REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-08)
Tax Implications of Eliminating the Employee Income Tax Exclusion for Employer-Sponsored Insurance
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2007 Interim Meeting, the House of Delegates adopted Recommendation 2 of Council on Medical Service Report 5, "Tax Treatment of Health Insurance: Comparing Tax Credits and Tax Deductions," which called for the American Medical Association (AMA) to study the tax ramifications of eliminating the employee income tax exclusion for employer-sponsored health insurance, including the possible impact of both payroll taxes (e.g., FICA and Medicare tax to employees and employers) and individual income taxes at the state, city and county levels. The Board of Trustees referred the study to the Council on Medical Service for a report back to the House at the 2008 Annual Meeting. Council on Medical Service Report 8-A-08, also before the House at this meeting, addresses a broader range of policies related to the tax treatment of health insurance. Together, these two reports are intended to strengthen AMA policy by making it more consistent and filling in policy gaps.

In recent years, the tax treatment of health insurance has attracted growing attention. Like a growing number of proposals to cover the uninsured and rein in rapidly rising health care costs, the AMA proposal seeks to replace the current employee income tax exclusion for employer-sponsored health insurance with federally funded health insurance tax credits targeted toward lower income individuals and families.

Similar to most tax credit proposals, the AMA proposal is silent on whether elimination of the employee income tax exclusion should also extend to federal payroll taxes, and whether state taxes should change in concert with federal taxes. These questions have important implications for businesses, particularly small employers and the self-employed—groups represented by a high proportion of physicians. In general, the potential tax implications of the AMA proposal on employers deserves closer scrutiny to ensure that any unresolved issues are appropriately addressed.

Two-thirds of the existing $180 billion federal tax subsidy results from the federal income tax exclusion, and one-third from the federal payroll tax exclusion. While there are compelling arguments on both sides of the issue, the Council concludes that the disadvantages outweigh the advantages of eliminating the exclusion of employer-sponsored health benefits from federal payroll tax. The main problems with subjecting employee health benefits to federal payroll tax are that doing so would significantly increase the tax burden of low-income workers and employers, while simultaneously generating no additional revenues to fund tax credits.

This report concludes with recommendations to: (1) modify AMA policy to explicitly state that, upon elimination of the income tax exclusion for employer-sponsored health insurance, health insurance expenditures should continue to be exempt from federal payroll tax; (2) advocate that states that eliminate the exclusion of employer-sponsored health insurance from state income tax should be required to use resulting tax revenues for tax credits, vouchers or other coverage subsidies; and (3) support legislation modifying provisions in the US tax code that discriminate against the self-employed by requiring them to pay federal payroll tax on health insurance premiums.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5 - A-08

Subject: Tax Implications of Eliminating the Employee Income Tax Exclusion for Employer-Sponsored Insurance

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Referred to: Reference Committee A (Linda B. Ford, MD, Chair)

At the 2007 Interim Meeting, the House of Delegates adopted Recommendation 2 of Council on Medical Service Report 5, "Tax Treatment of Health Insurance: Comparing Tax Credits and Tax Deductions," which called for the American Medical Association (AMA) to study the tax ramifications of eliminating the employee income tax exclusion for employer-sponsored health insurance, including the possible impact of both payroll taxes (e.g., FICA and Medicare tax to employees and employers) and individual income taxes at the state, city and county levels. The Board of Trustees referred the requested study to the Council on Medical Service for a report back to the House at the 2008 Annual Meeting.

This report describes the existing tax treatment of health insurance, comparing payroll and income taxes, as well as federal, state, and local income taxes; describes the impact of the employee income tax exclusion for employer-sponsored insurance (or the "employee tax exclusion" for short); discusses the tax implications of eliminating the employee tax exclusion; summarizes previous relevant Council on Medical Service reports and AMA policy; and presents several policy recommendations. Council on Medical Service Report 8-A-08, also before the House at this meeting, makes recommendations on a broader range of policies related to the tax treatment of health insurance. Together, these two reports are intended to strengthen AMA policy by making it more consistent and filling in policy gaps.

