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REDUCING THE FEDERAL DEFICIT BY INCREASING HOUSEHOLDS' RISK

Phaseout of tax exclusion for health insurance premiums leads to less health and financial security

BY ELISE GOULD

Currently, employer contributions to health insurance premiums (as well as most employee contributions) are excluded without limit from workers' taxable income. Over the last several years, policymakers have proposed various ways to limit the tax benefits workers and their families receive when they purchase health insurance through their workplace. The Illustrative Individual Tax Reform Plan set forth by the National Commission on Fiscal Responsibility and Reform in its 2010 report is the newest iteration of a proposed tax on workplace health benefits. Among other methods of reducing the federal budget deficit, the "Bowles-Simpson commission" suggests first capping the tax exclusion for employer-sponsored health insurance and then phasing it out entirely. The cap would be set at the 75th percentile of premium levels in 2014 (i.e. initially affecting the 25% of workers with more expensive employer-sponsored health plans), frozen in nominal terms through 2018, and then phased out by 2038.

This paper examines the percentage of workers in single and family plans who would be affected by the cap in its initial year and through 2018. It analyzes the dollars that could be taxed under the proposed plan and the populations most likely affected. The paper also

TABLE OF CONTENTS

The Bowles-Simpson Illustrative Proposal to tax benefits	2
The cap on the tax exclusion would affect more than half of single plans by 2018, and all when phased out	3
The cap would affect most family plans by 2018, and all at phaseout	4
Families with middle-of-the-road health insurance plans would face higher costs	4
Health reform's excise tax made moot	6
The cap on the tax exclusion would affect people with ordinary health coverage, not just those with 'Cadillac' plans	6
Consequences: Cost- and risk-shifting may lower coverage, care	6
The tax cap is not a very effective cost-containment device	8
Conclusion	10
Appendix: Methodology	11

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discusses whether reducing the value of the tax exclusion cap would make employers less willing to provide health insurance and the extent to which costs would shift onto workers and their families. Lastly, the paper cautions against expectations that taxing benefits would significantly contain overall health sector costs—both in regards to how much money is actually saved as well as who bears the burden of this cost-savings.

As the paper shows, the plan would have significant impacts at three levels:

The tax will hit many workers with ordinary health care plans, not exclusively those with high-value plans

- While setting the cap at the 75th percentile of plans suggests that only one-quarter of all people would be affected by this tax in 2014, freezing it in nominal terms for the subsequent four years would more than double the percent affected due to the expected growth of health insurance premiums.
- An estimated 61% of workers with family plans would be hit by 2018 and, obviously, 100% would be hit when the tax exclusion is fully phased out.
- Workers with family plans at the middle of the premium distribution would be affected starting in 2017, with the associated additional \$802 of premium dollars susceptible to taxes. By 2019, taxable premium dollars would increase to \$3,300 and by 2038 the full value of employer-sponsored premiums would be taxed—meaning that families could be facing taxes on an additional \$46,561.

The consequences of capping the tax exclusion for health care premiums are far-reaching

- Taxing health benefits could lead employers to drop health insurance coverage for their workers.
- Capping the health care tax exclusion would shift health costs and risks onto workers and their families, hitting those with high medical needs especially hard.

- The cost-savings achieved as patients respond to increasing out-of-pocket burdens may be realized by reducing medically indicated health care—a penny-wise, pound-foolish result.

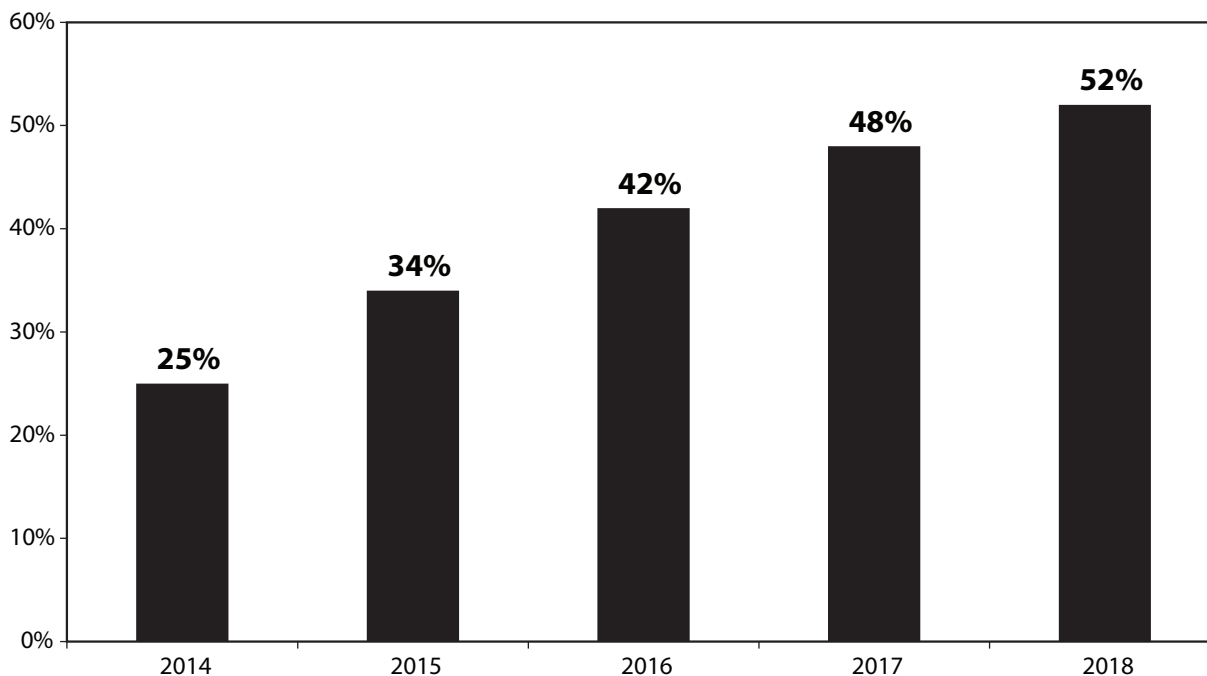
While the tax may raise substantial revenues, it would do little to contain the rapid growth of overall health care costs that constitutes the major budget challenge in coming decades

