

Beneath the Surface
**The Tax Exclusion
for Employer-Sponsored
Insurance Is Not Regressive—
But What Is It?**

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Abstract Conventional wisdom says that the tax exclusion for employer-sponsored health insurance (ESI) is “regressive and therefore unfair.” Yet, by the standard definition of regressive tax policy, the conventional view is almost certainly false. It confuses the absolute size of the tax exclusion with its proportional effect on income. The error results from paying attention only to the marginal tax rate applied to ESI benefits as a portion of income and ignoring the fact that benefits are normally a much larger share of income for people with lower wages. This article explains the difference and then considers other distributional effects of ESI. It suggests that ESI—for those who receive it—further redistributes toward those with lesser means or greater need. The most evident effect is by need, favoring employees with families over those without. Yet there is good reason to believe there is also a redistribution by income, with the package of wages plus benefits being less unequal than wages alone would be. Therefore reformers should be much more careful before criticizing either ESI or its subsidy through the tax code as “unfair,” especially as the likelihood of enacting something better in the United States seems quite low.

Keywords insurance, taxes, redistribution, employers

Labels tell stories, and those stories have power to persuade. One of the most pervasive persuasive labels in US health policy discourse refers to the tax exclusion for employer-sponsored health insurance (ESI) as “regressive.” That quickly communicates a judgment: that the tax exclusion is unfair and that liberals, of all people, should not defend it.

When an employer pays for an employee's health insurance coverage,¹ this compensation is not taxed as income for the employee. So the value of the coverage is *excluded* from taxation. This tax exclusion—also called a “break,” “preference,” or “expenditure”—reduces federal revenue compared to what it would be if the employee received money wages instead. Many economists and public finance experts believe tax expenditures in general are an inefficient and inequitable public policy tool (Huang and Shaw 2009; Kleinbard 2012).

In *The Economist's* (n.d.) words, a regressive tax “takes a smaller portion of income as the taxpayer's income rises,” while a progressive tax (such as the federal income tax) takes a larger share. A tax provision is regressive if it makes the overall distribution of tax burdens more regressive. Economists across the political spectrum declare the ESI tax exclusion “is regressive” (Joseph Antos of the American Enterprise Institute [Antos 2015]), is “highly regressive” (Obama adviser Jonathan Gruber [2011: 511]), or that “unions, along with left-of-center politicians and policy experts, have defended the tax preference in spite of its regressive nature” (Uwe Reinhardt 2009).

Yet a series of studies have (1) explained why the tax exclusion is not, in and of itself, regressive, and (2) been ignored by virtually the entire health economics and public finance communities. This article will first show why the conventional wisdom is wrong and then ask the more difficult question: what distributional effects should we see when we peel back the label and look more closely at the tax exclusion? Mostly, we should discover how little we know.

Regressivity, in Principle

The staff of the Joint Committee on Taxation (2008: 13) summarized that the tax exclusion is commonly called “regressive, and thus unfair” because “those with the greatest income are in the highest tax brackets, and therefore receive the greatest tax benefit from the exclusion from income.” For example, a \$10,000 tax exclusion is worth \$2,800 if applied to income that would be in the 28 percent bracket, but \$1,500 for someone in the 15 percent bracket.

1. This may be either by buying coverage from an insurer, a “health plan,” or by paying bills directly, in which the employer takes on insurance risk but hires a health insurer to manage the coverage, a “self-financed” plan. Self-financed insurance is governed, somewhat, under the Employee Retirement Income Security Act of 1974, ERISA.

Table 1 Effects of a 50% Total Income Tax Cut for Lower-Income and 20% Cut for Higher Income Families (with 2016 Income Tax Brackets)

	Family Income of \$40,000		Family Income of \$160,000	
	Tax Before Reduction	Tax After Reduction	Tax Before Reduction	Tax After Reduction
Dollars	5,072	2,536	31,785	25,428
Savings (\$)		2,536		6,357
Percentage	12.68	6.34	19.87	15.89
Ratio of higher to lower income tax rates before change:	1.57			
Ratio of higher to lower income tax rates after change:	2.51			

Source: Author's calculation from Kyle Pomeroy, “2016 Tax Brackets,” Tax Foundation, taxfoundation.org/article/2016-tax-brackets.

