ianges such as a relatively high
A tax cap might become more
several reasons. First, as pointed
fects of a tax cap would be to
of both health insurance and
oyers and employees realize this
evelop a mutual interest in pro-
way to improve their economic
and wages could be improved if
ny resources on ineffective and

competitiveness of global mar-
ure on businesses to control the
, including the cost of health
using health insurance as a way
ould not allow firms to drop
ompetitive market would give
s to make marginal changes to
raise the reward for supporting
t promises to help firms be more

is highly unlikely that Congress
ap for the purpose of improving
ight be tempted to pass it for
ome firms would elect to have
ne additional taxes rather than
ay under the cap, it is logical to
ax cap proposal would be scored
nal revenue. This could play an
years as the costs of entitlement
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ng tax reform to reform health-
it blowing up anything. But we
incentives that will bring about
-effective healthcare system and
of change. The current system
volutionary change to create, so
now is a new set of policies that
lual change to a better system.

The Tax Exclusion for Health Benefits: The Loose Thread

By Jeanne M. Lambrew

Jeanne M. Lambrew is an associate professor in the department of health policy at George Washington University and a senior fellow at the Center for American Progress. She served on the White House National Economic Council and in the Office of Management and Budget from 1997 through 2000.

Tax reformers have set their sights on the tax exclusion for employer contributions to health insurance, as they periodically do. Clearly, excluding employer premium payments from taxable income is regressive as a subsidy for the purchase of health insurance. Low-income people who are most likely to be uninsured receive a low subsidy or none at all because they pay low to no taxes. That tax subsidy is significant: an estimated $140 billion in 2004. But from the perspective of health policy rather than tax policy, the tax exclusion for health benefits plays a complex and critical role in our voluntary coverage system. It should be changed only in the context of legislation that ensures adequately financed, alternative insurance options for all Americans.

The health benefit tax exclusion is more than an individual subsidy. It leverages $450 billion in employer payments for premiums for their workers — over twice the amount that workers directly pay. Ironically, the tax exclusion's limitation as an individual subsidy contributes to its success in generating financing. Employers generally make decisions about health coverage based on higher-wage workers. Because higher-wage workers receive a greater tax benefit, the policy yields voluntary, sizable employer contributions for all workers in their firms. Theory suggests that the tax preference for employer contributions is the primary reason for the premium split between employers and employees; it all is essentially financed from compensation. However, lessons from pension research suggest that the more employers manage benefit policy choices, the higher the participation. Moreover, workers may be more willing to have their wages reduced for health coverage than pay out of pocket for it. Thus, the employer role in the health insurance system — encouraged by the tax exclusion — results greater financing of, and participation in, health insurance than might otherwise exist.

Beyond its role in financing, the tax exclusion has played a significant role in the design of health insurance. Because coverage is purchased for all workers in the firm, premiums are set for a diverse group of participants. That somewhat random form of risk pooling has served to make insurance accessible and affordable for millions of Americans. And, because employers use the design of benefits and provider networks to attract and retain employees, it roughly reflects the demand of those workers. To achieve the same community-rated, comprehensive insurance without the employer acting as an intermediary would require significant regulation — unlikely in today's political climate.

That is not to say that the tax exclusion for health benefits is ideal tax or health policy. Beyond its regressivity, it has other well-documented flaws. It encourages "job lock" since firms do not offer equally accessible and generous benefits. It is blind to the nature of the benefits covered by insurance, setting no real standards. And, most importantly, it has not succeeded in ensuring that all who work have health insurance. In particular, small firms are less likely to have the human resources capacity, wage base, or size to efficiently purchase health insurance on behalf of their workers. About 80 percent of the uninsured are in households with workers.

But the tax exclusion is a thread that, if pulled in isolation, could unravel health coverage in the United States. Obviously, any reduction in this tax preference will reduce employers' role in health coverage. If there is no realistic, affordable alternative source of health insurance, a net reduction in coverage could occur. That raises one of the most contested health policy questions: What should that alternative be? Conservatives believe that the individual, nongroup market could be expanded to replace employer coverage. Progressives argue for the creation of a group-purchasing pool for private insurance, similar to that offered to federal employees. And liberals call for Medicare for all. Regardless of the merits of each, none could quickly or easily absorb the 155 million Americans who get their insurance through the employer system today. Even minor changes to the exclusion could accelerate the recent trends; the number of workers with employer coverage dropped 5 percentage points in the last four years. Public policy should first create and expand an alternative source of insurance before cutting the ties that hold the employer system together.

An even more daunting challenge for tax as well as health reformers is financing. New financing would be needed to create the alternative system in advance of changing the employer exclusion. For example, a new group insurance pool would require both premium assistance for low-income enrollees and risk subsidies for high-cost enrollees. While modifying the exclusion could partially offset that cost, doing so prematurely or carelessly could create erosion of employer coverage.

Even assuming an alternative delivery system is available and affordable to all, the revenue from eliminating the employer exclusion may be insufficient to finance the new system. Eliminating the exclusion could probably fund premium subsidies for individuals with income up to 200 percent to 300 percent of poverty. It is politically difficult to take a subsidy from most to give to a few. From a policy perspective, the cost to middle-income people may be too high: With premiums averaging $11,000, families could easily spend 15 percent of their income on health insurance premiums. The loss of the employer contribution, more than the tax exemption, could create public demand for additional financing.

Those challenges are serious but surmountable. A number of options exist to lay the groundwork for improving our health benefits tax policy. My colleagues at the Center for American Progress and I proposed a

plan to improve and expand health insurance for all by 2010. It would create a new group health insurance pool, progressive tax credits, and a requirement that, if insurance is available and affordable, all Americans must purchase it. We would finance our short-term investments with a 3 percent to 4 percent VAT. That use of a VAT is not only consistent with our global competitors' approach but broadens the base for funding health coverage.

Our plan and others like it could be a bridge. Once the basis for affordable coverage exists, the important work of rationalizing the system could begin. The exclusion could be phased out with a broader financing system in place. New financing could be used to smooth the seams between Medicare, Medicaid, and private insurance. But first, practical policy must be enacted to prevent changes to the employer exclusion from doing more harm than good.