- Higher cost-sharing could lead to consumption of less effective care and therefore higher overall health care spending.
- Any cost-containment would be driven by reduced medical care, not reduced prices.

The Bowles-Simpson Illustrative Proposal to tax benefits

In 2010, President Barack Obama established the National Commission on Fiscal Responsibility and Reform. The commission was charged with identifying policies to reduce the federal budget deficit in the medium term and to achieve long-term fiscal sustainability. The commission co-chairs, former Clinton White House Chief of Staff Erskine Bowles and former Senator Alan Simpson (R-Wyo.), reported their findings in a December 2010 report, “The Moment of Truth.”

The report proposed reforming the individual tax system by limiting tax expenditures in order to increase revenues while lowering marginal tax rates. To show how this goal could be achieved, the report presented an “Illustrative Individual Tax Reform Plan” offering a menu of options. Among the highlighted options was a cap on the tax exclusion for employer-sponsored health insurance benefits (National Commission on Fiscal Responsibility and Reform 2010, page 31). Under the “illustrative plan,” the cap would be set at the 75th percentile of the distribution of premium levels in 2014, and frozen in nominal terms through 2018. (In other words, the cap would be set at the value at which, if total premiums associated with each policyholder plan lined up in ascending order of

FIGURE A**Percent of private-sector workers with single health insurance plans affected by Bowles-Simpson tax exclusion cap, 2014–2018**

SOURCES: EPI analysis of U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2009 Medical Expenditure Panel Survey—Insurance Component, Table I.G.1; Centers for Medicare and Medicaid Services, National Health Expenditure Projections, 2009–2019.

total cost, the first 75% would fall below the cap.) The tax exclusion would be phased out by 2038, in an unspecified manner. The excise tax on high-priced health plans established in health care reform (the Patient Protection and Affordable Care Act or PPACA) of 2010 would remain but be lowered from 40% to 12%.

The cap on the tax exclusion would affect more than half of single plans by 2018, and all when phased out

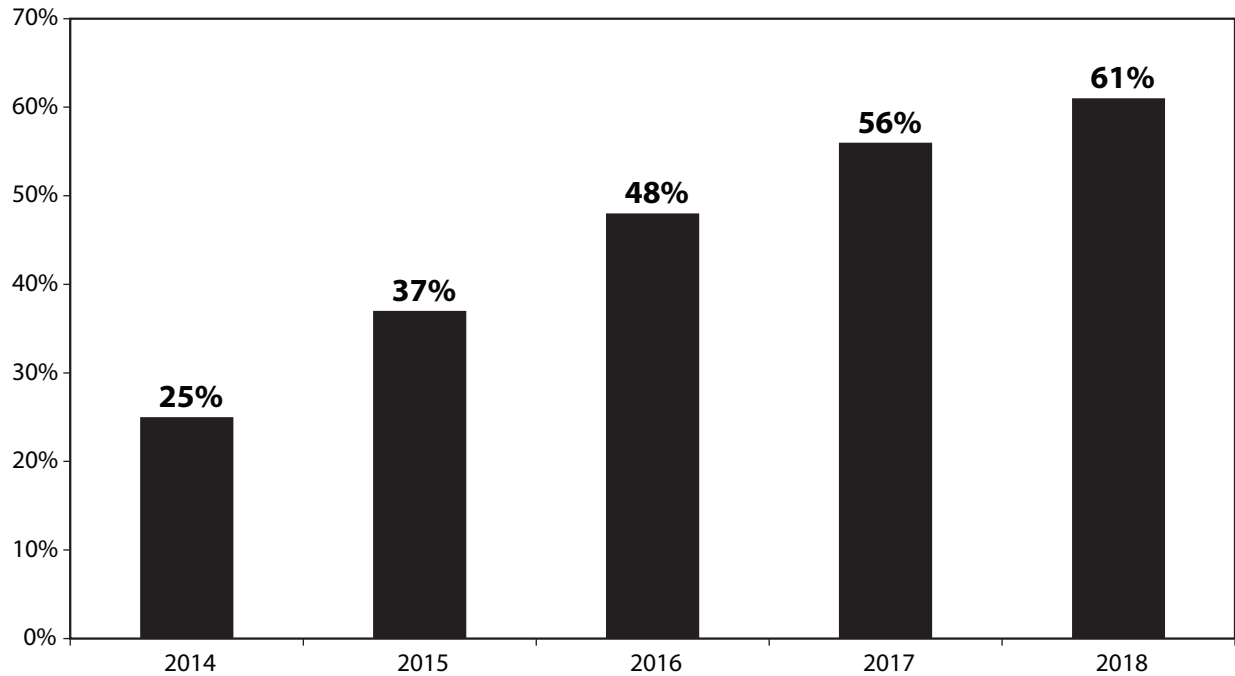
Figure A shows the percentage of private-sector workers with individual health insurance plans (single plans) affected by the tax exclusion cap from 2014 to 2018. As the figure shows, 25% of workers with single plans would be subject to the cap when it goes into effect in 2014. Workers whose plans hit the cap could either keep

