TAX POLICY CENTER
URBAN INSTITUTE & BROOKINGS INSTITUTION

REFORMING TAX EXPENDITURES FOR HEALTH CARE

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This brief examines major tax expenditures for health care under current law and analyzes three potential reforms to the tax exclusion for employer-sponsored health insurance (ESI) premiums. We use the Tax Policy Center microsimulation model's revamped health module as well as health insurance coverage simulations from the Urban Institute's Health Policy Simulation Model (HIPSM). [1]

FIVE LARGEST TAX EXPENDITURES FOR HEALTH CARE

The five largest tax preferences for health care are projected to reduce federal income tax revenues by $257 billion in fiscal year 2020 (table 1). Including lost payroll taxes, the revenue loss would be $381 billion.

By far the largest health tax expenditure is the exclusion from taxable income of employer contributions for ESI premiums. This exclusion is expected to reduce income tax revenues by $177 billion in 2020. Employer contributions for health insurance premiums are also excluded from employees' taxable wages when calculating payroll taxes. Including its impact on income and payroll taxes, the ESI exclusion will reduce federal government revenues by $299 billion in 2020. Average income and payroll tax benefits from the exclusion increase with income, from about $160 for tax units in the bottom income quintile to about $4,700 for tax units in the top income quintile in calendar year 2020 (figure 1). As a percent change in after-tax income, the ESI exclusion benefits taxpayers in the middle and fourth quintiles of the income distribution the most, increasing after-tax income 3 percent for average taxpayers in those quintiles as opposed to 1.1 percent for the bottom quintile and 1.6 percent for the top quintile (figure 2).

[1] The health module is based on health insurance coverage imported from HIPSM into the tax model. For more information on the tax model see "Brief Description of the Tax Model," Urban-Brookings Tax Policy Center, last updated August 23, 2018, https://www.taxpolicycenter.org/resources/brief-description-tax-model. For more information on HIPSM see "The Health Insurance Policy Simulation Model HIPSM," accessed December 17, 2019, http://www.urban.org/hipsm.

TABLE 1

Five Largest Tax Expenditures for Health Care

Billions of dollars, fiscal year 2020

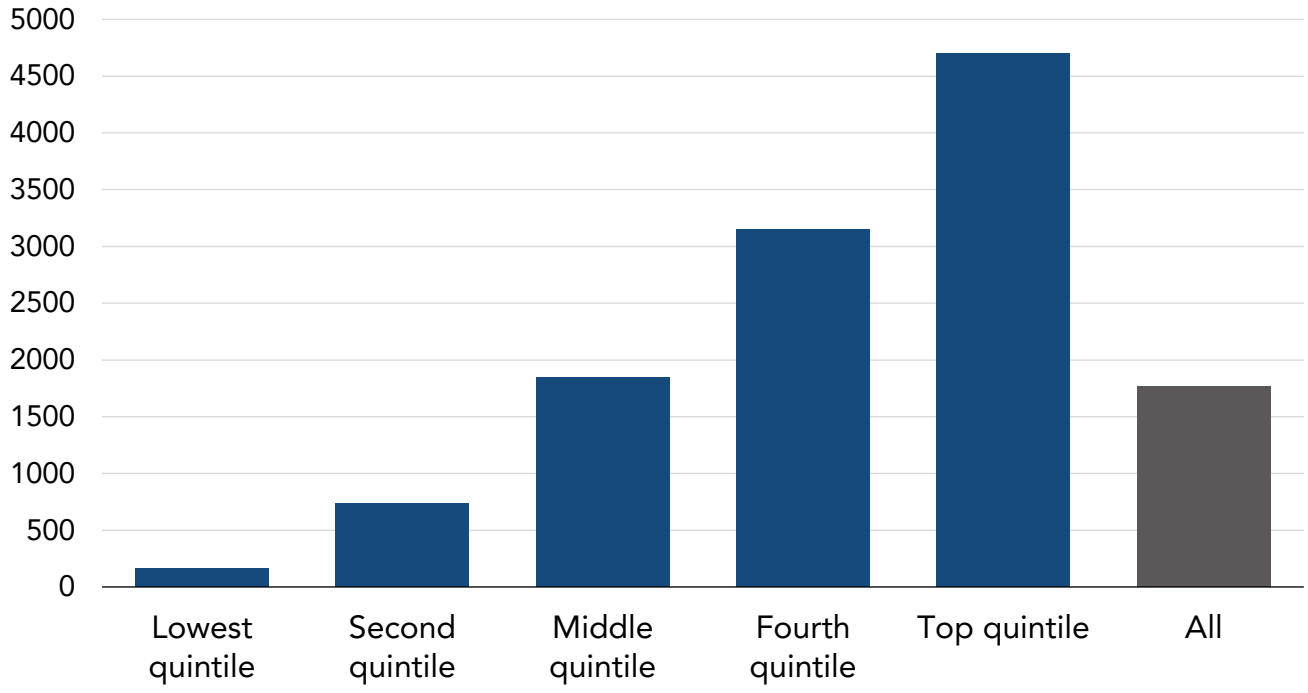
	Income tax loss	Income and payroll tax loss
Exclusion of employer contributions for health insurance premiums	177	299
Premium tax credit for health insurance purchased through ACA Marketplaces	57	57
Self-employed health insurance deduction	9	9
Health savings accounts	6	8
Medical expense deduction	8	8
Total	257	381

Source: Joint Committee on Taxation, JCX-81-18, 2018 and Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model.
Note: Total does not include interactions among the five tax expenditures.