BACKGROUND

In recent years, the tax treatment of health insurance has attracted growing attention, featuring prominently in numerous health system reform proposals. Like a growing number of proposals to cover the uninsured and rein in rapidly rising health care costs, the AMA proposal seeks to replace the current employee income tax exclusion for employer-sponsored health insurance with federally funded health insurance tax credits targeted toward lower income individuals and families. Since its inception in 1998, the AMA proposal has evolved into an increasingly detailed, sophisticated, and flexible blueprint for the US to expand health insurance coverage and choice. Similar to most tax credit proposals, however, the AMA proposal is silent on several key policy issues that must be decided before implementation can occur. Specifically, AMA policy is not explicit on whether elimination of the employee income tax exclusion should also extend to federal payroll taxes, nor does it specify whether state income and payroll taxes should change in concert with federal taxes. Both of these questions have important implications for businesses, particularly small employers and the self-employed—groups represented by a high proportion of physicians. In general, the potential tax implications of the AMA proposal for employers deserves closer scrutiny to ensure that AMA policy appropriately addresses any unresolved issues that are found.

EXISTING TAX TREATMENT OF HEALTH INSURANCE

The US tax code contains various provisions designed to encourage the purchase of health insurance, many of which also apply to state and local taxes.

Tax Subsidies for Health Insurance: These provisions effectively lower the individual or family's price for health insurance by lowering the amount of taxes owed. For this reason, such tax provisions are considered tax breaks or tax subsidies. Council on Medical Service Report 5-I-07 contains a detailed description of various tax subsidies for health insurance. Although higher income households generally pay higher taxes than lower income households, they also typically receive bigger health insurance subsidies because existing tax policies effectively reduce premiums more for higher income households than for lower income households.

The Employee Federal Income Tax Exclusion: Employer payment of an employee's health insurance premium does not count as part of the employee's taxable compensation. Because employers' expenditures on premiums are not reported as compensation, they do not appear on the employee's W-2 statement, and are classified as a tax exclusion. Employer premium contributions are excluded from both the employee's income and payroll tax. The federal government taxes higher income households at higher rates than lower income households. Consequently, excluding employer-sponsored health insurance from income tax gives higher income households bigger tax subsidies.

Given the heightened attention to the tax treatment of health insurance in recent reform proposals, it is worth clarifying the difference between a tax exclusion and a tax deduction. From the individual taxpayer's perspective, income tax exclusions and income tax deductions are generally equivalent, each being a type of income tax exemption. The difference between the two is simply administrative. A tax exclusion is never reported as income, whereas a tax deduction is reported as—but subsequently subtracted from—gross income, resulting in lower taxable income and, in turn, lower income taxes.

Employer vs. Employee Shares of Premium: In most cases, both the employee and employer shares of premium are excluded from both the employee's income and payroll tax, and both shares are deductible by the employer as a business expense and excluded from the employer's payroll tax. More than 60% of employers arrange for employees' shares, typically 20 to 30% of premium, to be paid through a Section 125 cafeteria plan using withheld, pre-tax wages (Kaiser Family Foundation/Health Research and Education Trust, Annual Survey of Employer Health Benefits, 2007). Virtually all large firms process employee premium payments this way but, because the administrative burden of establishing a Section 125 cafeteria plan is prohibitive for many small employers, employees of small firms are much less likely to benefit from such arrangements.

State and Local Income Taxes: Most states conform to the federal tax code with respect to what expenses are exempt from income tax. Thus, in most cases, employer-sponsored insurance is excluded from the employee's state income taxes. Like the federal government, most states tax higher income households at higher rates than lower income households. The state income tax exclusion gives employees a relatively modest tax break because state income taxes are lower than federal income taxes, ranging from a flat 3% in Illinois to 10.1% for the highest income households in California. Seven states have no state income tax (Alaska, Florida, Nevada, South Dakota, Texas, Washington, and Wyoming), and another two states tax only dividend and interest income

(New Hampshire and Tennessee). In these states, there is no additional tax benefit for employer-sponsored coverage beyond the federal tax exclusion.

Some states allow cities or counties to impose additional income tax on residents and/or non-residents employed in the locality. Overall, income tax plays a relatively small role in local tax revenues, which primarily consist of property and sales taxes. Detailed information on local income taxes is not readily available. However, data show that 20% of all tax revenue (income, property, sales, business, etc.) was collected by local governments, compared to 30% for states and 50% for the federal government (US Census Bureau, 2007).

Payroll Taxes: Health insurance obtained through an employer is excluded from federal payroll tax as well as income tax. Established by the Federal Insurance Contributions Act (FICA) as part of the Social Security Act of 1935, the payroll or FICA tax consists of two parts, which are used to fund the Social Security and Medicare Part A trust funds. Employees and employers each pay 6.2% of the employee's gross wages or salary, up to a cap, toward the Social Security portion, also called the OASDI tax (for Old Age, Survivors, and Disability Insurance). No additional Social Security tax applies to wages greater than $102,000 in 2008. In addition, employees and employers each pay 1.45% of wages toward the Medicare portion, also called the Medicare HI tax (for Hospital Insurance), with no cap. Thus, the employee and employer each pay up to 7.65% of wages in Social Security and Medicare payroll taxes. The self-employed pay both the employee and employer shares of the payroll tax, or up to 15.3% of earnings.

