

Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible?

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Executive Summary

Employer payments for health insurance are exempt from income and payroll taxes. Some policymakers propose limiting the amount of such payments that receive favorable tax treatment, arguing that capping the employer exclusion would both reduce companies' incentive to offer very generous coverage and raise revenue to finance subsidies for the uninsured.

However, if the application of such a cap is determined by the premiums paid for employer-sponsored insurance (ESI), the generosity of coverage will not be the only factor that determines whether benefits are taxed as income. Because of geographic differences in health care costs, premiums for the same benefits can more than double when an individual crosses state lines. Workers' age, company size, and the categorization of dependent coverage can likewise change premiums, even if benefits remain fixed. Here are examples of the resulting inequities under a leading 2005 proposal, from the President's Advisory Panel on Federal Tax Reform, which would count as taxable income ESI premiums to the extent they exceed the national average for single or family coverage:

- At firms where at least 60 percent of workers are age 50 or older, 41.2 percent of employees would be taxed on their health benefits. Where fewer than 20 percent of employees are 50 or older, only 16.0 percent of workers would be taxed.
- At small firms with fewer than 10 employees, 29.7 percent of workers would see their benefits taxed, compared with 17.4 percent at companies with 1,000 or more employees.
- 41.3 percent of workers with family coverage would pay taxes on their health insurance. By contrast, only 19.5 percent of enrollees in worker-only ESI would be subject to taxation.

This paper explores a way to cap the tax exclusion that avoids these inequities. Benefits would be taxed based on their generosity, not on premiums. Such generosity would be measured by actuarial value, which is the claims costs that actuaries estimate would result if a nationally representative population received the covered benefits. Utterly irrelevant would be geographic variation in health care costs, the age of workers at a particular firm, the company's size, and whether workers have family or individual coverage.

Actuarial value already plays a major role in defining covered benefits for the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA), the Children's Health Insurance Program, and prescription drug coverage under Medicare Part D. In addition, employer-sponsored group life insurance is excluded from taxation only up to a capped level, and the taxable value of a given employee's benefits is determined by imputation, rather than employer cost.

If an actuarial value cap for ESI had the Internal Revenue Service (IRS) develop comprehensive and detailed guidelines for actuarial valuation using a nationally representative enrollee population, the ability of employers to "game" the system would be greatly limited. At the same time, employers' administrative burdens would be kept to a minimum. Insurers could calculate the actuarial value of each product they sell to firms, since that value would be the same for all purchasing employers. Further, for typical benefits, actuarial value could be calculated, without any need to hire an actuary, based on decision rules published by IRS.

A disadvantage of this approach is that employers would not receive any tax advantages from lowering costs through methods other than reducing benefits. Such methods could include using

restrictive provider networks, bargaining effectively with insurers, or improving workers' health by encouraging exercise on the job.

Of course, employers have powerful incentives to lower health care spending under current law, even though such reductions yield no tax advantages. Those same incentives would continue under an actuarial value cap. But it could be seen as inequitable to tax workers at the same level, based purely on covered benefits, without reducing tax burdens when their employers apply effective methods of cost control.

Another approach to avoiding the inequitable application of a tax cap would adjust employer premiums to compensate for objective factors like firm size, industry of employment, and each covered worker's age, gender, and area of residence. However, these adjustments would not fully account for health status, which has a major impact on health care spending. As a result, if a company's covered workers, dependents, and retirees tend to be disproportionately unhealthy, the employees of that company would be more likely to pay taxes on covered benefits. This effect could be particularly troublesome if, at a particular company, a small number of enrollees happened to experience major accidents or costly illnesses, substantially increasing premiums and average health care costs at the firm. This could subject all covered employees to higher tax liability.

Neither actuarial value caps nor premium adjustments would be easy to explain (though the actuarial value approach would probably be more difficult). Each approach would require administrative agencies to develop complex formulas but could be structured to avoid major new administrative burdens on employers.

Put simply, if policymakers wish to cap the amount of the employer exclusion without creating serious inequities, no perfect solution is available. But reasonable solutions appear feasible.

Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible?

Employee compensation provided as health insurance is exempt from federal payroll and income taxation. No limit applies to this tax exclusion. For decades, many observers have criticized the absence of any limit as encouraging employers to provide unduly generous coverage, which increases health care use. Others note that the exclusion's largest benefits go to the affluent, who pay the highest marginal tax rates and who tend to receive the most generous health benefits.

Such legislative leaders as Chairman Baucus of the Senate Finance Committee and Senators Wyden and Bennett have suggested capping the amount of this exclusion. Caps have been proposed both to reduce the cost of employer-sponsored insurance (ESI) and to obtain revenue needed to cover the uninsured.