FIGURE 1

Income and Payroll Tax Benefit of ESI Exclusion

Average federal tax benefit, calendar year 2020



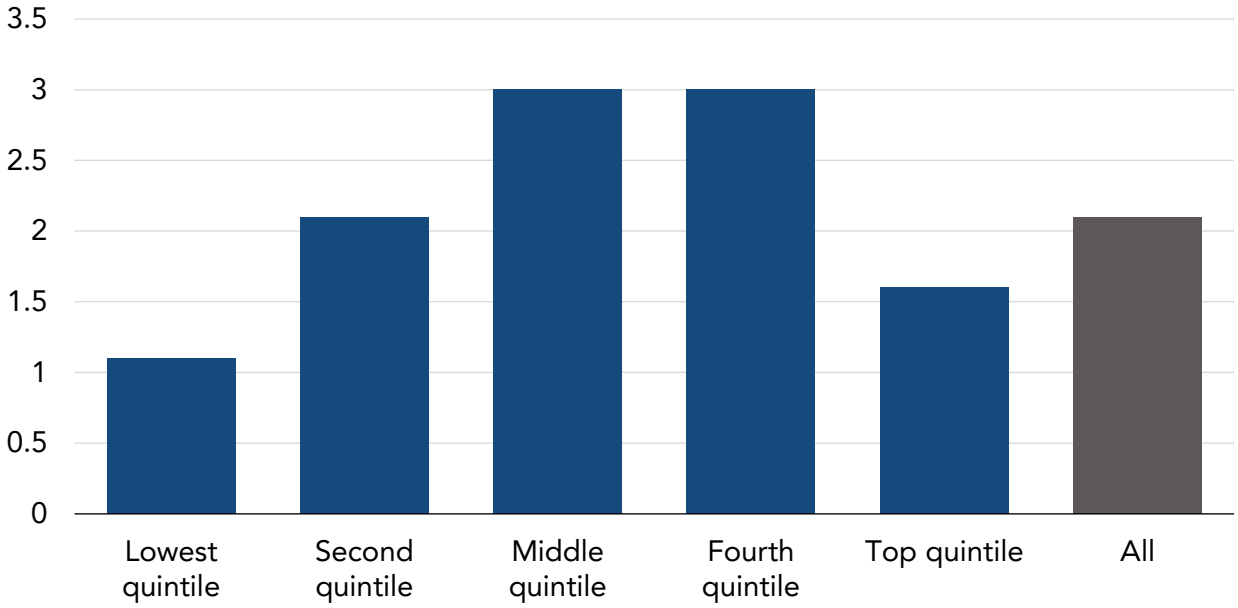
Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model.

People ineligible for ESI or public health insurance may receive a premium tax credit (PTC) to purchase insurance on the Marketplaces created by the Affordable Care Act. The PTC is projected to reduce revenues by $57 billion in 2020. Unlike the other health tax expenditures, average benefits and benefits as a percent of after-tax income from the PTC are largest for taxpayers in the bottom two quintiles (figures 3 and 4).

FIGURE 2

Income and Payroll Tax Benefit of ESI Exclusion

As percentage of after-tax income, calendar year 2020



Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model.

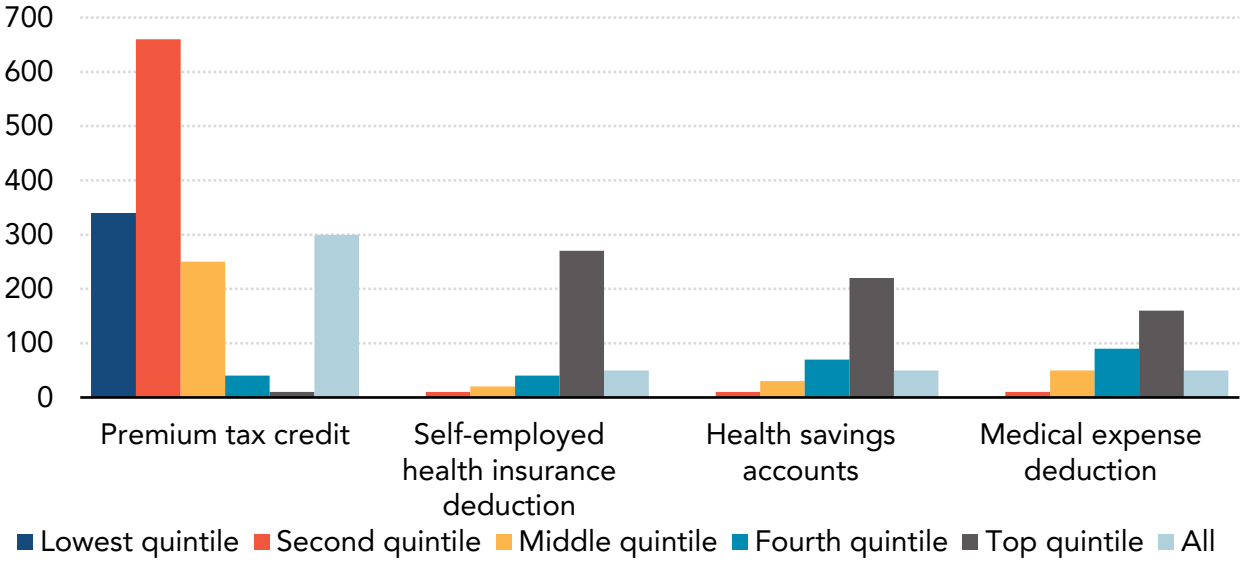
Self-employed individuals may deduct health insurance premiums from their income. The self-employed health insurance deduction is expected to reduce revenues by $9 billion in 2020. The deduction only meaningfully affects taxpayers in the top quintile, increasing after-tax income 0.1 percent.