But applying the label based on the absolute size of a tax preference is simply wrong. It would be equivalent to calling Social Security “regressive” because it pays larger benefits to people with higher incomes. Social Security benefits are based on beneficiaries' earnings during their working years. They contribute in proportion to their earnings. People who earned more contribute more, so get more. But people who earned less get a higher “replacement rate” or “rate of return” on contributions—higher benefits relative to their contributions. Monthly benefits are much more equal than the earnings on which they are based.²

Table 1 illustrates why the dollar value of the exclusion can be the wrong question. Imagine that legislation created a reverse surcharge on income taxes, on a progressive sliding scale. Income tax would be cut in half for a family with an income of \$40,000, and reduced by 20 percent for a family with a \$160,000 income. Table 1 shows that the absolute savings would still be much larger for the higher-income family. But it is a much larger reduction in percentage terms for the family with \$40,000 income, and it changes the ratio of income taxes paid from progressive (the higher income family pays 57 percent more of its income) to much more progressive (the higher income family pays 151 percent more of its income).³

2. The benefits are not as progressive as the difference in monthly payments suggests, because people who earn more while working tend to live longer and so collect more checks. Yet benefits remain progressive even over a lifetime; see CBO (2006).

3. My argument here is similar but not identical to the point that, when the underlying tax rates are progressive, all sorts of tax expenditures will be of greater absolute value to people who have higher incomes so who already are paying proportionally more (Malani 2008). So an exclusion looks “regressive” only because the tax rates were progressive to begin with. But the example here, and the actual effect of the tax exclusion for ESI, actually increase progressivity.

The standard analyses of the ESI tax exclusion focus on the dollar value of the savings. As in the example above, that value depends on the employee's marginal tax rate: the rate at which she would have paid taxes if she had received wages instead of benefits. Yet, for at least a quarter century, the Employee Benefit Research Institute (for example, EBRI 1992, 2005; Fronstin 2006) has been pointing out that the focus on marginal tax rates misses a major point: *health benefits are a much larger share of total compensation for lower-income workers*. Therefore, *eliminating some portion of the subsidy will affect more of the income of lower-wage workers, and this income-share effect more than offsets the tax rate effect*. As the Institute of Medicine (Field and Shapiro 1993: 111) explained, “were the exclusion to be eliminated or capped . . . the dollar burden would . . . be higher for the well-off. However, lower-income groups would likely find that the resulting increase in taxes constituted a greater percentage of their taxable income.”⁴

In one example, an Urban Institute analysis of 2004 data concluded the subsidy from tax deductibility of health insurance averaged 5.8 percent of after-tax income for people with incomes between \$30,000 and \$40,000, 3.2 percent for individuals with incomes between \$100,000 and \$200,000, and only 1 percent for those with incomes above \$200,000 (Burman, Garrett, and Khitratrakun 2008, cited by Schoen et al. 2009). As Cathy Schoen and colleagues concluded in a Commonwealth Fund report, “the current exemption represents a larger tax break as a percentage of income for low-income households with employer coverage and a smaller tax break for higher-income households.” Therefore, “a cap on the tax exemption of health benefits would represent a regressive—not progressive—change in tax policy” (Schoen et al. 2009: 2).

If we want to understand the distributional impacts of employer-funded health insurance, we need to look beyond the tax policy aspects. But first we should consider some complications.

Complications

Since it only helps workers who receive ESI, the tax exclusion favors those workers over those who do not receive ESI. The overall effect of that must be regressive, as employees in low-wage firms are less likely to receive benefits (Long and Marquis 1993). One could address that problem by, for example, creating a separate insurance system with different subsidies

for those employees (oh wait, that was already done—it was called the Affordable Care Act). Or one could finance health care in many other ways. But the basic problem is not the tax exclusion but the fact that public policy leaves employees and employers to fend for themselves through employment group insurance. The tax exclusion does not create the inequity, which is based on some pools being too poor or high-risk to afford insurance.

A second issue is whether firms provide the same coverage to all employees. If firms instead provide better coverage to higher earners, the difference between shares of total compensation that receive the tax break would be less than the EBRI and Commonwealth studies say. There appear to be no significant studies of this issue, but there is reason to believe such effects are minor.⁵

One reason is that federal law requires that self-funded (ERISA) plans *not* discriminate by providing better benefits to “highly compensated employees” (hereafter, HCEs). About 63 percent of employees with coverage are in self-funded plans (KFF 2015: Exhibit 10.1). These plans may legally distinguish among groups of participants by “bona fide employment-based classifications consistent with the employer’s usual business practice,” but those do not include favoring HCEs (US Department of Labor n.d.: 66).⁶ The ACA extended these limits to insurer-sold health plans, though the Treasury has yet to issue the required regulations. In fact some employers, such as General Electric (Andrews 2011), have favored lower-wage employees by requiring lower premium contributions from them. In 2012 about 12 percent of employers were charging less to lower-wage employees, and the number was projected to grow quickly (Cook 2013).⁷

The most serious concern is that premiums may seem unaffordable for some low-wage employees within a firm, so they decline the coverage and so receive less total compensation (Burman, Garrett, and Khitratrakun 2008; Halperin 2008). That is why firms have begun to income-relate employee contributions. We do not have direct evidence of the size of this

5. I have consulted some of the leading experts on insurance in the country, and none can direct me to data. None believe there is a large amount of discrimination; one reason may be that higher-income employees are offered not better mainstream health insurance benefits but extra benefits of other sorts.

