EBRI

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UNITED STATES SENATE
COMMITTEE ON FINANCE

HEARING ON

THE TAX TREATMENT OF EMPLOYEE BENEFITS

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Statement of*

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*The views expressed in this statement are those of the witnesses and do not necessarily reflect the views of the Employee Benefit Research Institute, its Trustees, members or other staff.

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Mr. Chairman, it is a pleasure to appear before you today. I am Dallas Salisbury, Executive Director of the Employee Benefit Research Institute. With me is Deborah Chollet, a Research Associate EBRI. EBRI is a nonprofit, nonpartisan, public policy research organization founded in 1978. EBRI sponsors research and educational programs in an effort to provide a sound information basis for policy decisions. EBRI does not take positions on public policy issues.

We are pleased to address the Committee concerning the taxation of employee benefits.

Introduction

The growth of employee benefits as a form of employee compensation has attracted increasing attention in recent years. Attention has intensified because of a concern that the growth of benefits occurs at the expense of growth in wage and salary income. Slower growth of wage and salary increase, in turn, implies slower growth of the tax base. Erosion of the tax base affects the public sector's ability to finance government programs in general, and the Social Security system in particular. In addition, growth of nontaxable benefits may imply an important redistribution of tax burden across the population. These effects of growth in employee benefits, and in tax-exempt benefits in particular, certainly merit careful attention from the Congress. EBRI is pleased to provide information that will assist the Congress in valuating the consequences of emplloyee benefit growth. First, our testimony deals with the broad issue of employee benefits and erosion of the

tax base. Second, it reviews the results of recently completed EBRI research on proposals for a tax cap on employer contributions health insurance.

The Composition of Employee Benefits

Possibly the most often-quoted figures on the level and growth of employee benefits are compiled by the Chamber of Commerce of the United States. The figures are based on annual survey responses by a small number of employers (fewer than 1000); the employer sample is not scientifically selected, nor is it weighted to be representative of true national totals. Nevertheless, estimates based on these data capture a picture of the general distribution of employee benefits among (1) legally required employer payments, (2) fully taxable employee benefits and (3) tax-favored employee benefits. Disaggregating the total level of employee contributions reported in the Chamber of Commerce data among these three groups clarifies the magnitude of tax-base erosion that can be attributed to the growth of employee benefits.

According to the Chamber of Commerce data, employer contributions to employee benefits totaled more than 32 percent of wages and salaries in 1981. Nearly three-fourths (23.7 percent of wages and salaries) of this figure represent either legally required employer payments (9.6 percent of wages and salaries) or discretionary employer payments (14.1 percent of wages and salaries) that are fully taxable (See Table 1). Legally required employer payments include contributions for FICA, unemployment compensation insurance, workers compensation insurance, and a variety of smaller public insurance programs.

Discretionary employer contributions to benefits in the Chamber of Commerce data represented 22.9 percent of wages and salaries in 1981. Of this amount, nearly two-thirds (60.3 percent) were fully taxable both by FICA

TABLE 1

COMPOSITION OF EMPLOYEE BENEFITS BY BENEFIT GROUP, 1981

Benefit Group	Employer Payments as a Percent of Wages and Salaries	Employer Payments as a Percent of All Benefits
Total benefit payments	32.5	100.0
Legally required employer payments	9.6	29.5
FICA	5.3	16.3
Unemployment Compensation	1.0	3.1
Workers' Compensation	0.9	2.8
Other legally required payments 1/	2.4	7.4
Discretionary taxable benefits	14.1	43.4
Time not worked 2/	10.0	30.8
Rest priods	3.8	11.7
Other taxable benefits 3/	0.3	0.9
Discretionary tax-favored benefits	8.8	27.1
Contributions to pension ans profit-sharing plans 4/	3.9	12.0
Group healt, life, short-term disability insurance	4.2	12.9
Other tax-favored benefits 5/	0.7	2.2
SUMMARY:		
Legally required employer payments and discretionary taxable benefits	23.7	72.9
All discretionary benefits	22.9	70.5
Fully taxable benefits	14.1	43.4
Tax-favored benefits	8.8	27.1

SOURCE: EBRI tabulations of estimates produced by the Chamber of Commerce of the United States. Chamber of Commerce of the U.S., Employee Benefits 1981 (1982), pp. 8 and 30.

1/ Includes government employee retirement, Railroad Retirement Tax, Railroad Unemployment and Cash Sickness Insurance and state sickness benefits insurance.
2/ Includes paid vacations and payments in lieu of vacation; payments for holidays not worked; paid sick leave; payments for State or National Guard Duty; jury, witness and voting pay allowances; and payments for time lost due to death in family or other personal reasons.
3/ EBRI estimate based on Chamber of Commerce report of amount of Christmas or other special bonuses, service awards, suggestions awards, special wage payments ordered by courts, and payments to union stewards.
4/ EBRI estimate of Chamber of Commerce report of employer contributions to profit-sharing plans.
5/ EBRI estimate of Chamber of Commerce report of employer-paid dental premiums, merchandise discounts, employee meals furnished by company, payments for vision care and prescription drugs, moving expenses, contributions to employee thrift plans and employee education expenditures. Tax-preferred benefits are over-stated by the amount of separation or termination pay received by employees but not distinguishable from other tax-favored benefits in the Chamber of Commerce estimates.

and by the individual income tax. The fully taxable benefits reported in the Chamber of Commerce data include employer payments for time not worked (that is, paid vacations, holidays and sick leave) as well as paid rest periods, lunch periods and other paid employee time not directly spent in production. Less than one-third (27.1 percent) of the total level of employee benefits reported in the Chamber of Commerce data represent discretionary tax-favored benefits paid by employers. Tax-favored benefits totalled only 8.8 percent of wages and salaries in 1981, and about 8.5 percent of total compensation.

The Size of Tax-Favored Benefits

Employer contributions to tax-favored benefits that are not taxed as current income to the employee can be divided into two groups: benefits on which taxes are deferred and benefits that are tax-exempt.

- o Tax-deferred benefits include, primarily, employer contributions to retirement income and capital accumulation plans. These constituted about 3.4 percent of total compensation in 1981. Taxation of these benefits is deferred until the employee withdraws funds from the plan.