the plan they have (if it's still offered) and pay the tax or avoid the tax by choosing plans that fall below (or right at) the cap value—presumably receiving less comprehensive coverage as a result. Either way, the tax cap is “binding” for these workers. They no longer would have the option of remaining in the plan they have chosen without incurring additional costs. Since its value stays constant from 2014 through 2018 while health premiums rise, the cap would affect an increasing share of workers with single plans each year, with about 52% of single-plan participants affected by 2018.¹

As the tax cap falls in nominal terms between 2018 and 2038, it accelerates the likelihood that a given worker's plan would be hit. By 2038, the tax exclusion is completely phased out and the entire premium of all plans would be included as part of taxable income.

FIGURE B

Percent of private-sector workers with family health insurance plans affected by Bowles-Simpson tax exclusion cap, 2014–2018



SOURCES: EPI analysis of U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2009 Medical Expenditure Panel Survey—Insurance Component, Table I.G.1; Centers for Medicare and Medicaid Services, National Health Expenditure Projections, 2009–2019.

The cap would affect most family plans by 2018, and all at phaseout

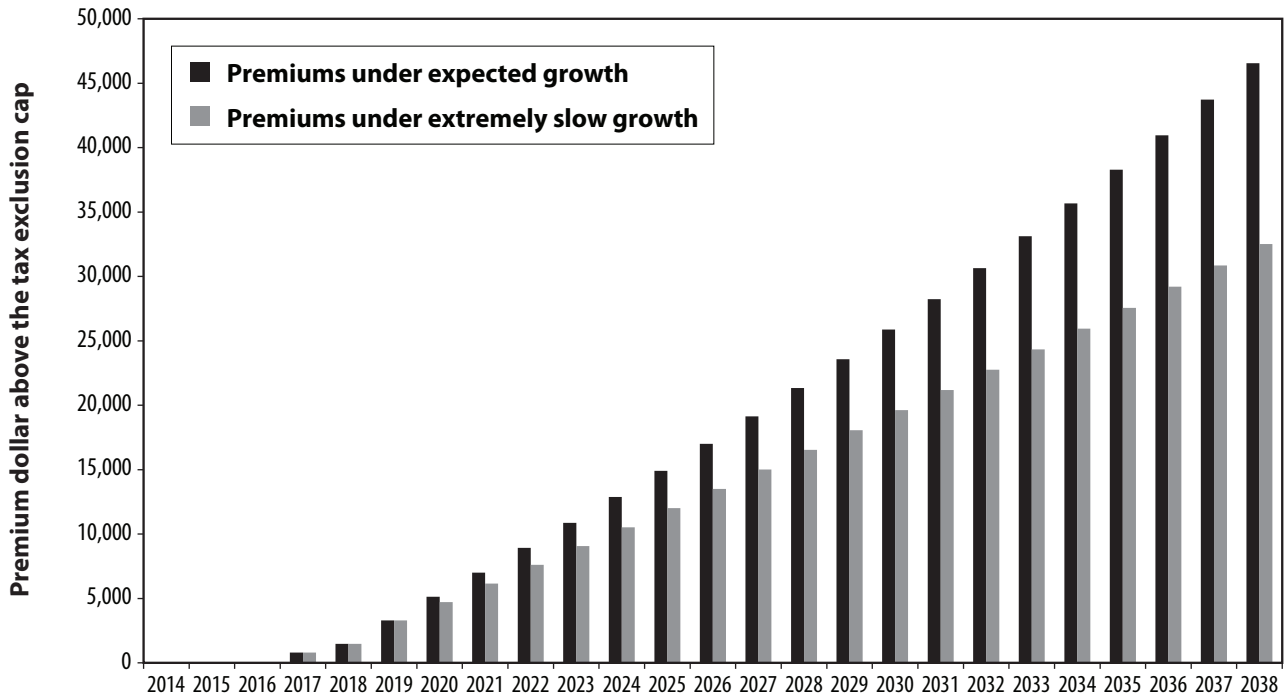
Similar trends are found among family health insurance plans, and are depicted in **Figure B**. Assuming that the cap for family plans is set at the 75th percentile of the family premium distribution in 2014 as outlined in the illustrative plan, 25% of workers with family plans would be subject to the cap. As with single-plan holders, these workers would either pay the tax or avoid the tax by purchasing less expensive (and therefore less comprehensive) coverage. Since its value stays constant through 2018 while health premiums rise, the cap would affect an increasing share of workers with family plans, with about 61% of those workers' plans exceeding the cap value by 2018.