6. Examples of acceptable classifications “include: full-time versus part-time employee status; different geographic location; membership in a collective bargaining unit; date of hire or length of service; or differing occupations” (DOL: 66; see also Klingner 2016).

7. One example is my own employer, Case Western Reserve University. This approach was further encouraged by the Affordable Care Act’s requirement that employees’ shares of a premium be no more than 9.5 percent of their household income.

4. IOM referred to estimates of effects in EBRI (1992: 21–23).

effect within specific employers. Across the population, lower earners are less likely to take up health insurance (BLS 2016), but much of this effect is between firms. Take-up in low-wage firms is lower, apparently due to higher-cost coverage in those firms (Cunningham, Schaefer, and Hogan 1999; KFF 2015: 58, 85). A substantial portion of employees who decline coverage from one employer also obtain it elsewhere (Cunningham, Schaefer, and Hogan 1999).

On balance, the overall effect of the tax exclusion seems most likely to be progressive. The exceptions are due to the weakness of some employers as insurance pools and the very high costs of US healthcare (which makes premiums unaffordable)—not the tax exclusion itself.

Paying for Health Care versus Paying Wages

Further beneath the surface, we may find more complications. The effect of the tax exclusion for ESI that has generated the most controversy is how health benefits influence *total compensation*. Many analysts, following beliefs about equilibrium outcomes in labor markets, say there is no change in total employer payments. Hence employees pay the full cost of insurance in the form of lower wages. Accordingly, spending on ESI would, though perhaps with some transition difficulties, be fully replaced with wages if ESI were eliminated (Furman 2016; Orszag 2008). Analysts who study employer behavior directly might agree instead with Paul Fronstin (2011: 12) when he wrote that “at this time it is impossible to predict how employers will respond in terms of giving workers a portion of the employer share of the premium if workers were no longer eligible for employment-based coverage.” Most employers interviewed about planned responses to the “Cadillac tax” cap on benefit expenses, for example, did not expect to replace all benefit reductions with wages (Jost and White 2010; Troy and Wilson 2015). The behavioral (as opposed to theoretical) evidence that wages would fully replace lost benefits is, in Sarah Kliff’s (2015) words, “thin.” Employer behavior surely will vary substantially with economic and market conditions. If any part of ESI expense is extra compensation, then the coverage redistributes to workers from either customers or capital.

Another question, however, has not been asked enough: how do health benefits influence *relative compensation* among jobs or employees?⁸ One

way of thinking about this is to ask how, if the IRS wanted to impute an insurance value to each employee, it would do so. With difficulty. Daniel Halperin (2008: 58) writes that “Treasury officials decided in 1943 to exempt health insurance premiums because it was too difficult to allocate the cost among employees.” He adds that “if provision of health insurance results in a wage cut by either the pretax cost of health insurance or the cost plus the tax savings, it is not clear whose wages are cut” (2008: 59).

Employer-sponsored health insurance involves a series of redistributions.⁹ The most obvious is between employees who get family vs. individual coverage. In 2015 the average employer contribution for family coverage was \$12,591 vs. \$5,179 for individual coverage (KFF 2015: Exhibits 6.3, 6.4). So employers were spending about \$7,000 more on employees with families. Employers who reward employees with higher wages for having families must be rare, so ESI must redistribute from single workers to those with families.

ESI also redistributes compensation from healthier to sicker employees. Because older employees are likely to be sicker, and are also likely to have higher incomes, the dollar value of coverage will on average be greater for higher-income employees. The value of “peace of mind” may also be greater for older employees (Lyke 2008: 19). Does this make the tax exclusion more regressive? By that logic community rating would also be “regressive,” as would the individual mandate in the ACA and any other provision that favors older (probably sicker but wealthier) people over younger. In addition, between younger and older employees with the same salary, health benefits redistribute toward the older, higher-risk, employees. To the extent the tax exclusion encourages employers to sponsor insurance, it favors higher-risk employees within the employer pool.

The first two factors involve differences in employees’ health care cost profiles. But what would we expect even if there were no such differences? Standard analyses presume employers subtract the average value of insurance provided (for example, \$10,000) from what would otherwise be each employee’s wages; and so they would add back a flat amount if they did not pay for health coverage. Then an employee who now receives \$30,000 in wages would instead receive \$40,000, and an employee with a \$90,000 wage would instead be paid \$100,000. We have already seen two

9. I cannot address here, but do not want to imply that I agree with, the kind of arguments made in Havighurst and Richman (2006), Pauly (2006), and Zelenak (2006) about employees’ preferences and access to care. An example is that the benefit level in ESI reflects the preferences of higher-wage employees and is imposed on lower-wage employees who would prefer less coverage. Nor does this article address the broad presumption among American economists that the tax exclusion causes excess care by creating excessive insurance.