- o Tax-exempt benefits include employer contributions to group health and life insurance, long-term and short-term disability income insurance, and a variety of smaller benefits that include dental insurance, child care, merchandise discounts and employer-provided meals. These benefits constituted 3.5 percent of total compensation in 1981. 1/

Failure to distinguish among the growth of legally required employer payments, fully taxable employee benefits, tax-deferred benefits and tax-exempt benefits has greatly magnified the perception of the tax-base erosion that can be attributed to tax-favored and tax-exempt benefits. This common misperception was recently highlighted by Secretary of the Treasury Donald Regan; his May 22, 1983 statement to ABC News includes the following comment:

> I think that when you look at the way our pension systems, our medical systems and the like are just running at full throttle, and are increasing year after year, that sooner or later they're going to have

1/ National Income and Product Accounts, U.S. Department of Commerce.

to be slowed down or else we'll never get these deficits under control. 2/

The magnitude of tax-favored benefits as a proportion of total compensation however, is much smaller at 8.8 percent of wages and salaries than such statements suggest. Tax-exempt employee benefits are only 4.7 percent of wages and salaries; benefits on which taxes are deferred but ultimately paid are 4.1 percent. The distribution of tax-favored benefits between those that are tax-deferred versus those which are entirely tax-exempt is summarized in Table 2.

The Growth of Tax-Favored Employee Benefits

Tax-favored employee benefits have grown more rapidly than wages and salaries, and slightly faster than either legally required employer payments or fully taxable employee benefits over the last thirty years. Consequently, tax-favored benefits have absorbed a rising share of total compensation. In the context of strong and increasing tax incentives for employees to demand a greater share of compensation in the form of tax-deferred or tax-exempt benefits, however, the growth of these benefits as a share of total compensation has been remarkably slow.

The national income and product accounts compiled by othe U.S. Department of Commerce indicate that employer contributions to major tax-preferred benefits as a fraction of total compensation increased at an average annual rate of 4.4 percent between 1950 and 1981. The long-term growth of tax-preferred benefits relative to total compensation growth is presented in Table 3. Although the growth of tax-favored employee benefits

2/ "This week with David Brinkley," Show #82, Transcript (May 22, 1983) produced by Journal Graphics, Inc. New York, N.Y., p. 8.

TABLE 2

TAX-FAVORED EMPLOYEE BENEFITS BY SPECIFIC TAX TREATMENT, 1981

Tax Status/ Benefit Group	Employer Contributions As a Percent of Wages and Salaries	Employer Contributions As a Percent of All Benefits	Employer Contributions As a Percent of Tax-Favored Benefits
All tax-favored benefits	8.8	27.1	100.0
Tax-deferred benefits	4.1	12.6	46.6
Pension and Profit-sharing plans 1/	3.9	12.0	44.3
Other tax-deferred benefits 2/	0.2	0.6	2.3
Tax-exempt benefits	4.7	14.5	53.4
Contributions to group health and life insurance, and short-term and long-term and disability income insurance	4.2	12.9	47.7
Other tax-exempt benefits 3/	0.5	1.5	5.7

SOURCE: EBRI tabulations of estimates produced by the Chamber of Commerce of the United States. Chamber of Commerce of the U.S., Employee Benefits 1981 (1982), pp. 8 and 30.

1/ Includes EBRI estimate of employer contributions to profit-sharing plans based on Chamber of Commerce figures.
2/ Includes EBRI estimate of employer contributions to employee thrift plans based on Chamber of Commerce figures.
3/ EBRI estimate of employer contributions to dental insurance premiums, discounts on merchandise, employee meals furnished by company, payments for vision care and prescription drugs, moving expenses, and employee education expenditures, based on Chamber of Commerce figures.

TABLE 3

EMPLOYER CONTRIBUTIONS TO PENSION AND SELECTED WELFARE FUNDS AS A PERCENT OF COMPENSATION, SELECTED YEARS 1950-1981, AND AVERAGE ANNUAL RATES OF GROWTH

	Total	Pension and Profit-Sharing Plans	Group Health	Group Life
1950	1.8	1.1	0.7 1/	-
1955	2.5	1.5	0.8	0.2
1960	3.1	1.6	1.1	0.4
1965	3.8	1.9	1.5	0.4
1970	4.5	2.1	1.9	0.5
1975	6.2	3.0	2.7	0.5
1976	6.4	3.2	2.8	0.4
1977	6.7	3.3	3.0	0.4
1978	6.8	3.4	3.0	0.4
1979	6.8	3.4	3.0	0.4
1980	6.9	3.4	3.1	0.4
1981	6.9	3.4	3.1	0.4
Average Annual Growth Rates:				
1950-1981	4.4	3.7	4.9	2.3
1970-1981	4.0	4.5	4.6	-2.0
1970-1975	6.6	7.4	7.3	-
1976-1981	1.5	1.2	2.1	-

SOURCE: National Income and Product Accounts, U.S. Department of Commerce.

1/ Includes both group health and group life for this year.

relative to total compensation was strong between 1970 and 1975, (6.6 percent per year), it slowed dramatically between 1976 and 1981 to just 1.5 percent. Growth between 1970 and 1975 reflects several factors: the slow growth of wages both before and during economic recession, employer efforts to improve pension funding in anticipation of and response to ERISA, net growth in pension and health plan participation, and sudden increases in the employer cost of group health insurance benefits. The relatively slow growth of employer pension contributions relative to total compensation growth between 1976 and 1981 reflected employer adjustment to ERISA as well as employee demand for higher nominal wage compensation in response to slow real wage growth. The slower growth of employer health insurance contributions as a share of total compensation may reflect the maturation of group health coverage and benefits, as well as employer efforts to contain the cost of private health insurance plans.

Estimates of Tax Base Erosion

The debate over Social Security Reform focused in part on the issue of tax base erosion. The revenue-enhancement debate also involves this issue. Estimates of future tax-base erosion that can be attributed to the growth of employee benefits, however, have been misleading for two reasons.