Individuals younger than 65 covered by high-deductible health insurance plans may take an income tax deduction for contributions to health savings accounts (HSAs). Employers also may make HSA contributions that are excluded from income and payroll taxes. Further, HSA balances grow tax free, and withdrawals from them for medical expenses are not subject to income tax. HSAs are expected to cost the federal government $8 billion in forgone revenue in 2020. Tax subsidies for HSAs only meaningfully affect after-tax income for taxpayers in the top two income quintiles, increasing after-tax income about 0.1 percent for both groups.

FIGURE 3

Income and Payroll Tax Benefits of Other Health Tax Expenditures

Average tax benefit, by expanded cash income quintile, calendar year 2020

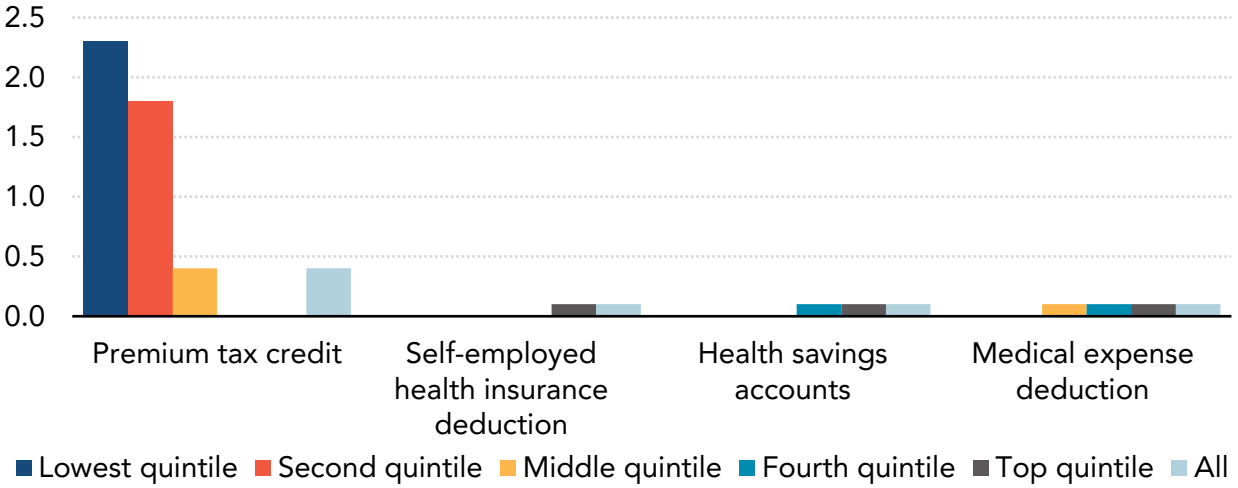


Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model.

FIGURE 4

Income and Payroll Tax Benefit of Other Health Tax Expenditures

As percentage of after-tax income, by expanded cash income



Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model.

Individuals may claim as an itemized deduction out-of-pocket medical and long-term care expenses and premiums. Expenses and premiums must be paid with after-tax dollars, and only the portion exceeding 10 percent of adjusted

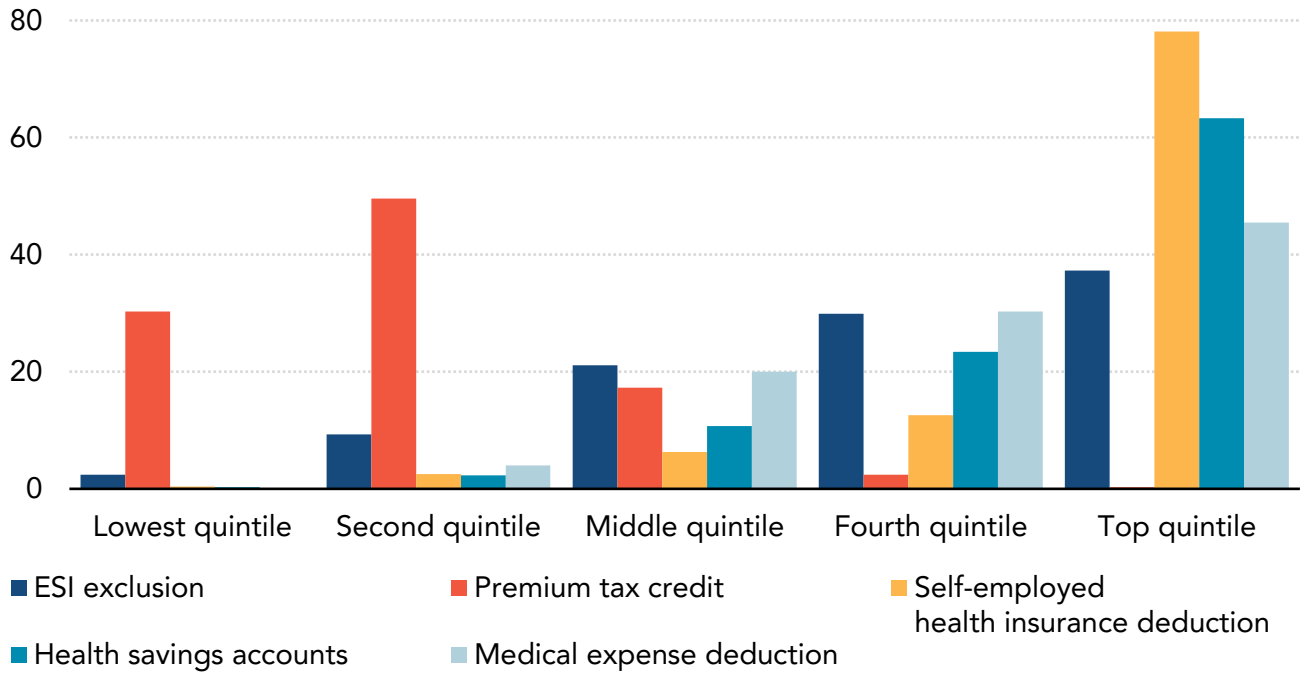
gross income (for years after 2018) is deductible. The medical expense deduction is expected to reduce revenue by $8 billion in 2020. The deduction is of essentially no value for taxpayers in the bottom two quintiles and increases after-tax income 0.1 percent for taxpayers in the top three quintiles.