8. Pauly (2006) provides some discussion of this issue and refers to an unpublished analysis by Len Nichols.

exceptions to this logic—higher compensation for families and employees that charge lower premiums to lower-income employees. But consider the effect of such a change on how *employees* perceive their compensation.

Most analyses presume that wage income is far more visible than health insurance income. Indeed, one of the main criticisms of health insurance benefits is that employees don't recognize their value (Havighurst and Richman 2006). How, then, would employees respond to a large change in proportional, visible incomes? Both economists (for a good summary see Akerlof and Yellin 1990: 259, 269) and the HR community (for one example, see Cepinski 2013) have long recognized the importance of how workers compare their compensation to that of other persons, including "relative deprivation" within a firm.¹⁰ So we should expect higher-income employees to resist having their *visible relative* compensation reduced. A pure relative-wage logic would project that, in the example above, the \$20,000 in insurance payments for both employees would be divided according to their previous wages: so the \$30,000 wage would be raised to \$35,000 and the \$90,000 wage to \$105,000.

In short, we don't know whether "the provision of health insurance" means that "each employee gets a pay cut equal to the pro rata cost of health insurance," or wages are "cut by an equal percentage" across employees (Halperin 2008: 59).¹¹ So we don't know what would happen to money wages if employers stopped offering insurance. I'd guess that relative wages would be somewhere between the two scenarios. But if perceptions of relative wages are relevant, then *the fact that employers currently provide roughly equal health benefits to all full-time employees means that there is already a redistribution, from higher- to lower-income employees, within the firm*. Thus the overall social effect of employer-sponsored insurance—given the laws and customs that inhibit "discrimination" within the firm—is likely to be more "progressive" than the EBRI or Common-wealth calculations suggest.

In Conclusion

The tax exclusion for employer-sponsored health insurance is not generally regressive. Therefore capping or eliminating it is not likely to be progressive. This does not mean that the current role of employers in

10. In our own lives we read about how shortstops, or midfielders, negotiate through comparisons to other shortstops or midfielders, or to teammates. And we know the last thing any department chair or dean wants is for everyone to know what everybody else is paid.

11. Pauly (2006: 87) reports that Len Nichols had argued that higher-income employees could even, under some circumstances, pay the full cost of coverage for low-wage employees. I am not raising that possibility.

the US health insurance system is ideal policy. The current employer role has two major failings with serious distributional effects. First, some employment pools are too small, or include too little average income or employees with too much risk, to be the basis for insurance. Over the past two decades, these factors drove German reforms that have significantly reduced employers' roles as separate risk and financing pools (Busse and Blümel 2014). Comparison to other systems in which coverage is or has been related to employment shows another factor. US employers, without government or other help to consolidate into all-payer systems to impose market power on the providers, have been much less able to control costs (White 2013). High costs explain or exacerbate the failures of some employers to offer coverage and some employees to take up the offers.

Employer-sponsored insurance as currently practiced in the United States, however, has significant risk-pooling advantages and likely involves useful redistributions, compared to any but a very highly regulated individual market with substantial government subsidies. The likelihood of constructing such an individual market—never mind more of a single-payer system—in the United States is quite small. Under these circumstances, advocates who attack the tax exclusion that encourages employer-sponsored insurance should be much more hesitant to claim that is the "fair" thing to do.

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A Failure to Communicate? Doctors and Nurses in American Hospitals

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Abstract This article showcases the realities and challenges of teamwork in American hospitals based on the in situ comparison with France. Drawing on observation of nurse-physician interactions in hospitals in the two nations, this article highlights a troubling conflict between teamwork rhetoric and realities on the ward. Although the use of informatics systems such as electronic health records is supposed to increase cooperation, the observations presented here show that on the contrary, it inhibits communication that is becoming mainly virtual. While the nursing profession is more developed and provides stronger education in the United States, this story highlights the challenges in creating a shared environment of work and suggests the importance of balancing professional autonomy and effective teamwork.

Keywords teamwork, doctors and nurses, comparative study, ethnography

Reliable teamwork and human resources management are often described as an indispensable element of superior health system performance (Buchan 2004). Several studies have highlighted the importance of an effective relationship between physicians and nurses for patient safety, care quality, and nurses' satisfaction (Brunetto et al. 2013). Others have documented serious problems linked to missed communications—for example, the Joint Commission (2012) reported that nearly two-thirds of sentinel events had their root cause in communication failure. The RN4CAST, a major

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