First, these estimates fail to recognize the factors that affect the growth of tax-favored benefits relative to total compensation. In general, higher pension contributions as s proportion of compensation reflect greater participation in employer pension plans. Employer contributions to defined-benefit pension plans move directly with wages; as a matter of actuarial practice, employers target pension contributions to be a constant proportion of compensation. Employer contributions to health insurance,

however, are independent of wages. As a result, slow wage growth together with higher rates of health care cost inflation always produce a jump in employer contributions to health insurance coverage as a percent of total compensation. Employer contributions to group life insurance and disability income insurance also have little relationship to near-term changes in wage growth.

In contrast to tax-favored benefits, both legally required employer payments and fully taxable discretionary benefits automatically grow with wages. In the absence of a statutory change in the required rate of employer contributions to social insurance programs, legally required payments are uniformly defined as a proportion of wage and salary income. The value of fully taxable discretionary benefits -- primarily employer payments for time not worked -- is defined at the employee's wage. The fact that employer contributions to pension and insurance benefits are not fixed relative to wages makes the growth of tax-favored benefits as a share of total compensation rise during periods of slow wage growth and fall as wage growth accelerates. The straight-line estimates of tax-favored wage growth relative to total compensation incorporated in Social Security's projections fail to reflect sources of variation in tax-favored benefit growth relative to total compensation, and the dramatic slowing of this growth during recent years.

Second, estimates of tax-base erosion that results from the growth of tax-favored benefits fail to distinguish between tax-deferred benefits and tax-exempt benefits. Although this distinction may not assist projections of the FICA tax base, it is an important distinction with respect to general revenues. Employer contributions to private pensions, profit-sharing plans and employee thrift plans do not represent total forfeitures of potential

revenues. Estimates of tax expenditures attributable to the deferral of taxes on employer pension contributions recognize this by subtracting out revenues from the taxation of pension benefits received by current retirees. It is likely, however, that these estimates exaggerate the long-term tax revenues that are foregone in the tax-deferral of employer pension contributions. 3/

Tax-Favored Benefits: Goals, Achievements and Tax Effects

Employee benefits serve a number of purposes. Pensions, profit-sharing plans and employee thrift plans provide for income deferral and encourage private saving for retirement. Health benefits, disability income plans, life insurance and supplemental unemployment benefits provide insurance protection against unanticipated, catastrophic events. Some profits provide for consumption; these include day-care benefits and, possibly, routine dental and vision care benefits. Many of these consumption benefits, together with employee vacation time and rest periods, are intended to raise employee productivity, reduce time lost from work and build positive employee relations.

The expansion of employer pension and welfare plans over the last thirty years have achieved major improvements in the income security of current workers and future retirees. Growth of employer group health insurance coverage among workers and their dependents has promoted wide

3/ The calculation of tax expenditures exaggerates the true revenue loss that results from the tax deferral of pension contributions for several reasons. These include an implicit assumption about the marginal tax rates applicable to future retirees as well as a misunderstanding of the relationship between contributions and benefit payments in amaturing private pension system. See: Employee Benefit Research Institute, "Retirement Program Tax Expenditures: A Case of Unsubstantiated, Undocumented, Arbitrary Numbers." EBRI Issue Brief, Number 17 (April 1983), p. 4.

access to health care throughout the nonelderly population. These achievements are, in part, a response to tax incentives.

Between 1950 and 1979, the rate of worker participation in employer pension plans grew by 23 percent; participation in absolute numbers rose by 263 percent. 4/ Although the sustained growth of pension participation rates was interrupted by the passage of ERISA, recent data suggest that the post-ERISA contraction of pension participation rates was a temporary phenomenon. Between 1977 and 1979, the rate of worker participation in private pension plans showed modest growth, an achievement that is particularly remarkable in terms of the accelerated labor force growth that occurred during that period.

In 1979, more that 68 percent of private-sector, n onagricutlural workers between the ages of 25 and 64 were covered by an employer pension plan. 5/ At current coverage rates, 73 percent of current workers aged 25 to 29 can expect to receive a private pension when they retire. 6/ Recent econometric studies indicate that at least one third of the increases in pension contributions as a proportion of total compensation over the last twenty years can be attributed to changes in real marginal tax rates. 7/ Given the growing importance of the private pension system in providing

4/ S. J. Schieber and P. M. George, Retirement Income Opportunties in an Aging America: Coverage and Benefit Entitlement (Washington, D.C.: Employee Benefit Research Institute, 1981), pp. 54-55.
5/ Op. cit., p. 41.
6/ Background Analysis of the Potential Effects of Minimum Universal Pension System developed by ICF, Incorporated, for the President's Commission on Pension Policy and the Office of Pension and Welfare Benefit Programs (Washington, D.C., 1981), p. 38.
7/ See: Sophie M. Korczyk, The Federal Tax Treatment of Pensions and Deferred Compensation Programs: Background, Issues and Options (Washington, D.C.: Employee Benefit Research Institute, forthcoming).

retirement income security for most Americans, the tax-deferral of pension contributions until retirement appears to be a reasonable, equitable and effective incentive for private retirement saving. The reduction or elimination of this incentive would threaten the adequacy of private pension income for future retirees at the very time that Social Security will be least capable of expanding benefits. Further, the long-term revenue loss associated with the tax-deferral of employer contributions to pensions may be negligible: The marginal tax rates affecting future retirees are likely to be significantly higher than those affecting current retirees. In addition, as the private pension system is maturing, the mix of workers and beneficiaries is beginning to change. 8/

By comparison to the impact of tax-deferring pension contributions, the tax exemption of employer contributions to health insurance has probably had a much smaller effect on the growth of employer spending for health insurance. Recent econometric estimates suggest that the tax exemption of employer contributions may have accounted for only about 17 percent of the rise in health insurance contributions as a share of compensation between 1960 and 1981. 9/

The rapid growth of employer contributions to health insurance as a share of total compensation is attributable to at least three sources:

- o expansion of health insurance coverage rates among workers and their dependents, including the growth of family coverage and the extension of health insurance benefits to part-time and seasonal workers;

8/ Employee Benefit Research Institute, "Retirement Program Tax Expenditures: A Case of Unsubstantiated, Undocumented, Arbitrary Numbers," EBRI Issue Bried, Number 17 (April 1983), p. 4.

9/ See: Deborah J. Chollet, Employer-Privided Health Benefits: Coverage, Provisions and Policy Issues (Washington, D.C.: Empoloyee Benefit Research Institute, forthcoming).

