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How to Design a Tax Cap in Health Care Reform

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The Obama Administration and congressional Democrats have recently opened the door to a change in the tax treatment of employer-sponsored health benefits as part of health care reform. In doing so, they have joined with a wide range of health economists across the political spectrum.

Rationale for a Tax Cap. For years health economists have argued that the tax-free status of employer-sponsored health insurance (ESI) should be limited—or even ended completely—and replaced with greater tax relief for lower-income families with ESI and new tax relief for families buying their own insurance. Economists call for either a tax deduction or tax credits for these families.

There are two objectives behind proposals to reform the "exclusion" of ESI benefits from a worker's taxable compensation:

1. It would focus the unlimited special tax break—which, after all, is a distortion in the underlying tax code—on those who need help the most. Currently the total value of the tax exclusion is about $270 billion annually to families at the federal level (there is also tax relief from state taxes), with most going to upper-income families who are in higher tax brackets.
2. It would achieve efficiencies and cost reductions in health care over time by making workers more attuned to their health benefits. Economists generally agree that the tax-free status of health benefits means their true cost is essentially hidden: Their value does not even appear in paychecks or year-end W2s. This discourages workers from questioning value for money in health insurance or whether they are overusing services. This in turn pushes up the cost of these benefits and correspondingly reduces the cash income component of worker compensation.[1] A cap would focus workers' attention on the total cost of their insurance and make workers a self-interested partner with employers in seeking more efficient and less costly plans.

Key Bipartisan Principle: Tax Reform, Not Tax Hikes. A threshold principle in designing a cap on the tax exclusion—if bipartisan support for the idea is to be maintained—is that it must be a tax *reform* element of health reform, not a device to raise taxes to pay for new health spending programs. Thus revenue raised from a tax cap from some workers should go to other taxpaying workers to help pay for coverage. The revenue should not go toward, say, expanding Medicaid or other direct spending. To the extent that health programs or subsidies to families below the federal tax threshold are to be financed, that should come from savings elsewhere. The whole process should result in no net new taxes.

Given that principle, there are several questions about the nature and design of a tax cap that need to be answered:

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Q: Does This Mean Workers Will Just Pay More Taxes on Their Existing Benefits? Over time it is more likely that workers will bargain for a change in their compensation to keep health benefits at or near the cap.

The effect of capping the value of the exclusion would be similar to limiting tax-free contributions to 401(k) plans or the tax cap for employer-provided life insurance. In those cases employees typically elect or bargain to take compensation as cash income rather than have their contributions and benefits exceed the cap.

Thus while it is true that some employees with health benefits above the cap might prefer to keep them and pay the tax, most would likely bargain to have more economical health plans and more of their compensation in (taxable) cash, meaning bigger paychecks. Most labor economists and the Congressional Budget Office agree that changes in non-cash benefits lead to almost dollar-for-dollar changes in cash earnings in any compensation package.[2]

Q: How Is a Tax Cap Set? The simplest way would be to specify a dollar amount, similar to the 401(k) limit for individual and family coverage, with the "excess" identified in a worker's paycheck as taxable compensation. The cap could be the national cost of a benchmark plan determined to be a reasonable basic level of coverage. The cap would apply to actual premiums paid or, in the case of self-insured forms, to average per-employee health benefits spending by the firm.

The limit could be held permanently at the same dollar level until Congress adjusts it, or it could be indexed. That index might be the Consumer Price Index (CPI). That means the cap would likely become steadily tighter over time since insurance costs have risen faster than CPI, so there would be a steady increase in pressure to trim costs or switch the cash/benefit balance of compensation. Or the IRS could be instructed to use one of the medical indexes, which are higher than the CPI.

A simple dollar cap is often challenged as unfair because some workplace groups or individual insurance purchasers face significantly higher or lower costs because of such things as their health status. Adjustments can be made to the cap to reflect these factors (see below). But it is also important to note that most health reform proposals also envision regulations or devices such as risk adjustment to limit premium variations, so the future variation of premiums would likely be less than today, so there would be fewer inequitable situations to address.

Q: What About People in Higher-Cost States? Some say that a dollar cap would unfairly "overtax" families who live in states where medical costs and insurance premiums are higher while "undertaxing" families in many other states. While this concern is understandable, it should be remembered that one of the objectives of health reform—and the cap itself—is to trigger pressure to confront and reduce costs in these higher-cost states.

But to the extent that Congress wishes to partially insulate people in higher cost states—at least temporarily during an adjustment phase—it could use the local cost of the benchmark plan for the cap rather than the national average cost. Thus an adjustment could be made state-by-state. Also within a state there might be a further "high" and "low" refinement of the cap, typically to offset rural and urban differences.

Q: Wouldn't Older Workers Often Pay a Higher Cost? Health costs do rise with age, so a tax cap not adjusted for age would mean higher taxes for an older individual with the same insurance coverage. Among the ways to address this would be to include an adjustment for the worker's age in the federal tax return worksheet for computing the tax. (Employers make a similar age adjustment in reporting the taxable value of employer-sponsored life insurance in a worker's W-2 form.)

Q: But What About Firms with Abnormally High Health Costs? Workers in some firms still face

1. See James Sherk, "Analyzing Economic Mobility: Compensation Is Keeping Pace with Rising Productivity," Heritage Foundation *Backgrounder* No. 2040, June 11, 2007, at *http://www.heritage.org/Research/Labor/bg2040.cfm*.
2. For a discussion of how changes in employer-sponsored benefits affect cash compensation and taxes see Douglas Elmendorf, Director, Congressional Budget Office, letter to Senator Edward Kennedy (D–MA), June 15, 2009, pp. 5–6, at *http://www.cbo.gov/ftpdocs/103xx/doc10310/06-15-HealthChoicesAct.pdf* (July 1, 2009).

unusually high costs for the same broad insurance services, even after the adjustments to the cap discussed above, and this might be considered unfair. For instance, people in certain industries tend to have higher medical costs. One possible solution is to use the "actuarial" value of the coverage, rather than its actual cost, to compute any tax.[3]

A problem with this general approach is that it is less effective in encouraging workers to challenge actual benefit costs. But it could provide a last-resort adjustment for workers in an abnormally high-cost firm. If a firm, on behalf of its workers, could demonstrate that a tax cap based on cost meant that the taxable amount was, say, at least 10 percent higher than the typical level for a firm with similar demographics in the state, then the firm could apply for an actuarial value assessment on behalf of its workers, and this would be used for establishing the tax cap.

Tax Caps Done Right. The tax exclusion for employer-sponsored insurance has long been criticized as inequitable, unfocused on those who need help to afford coverage, and a significant factor fueling insurance costs. Addressing it with a tax cap in the context of health reform would distribute existing tax breaks among taxpayers in a more rational manner while helping to defuse the rapid upward trend in health costs. And if designed carefully, with no net tax increase, it could do this in a way that is fair and reasonably adjusts for existing variations in insurance costs.

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3. The actuarial value of a health plan is the total claims cost that actuaries estimate would occur in a particular plan if it had a nationally representative population as its enrollees. For the argument that this method should be used generally for a tax cap, see Stan Dorn, "Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible?" Urban Institute, June 2009, at *http://www.urban.org/publications/411894.html* (July 1, 2009).