Because the Social Security tax is a flat percentage of wages with a cap for employees earning more than $102,000 per year, the payroll tax places a relatively high burden on low income households. For lower income employees, payroll taxes represent a relatively large share of total tax burden. Forty-four percent of households pay more in payroll tax than income tax, including the 30% of households that earn too little to owe income tax (Burman and Leiserson, Urban-Brookings Tax Policy Center *Tax Notes*, April 2007 and Burman et al., Brookings white paper, February 2007). Conversely, the exclusion of employer-sponsored health insurance from payroll tax gives lower-wage employees as much or more tax benefit than higher-wage employees—just the opposite of the income tax exclusion. Thus, the payroll tax exclusion partially offsets the income tax exclusion's disproportionate tax benefit to higher income households.

Taxes on Employers: Like households, businesses are subject to federal income and payroll taxes, as well as other federal, state, and local taxes. The federal income tax rate for businesses ranges from 15% to 39% depending on the firm's revenues. Nationwide, state business income tax rates average 6.6%, ranging from zero in Nevada, South Dakota, and Wyoming to 12% in Iowa (Hodge, Tax Foundation Fiscal Fact No. 119, March 2008). As with personal income taxes, most states use federal taxes as the starting point for determining the taxation of business income. Section 162 of the US tax code allows employers to deduct a wide range of business expenses from business income subject to federal income tax, including expenditures on employee wages and salary (including earnings used to pay employee premium shares through cafeteria plans), health insurance, and other fringe benefits.

For purposes of an employer's federal income tax, all forms of compensation are the same. However, employer payroll taxes apply only to wages and salary, and not to health insurance benefits or other non-monetary compensation. Employer payroll taxes include federal (FUTA) and state (SUTA) unemployment taxes in addition to FICA Social Security and Medicare taxes. Exclusion of fringe benefit expenditures from employer payroll taxes gives employers a financial

incentive to allocate more employee compensation to health and other fringe benefits, and less to wages and salary, than they otherwise would.

Self-Employed Income Tax Deduction: The self-employed file taxes both as individuals and as businesses. Accordingly, they are subject to income tax, business taxes, and both the employee and employer shares of payroll tax. Since 2003, the self-employed have been allowed to deduct 100% of their health insurance premiums from taxable income, and the IRS recently expanded the definition of self-employment for purposes of deducting premiums (IRS Notice 2008-1, January 2008). Unlike ordinary employer premium contributions, however, Section 162(l)(4) of the US tax code prohibits premium expenditures by the self-employed to be tax deductible as a business expense. As a result, premium expenditures by the self-employed are subject to the full 15.3% federal payroll tax. Roughly 10% of the US workforce is self-employed, with another one-quarter employed by small to medium firms (less than 100 emloyees), and two-thirds employed by larger firms (Fairlie, Small Business Administration (SBA), December 2004; and SBA, *Private Firms, Establishments, Employment, Annual Payroll and Receipts by Firm Size, 1988-2005*). By comparison, physicians are much more likely to be self-employed (62% in 1999), small business owners, and/or members of solo or small group practices (Kane, AMA Center for Health Policy Research *Physician Marketplace Report*, February 2004).

IMPACT OF TAX PROVISIONS RELATED TO HEALTH INSURANCE

Policy analysts have identified several major, historical impacts of excluding employer-sponsored health insurance expenditures from taxable income, including the growth of employer-sponsored insurance, access to coverage for those unable to obtain individual market coverage, the growth of third-party payment, job-lock, restricted choice, over-insurance, accelerated health care costs, and, more recently, increased numbers of uninsured. In 1943, when the federal government first ruled that health benefits could be excluded from taxable income, regulations stipulated that health benefits could not exceed 5% of employee wages, a limit that was superseded by legislation in 1954 (Helms, white paper presented at the Brookings Institution, February 2008). The immediate tax implications of the income tax exclusion were relatively inconsequential, given that health insurance costs were a trivial share of employee compensation at the time. Between 1948 and 2006, health benefits as a share of total compensation climbed steadily from 0.3% to 8.3% (EBRI Databook on Employee Benefits, September 2007).