- o the enhancement of benefits, including expansion of the range of health care services covered by employer group plans;

and

- o increases in the cost of health insurance as a result of inflation in health care costs.

The relative importance of these factors in raising employer contributions to health insurance over time cannot be established from available data. Similarly, the effect of the tax exemption of health insurance contributions on coverage rates, benefit enhancement, and employer willingness to absorb health care cost inflation has not been established.

Employer-Provided Health Insurance Coverage and Benefit Growth

The 1980 Current Population Survey indicates that more than 60 percent of the civilian population was covered by an employer group health plan during 1979. 10/ Three quarters of all workers, and nearly 90 percent of full-time full-year workers, participated in an employer group health plan that year. Although it is clear that coverage rates have expanded rapidly over the last thirty years, the absence of time-series data on employer health coverage rates precludes the measurement of its relative importance.

Several factors have encouraged the expansion of employeer group health insurance among workers and their dependents. Scale economies associated with greater inclusion of employees in the insurance group have

10/ Detail on 1979 employer group health coverage is supported by EBRI tabulations of the March 1980 Current Population Survey. See: Deborah J. Chollet, Employer-Provided Health Benefeits: Coverage, Provisions and Policy Issues (Washington, D.C.: Emploee Benefit Research Institute, forthcoming), Chapter 1.

encouraged the extension of health insurance coverage to lower income workers. The growth of real marginal tax rates since 1960, moreover, has probably increased the demand for employer-provided health insurance. At the same time, the absorbtion of preferred risks into emplolyer group plans has raised the cost of individually purchased health insurance relative to the pre-tax value of employer group coverage.

All of these factors have served to raise the rate of health insurance coverage provided through employer group plans. In 19797, more than 83 percent of all persons with private health insurance were covered by an employer group plan.

The expansion of health insurance benefits offered by employer group plans and employer willingness to absorb health care cost inflation have become highly controversial elements in the debate to reform the tax treatment of health insurance. Critics of current tax policy reform contend that the "generosity" of employer group coverage and the insensitivity of employer plan benefits to rising costs encourages continued inflation in health care costs.

Health insurance benefits in the United States, on average, have traditionally been generous. This has been in part a response to the historical precedent of Blue Cross/Blue Shield plans. First-dollar coverage of hospital care, in particular, has been a common feature of employer group health plans. Expansion in health insurance benefits to include a broader variety of health care services, however, has occurred largely as an attempt by employers to control the cost of their health plans. Coverage of alternative health care services is often intended to discourage hospitalization when an equivalent service can be delivered in a less costly setting.

Although employers have been reluctant to reduce health insurance benefits for their employees, their success in containing the real cost of health insurance benefits by revising coverage offered under the plan has been considerable. Between 1965 and 1981, real employer contributions to health insurance as a percent of compensation fell at an average annual rate of more than 7 percent (see Table 4). Between 1975 and 1981, real employer contributions to health insurance as a share of compensation fell at an average annual rate of nearly 8 percent. The decline of real employer contributions to health insurance during a period of expanding participation in employer group plans suggests that these plans have not simply absorbed inflation in health care costs. Employees have borne at least part of the burden of inflation through reductions in the real value of employer-provided health insurance. Although data that would directly reflect changing coverage provisions in response to health care cost increases are not available, the significant decline in real employer contributions suggests that modification of the coverage offered by employer group plans has occurred.

Proposals to Reform Tax Preferences for Health Insurance

Proposals that would modify the tax exemption for health insurance expenditures are of two types: those that would place a ceiling on the exemption of employer health insurance contributions in order to discourage comprehensive coverage under employer group plans, and those that eliminate all tax preferences for employer health insurance contributions within the framework of comprehensive tax reform. The first type, those that "cap" the exemption of employer contributions, would inpute all employer health insurance contributions in excess of a specified cap as employee earnings.

TABLE 4

INFLATIONARY AND REAL COMPONENTS OF EMPLOYER CONTRIBUTIONS TO GROUP HEALTH INSURANCE BENEFITS, SELECTED YEARS 1960-1981

	Nominal Employer Contributions as a Percent of Compensation	Inflation Adjustment as a Percent of Compensation 1/		Real Benefits and Insurance as a Percent of Compensation	
		Amount	Percent of Contribution	Amount	Percent of Contribution
1960	1.1	-	-	1.1	100.0 2/
1965	1.5	0.2	13.3	1.3	86.7
1970	1.9	0.7	36.8	1.2	63.2
1975	2.7	1.4	51.9	1.3	48.1
1976	2.8	1.6	57.1	1.2	42.9
1977	3.0	1.8	60.0	1.2	30.0
1978	3.0	1.9	63.3	1.1	36.7
1979	3.0	2.1	70.0	0.9	30.0
1980	3.1	2.2	71.0	0.9	29.0
1981	3.1	2.3	74.2	0.8	25.8
Average Annual Growth					
1965-1981	4.6	16.5	11.3	-3.0	-7.3
1970-1981	4.6	11.1	6.6	-3.6	-7.8
1975-1981	2.3	8.6	6.1	-7.8	-9.9

SOURCE: EBRI estimates from the National Income and Product Accounts, U.S. Department of Commerce.

1/ Estimate is based on levels of the medical care component of the Consumer Price Index between 1960 and 1981.

2/ Because base prices are assumed at the 1960 level, all employer contributions to health insurance are allocated to real benefits for 1960.

Contributions above the cap would be fully taxable by both the individual income tax and FICA. In the case of S. 640, the amount of the cap varies for individual versus family coverage, and is adjusted annually by the Consumer Price Index. Proposals of the second type, those which eliminate all federal tax preferences for employer health insurance contributions, include the Bradley-Gephardt comprehensive tax reform bill (S. 1421/H.R. 3271). The Bradley-Gephardt bill requires that all employer health insurance contributions be imputed as employee earnings, and at the same time raises the idividual income tax floor for deducting health insurance expenditures to 10 percent of adjusted gross income.

The difference between proposals that would modify tax preferences for employer health insurance contributions and those that would eliminate them altogether is probably in the magnitude of effects rather than in the nature of effects. The effects of these proposals fall into four categories: (1) changes in the generosity of coverage provided by employer group plans, (2) changes in employer costs, (3) changes in the rate of health insurance coverage among workers and their dependends, and (4) tax revenues and the distribution of the tax burden. Each of these effects is discussed in turn.