Families with middle-of-the-road health insurance plans would face higher costs

The estimated cap value for family plans is \$18,752 (in 2014 dollars) for each year from 2014 to 2018. For a worker whose family health insurance premium costs fall right in the middle of the distribution of plan premium prices (i.e., at the 50th percentile), annual premiums would be \$16,252 in 2014, falling short of the tax cap in 2014, 2015, and 2016. However, given the expected increase in health insurance premiums into the future, that family's plan premium would be *above* the \$18,752 cap by 2017, by roughly \$800. Assuming for analysis purposes that there is no change in plans families choose because of the cap, a family whose plan falls at the 50th percentile of premiums

FIGURE C

Premium dollars affected, for workers with family plans at the median family premium, 2014–2038



SOURCES: EPI analysis of U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2009 Medical Expenditure Panel Survey—Insurance Component, Table I.G.1; Centers for Medicare and Medicaid Services, National Health Expenditure Projections, 2009–2019.

would be expected to pay approximately \$20,235 in premiums in 2018. If they kept that plan, their taxable income would increase by \$1,483. If they switched to a cheaper plan, they would be responsible for a higher share of their medical costs as their new plan shifts costs onto the family through a higher deductible, higher co-pays, or the like. In addition, either their total compensation would fall or they would pay higher taxes on any increase in wages extended by their employers to compensate for less-generous health coverage (for a lengthier discussion of these effects, see the *Consequences* section later in this paper).

By 2038, the Bowles-Simpson Illustrative Individual Tax Reform Plan calls for the tax exclusion for premiums on employer-sponsored health plans to be completely phased out. Assuming the cap is evenly phased out from 2019 through 2038 and premiums grow at a reasonable rate, the amount of premium dollars affected can be projected

into the future.² As stated earlier, the cap on the tax exclusion wouldn't directly hit families at the median until 2017. However, as premiums grow and the cap falls, a growing share of premiums would become subject to the tax cap over time.

Figure C shows how many dollars fall above the tax exclusion cap for workers with a middle-priced family plan as premiums rise at the expected 4.3% annual rate and as the nominal value of the cap falls (see the Appendix for reasons behind the choice of premium-growth and other parameters). For example, in 2019, premiums at the median of the distribution are expected to be \$21,115, or about \$3,300 above the cap. If families with these plans don't move toward less expensive plans, they would have to pay taxes on 3,300 more dollars. By 2038, the entire projected premium, \$46,562, would be added to these workers' taxable income.

The figure also shows how many premium dollars are affected even if premiums rise at a far slower growth rate of 2.3% (matching projected growth in the overall Consumer Price Index). This much smaller growth rate implicitly credits the tax cap with reducing premium growth through very large changes in health care utilization, which lowers total health care spending directly and insurance and provider prices indirectly. Even under this extremely optimistic scenario, a rapidly growing share of workers' health insurance premiums would still be taxed into the future: In 2038, workers with family plans would pay taxes on an additional \$32,526 of income if they had kept the same plan that they had in 2014.

Health reform's excise tax made moot

This analysis ignores the excise tax on high-cost premiums as set out in health reform. The excise tax hits family plans with premiums above \$27,500 in 2018. Under Bowles-Simpson, the projected tax cap by 2018 is \$18,752, a figure lower than the excise tax threshold. Therefore, the excise tax would be non-binding, that is, since it would have a far higher cut-off value than the tax exclusion cap, any effects of the excise tax on behavior would almost surely have been accounted for by the cap. To the extent that this assumption is too strong, workers who continue to choose plans above *both* the cap *and* the excise tax threshold would have to pay taxes on their benefits and absorb the value of the excise tax in their even higher premiums.

The cap on the tax exclusion would affect people with ordinary health coverage, not just those with 'Cadillac' plans

A cap on the tax exclusion would hit many workers with ordinary health plans, not exclusively those with high-value plans. By 2017, workers with family plans in the middle of the distribution would be affected by the cap. By definition, these are ordinary health plans.

Further, even workers with high-*cost* plans, who would be affected earlier, don't necessarily enjoy high-*value* plans. Many health plans are expensive because the population

covered is older or sicker than average, but they still do not provide more comprehensive coverage. This is a much larger problem than is often recognized. Gould and Mini-cozzi (2009) have shown that some of the most powerful predictors of a plan's high cost are the size of the firm and the age of its workers. This is surely not a coincidence—small firms and firms with older workforces tend to have less bargaining power with insurance companies and this leads to higher prices for insurance coverage that may be no more comprehensive than lower-priced coverage for larger or younger firms.

Furthermore, Gabel et al. (2010) find that only 3.7% of the variation in premiums for family plans is determined by a plan's actuarial value, that is, the share of average medical expenditures paid for by insurance (instead of by out-of-pocket spending). And, previous research has shown that smaller firms pay premiums 18% higher than large firms pay *for equivalent health coverage* (Gabel et al. 2006)).

The health care reform law recognizes this reality and specifically raises the threshold of the excise tax explicitly on the grounds that high-cost is not synonymous with high-value. For instance, the threshold is higher for health plans covering high-risk professions. The Bowles-Simpson illustrative proposal suggests no such allowances. Nor does it allow for the wide variation in premiums across the country (Gould, 2009). A uniform cap, as proposed by Bowles-Simpson, would disproportionately affect workers living in high-cost areas (Schoen et al. 2009).

Consequences: Cost- and risk-shifting may lower coverage, care

A cap on the tax exclusion as proposed under Bowles-Simpson would have a series of consequences for health care in America.