Table 1 shows the total tax subsidy for employer-sponsored health insurance in 2004, broken down by foregone revenues from federal income and payroll taxes, the federal self-employed income tax deduction, and state income taxes. The table helps to illustrate the following key points:

- The total value of "the tax exclusion" was $200 billion in 2004.
- This constitutes a 35% subsidy for the purchase of employer-sponsored health insurance, which totaled $576 billion in 2004 ($200 / $576 = 35%), or a 30% subsidy for all private health insurance, which totaled $658 billion ($200 / $658 = 30%).
- This amount rivals Medicaid and Medicare expenditures, which were $309 billion and $298 billion, respectively, in 2004.
- About 90% of the $200 billion total was due to federal tax and 10% to state tax ($180 billion vs. $21 billion).
- The federal exclusion ($180 billion) was three times the federal homeowner mortgage interest income tax deduction in 2004 ($62 billion).

- About two-thirds of the $200 billion total was due to income tax and one-third to payroll tax ($135 billion vs. $66 billion).
- Of the subsidy due to federal payroll tax, roughly 80% is from the Social Security trust fund ($52.2 billion), and 20% from the Medicare Part A trust fund ($14.2 billion).

Table 1. Foregone Tax Revenue / Tax Subsidy for Employer-Sponsored Health Insurance Resulting from its Exclusion from Employees' Federal Income Tax ($ billions, 2004)

Federal ($180 billion)	
Income tax exclusion	$109
Payroll tax exclusion	$66
Self-employed income tax deduction	$5
State income tax exclusion	$21
TOTAL	$200

Source: Adapted from Sheils and Haught, *Health Affairs*, February 2004.
Notes: Total does not equal sum due to rounding. Federal income tax exclusion includes employee premium shares paid through Section 125 cafeteria plans, and includes both active employees ($101 billion) and retirees ($7.5 billion). Payroll tax exclusion includes both Social Security OASDI tax ($52 billion) and Medicare HI tax ($14 billion). Does not include HSA and HRA account contributions.

Table 2 shows the distribution of the $180 billion federal tax subsidy for employer-sponsored health insurance across households of various income levels for 2004. On average, higher income employees receive larger tax breaks on their employer-sponsored coverage compared to lower income employees—$2,780 for those with annual income greater than $100,000 compared to $725 for those earning less than $50,000 per year (with median income equal to $44,389). Higher income households receive larger coverage subsidies primarily because they are in higher tax brackets, but also because they are more likely to have employer-sponsored health insurance, and are more likely to be enrolled in more expensive health plans.

Table 2. Distribution of the $180 Billion Federal Tax Subsidy Resulting from the Exclusion of Employer-sponsored Health Insurance from Employees' Federal Income and Payroll Taxes (2004)

Household Income	Average Subsidy	Share of Tax Subsidy	Share of Households
Less than $50,000 (median = $44,389)	$725	28%	58%
$50,000 to $99,999	$2,304	45%	29%
$100,000 or more	$2,780	27%	14%
TOTAL	$1,482 (median subsidy)	100.0%	100.0%

Sources: Adapted from data in Sheils and Haught, *Health Affairs*, February 2004; DeNavas-Walt et al., US Census Bureau Current Population Report No. P60-229, August 2005.
Note: Median income was $44,389 in 2004.

In 2004, nearly three-quarters of the federal income and payroll tax exclusion (27% + 45%) went to the less than half of all households with annual incomes above $50,000 (14% + 29%). Conversely, little more than a quarter of the subsidy (28%) was spread across the lowest earning 58% of households. For this reason, the tax exclusion for employer-sponsored coverage is considered to be inefficiently targeted, with relatively little subsidy reaching those most likely to be uninsured, those with lower incomes.

Table 3 illustrates the opposite effects of the federal income and payroll taxes. The table shows how much employees' taxes are reduced by the exclusion of $10,000 in health insurance premiums from taxable wages and income. As the income tax bracket goes up from 10% to 35%, the dollar value of the income tax exemption increases from $1,000 to $3,500, whereas the value of the payroll tax exemption decreases from $765 to $145. Overall, the tax benefits of the federal tax exclusion for employer-sponsored health insurance is still skewed toward those with higher incomes (increasing with income from $1,765 to $3,645), but less so than for the federal income tax exclusion alone. The last column of the table shows that the relative importance of the payroll tax exclusion diminishes as income rises. Regardless of income, the payroll tax exclusion is of no benefit to the self-employed, who must pay the full payroll tax on income used for health insurance premiums.