(i) Impact on the generosity of health insurance coverage.

The most common argument used argument for reducing or eliminating tax preferences for employer contributions to health insurance is the potential effect on the generosity of coverage offered by employer group plans. Advocates of reduced tax preferences cite the scarce literature on the relationship between insurance prices and the degree of cost-sharing demanded by consumers, and the relatively abundant literature on the relationship between greater cost-shariang and lover health care costs.

Based on this literature, they suggest that tax-exempt employer contributions encourage coverage with little cost-sharing and consequently, greater utilization of health care services, removal of tax exemptions, they conclude, will encourage less comprehensive coverage and lower utilization levels. Lower levels of health care utilization will, in turn, reduce aggregate health care costs and ultimately dampen inflation in health care prices.

Opponents of reduced tax preferences for employer health insurance contributions claim that this argument ignores the complexity of consumer demand for health insurance in an interdependent, multi-product market. They argue that rational consumers are unlikely to reduce coverage for the particular service category -- hospital care -- that drives health care cost inflation. Other service categories -- primary physician coverage, preventive service coverage, and routine dental and vision care coverage -- are more vulnerablethan hospital coverage to tax polity that would incrase the price of health insurance to consumers. The cost of these services, however, has been remarkably stable relative to the cost of hospital care. They conclude that tax policy, if at all successful, is likely to be an inefficient way to contain further inflation in health care costs.

These arguments have not been satisfactorily resolved; neither position is based on a substantial body of research. In seeking to break the deadlock, other arguments that might support the revision of tax preference for employer health insurance contributions must be considered. These include the impact of taxation on:

- employer costs;

- rates of health insurance coverage among worker households; and

- federal revenues and tax burden.

(ii) Impact on Employer Costs.

Employer group health plans, as a rule, cover most if not all employees of the firm. In spite of potentially wide variation in the health care risks represented by different employees, broad participation in the plan is achieved by keeping the price of coverage to employees low. Merged survey data on employer plan provisions between 1977 and 1980 indicate that more than 80 percent of all plan participants make no contribution to coverge under the plan; more than 60 percent make no contribution for dependents' coverage.

The pooling of risks within employer group plans can generate significant cross-subsidization among employees who participate in the plan. Low-risk employees (for example, men, young employees and those with no history of chronic illness or impairment) receive benefits from the plan that may be considerably less than the employer's average cost of providing health insurance to them. Conversely, higher-risk employees (for example, women, older employees or employees with chronic health problems) receive benefits in excess of the employer's average plan costs. Because low-risk empoloyees pay little or none of the cost of the plan, however, they are indifferent to their subsidization of higher-risk participants in the health plan.

Taxation of employer contributions to health insurance raises the cost of coverage to participants in employer group health plans. Low (that is, strigent) levels of a tax cap on employer contributions create an

incentive for low-risk employees to reduce their after-tax health cost by seeking less complete or less comprehensive health insurance coverage. The exit of low-risk participants from existing plans (that is, adverse selection) raises the average risk that plan-stayers represent. As a result, the average cost of the plan arises.

Employers have objected to the proposed taxation of contributions to health insurance contributions because they expect taxation to significantly raise their costs of providing health insurance benefits. Increased employer costs might result in several ways. First, employer tax liability under FICA would rise. Since employer payments to FICA are deductable under the corporation income tax, however, the net increase in employer tax liability is likely to be modest. It should be noted, however, that part of the FICA taxation of employer contributons involves shifting funds out of general revenues and into Social Security.

Second, employers anticipate that workers will respond to taxation of health insurance contributions by demanding higher cash wages or greater levels of other tax-exempt benefits in an effort to maintain pre-rax compensation levels. The adverse selection of low-risk employees from existing plans, moreover, may generate a second-round increase in employee demand or greater pre-tax compensation. As low-risk plan participants exit from the "standard" plan, the average cost of the plan -- and employer contributions for the remaining participants -- will rise. Employers are likely to be under substantial pressure from employees who benefit from generous plan coverage to continue to offer that coverage. At the same time, equivalent compensation for employees who leave generous plans would rise with increases in the average cost of the "standard" average.

Finally, because of pressure from some employees to offer less expensive alternative health insurance coverage, employers foresee increased administrative costs as well as the loss of some scale economies in their group plan benefits. The fragmenting of existing employer group plans into a number of smaller plans may increase insurance costs for smaller employers, or reduce the coverage employers are able to provide at current outlays

(iii) Impact on the rate of Health Insurance Coverage.

A potentially important problem that arises in the context of higher employer and employee costs for health insurance is the possibility that some employees would lose health insurance coverage altogether. Increases in the employer cost of providing coverage to marginal workers -- part-time or seasonal workers, and workers who are laid off -- suggests increases in the rate at which these workers and their dependents might be excluded from coverage.

To investigate the problem of coverage loss among some workers, EBRI performed a simulation of the rates of health insurance coverage that might emerge among the currently insured population in the absence of an employer contribution. EBRI's simulation of private insurance coverage rates that emerge in the absence of employer contributions provided some dramatic results. Fewer than half of all persons living in households with annual incomes less than $15,000 (in 1979) would have had private health nsurance coverage in the absence of any employer contribution (see Table 5). In addition, periods of unemployment appear to have a more significant impact on insurance coverage. It is likely that even moderate periods of unemployment (12 weeks or less) generate very long lapses in health insurance coverage among individuals and their dependents when re-employment does not provide an

TABLE 5

SIMULATION OF THE EFFECT OF INCOME ON THE PROBABILITY OF PRIVATE HEALTH INSURANCE COVERAGE, PERSONS WITHOUT EMPLOYER CONTRIBUTION TO COVERAGE BY WORKFORCE STATUS

	All Persons 1/		Workers 2/	
Family Income	Probability of Private Coverage	Change in Probability Per Income Change 3/	Probability of Private Coverage	Change in Probability Per Income Change 3/
5,000	0.3106	0.0875	0.3428	0.0785
10,000	0.3900	0.0794	0.4104	0.0712
15,000	0.4612	0.0713	0.4778	0.0638
20,000	0.5244	0.0632	0.5343	0.0564
25,000	0.5795	0.0551	0.5834	0.0491
30,000	0.6264	0.0470	0.6252	0.0410
35,000	0.6653	0.0389	0.6596	0.0344
40,000	0.6961	0.0377	0.6867	0.0271
45,000	0.7187	0.0267	0.7064	0.0197
50,000	0.7333	0.0146	0.7188	0.0124

SOURCE: EBRI analysis of private health insurance coverage.