Health care costs and risks would shift onto workers and their families, hitting those with high medical needs especially hard

In response to health care reform's excise tax, nearly two-thirds of employers plan to cut health benefits to avoid the tax and a full 7% would eliminate their health plan

altogether (Mercer 2009). For those choosing just to reduce benefits, the vast majority expect to increase deductibles and copayments. Compared with the excise tax, the tax cap proposed in the Bowles-Simpson illustrative plan hits people sooner at a lower threshold and extends its reach more quickly because of its constant value (i.e. its lack of indexing, and, after 2018, its negative indexing).

Forcing people into less-comprehensive plans would expose them to higher out-of-pocket costs and greater health-related financial shocks. People value insulation from these shocks (the reason people purchase insurance), so forcing them into less-insulating plans has a cost. This movement of people into less-comprehensive coverage is actually often identified as a policy benefit of taxing health benefits—under the theory that when people have more “skin in the game” (i.e., face a higher share of total health spending) they will become more careful consumers of health care and will forego care that is unneeded and was only previously purchased because they were not facing its full cost. However, pressuring people into less-comprehensive coverage has some adverse consequences that may not have been properly considered by those arguing for its desirability.

Consumers could respond to increasing out-of-pocket burdens by cutting back on medically indicated health care

If the tax cap pressures people to purchase health plans with increased cost-sharing (e.g., higher copayments), consumers could very well respond to this effective price increase by haphazardly cutting back on medical spending. However, many of the interventions that are avoided may turn out to be health-improving. This problem is especially true for vulnerable populations and those with chronic conditions.

Research has shown that higher cost-sharing could lead families to cut back on medically indicated and effective health care. For instance, Gruber (2006) and Hsu et al. (2006) demonstrate that higher cost-sharing is detrimental to the health of the chronically ill. On the flip side, Rosen et al. (2005) find that reduced cost-sharing for ACE inhibitors among Medicare beneficiaries with diabetes extends life-expectancy.

Overall, the evidence clearly shows that an optimal cost-sharing design should take all of the considerations raised by different patient populations, therapies, and conditions into account. In short, efficient cost-sharing designs cannot be one-size-fits-all. A universally applied tax cap does not create the right incentives for the creation of the most efficient insurance policy; in fact, it is a blunt instrument that creates no incentives except to purchase cheaper policies.

Less comprehensive coverage would mean less financial protection for workers and families

Shifting health coverage costs onto workers and their families would hurt their ability to maintain and secure affordable health care. Such costs have already risen in recent years with increasing out-of-pocket burdens and increasing difficulty in paying medical bills (Gabel et al. 2009; Tu and Cohen 2009). Furthermore, Himmelstein et al. (2009) find a striking growth in bankruptcies associated with medical costs, even for those households covered by health insurance. Pushing insurance plans to be less comprehensive would just make these financial problems worse.

Even if wages increase in exchange for benefit cuts, total compensation could still decline as increased health costs consume wages

Proponents of the tax exclusion cap often note that if it encourages workers to take less compensation in the form of health insurance premiums, then this could raise other forms of compensation, especially cash wages. And given that the tax cap is forecast to lead to non-trivial cuts in premiums, this means that cash wages may indeed rise. However, the lion's share of these wage increases will just be used by workers to pay the higher out-of-pocket health costs they will incur due to the imposition of the tax cap *even if the tax cap proponents are right about its impact on overall health spending*.³ Given the large variation in annual health spending (i.e., many families spend next to nothing on health costs in a given year while some spend enormous amounts), many workers would see increases

in out-of-pocket costs that far exceed the potential addition to cash wages that accompanies the imposition of the tax cap. Again, this is a consequence of the risk-shift that would be spurred by the tax cap.

Of course, if the tax cap does not reduce health spending by as much as its proponents forecast, then an even higher share of the increased cash wages would go to paying for out-of-pocket costs that were once covered through insurance.

Furthermore, the characterization of the potential for cash wages to rise in response to the tax cap as a “raise” for American workers is incorrect: The tax exclusion cap reduces overall compensation, period. Rising cash wages just mean that other forms of compensation are falling. And because some compensation that was previously being subsidized through tax policy (employer-paid insurance premiums) is now being taxed, the result is a cut, not a raise, to total (after-tax) compensation for American workers. There is no ambiguity about this.

Employers could stop offering benefits as insurance becomes more expensive

Employers provide health insurance as a fringe benefit to attract employees in competitive labor markets. The current tax exclusion provides an implicit subsidy for compensation to be provided in the form of premiums. Removing this subsidy therefore reduces the incentive for employers to provide compensation in the form of premiums rather than cash. Providing health insurance as compensation generally imposes some fixed costs on firms—for example, the salary of a benefits manager to keep track of health care coverage. Also, high and volatile rates of inflation for health insurance premiums make it hard for employers to promise *both* a given level of health insurance coverage and also a target level of growth in cash compensation without exposing the employer to big risks from rapid premium growth year-to-year. Given these two considerations (among others), some firms (especially small firms that would find the administrative costs especially burdensome) could choose to provide insurance only if the implicit subsidy of the tax exclusion remains in place.