Table 3. Tax Subsidy to Employees Resulting from the Exclusion of $10,000 in Health Insurance from Federal Income and Payroll Taxes

	Subsidy from Tax Exclusion			**Subsidy from payroll tax exclusion as % of total**
Income tax bracket	**Income tax**	**Payroll tax**	**Total**	
10%	$1,000	$765	$1,765	43%
15%	$1,500	$765	$2,265	34%
25%	$2,500	$145	$2,645	5%
28%	$2,800	$145	$2,945	5%
33%	$3,300	$145	$3,445	4%
35%	$3,500	$145	$3,645	4%

Source: Employee Benefits Research Institute (EBRI) Issue Brief No. 294, June 2006.
Note: Based on 2005 data for married couples filing jointly. Assumes that household wages exceed the Social Security wage cap ($90,000 in 2005) for all employees in the 25% and higher tax brackets.

TAX IMPLICATIONS OF ELIMINATING THE TAX EXCLUSION

Eliminating the employee income tax exclusion for employer-sponsored health insurance will have different tax implications for individuals and families, employers, and federal and state governments. Proposals to restructure the tax treatment of health insurance, including the AMA proposal, do not seek to eliminate the tax exclusion for employer-sponsored heath insurance in isolation, but rather, in conjunction with new forms of coverage subsidies such as tax credits or tax deductions, and through incremental steps rather than wholesale elimination. Accordingly, the full tax implications of eliminating the tax exclusion depend critically on the following factors:

- Whether exclusions from state and local taxes would also be eliminated;
- Whether the exclusion from federal payroll (FICA) taxes would also be eliminated, and if so, for employees, employers or both;

- Whether the income tax deduction of health insurance for the self-employed would also be eliminated;
- Whether consideration is given to secondary effects that, while beyond immediate tax implications, are clearly identifiable and important, for example, changes in coverage, wages, and employment;
- What new tax subsidies would also be introduced (e.g., tax credits, vouchers, and/or tax deductions for individually purchased insurance); and
- Whether the tax exclusion is eliminated abruptly, phased out or limited.

Implications for Individuals and Families: For individuals and families, the effects of eliminating the employee income tax exclusion for employee health benefits would be similar for federal and state income taxes, but of smaller magnitude at the state level. The direct implications to households of eliminating the income tax exclusions would be to:

- Raise taxes for those with employer-sponsored coverage, by roughly $109 billion in aggregate for federal income tax and $21 billion for state income taxes;
- Raise taxes by greater dollar amounts for those with higher incomes—though generally by a smaller percentage of income compared to those with lower incomes;
- Shift the distribution of government transfers (government benefits minus taxes) from higher income households to lower income households;
- Effectively raise the price of health insurance relative to other goods and services, and for employer-sponsored insurance relative to individually purchased insurance; and
- Have no direct impact on those without employee coverage.

Eliminating the federal payroll (FICA) tax exclusion would:

- Further raise taxes for those with employer-sponsored coverage, by at least $33 billion (half of $66 billion) in aggregate;
- Raise taxes by greater amounts for those with lower incomes, imposing significant new tax burdens on low income employees in absolute dollar terms and as a percentage of income;
- Partially shift the distribution of government transfers (government benefits minus taxes) back toward higher income households;
- Further raise the effective price of health insurance relative to other goods and services, and employer-sponsored insurance relative to individually purchased insurance; and
- Provide employees with larger Social Security benefits upon retirement, to the extent that they contribute more in Social Security payroll taxes while working.

In the absence of additional coverage subsidies, eliminating the income and/or payroll tax exclusion for employee coverage would also lead some currently covered employees to:

- Pressure employers for higher wages to offset the effective loss of compensation;
- Switch to individually purchased insurance;
- Seek less comprehensive coverage in order to keep premiums down, creating pressure for insurers to offer better-value coverage options, which over time would reduce over-insurance and rein in health care cost inflation;
- Drop coverage, driving up the number of uninsured, at least in the short-term; and/or
- Switch jobs, change the number of hours worked or drop out of the workforce.