Comparing across the five tax expenditures, the self-employed health insurance deduction delivers the largest share of benefits to taxpayers in the top quintile (figure 5). Seventy-eight percent of the benefit from the self-employed health insurance deduction goes to taxpayers in the top income quintile; this is 15 percentage points more than for health savings accounts, the tax preference with the next-highest share going to the top quintile. The ESI exclusion and the medical expense deduction both provide the largest shares for the middle quintile (20 percent). The PTC is by far the tax expenditure most targeted to taxpayers in the bottom two quintiles, delivering 30 percent of benefits to taxpayers in the bottom quintile and 50 percent of benefits to taxpayers in the second quintile of the income distribution.

FIGURE 5

Share of Health Tax Expenditure Benefits

By expanded cash income quintile, calendar year 2020



Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model.

A CASE FOR REFORMING THE ESI EXCLUSION

Employer-paid premiums for health insurance are exempt from federal income and payroll taxes. Further, the portion of premiums employees pay is typically excluded from taxable income. Excluding premiums lowers most workers' tax bills and thus reduces their after-tax cost of ESI coverage. On average, if employers shift a dollar of compensation from wages into additional ESI premiums, federal income and payroll taxes are reduced by 29 cents (figure 6), effectively reducing the price of ESI 29 percent.[2] This effective subsidy increases the number of employers offering ESI coverage

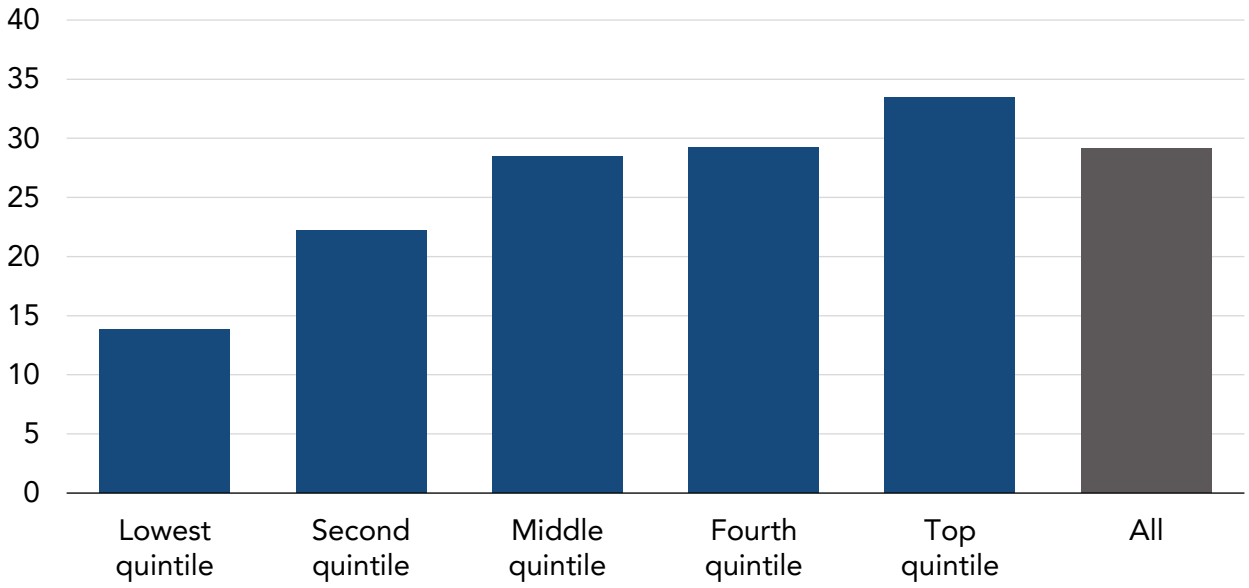
[2] We assume that workers pay the full cost of employer contributions to ESI through lower wages. The analysis excludes the impact of the exclusion on state income taxes, which would increase the effective subsidy rate. Shifting compensation into additional ESI premiums also reduces workers' future Social Security benefits through reduced covered earnings. Accounting for the reduction

and increases the number of employees who enroll in such coverage. Additionally, by reducing workers' cost of coverage, the subsidy encourages healthy employees to enroll which helps limit adverse selection (Selden 1999). According to HIPSM, repealing the exclusion would reduce ESI coverage by about 16 million people, an 11 percent decline.

FIGURE 6

Effective Marginal Tax Benefit of Employer Contributions to Health Insurance Premiums

As percentage of additional contributions, by expanded cash income quintile, calendar year 2020



Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model
Note: Effective marginal tax benefit equals the reduction in income and payroll taxes from shifting $1,000 in compensation from wages and employer payroll taxes into additional employer provided health benefits divided by 1,000. Tabulation is weighted by initial amount of employer-provided health benefits.

The tax subsidy for ESI is very expensive. The ESI exclusion is projected to reduce income and payroll taxes by $299 billion in 2020, which is over 8 percent of federal government revenues and nearly 30 percent of the projected federal budget deficit. This lost revenue could be used to reduce the deficit or to fund other policy priorities.