1/ Estimates based on persons under age 65 living in households of civilian wage and salary workers.
2/ Estimates based on civilian wage and salary workers.
3/ Income unit is five thousand dollars.

employer contribution to health insurance.

The importance of demographic variables in explaining health insurance coverage, controlling for the effects of income and unemployment, is of particular interest. Persons living in households with no spouse present are significantly less likely to have health insurance coverage in the absence of an employer contribution than are persons living in households with a spouse present. This remains true, even when children are present in the household. Younger families (persons living in a household with a younger primary earner) are also much less likely to have health insurance coverage. The significance of demographic variables in determining private health insurance coverage implies that the current system of employer contributions has significantly raised "normal" rates of health insurance coverage throughout the population, despite perverse demographic trends.

Thse simulations cannot provide precise estimates of the changes in health insurance coverage among the population that might ensue if employer contributions to health insurance were taxed either in whole or in part. They do indicate, however, the function served by current tax preferences for employer health insurance contributions. Current tax policy probably raises private coverage rates significantly among lower-income worker households, households with fragmented employment histories, younger households, and both single-person and single-parent households.

(iv) Impact on Tax revenue and burden.

Estimates of the tax revenues that might result from the taxation of employer contributions to health insurance have attracted considerable attention from those seeking new sources of federal revenues. These estimates have invariably been high and, based on assumptions of contiued

growth in employer health insurance costs, rise significantly over the next few years. The Congressional Budget Office (CBO) estimate of new federal revenues that might result from a low (that is, stringent) cap -- $1440 annually for family coverage and $576 for individual coverage -- effective in 1983, is $4.6 billion. Based on static coverage assumptions, CBO's projected estimates of potential federal revenues between 1983 and 1987 reflect an average annual growth rate of more than 30 percent. In spite of their size, however, estimates of federal revenues that might result from taxation of employer health insurance contributions are fragile. They are susceptible to their assumptions about post-tax levels of employer contributions, as well as to the particular level of taxation proposed.

The primary assumptions behind projected federal revenues from the taxation of employer contributions include: (1) the cost of health insurance coverage, (2) the rate of employer contributions as a percent of cost, and (3) the rate and distribution of health insurance coverage among worker households. The usual cost factor used for projecting health insurance premiums is the medical care component of the Consumer Price Index. Generally, both the rate of employer contributions, and the rate and distribution of health insurance coverage, are assumed to remain at their present levels after a tax cap is imposed.

Although use of these assumptions probably introduces substantial error into the calculation of potential revenues, virtually any other assumptions would be equally hypothetical. The cost of private health insurance relies, for example, on the package of health benefits offered by employers, reimbursement arrangements made with providers and the shortfall of Medicaid and Medicare reimbursements relative to provider costs. All of

these factors are in the midst of dramatic change. Researchers have not developed a method, however, for accurately predicting the effects of these changes on employers' insurance costs. Nevertheless, it is clear that they will affect the ultimate yield of a tax on health insurance contributions. While the use of the CPI to adjust health insurance costs may understate the near-term cost trend of private health insurance, assuming (1) constant rates of employer contribution and (2) constant coverage rates across worker households, however, probably biases tax revenue estimates upwards. Ironically, both advocates and critics of revised tax policy cite the reductions in the comprehensiveness of coverage and redistribution of the scope and rate of insurance coveage as likely effects of reduced tax preference. These effects are not reflected, however, in federal revenue projections.

Possibly of more interest than the level of potential revenues from a cap on the exclusion of employer contributions is the sensitivity of revenue estimates to different levels of the cap. CBO's projections of potential revenues indicate that a relatively small increase in the level of contributions excluded from federal income and payroll taxes would produce a significant drop in projected revenues. Raising the cap from $1980/$792 (family coverage/individual coverage) to $2160/$864 (a 9 percent increase in the level of contributions excluded from earnings), reduces the estimated revenues that might result by 22 percent (see Table 6).

The sensitivity of these revenue estimates to modest adjustments in the level of the proposed cap reflects the relatively narrow dollar range of employer contributions to health insurance, and the weak relationship between the size of employer health insurance contributions and household income.

TABLE 6

SENSITIVITY OF PROJECTED FEDERAL REVENUES TO SELECTED TAX EXCLUSION LIMITS, 1983

Proposed Limit Family/Individual Coverage (annual)	Projected Federal Revenue 1/ (in billions)	Increase in Limit (per cent)	Decrease in Projected Revenue (percent)
$1440/576	$ 4.6	-	-
1620/648	3.7	12.5	19.6
1800/720	2.9	11.1	21.6
1980/792	2.3	10.0	20.7
2160/864	1.8	9.1	21.7

SOURCE: Congress of the United States, "Congressional Budget Office, Containing Medical Care Costs Through Market Forces," (May 1982), p. 35.

1/ Includes revenues from both individual income and Social Security taxation of simulated employer contributions above the exclusion limit in 1983. Social Security tax revenues represent about one quarter of total projected tax revenues.

Among all employer group health plan participants included in the National Medical Care Expenditures Survey, 75 percent of those with an employer contribution to individual coverage received a contribution amount between $100 and $500 in 1977. The range of employer contributions to family coverage was comparably narrow. More than half of all plan participants with an employer contribution to family coverage received a contribution amount between $500 and $1200 in 1977. 11/ Because of the relatively narrow range of these contributions, modest adjustments to the level of proposed cap can affect a significant proportion of all persons who receive an employer contribution to coverage.

Employer contributions to health insurance are broadly distributed across households at most levels of income. In 1979, the rate of coverage among persons with family income above $15,000 was high (73 percent or more) and varied little by income (see Table 7). More than 90 percent of all persons with employer group coverage, including persons in the very lowest ranges of income, received an employer contribution to coverage. As a rsult, the distribution of employer contributions to health insurance coverage is very similar to the distribution of employer group coverage across the population, with little variation in the dollar amount received by households at different levels of income.