Replacing the income tax exclusion for employee coverage with tax credits following AMA Principles for Structuring Tax Credits (Policy H-165.865, AMA Policy Database) would:

- Lower taxes for those with lower incomes, effectively lowering their price for insurance;
- Increase taxes for those with higher incomes, effectively increasing their price for insurance;
- Shift the distribution of government transfers (government benefits minus taxes) from higher income households to lower income households;
- Lower the relative price of individually purchased health insurance, and increase the relative price of employer-sponsored insurance, inducing a net shift toward individually purchased insurance;
- Induce some previously uninsured people to purchase insurance, especially at lower incomes;
- Induce a smaller number of previously insured people to drop coverage, especially at higher incomes;
- On net, decrease the number of uninsured;
- Make premiums more affordable by reducing the burden of uncompensated care for the uninsured that is borne indirectly through higher premiums $922 higher for a family policy and $341 for a single policy in 2005 (Families USA Publication No. 05-101, July 2005);
- Reduce the burden of uncompensated care paid directly through taxes;
- Make people more sensitive to the price of insurance, prompting them to seek less comprehensive coverage, and creating pressure for insurers to offer more cost-effective coverage options; and
- Increase job mobility and coverage stability.

Implications for Employers: There would be no direct tax implications of eliminating the federal and/or state employee income tax exclusion for health benefits for employers who make no changes in the level or composition of employee compensation. Whether in the form of employer-sponsored, defined benefit health insurance or defined dollar contributions toward employee purchased health insurance, employers' health benefit expenditures would continue to be deductible business expenses, not subject to business income tax. Furthermore, employers' health benefit expenditures would continue to have the direct advantage of being excluded from employer payroll taxes. Although eliminating the employee income tax exclusion would have no direct tax implications for employers, employers might respond because of the impact on employees. From the employee's perspective, there would be a near-leveling of the tax treatment of employer-sponsored health insurance and individually purchased coverage, and of health benefits and wages. Thus, employers might shift compensation from health benefits to salary and wages. However, employers who are contemplating reducing or dropping health benefits would have to consider any offsetting wage increases that would be necessary to retain and attract employees, and the fact that such wages would be subject to payroll tax for both the employer and the employee.

Eliminating the exclusion of health benefits from payroll taxes would have direct tax implications for employers. Employers would pay higher payroll taxes regardless of any reallocation of compensation, so long as they maintained the same overall level of compensation spending. The direct tax advantage to employers of providing health benefits in lieu of wages would be lost, resulting in a greater shift from health benefits to wages.

Replacing the employee income tax exclusion (but not the payroll tax exclusion) with appropriately structured tax credits would have no direct tax implications for employers. While some employers might shift compensation toward wages, small employers and employers of low-wage workers in particular could become more willing to offer employee health benefits once employees are

equipped with tax credits to help pay premiums. Providing uninsured workers with health insurance coverage would also impact employers by increasing worker productivity.

Implications for the Self-Employed: The self-employed income tax deduction for health insurance was enacted to level the playing field between employees hired by firms and the self-employed. If the employee federal and/or state income tax exclusion for employee health coverage were to be eliminated, the self-employed income tax deduction for health insurance would likely be repealed as well. Alone, this change would reduce the ability and incentives for the self-employed to obtain coverage, increasing the number of uninsured. In contrast, revoking the payroll tax exclusion for health benefits would not impact the self-employed, because they currently are not entitled to exclude premiums from payroll tax. Replacing the employee income tax exclusion with tax credits inversely related to income would raise taxes for some self-employed individuals and lower it for others, similarly, raising the relative price of insurance in some cases and lowering it in others, depending on household income and details of the tax credit. As for other individuals and households, reducing the number of uninsured and the amount of uncompensated care would reduce the burden self-employed workers bear through higher premiums and taxes.

Implications for Government: Simply eliminating the tax exclusion of health benefits from income tax would increase federal and/or state income tax revenues, though probably not by the full amounts shown in Table 1, because people would respond to the tax increase by spending less on health insurance, either declining to purchase it or choosing lower-cost coverage. Increased income tax revenues collected by the federal government and/or states could go a long way toward financing health insurance tax credits. Subjecting employee health benefits to payroll tax would create a substantial tax transfer from households and businesses to the Social Security and Medicare trust funds, but would not generate any additional funds that could be used to finance health insurance tax credits. If tax credits or vouchers were to be introduced along with the elimination of tax exclusions, government expenditures on tax credits would offset increased tax revenues, the net effect depending on details of the reforms. In addition, reduced public program expenditures could somewhat offset increased tax credit expenditures to the extent that tax credit recipients leave Medicaid and SCHIP, or apply credits or vouchers to coverage of their choice within these programs.

Implications of Phasing Out or Limiting the Tax Exclusion: Phasing out tax exclusions for employer-sponsored health insurance would enable numerous, interacting transitions to play out in a relatively undisruptive manner. Households, business, government, and the health care industry would have greater opportunity to navigate changes and make decisions in an informed, deliberate manner while health insurance and employment markets equilibrate and evolve. In its final November 2005 report, the President's Advisory Panel on Federal Tax Reform proposed the incremental step of limiting the amount of employer-sponsored health insurance premium that can be excluded from employees' incomes to $11,500 for families and $5,000 for single employees.