Research has verified that an employer’s decision to offer insurance is indeed sensitive to the “tax price” of insurance, where the tax price is defined as how many after-tax dollars are needed to purchase one dollar’s worth of insurance premiums (Finkelstein (2004), Gruber and Lettau (2004), and Royalty (2000)). Given the tax exclusion, the tax price of insurance is well under \$1. The research shows that as the tax price of insurance rises, employers will be less likely to offer insurance. If it were eliminated altogether today, as would happen in 2038, an estimated 20 million people nationwide would lose employer-sponsored health insurance.⁴

The tax cap is not a very effective cost-containment device

The tax cap in the Bowles-Simpson illustrative plan would raise a lot of revenue. But, raising revenue is no real feat (at least economically)—and scrapping the tax exclusion for health care premiums would constitute a significant tax increase on tens of millions of nonwealthy Americans. Given its obvious political difficulties, it’s worth asking why it is pursued. At least part of the reason is its popularity among many health policy wonks who claim—as they did with the excise tax that helped finance 2010 health reform—that the tax cap could be a powerful tool in restraining the overall growth of American health care costs. Given that these rapidly growing costs provide real strains on both the federal budget and family incomes, restraining them is indeed a worthy policy goal. However, tax policy changes are an extremely blunt tool for this.

The claim that changing the tax treatment of employer-sponsored premiums can restrain overall cost growth is based on the following theory. The tax cap penalizes high-cost health plans. If one assumes that high-cost health plans are high-value plans—that is, plans that provide comprehensive coverage of health care costs and expose beneficiaries to very low cost-sharing (co-pays, co-insurance, and deductibles), then these plans could lead beneficiaries to consume more health care services than they would if they faced more of the marginal cost of each health intervention.

Facing a higher share of the marginal cost of health care (as again, “having more skin in the game”) will, the theory holds, provide incentives for consumers to spend less on health care, freeing up money to spend on non-health care goods and services.

While this story is clearly reasonable economics, its full implications need to be considered. What follows are some reasons why the benefits to restraining growth in health care costs through tax changes are not as large as often advertised.

The tax cap misses the most expensive costs

Even if all goes as its proponents claim, the Bowles-Simpson proposal to cap the tax exclusion on employer-sponsored health care premiums does not promise to arrest the upward march of American health care costs. For one thing, the sickest 20% of the population account for 80% of total health spending in a given year. Clearly, nobody thinks there should be significantly greater cost-sharing on the truly big-ticket items of health care—transplants, major life-saving surgeries, or the management of chronic diseases like diabetes. But if cost-sharing is not enforced on these big-ticket items, its capacity to affect the really big drivers of health care costs is limited.

Consumers could respond by cutting back on cost-effective medical care, increasing overall health costs

If workers move into plans with increased cost-sharing, consumers could very well respond to this effective price increase by haphazardly cutting back not only on *health-improving* medical spending but also medical spending that is *cost-effective* in the long-run. Research has demonstrated that low-income and chronically ill populations are generally harmed by higher cost-sharing and may actually incur *higher* overall costs in response to the introduction of this cost-sharing, as they cut back too much on cost-effective managing of chronic conditions.

This same research shows that increased cost-sharing in certain areas (e.g., prescription drugs or primary care) can lead to higher overall costs due to increased health services utilization in other areas (e.g., hospitalization) and that the optimal cost-sharing rate for many chronic

conditions and large classes of prescription drugs is very low or even zero. Chandra, Gruber, and McKnight (2009) find that there are substantial “offset” effects to broad increases in cost-sharing rates for physician visits and prescription drugs; spending on these categories fell with higher cost-sharing but hospitalization costs rose substantially. In one related study, Goldman et al. (2007) find that higher cost-sharing for pharmaceuticals is associated with an increased use of overall medical services, particularly for patients with greater needs (e.g. heart disease, diabetes, or schizophrenia).

Likewise, lower cost-sharing is associated with a reduction in overall health spending, particularly for those with chronic diseases. For instance, Chernew et al. (2008) demonstrate that cost-sharing with lower costs for those for whom the intervention would be most cost-effective (generally the chronically ill) leads to higher compliance. Furthermore, Muszbek et al. (2008) find that increased compliance with drugs for hypertension, diabetes, and a series of other ailments will lead to higher drug costs but lower non-drug costs, leading to overall cost savings. Mahoney (2005) also finds that lowered cost-sharing for diabetes patients reduced health costs per plan.

Unfortunately, the design of the tax exclusion cap as discussed in the Bowles-Simpson illustrative plan addresses none of these considerations, suggesting that it is far too blunt an instrument to make efficient cuts in health care utilization. The proper place to cut out inefficient health care is on the supply-side—through delivery system reform and comparative effectiveness review (see Cutler (2009) on the promise of delivery-system reform for cost-savings)—not on the demand-side by squeezing patients with higher out-of-pocket costs.

Any cost containment from capping the tax exclusion is driven by reduced medical care, not reduced prices

The mechanism for cost-containment should be well-understood: The tax cap will not lower premiums or the price of health care for anybody not directly affected by it. Instead, if it works to contain costs, it would do so by encouraging the people affected by it to *buy less health care*. If one believes that high prices, not high utilization, are the biggest weakness of American health care compared

with our industrial peers, then the tax cap does little to remedy this (Andersen et al. 2003).

Any reduction in national health spending caused by the tax cap will result from households consuming less health care because it has been made more expensive to them—not because health care is made cheaper or delivered more efficiently.