The distribution of tax burden that would result from limiting the tax exclusion of employer contributions to health insurance reflects the flat distribution of employer contributions to health insurance over most levels

10/ G. R. Wilensky and A. K. Taylor, "Tax Expenditures and Health Insurance: Limiting Employer-Paid Premiums," Public Health Reports (July-August, 1982).

TABLE 7

RATES OF EMPLOYER GROUP COVERAGE AND EMPLOYER CONTRIBUTIONS TO GROUP COVERAGE BY TOTAL FAMILY INCOME 1/, 1979

Total Family Income	Proportion of Persons With Employer Group Coverage	Proportion of Covered Persons With Employer Contribution	Proportion of All Persons With Employer Contributions
Loss	16.7	85.0	14.2
$ 1- 4,999	9.3	88.2	8.2
5,000- 7,499	22.7	86.3	19.6
7,500- 9,999	33.3	89.5	29.8
10,000-14,999	53.1	91.5	48.6
15,000-19,999	72.4	92.5	67.0
20,000-24,999	78.8	94.0	74.1
25,000-29,999	81.9	94.7	77.6
30,000-34,999	83.6	94.4	78.9
35,000-39,999	82.0	94.5	77.5
40,000-49,999	82.0	93.9	77.0
50,000-59,999	81.8	92.1	75.3
60,000-74,999	77.4	91.9	71.1
75,000 +	73.6	87.0	64.0
Total, all persons 2/	60.6	92.9	56.3

SOURCE: EBRI tabulations of the March 1980 Current Population Survey (Bureau of the Census, U.S. Department of Commerce).

1/ Includes earnings, property and transfer income.
2/ Includes some persons reporting no income in 1979.

of family income. Employer contributions that are relatively constant at all income levels represent a larger percentage addition to family income at lower levels of income than at higher levels of income. As a result, limiting the exclusion of employer contributions to health insurance tends to place a relatively heavy tax burden on families at lower levels of income. In general, the federal income tax structure is not sufficiently progressive to offset both the distribution of employer contributions and the regressivity of the Social Security tax on earnings.

CBO's estimates of the tax burden that would result from capping the exclusion of employer contributions to health insurance are presented in Table 8. These estimates indicate that the distribution of tax burden across households at all income levels would be only mildly progressive, and regressive at income levels above $30,000. The mild degree of progressivity over very low levels of income is due primarily to lower rates of employer group coverage among low-income persons with relatively fragmented workforce participation patterns.

Among households that would be affected by a cap of the exclusion of employer contributions to health insurance, the tax burden would be severely regressive. As a proportion of income, persons at the lowest levels of income (those reporting less than $10,000), would pay more than six times the amount of additional tax than would persons with income over $50,000. The regressive impact of taxing employer contributions to health insurance is a major argument against porposals to limit the exclusion of contributions at all but the very highest level. The argument for pursuing a high exclusion limit, however, is weak; a high cap would affect only a small proportion of all households and yield very little additional federal revenues.

TABLE 8

DISTRIBUTION OF ADDITIONAL ANNUAL TAX BURDEN OF $1800 ANNUAL EXCLUSION LIMIT IN CALENDAR YEAR 1983, BY HOUSEHOLD INCOME (in dollars) 1/

Annual Household Income 2/	All Households		Households Affected		
	Average Additional Taxes	Percent of Income	Percent Affected by Limit	Average Additional Taxes	Percent of Income 3/
$ 0-10,000	3	0.05	2	138	2.76
10,001-15,000	14	0.11	9	168	1.34
15,001-20,000	21	0.12	14	147	0.84
20,001-30,000	44	0.18	23	191	0.76
30,001-50,000	88	0.22	33	267	0.68
50,001-100,000	116	0.18	36	323	0.43
Over 100,000	108	0.08	27	403	0.40

SOURCE: Congress of the United States, Congressional Budget Office, "Containing Medical Care Costs Through Market Forces" (May 1982), p. 36.

1/ Includes both federal income tax and the employer's and employee's share of federal payroll taxes. About three-quarters of the tax burden results from federal income tax liability. State and local income taxes are excluded. Estimates assume that taxable excess contributions are ineligible for the medical expense deduction under the federal income tax.
2/ Household income before taxes, but including cash transfer payments (e.g., Social Security benefits, projected to calendar year 1983.
3/ Estimated at the midpoint of the income range.

The Effectiveness of Tax policy in Containing Health Care Costs

Although industry surveys indicate that employers have been raising deductibles and copayments in their group plan coverage, these plans have traditionally been generous. Coverage of hospital care, in particular, has traditionally involved little cost-sharing on the part of insured consumer. This pattern of generous coverage for hospital care emerged for many reasons; possibly the most imporant is simply the historical precedent established by hospital and physican-owned Blue-Cross/Blue Shield plans in the 1930s. Federal tax policy has not discouraged the emergence of generaous health insurance plans. At the same time, empirical studies suggest that tx policy has been only a minor contributor to the development and growth of these plans.

Private insurance that requires little or no cost-sharing by consumers of health care has probably raised the demand for health care services and contributed to inflation in health care costs. The relative importance of private insurance as a source of demand and inflationary pressure in the health services market, however, has been declining.

Hospital care is the most inflationary component of health care services. Since 1965, the proportion of all hospital care purchased with private insurance has fallen steadily. Since 1975, moreover, private consumers have paid an increasing share of most health care services, including hospital care, directly out of pocket. Between 1975 and 1981, the real burden of hospital care borne directly by private consumers rose by almost one third (see TAble 9).

The most important source of expanding coverage and rising health service demand over the last two decades has been the public sector. Since

TABLE 9

PERCENTAGE DISTRIBUTION OF EXPENDITURES FOR HOSPITAL CARE BY SOURCE OF PAYMENT, SELECTED YEARS 1965-1981

	Private				Public		
	Total	Patient Direct Payments	Health Insurance	Other	Total	Medicare and Medicaid	Other
1965	61.2	17.2	41.8	2.2	38.9	--	38.9
1970	47.2	10.0	35.8	1.4	52.9	26.3	26.6
1975	44.7	8.2	35.4	1.1	55.3	31.3	24.0
1978	45.6	8.6	35.8	1.2	54.4	33.6	20.9
1979	46.2	9.9	35.0	1.3	53.8	33.9	19.9
1980	45.9	10.0	33.5	1.5	54.1	35.3	18.8
1981	45.7	10.8	33.4	1.5	54.3	35.7	18.6

SOURCE: R.M. Gibson and D.R. Waldo, "National Health Expenditures, 1981," Health Care Financing Review 4:1 (September 1982), pp. 24 and 27. R.M. Gibson and D.R. Waldo, "National Health Expenditures, 1980," Health Care Financing Review, 3:1 (September 1981), pp. 44-47.