Because excluding premiums for ESI reduces taxable income, it is worth more to taxpayers in higher tax brackets than to those in lower tax brackets. For tax units in the top quintile with ESI, the effective subsidy rate for an additional dollar of ESI premiums is 33 percent; the subsidy rate is just 14 percent for tax units in the bottom quintile. Moreover, lower-income families are less likely to have ESI. Only 14 percent of tax units in the bottom quintile have ESI as opposed to 83 percent in the top quintile (figure 7). Consequently, the exclusion is worth only about $160 on average to tax units in the bottom quintile versus $4,700 for tax units in the top quintile (figure 1). The exclusion is less regressive when tax benefits are considered relative to income. Because ESI premiums do not increase proportionally with income (meaning

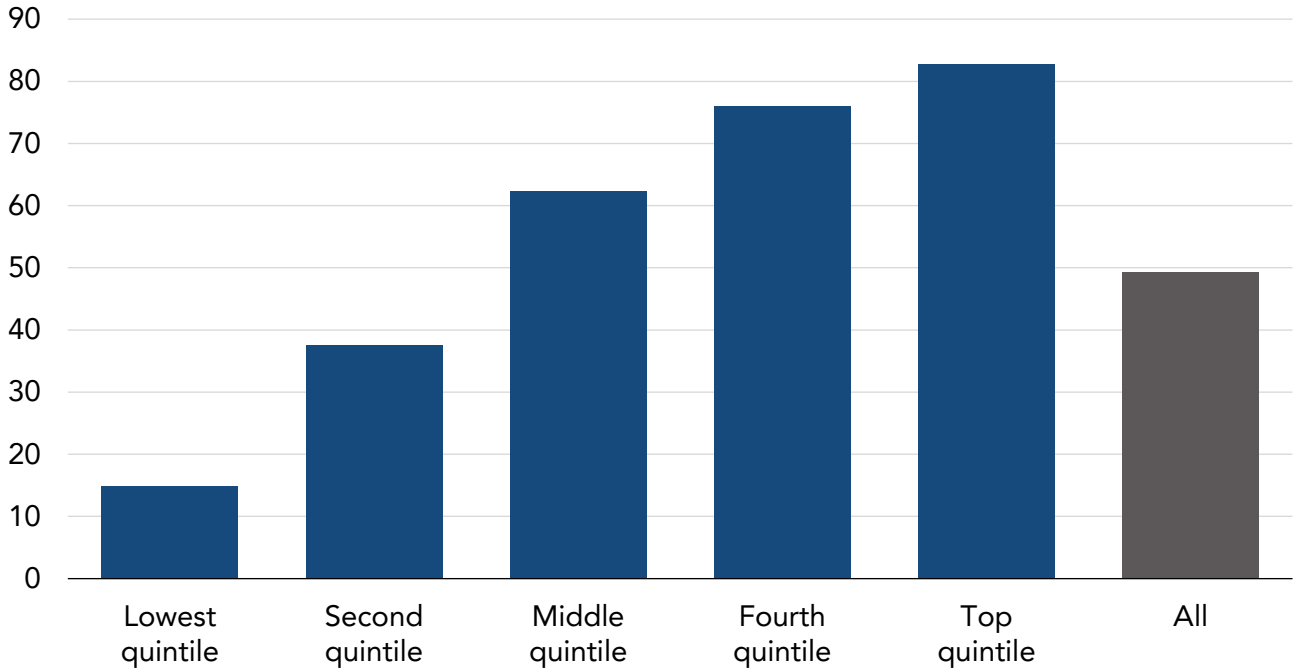
in Social Security benefits would reduce the net subsidy rate for ESI. However, workers may not correctly perceive the connection between covered earnings and future benefits.

premiums generally constitute a smaller share of compensation for high-wage workers), the ESI exclusion increases after-tax income by the largest percentage change for the middle and fourth quintiles (figure 2). Still, although it is not the most regressive tax expenditure, the ESI exclusion is likely less progressive than what policymakers would choose if designing a new subsidy to promote health insurance coverage.

FIGURE 7

Percent of Tax Units with Employer-Sponsored Health Insurance

By expanded cash income quintile, calendar year 2020



Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model.

The exclusion encourages employers to offer coverage, but it may also contribute to higher health care outlays. The 29 percent effective subsidy rate on additional ESI premiums means an employer can provide an additional $1,000 in health benefits at an after-tax cost to employees of $710. Consequently, employers may choose health insurance that covers more services, that has less tightly managed care, or that has lower cost sharing than they would offer otherwise, resulting in greater utilization of health care and higher health care costs in the aggregate. The proliferation of high-deductible health plans in recent years may have reduced this effect to some degree.

Because the ESI exclusion is very expensive in terms of forgone revenue, provides little benefit to lower-income families, and possibly increases health care costs, policy analysts have long suggested limiting it. In fact, the ACA's "Cadillac tax" would have effectively limited the ESI exclusion starting in 2022. The Cadillac excise tax would have equaled 40 percent of the value of employer-provided health benefits exceeding certain thresholds, projected to initially be about the 85th percentile of health benefits (Congressional Budget Office 2018). But the tax, which was originally to take effect in 2018, was twice delayed and ultimately repealed by legislation before ever taking effect.[3] The Joint Committee on Taxation (JCT) projects repealing the tax will cost the federal government $197 billion between 2022 and 2029 (JCT 2019).

[3] H.R. 1865, the Further Consolidated Appropriations Act, 2020 repealed the Cadillac tax and was enacted in December of 2019.