Conclusion

The current tax exclusion is a linchpin of the employer-based health insurance system in the United States. While this system is far from perfect, it does pool and spread risk, and it is how 156 million U.S. residents under age 65 receive health insurance. Though employer-sponsored insurance significantly eroded throughout the 2000s—dramatically during the recessions, but notably as well during the expansion—it remains the predominant form of health coverage for the nonelderly (Gould 2010). Even after health reform is fully phased in, the Congressional Budget Office estimates that nearly 160 million people will hold employer-sponsored insurance plans (CBO 2010). As it stands, health care reform relies on a strong employer-based health insurance system.

Many workers and their dependents may be able to find insurance through another source, notably the newly created insurance exchanges. However, taxing benefits and increasing the potential that employers will

drop coverage is an unwise gamble to take before the insurance exchanges are proven to be an effective and affordable alternative. For many workers, moving into exchanges will mean less comprehensive coverage (if not immediately then as the subsidies erode over time). Isn't it time we looked at other forms of cost containment than pushing costs onto individuals?

A tax cap would hit more than half of all workers with plans by 2018 and all workers when the tax exclusion is completely eliminated. It should not be confused with a tax on a small number of high-cost plans. Removing the tax exclusion has the potential to create a financial hardship for many working families, particularly those who rely on comprehensive coverage to cover costs of their serious illnesses. It is equivalent to a cut in benefits, a cut in total compensation, and a shift of risk onto workers. While it is touted as a cost-containment mechanism, the tax exclusion may simply lower health care usage, not prices, and actually increase total health costs for chronically ill people who go without cost-effective treatments.

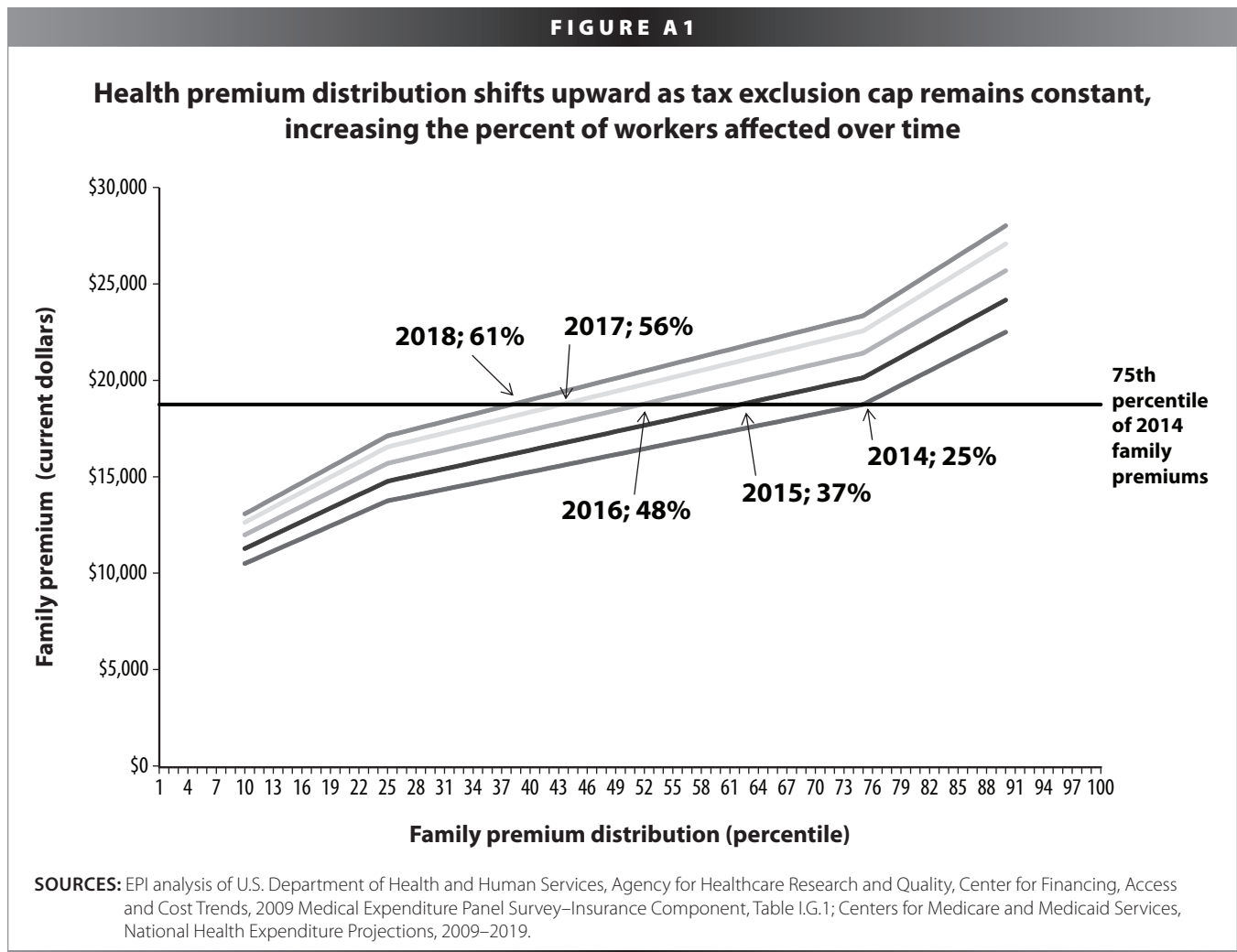
The Bowles-Simpson tax exclusion cap is designed to balance the budget and not invest in the health of our nation. If we are truly interested in reining in health costs—the long-run challenge to our fiscal ills—a robust public option should be back on the table as well as other cost-containment strategies that don't simply shift risk onto workers and their families.