1967, the public sector has purchased more than a third of all personal health care, and more than half of all hospital care. Most of the growth of public-sector spending for personal health care is attributable to the growth of Medicare and Medicaid spending. In 1981, these programs purchased more than one third of all hospital care delivered in the United States.

The size of public-sector spending relative to privately-insured spending for personal health care is important in considering a revision of federal tax policy toward private health insurance, both at a philosophical and a practical level. In legislating the Medicare and Medicaid programs, Congress established a standard of access to comprehensive health insurance coverage across the population. Federal tax policy that would significantly reduce levels of private health insurance coverage, or jeopardize access to coverage among middle-and low-income persons, promotes gross inequities between the general population and persons eligible for coverage through the public sector. Federal policy that would reduce eligibility or coverage under Medicare or Medicaid, moreover, is reasonable only if persons who lose public-program benefits are likely to obtain health insurance coverage in the private sector. It is difficult to reconcile reductions in both public-program benefits and private-sector incentives for health insurance coverage in terms of coordinated federal policy.

In practical terms, the size of public spending for personal health care relative to privately insured spending suggests that federal policy to contain health care cost inflation might be most effective within the context of federal spending programs. In spite of efforts to curb the burgeoning costs of Medicare and Medicaid, these programs have supported much of the inflation of aggregate health care costs, and of hospital costs in

particular. The average Medicare beneficiary spends far more for hospital care than privately insured persons. Over the last five years for which data are available, per capita spending for hospital care among Medicare enrolles exceeded per capita spending among the privately insured population by more than 400 percent (see Table 10). While part of the discrepancy in per capita spending for hospital care is the result of differences in the insured population, at least some of the difference is attributable to hospital practices that are attuned to Medicare and Medicaid reimbursement policy.

Possibly due to the success of health care providers in gaming Medicare and Medicaid reimbursement, these public programs have led inflation in hospital costs. Beween 1976 and 1980, the rate of increase in average Medicare and Medicaid spending consistently exceeded the growth of privately insured spending for hospital care. During those years, average hospital costs among Medicare enrolles and Medicaid beneficiaries rose at an average annual rate of 14 and 18 percent, respectively. Average private health insurance costs, by comparison, rose by less than 12 percent, and maintained a stable decline during 1979 and 1980. It is unlikely that these persistent differences in per capita spending between public-sector programs and privately insured consumers are the result of qualitative changes in the covered populations.

Federal tax policy that would dampen private-sector demand for health care will probably have little effect on health care cost inflation as long as Medicare and Medicaid spending continues to rise. Inflation in privately insured spending for hospital care and other health care service has been slowing, possibly in response to adjustments in the coverage provided by employer group plans. Modifying the tax-exempt status of

TABLE 10

ESTIMATED AMOUNT AND ANNUAL GROWTH OF EXPENDITURES FOR HOSPITAL CARE PER INSURED PERSON BY SELECTED SOURCE OF PAYMENT, 1976-1980

	Private Health Insurance 1/	Medicare 2/	Medicaid 3/
	(dollars per insured person)		
1976	$122	$486	NA 4/
1977	134	540	NA
1978	149	687	$315
1979	164	772	442
1980	181	926	495
Average, 1976-1980	150	682	417
	(percent annual growth)		
1976	18.4	3.2	NA
1977	9.8	11.1	NA
1978	11.2	27.2	13.6 5/
1979	10.1	12.4	40.3
1980	10.4	19.9	12.0
Average annual growth, 1976-1980	11.9	14.5	18.3

SOURCE: R.A. Gibson and D.R. Waldo, "National Health Expenditures, 1981," Health Care Financing Review, 4:1 (September 1982), pp. 24, 27. R.A. Gibson and D.R. Waldo, "National Health Expenditures, 1980," Health Care Financing Review 3:1 (September 1981), pp. 44-46. Health Insurance Association of America, Source Book of Health Insurance Data, 1981-1982 (Washington, D.C.), p. 12. U.S. Department of Health and Human Services, Social Security Administration, Social Security Bulletin Annual Statistical Supplemental, 1981 (Washington, D.C.), pp. 207,220.

1/ Private insurance expenditures per person insured for hospital care.
2/ Medicare expenditures per Medicare Part A enrollee.
3/ Medicaid expenditures per Medicaid recipient (unduplicated count) of any personal health care services, including hospital care.
4/ Published figures not available.
5/ Average annual compounded growth between 1975 and 1978.

employer contributions to health insurance may accelerate this trend. It is very unlikely, however, that further slowing of privately insured spending for health care can successfully offset continued inflation in public-sector spending.

Concluding Remarks

Employers and employees, public and private, have placed a consistently high value on employee benefits. Many benefits, such as holidays and other time off, are fully taxed. The government has encouraged the growth of other benefits through tax incentives. Past concern over low rates of private health insurance and pension coverage among workers, even with tax incentives, has led to discussions of national health insurance and mandatory private pensions. Now, concern over deficits is leading to proposals that could have the effect of reducing coverage in these tax-favored programs.

Without question, the federal government must draw lines to specify which employee benefits should be tax-favored. Great care, however, must be taken to avoid unintended consequences. Consideration of tax policy change must include a clear definition of objectives, the assessment of individual benefits against these objectives, and, finally, a thorough understanding of the tax costs of each benefit. This process can only be effective if analysts understand the distinction between mandated versus voluntary benefits; fully taxed versus tax favored benefits, and tax-exempt versus tax-deferred benefits. Most analyses and debate in recent years have not made these distinctions.

We thank you for the opportunity to appear today. We stand ready to assist the Congress in its debate with further analysis of the tax treatment of employee benefits and related issues.