THREE REFORMS TO THE ESI EXCLUSION

Three substantial potential reforms of the ESI exclusion are as follows:

1. Repeal the ESI exclusion starting in 2020. This would generate substantial revenue to reduce the deficit or pursue other policy priorities and eliminate incentives for employers to choose more expensive health plans. But it would also eliminate all incentives for employers to offer ESI.
2. Limit the income and payroll tax exclusion for ESI above the 50th percentile of premiums starting in 2020. The portion of ESI premiums above $7,150 for single coverage and $18,500 for family coverage would be subject to income and payroll taxes. The thresholds would be indexed by health growth to prevent the exclusion from eroding over time. This would both generate government revenue and reduce incentives for higher-cost health plans.
3. Replace the exclusion with a refundable individual income tax credit for ESI coverage starting in 2020. The credit would be $2,275 for single coverage and $5,700 for family coverage in 2020. The credit would be roughly the same value as the average income and payroll tax exclusion and would grow over time with health cost growth. Workers could claim the credit if they receive ESI from their employers that meets certain standards, but the size of the credit would not depend on the cost of the insurance.[4] The credit would be roughly budget neutral by design. It would eliminate subsidies for additional ESI spending while encouraging coverage. It would be more progressive than the current exclusion because the credit would not increase with income and would be refundable for workers without income tax liability.

Impact on Coverage

HIPSM projects repealing the exclusion would reduce ESI coverage by 16 million people, with 3 million switching to Medicaid, 5 million switching to non-group coverage, and 8 million becoming uninsured (table 2). Capping the exclusion at the 50th percentile of premiums would reduce ESI coverage by 8 million people, with 2 million switching to Medicaid, 3 million switching to non-group coverage, and 4 million becoming uninsured. Replacing the exclusion with a credit would create flows in and out of ESI, with a net reduction in ESI coverage of 2 million people. The small net reduction in ESI coverage would be offset by increases in Medicaid and non-group coverage of 1 million people each, resulting in no change in the number of uninsured.

TABLE 2

Impact on Health Insurance Coverage of Reforms of ESI Exclusion

Millions of individuals, calendar year 2020

	Coverage Change			
	ESI	Medicaid	Non-Group	Uninsured
Repeal ESI exclusion	-16	3	5	8
Limit ESI exclusion	-8	2	3	4
Replace ESI exclusion with credit	-2	1	1	-

Source: Health Insurance Policy Simulation Model (HIPSM).
Note: Coverage changes do not always zum to zero because of rounding.

Impact on Deficit

Repealing the ESI exclusion would increase tax revenues by $292 billion in fiscal year 2020, including the impact of changes in health insurance coverage on taxable compensation, the PTC, and employer-mandate penalties and the impact of higher marginal tax rates on reported taxable income (table 3).[5] Repealing the exclusion would also increase

[4] The proposed credit could not be used for non-group coverage.

[5] For these reasons, the revenue estimate of repealing the exclusion differs from the tax expenditure estimate in table 1.

federal Medicaid spending by $16 billion, reducing the federal deficit $276 billion in fiscal year 2020. Limiting the exclusion would increase revenues by $56 billion and increase Medicaid spending by $7 billion, reducing the deficit $49 billion in fiscal year 2020. Replacing the exclusion with a credit would reduce revenues by $13 billion in fiscal year 2020 and increase Medicaid spending by $4 billion, increasing the deficit $17 billion in fiscal year 2020.

TABLE 3

Impact on Deficit of Reforms of ESI Exclusion

Billions of dollars, fiscal year 2020

	Revenue	Medicaid spending	Deficit
Repeal ESI exclusion	292	16	-276
Limit ESI exclusion	56	7	-49
Replace ESI exclusion with tax credit	-13	4	17

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model (HIPSM). Changes in health insurance coverage and Medicaid spending from HIPSM.

Note: Revenue estimates include the impact of changes in health insurance coverage on taxable compensation, the premium tax credit, and employer mandate penalties.