AMA POLICY AND ANALYSES

Long-standing policy underlying the AMA proposal to expand health insurance and choice advocates that the current employee income tax exclusion for employer-sponsored coverage ultimately be replaced with federally funded tax credits or vouchers to individuals and families for the purchase of health insurance. Two of the major rationales for replacing the tax exclusion with tax credits are that the tax exclusion is socially inequitable, and that removing the tax exclusion would generate tax revenue that could be used to finance tax credits. The tax exclusion is seen as

inequitable because only those whose employers offer health insurance are eligible for it, and it provides a bigger tax break to employees in higher tax brackets (i.e., those with higher incomes). As previously noted, nearly three-quarters of the tax exclusion (federal and state) went to households with annual incomes above $50,000 in 2004. By comparison, tax credit eligibility as proposed by the AMA would not depend on employment, and the size of tax credits would be inversely related to income, providing more assistance for obtaining coverage to those who most need it, those with lower incomes. Additional rationales include removing the preferential tax treatment of employer-sponsored coverage; expanding individual choice beyond employers' plan offerings; reducing "job lock," whereby employees refrain from switching to otherwise more desirable jobs in order to maintain coverage; and reducing discontinuities in coverage due to job changes or employer switching of health plans.

The Council emphasizes that AMA policy does not call solely for the elimination of the employee income tax exclusion, but rather that the employee tax exclusion be replaced with appropriately structured tax credits. Similarly, AMA policy supports incremental replacement of the tax exclusion with tax credits, such as capping the amount of premium that may be excluded from taxes, which would be less disruptive than eliminating the exclusion overnight. The body of AMA policy on the tax treatment of insurance evolved as the House adopted the recommendations of the following Council on Medical Service reports:

- Council on Medical Service Report 9-A-98, "Empowering Our Patients: Individually Selected, Purchased and Owned Health Expense Coverage," which contained 17 principles, including support for replacing the existing employee income tax exclusion of employer-sponsored health insurance with individual tax credits for the purchase of health insurance (Policy H-165.920[11], AMA Policy Database). Another principle advocates that employment based health insurance continue to be available to the extent that the market demands it, rather than in response to preferential tax treatment (Policy H-165.920[5]).

- Council on Medical Service Report 4-A-00, "Principles for Structuring Health Insurance Tax Credits," which included the principles that tax credits should be inversely related to income, refundable to those who owe little or no income tax, available in advance, and contingent on the purchase of health insurance (Policy H-165.865).

- Council on Medical Service Report 5-A-02, "Impact of Eliminating the Current Threshold for Deductibility of Medical Expenses," which considered, but did not support, the elimination or reduction of the restriction that only medical expenses in excess of 7.5% of adjusted gross income can be tax deductible.

- Council on Medical Service Report 4-I-04, "Options for Implementing and Financing Tax Credits for Individually Selected and Owned Health Insurance," which supported incremental steps toward replacing the employee tax exclusion with tax credits, such as targeting tax credits to specific populations such as children or the chronically ill, and capping the amount of premium that may be excluded from employee income tax (Policy H-165.851).

- Council on Medical Service Report 5-I-07, "Tax Treatment of Health Insurance: Comparing Credits and Tax Deductions" studied the pros and cons of encouraging individual ownership of health insurance through both tax deductions, which would extend equivalent tax treatment of employer-sponsored insurance to individually purchased insurance, and tax credits. Based on the analysis in the report, the House adopted policy supporting the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage (Policy H-180.951[1]).

In late 2007, the AMA issued a series of advocacy publications articulating AMA policy underlying the AMA reform proposal. The series, available at www.VoiceForTheUninsured.org, includes two summaries that explain the current and proposed tax treatment of health insurance, "How the government currently helps people buy health insurance: The employee tax break on job-sponsored insurance" and "Illustration of how tax credits or vouchers would affect households."

AMA policy is silent on whether elimination of the employee income tax exclusion should: (a) extend to payroll taxes as well as income tax; and (b) be restricted to federal income tax, or apply to employees' state and local income taxes as well. Although payroll tax is distinct from income tax under the US tax code, the distinction is not necessarily well understood. Payroll taxes are mentioned only in Policy H-165.920[3], which advocates tax parity for employer expenditures on defined contribution and defined benefit coverage, "including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes." This policy suggests that under the AMA proposal, health insurance expenditures would continue to be excluded from federal payroll tax.