Appendix: Methodology

The analyses in this paper are based on data from the Agency for Healthcare Research and Quality’s Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) and projections from the U.S. Department of Health and Human Services’ Centers for Medicare and Medicaid Services (CMS)’s National Health Expenditures. I use MEPS-IC employer-sponsored health insurance (ESI) premiums provided at the 10th, 25th, 50th, 75th, and 90th percentiles of the single and family premiums, respectively, for 2009. I linearly extrapolate from these data points to get all the points in the distribution from the 10th to the 90th percentiles. Using National Health Expenditure Projections for 2009-2019, I estimate the growth rate of ESI premiums using 3rd party payments to ESI and the number of people with ESI. Using these

projections, I grow premiums identically across the premium distribution from 2009 to 2019. Under the Bowles-Simpson Illustrative Individual Tax Reform Plan, the tax exclusion cap is set at the 75th percentile of premium levels in 2014, with the cap frozen in nominal terms through 2018. Therefore, I fix the 75th percentile premium for single and family plans in 2014 through the period in question (2014-2018), and compare it to the estimated premium distribution for the same period to determine the percent of workers in single and family plans affected by the tax cap.

A visual representation of this analysis is presented in **Figure A1**. Along the x-axis is the distribution of family premiums and along the y-axis is the cost of the family premium. The horizontal line is the cap value, set at the



75th percentile of 2014 family premiums, and held constant through 2018. Each successive curve from bottom to top represents the family premium distribution from 2014 to 2018. The percent of families affected by the cap is identified by the points at which the premium curve for each year hits the cap value.

This analysis requires a few simplifying assumptions. I assume that the growth rate of 3rd party payments tracks the growth rate of premiums. In this short time frame, profits and administrative costs of private insurers in the employer-sponsored health insurance marketplace change little; therefore payments to reimburse individuals for health expenditures are likely to remain as a constant share of total premiums. Second, I assume that premium growth is identical across the premium distribution. Third, I assume no efficiency gains from the tax cap in the four years following its implementation (2015-2018). Therefore, any moral hazard effect (reduced consumption from higher effective prices), is not reflected in future premiums. Fourth, I ignore workers with “plus one” plans because their treatment under the illustrative plan is highly speculative. If they are treated in their own class with their own 75th percentile cap value, the trends would mimic those shown for single and family plans. Fifth, this analysis only includes private-sector plans. To the extent that public-sector plans may have higher premiums on average, the cap value (the value that hits the 75th percentile of the distribution of workers with either single or family plans) would be higher, affecting a smaller share of private-sector workers but a higher share of public-sector workers. Last, I do not account for the excise tax, which should have little to no effect in 2018 because its tax cut-off value is set higher than the tax exclusion cap.

For the projections of dollars affected through 2038, I assume a linear phaseout of the cap value by 2038. This assumption lowers the cap value by about \$938 each year. I project family premiums using the CMS growth rate between 2018 and 2019 (4.3%), rather than the higher 5.0% average growth rate over the 2010s. The 4.3% rate is also far slower than the historical increase of 8.2% in employer-sponsored premiums from 1999 to 2010 (Kaiser Family Foundation, 2010). Employer CMS actuaries estimate that National Health Expenditure growth rates will slow by “0.05% in 2019 and slightly more than that

for some years after” (Foster 2010, page 18). Assuming the CMS published growth rate in 2019 already accounts for the 0.05% slowdown, I subtract another 0.1% for the years 2020-2038 to reflect any savings from behavioral changes due to the tax on high-cost employer health plans. This is a rather generous interpretation of CMS’ actuaries prediction that growth rates will slow by “slightly more than” 0.05%.

As before, I assume that workers keep the plan they had and do not shift to one with a lower actuarial value, that is, a less generous plan. If they do shift to one with a lower actuarial value, however, economic theory would suggest they would now be paying taxes on their increased wages so any shift is not a particularly binding constraint on the question of taxable dollars (or lower after-tax pay). Next, I examine trends in a scenario created with an extremely generous assumption regarding the growth rate of premiums: I allow health insurance premiums to grow by just 2.3% a year, which is the Congressional Budget Office’s near-term projection of growth in the overall Consumer Price Index (CBO, 2011). This assumption credits the tax cap with significantly changing consumer behavior and affecting both insurance and provider prices to a degree no one would expect. This rather unrealistic exercise demonstrates the increasing bite the tax cap will take out of workers’ take-home pay regardless of how much savings are garnered by the tax cap itself.

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Endnotes

1. See the Appendix for full methodology and details on these estimates.
2. See the Appendix for methodological discussion.
3. See Bivens and Gould (2009) for a lengthier discussion of these effects. In particular, the text box on page 7, *The Excise Tax: A Horse Race between Higher Out-of-Pocket Costs and Higher Wages*, explains how this works.
4. This number is from the research of Buchmueller et al (2008) based on Senator John McCain's health care plan proposal in the 2008 campaign to end the tax exclusion and replace it with a credit. For a state-by-state analysis of losses in employer-sponsored health insurance from removing the tax exclusion, see Bivens and Gould (2008).

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