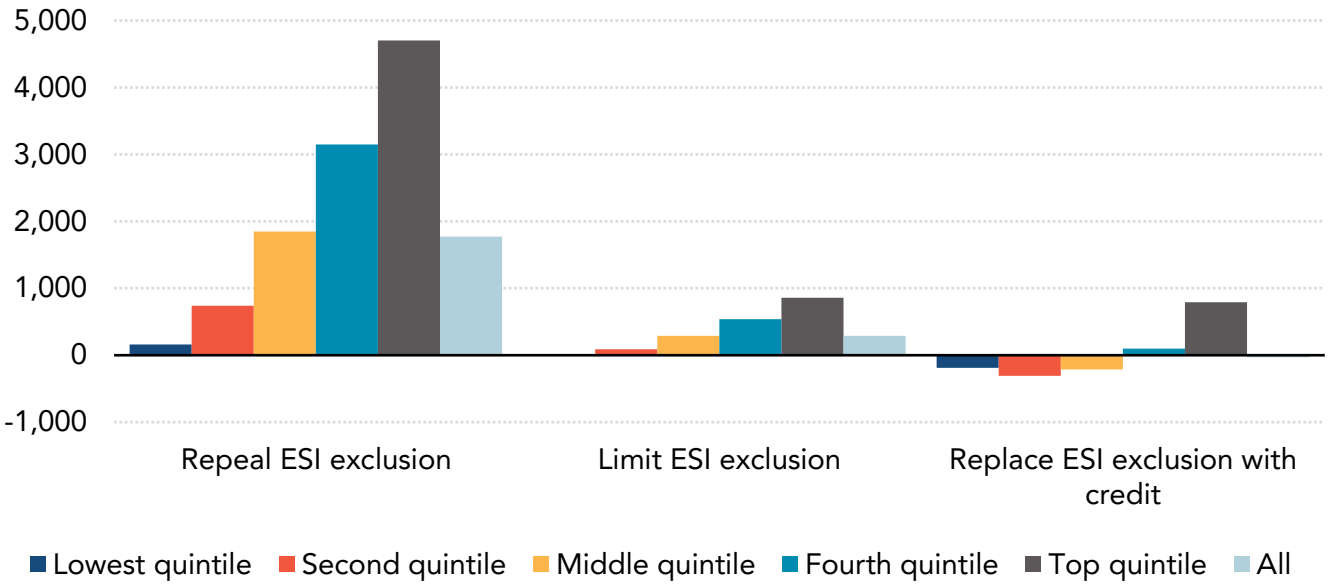
Impact on Distribution of Tax Burden

As discussed, repealing the ESI exclusion would increase taxes more for taxpayers in the top income quintiles of the income distribution and reduce after-tax income the most in percentage terms for the middle and fourth quintiles. Limiting the ESI exclusion follows a similar pattern, increasing taxes by about $10 for taxpayers in the bottom quintile, $290 for the middle quintile, and $860 for the top quintile and reducing after-tax income 0.5 percent for taxpayers in the middle and fourth quintiles while reducing after-tax income only 0.1 percent taxpayers in for the bottom quintile (figures 8 and 9). Replacing the ESI exclusion with a refundable tax credit would reduce taxes for taxpayers in the bottom three quintiles while increasing taxes for those in the top two income quintiles. The tax-credit policy option would increase after-tax income 1.3 percent for the average taxpayer in the bottom quintile and 0.9 percent for those in the second quintile and reduce after-tax income 0.3 percent for taxpayers in the top quintile. Replacing the ESI exclusion with a credit would increase the share of ESI tax expenditures going to taxpayers in the bottom two income quintiles from 12 percent to 18 percent (figure 10).

FIGURE 8

Average Federal Tax Change for Reforms of ESI Exclusion

By expanded cash income quintile, calendar year 2020

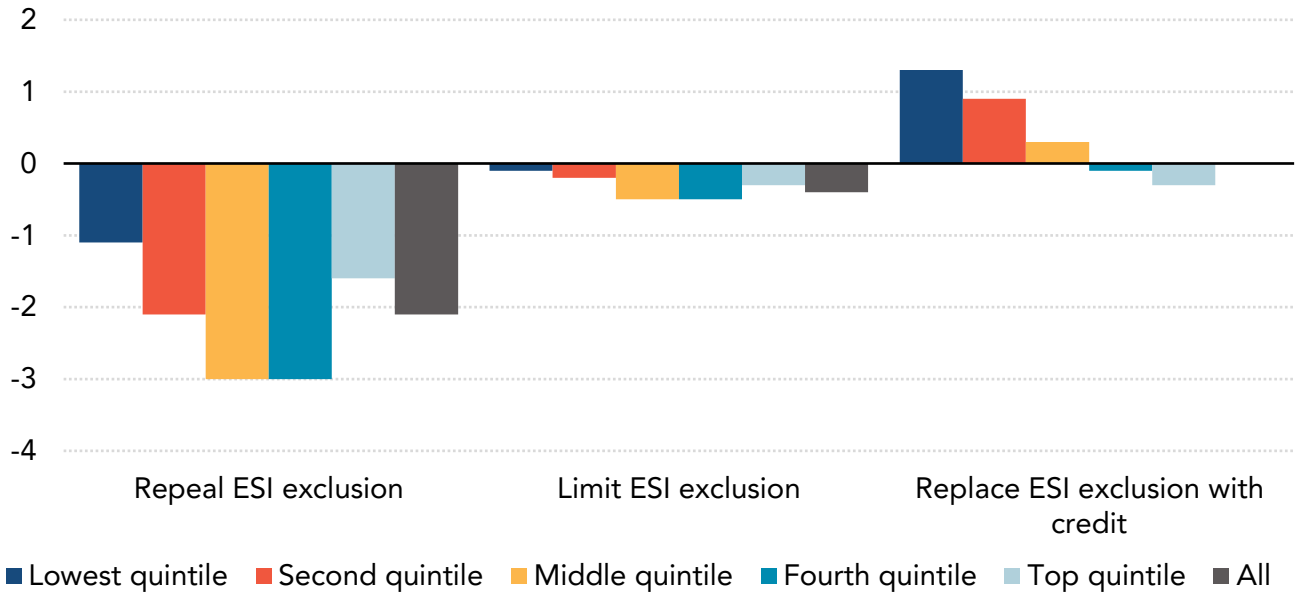


Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model.
Note: Distribution estimate does not include the impact of changes in health insurance coverage.