AMA policy repeatedly calls for changes to the federal tax code, federally funded and/or issued tax credits, or an end to federal discrimination against individually purchased insurance. In some policies, the tax in question is unspecified, but often implied by context to be federal. While AMA policy is clearly intended to reform the federal tax treatment of health insurance, it is not explicit on state tax treatment of health insurance.

DISCUSSION

Since the AMA established its reform proposal more than a decade ago, the tax treatment of health insurance has taken center stage in health policy discussions. Today, there is much more widespread understanding of, and consensus on, the existing tax subsidy for health insurance and its pernicious effects on growth of the uninsured and health care costs. Proposals to replace the existing employee income tax exclusion for employer-sponsored coverage with health insurance tax credits that are inversely related to income have gained momentum, garnering growing bipartisan support. Tax credit proposals such as the AMA proposal would expand health insurance coverage and choice by redirecting existing coverage subsidies toward those most likely to be uninsured, those with low incomes, and by leveling the playing field between employer-sponsored insurance and individually purchased insurance. Like most tax credit proposals, the AMA proposal is silent on whether elimination of the employee tax exclusion would be limited to federal income tax, or whether employee health benefits would also become subject to federal payroll (FICA) tax and/or state income taxes. These questions have important implications for businesses, particularly small employers and the self-employed—groups represented by a high proportion of physicians.

Nine-tenths of the existing $200 billion tax subsidy results from the exclusion of employer-sponsored coverage from federal taxes, and one-tenth from state taxes. Most states default to the federal tax code with respect to which expenses are tax exempt. If states continued to do so, and the federal government were to replace the federal tax exclusion with tax credits, then employer-sponsored health insurance would become subject to state as well as federal income tax. This would result in a tax increase to households, additional state tax revenues, and a more complete leveling of the playing field between individually purchased and employer-sponsored insurance. In theory, the additional state tax revenues could help finance tax credits, partially or fully offsetting the tax increase to households as a group. However, the Council on Medical Service has serious concerns about the difficulty of ensuring that states use this new revenue for health care subsidies rather than other purposes (e.g., balancing budgets, roads, bridges). The Council refrains from advocating that states eliminate the exclusion of employer-sponsored health insurance from state income tax, but does advocate that when states opt to do so, any resulting state tax revenues should be used to help fund health insurance tax credits or vouchers for use by individuals and families.

Two-thirds of the existing $180 billion federal tax subsidy for employer-sponsored health insurance results from federal income tax, and one third from federal payroll tax. There are compelling arguments on both sides of the issue of whether to eliminate the tax exclusion of employee health benefits from federal payroll tax as well as federal income tax. Advantages include the following:

- Consistency and administrative simplicity;
- Full tax parity between individually purchased and employer-sponsored health insurance;
- Full tax parity between the self-employed and those with employee coverage; and
- Increased revenues into the Social Security and Medicare Part A trust funds.

Disadvantages of eliminating the exclusion of employer-sponsored health insurance from federal payroll tax include:

- No additional revenues available to finance health insurance tax credits;
- Additional tax increase for employees with employer-sponsored coverage;
- Additional tax burden falls disproportionately on those with low incomes;
- Tax increase for employers offering employee coverage; and
- More abrupt disruption to employer-sponsored health insurance and labor markets.

The Council believes that these disadvantages outweigh the advantages of eliminating the exclusion of employer-sponsored health insurance from federal payroll tax, and that the major advantages can still be achieved through other means. The main problems with subjecting employee health benefits to federal payroll tax are that doing so would significantly increase the tax burden of low-income workers and employers, while simultaneously generating no additional revenues for tax credits. The Council also believes that full tax parity for the self-employed can and should be achieved through separate changes to the US tax code, and that in any case, parity would be more readily achieved by reducing payroll taxes of the self-employed than by increasing them for employees. In addition, allowing employer-sponsored health insurance to retain a modest tax advantage, at least initially, has the important advantage of making implementation of proposed changes less disruptive.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of this report be filed:

1. That our American Medical Association (AMA) amend Policy H-165.920[11] by insertion to read as follows: "(11) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax. " (Modify Current HOD Policy)

2. That our AMA advocate that, upon replacement with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies. (New HOD Policy)

3. That our AMA support legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures. (New HOD Policy)

Fiscal Note: Staff cost estimated to be less than $500 to implement.

References for this report are available from the AMA Division of Socioeconomic Policy Development.