, 2006-2016




**Source:** Gould and Minicozzi (2009b). Calculations based off of tabulations provided by the Agency for Healthcare Research and Quality using data from the Medical Expenditure Panel Survey Insurance Component.

The Tax Reform Panel further recommended indexing the tax preferred premium amount by overall inflation (CPI-U), mimicking other inflation-adjustments in the tax code. Yet, historically, health insurance premiums have grown much faster than overall inflation. From 1999 to 2008, employer-provided health insurance premiums grew over 4 times faster than overall inflation (KFF/HRET 2008). Therefore, setting increases in cap values to overall inflation gradually increases the affected population each year.

Figure 3 displays the growth in percent of affected enrollees from 2006 to 2016 by plan type. The CPI-U indexing results in an exclusion cap of $6,203 for single plans and $14,267 for family and plus one plans. Over the ten year horizon, the share of single plan enrollees with tax-preferred premiums in excess of the cap more than doubles in size from 23% to 65%. The share of family plan enrollees affected doubles as well over the 10 year period from 40 to 83%.

## Policy Discussion and Conclusions

In a climate of substantial budget deficits and scrambling to find money to fund health reform, the prospect of recouping upwards of $200 billion by taxing health benefits is enticing. But, we should proceed with caution before moving to cap or eliminate this tax exclusion. In trying to pay for coverage expansions, taxing health care benefits shouldn't be the first place we look, but rather the last, and only after large-scale health reform is in place to cover everyone, including those who may lose access to ESI as a result of such a tax change.

Assurances should be made to not harm children's chances of securing or maintaining quality, affordable coverage.

Taxing health benefits is indeed one way to bridge the funding gap, but it should not be adopted without serious consideration of the losers from such a policy. Care should be made to ensure that children and families on ESI family plans are not disproportionately affected by a cap on the amount of premiums that can be excluded from income or payroll taxes.

Recent proposals do not examine the reality close enough and assurances should be made to not harm children's chances of securing or maintaining quality, affordable coverage. If Congress goes ahead with setting a limit on the tax exclusion, thresholds for the cap should take actual ESI premiums into account, reflecting the current marketplace for health insurance. Similarly, subsidies to purchase insurance, for instance in a national exchange, ought to take into account the true relative price of insurance to keep families from being overly burdened or inadequately afforded high quality coverage. Children's coverage has already experienced large declines and policies which disproportionately disadvantage health insurance for kids (ESI dependent coverage) would exacerbate a weakness in the current system

Meaningful heath reform ought to ensure quality, affordable coverage for all Americans. There are many ways to accomplish this goal, but given that the current reform initiative is expected to build on the existing employer-sponsored insurance system, health reform should strengthen the ability of families to find and retain such insurance. Components of successful reform should include a national health insurance exchange with a public insurance option coupled with shared individual and employer responsibility and delivery system reforms. Not until a secure, safety-net system is in place to cover everyone should changes to the tax exclusion be considered. And, even then, care should be made to equally protect children and families from being disproportionately burdened.

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