FIGURE 9

Percent Change in After-Tax Income for Reforms of ESI Exclusion

By expanded cash income quintile, calendar year 2020

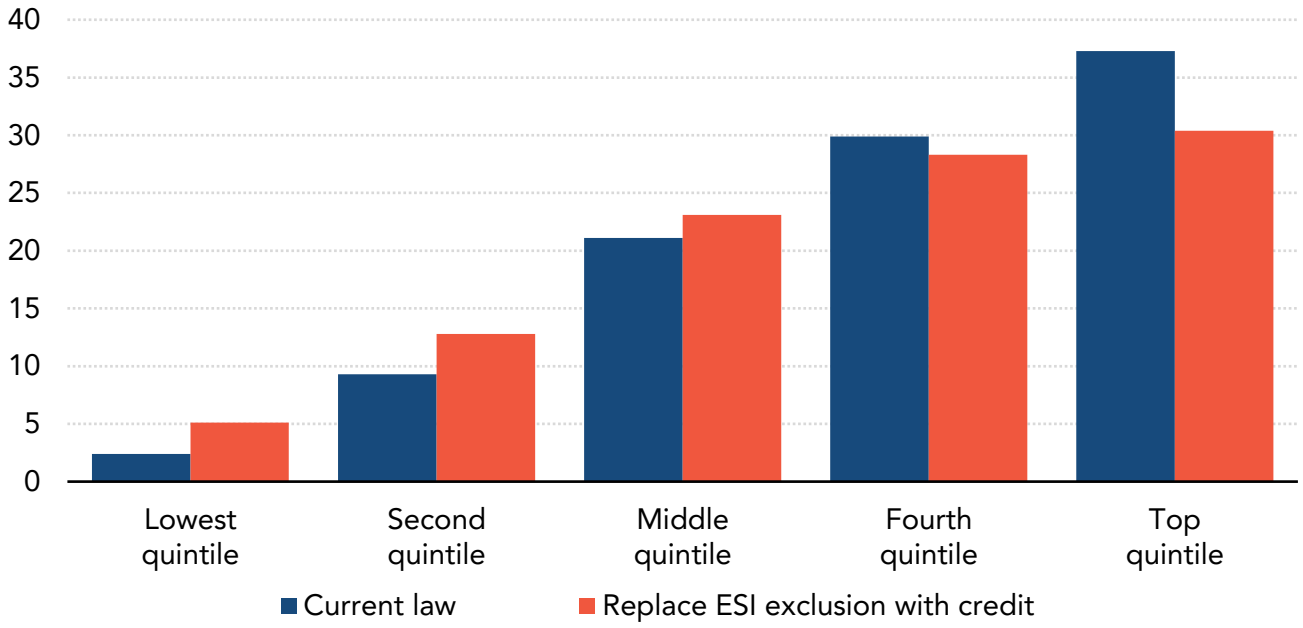


Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model.
Note: Distribution estimate does not include the impact of changes in health insurance coverage.

FIGURE 10

Share of ESI Tax Expenditure Benefits

By expanded cash income quintile, calendar year 2020



Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model.

Impact on Marginal Tax Benefit of Additional Dollar of Health Insurance

Both repealing the ESI exclusion and replacing the exclusion with a credit would eliminate all subsidies for additional ESI spending (table 4). Under the proposed flat credit, however, employers would still have a tax incentive to offer ESI benefits. Limiting the exclusion would cut the effective subsidy rate on additional ESI spending by more than half, bringing it to 12 percent.

TABLE 4

Effective Marginal Tax Benefit of Employer Contributions to Health Insurance Premiums

As a percentage of additional contributions, calendar year 2020

Current law	29
Repeal ESI exclusion	-
Limit ESI exclusion	12
Replace ESI exclusion with credit	-

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319TE-1) with health module based on health insurance coverage from Health Insurance Policy Simulation Model (HIPSM)
Note: Effective marginal tax benefit equals the reduction in income and payroll taxes from shifting $1,000 in compensation from wages and employer payroll taxes into additional employer-provided health benefits divided by $1,000. Tabulation is weighted by initial amount of employer-provided health benefits.

CONCLUSION

The five largest tax expenditures for health are expected to reduce government revenues by $381 billion in 2020. The ESI exclusion is by far the largest of the health tax expenditures. The ESI exclusion is costly, does not benefit low-wage workers very much, and may increase health care costs. The exclusion could be repealed or limited to raise revenue for deficit reduction or policy priorities or restructured as a refundable credit that would be more progressive. The size of the credit could be chosen to be budget neutral or raise funds. All three scenarios would increase incentives for controlling health care costs. Repealing or limiting the ESI exclusion without a new credit would modestly reduce ESI coverage and increase the number of uninsured. Consequently, policy makers might need to combine any net reduction in subsidies for ESI with other proposals to expand health insurance coverage.

REFERENCES

Congressional Budget Office. 2018. *Options for Reducing the Deficit: 2019 to 2028*. Washington, DC: CBO.

Joint Committee on Taxation. 2019. *Estimated Budget Effects of the Revenue Provisions Contained in The House Amendment to the Senate Amendment to H.R. 1865, The Further Consolidated Appropriations Act, 2020*. JCX-54R-19. Washington, DC: Joint Committee on Taxation.

Selden, Thomas M. 1999. "Premium subsidies for health insurance: excessive coverage vs adverse selection" *Journal of Health Economics*, Vol 18, Issue 6, December 1999, Pages 709-725.

Urban-Brookings Tax Policy Center. December 2019. T19-0135 - Income and Payroll Tax Benefit of the Exclusion of Employer-Sponsored Health Insurance, by Expanded Income Cash Percentile, 2020.

———. December 2019. T19-0136 - Tax Benefit of the Premium Tax Credit, by Expanded Income Cash Percentile, 2020.

———. December 2019. T19-0137 - Tax Benefit of Self-Employed Health Insurance Deduction, by Expanded Income Cash Percentile, 2020.

———. December 2019. T19-0138 - Income and Payroll Tax Benefit of Health Savings Accounts, by Expanded Income Cash Percentile, 2020.

———. December 2019. T19-0139 - Tax Benefit of Medical Expense Deduction, by Expanded Income Cash Percentile, 2020.

———. December 2019. T19-0140 - Limit Income and Payroll Tax Exclusion for Employer-Sponsored Health Insurance above 50th Percentile of Premiums, by Expanded Income Cash Percentile, 2020.

———. December 2019. T19-0141 - Replace Employer-Sponsored Health Insurance (ESI) Exclusion with Refundable Tax Credit, by Expanded Income Cash Percentile, 2020.

———. December 2019. T19-0142 - Baseline Effective Marginal Tax Benefit of Employer Contributions to Health Insurance Premiums, by Expanded Income Cash Percentile, 2020.

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