The most straightforward approach would define the tax-exempt amount of coverage in terms of premiums. But that would create serious inequities. Premiums (and claims paid by self-insured employers) are affected by many factors other than the generosity of covered benefits, such as local variation in health care costs, the age and health status of employees at the firm, the size of the company, state small-group rating rules, and so on.

This report asks whether such inequities can be avoided by using the actuarial value of covered benefits to decide whether ESI exceeds the cap. This approach would focus higher taxation on unusually comprehensive benefits, defined in a way that is not affected by any other factor, including the characteristics of a firm's workforce, the size of the company, family versus individual coverage, or geographic variations in health care costs.

The paper begins by exploring how a premium-based cap would work, analyzing potential inequities as well as administrative complexity and the potential for some employer circumvention. It then defines actuarial value and provides several examples of how this and similar concepts are used in major health care programs and in tax law. Based on that background, the paper explains how policymakers can apply actuarial value to define the maximum amount of ESI that is exempt from taxation. The paper also explores an alternative approach to avoiding inequity that would use premiums to determine whether ESI exceeds the cap but adjust those payments to compensate for differences in geography and other factors. The paper concludes that estimating the value of ESI using actuarial value could avoid serious inequities while allowing a cap on the employer exclusion to achieve many of its goals.

Selected issues involving a premium-based cap

In the past, most advocates of capping the employer exclusion have suggested basing the cap on premiums. For example, in November 2005 the President's Advisory Panel on Federal Tax Reform proposed that, in 2006, the employer exclusion should be limited to \$5,000 and \$11,500 for worker-only and family coverage, respectively, which the panel characterized as average premiums for such ESI. The Advisory Panel further proposed that, after 2006, the cap should increase based on general inflation (using the consumer price index for all urban consumers, or CPI-U). If health care cost growth continues to outstrip general inflation, such indexing would shield from taxation an ever-declining proportion of health care spending. Proposals along these general lines pose equity concerns and some administrative complexities.

Equity issues

If the tax exemption is capped based on premiums and health care costs, many factors other than generosity of covered benefits will determine whether and how heavily health benefits are taxed.

Geography. Geographical variation is one important factor that will affect the “bite” of cost-based caps. Local differences in health care costs can dramatically affect premiums, as illustrated by the premium variation in Medigap Plan C. In 2005, premiums for this fixed, nationwide benefits package averaged \$1,204 in New York and \$2,589 in nearby Connecticut (Fronstin 2009).

Table 1 suggests how premium-based caps could affect residents of various states differently. It shows how much average premiums for ESI in each state exceeded the national average in 2006. In 23 states, average benefits were at or below the national average. Many other states exceeded the national average, sometimes considerably. Workers in those states would experience disproportionately heavy federal taxation under a premium-based cap.

At the local level, variation is even more pronounced. Table 2 shows, in the 20 largest metropolitan areas, how much ESI premiums exceed the national average. In cities like New York and Boston, where premiums are particularly elevated, a strictly premium-based cap would impose unusually high tax levels on local residents.¹

Table 1. Amounts by which average premiums for worker-only and family coverage exceeded the national average, by state: 2006

State	Amount in dollars	
	Worker-only	Family
Alabama	0	0
Alaska	421	817
Arizona	162	*
Arkansas	0	0
California	*	*
Colorado	*	*
Connecticut	284	1,035
D.C.	422	881
Delaware	594	1,220
Florida	0	*
Georgia	0	0
Hawaii	0	0
Idaho	0	0
Illinois	*	400
Indiana	0	*
Iowa	0	0
Kansas	0	0
Kentucky	0	0
Louisiana	0	0
Maine	545	982
Maryland	0	*
Massachusetts	330	909
Michigan	328	*
Minnesota	*	*
Mississippi	0	0
Missouri	*	*
Montana	*	*
Nebraska	0	0
Nevada	0	0
New Hampshire	504	1,305
New Jersey	353	852
New Mexico	*	694
New York	487	*
North Carolina	*	0
North Dakota	0	0
Ohio	*	0
Oklahoma	0	*
Oregon	*	*
Pennsylvania	159	413
Rhode Island	477	553
South Carolina	*	0
South Dakota	0	0
Tennessee	0	0
Texas	*	309
Utah	0	*
Vermont	204	*
Virginia	*	*
Washington	*	*
West Virginia	231	*
Wisconsin	*	*
Wyoming	487	706

Source: Author's calculations, AHRQ, 2006 MEPS-IC.

* = the standard error exceeded the difference between the state's average premium and the national average.
 0 = the state premium was below the national average.

Table 2. Amount by which average premiums for worker-only and family coverage exceeded the national average, by metropolitan area: 2006

Metropolitan area	Amount in dollars	
	Worker-only	Family
New York-Northern NJ-Long Island	612	1,363
Los Angeles-Long Beach-Santa Ana	*	*
Chicago-Naperville-Joliet	216	606
Philadelphia-Camden-Wilmington	*	*
Dallas-Ft. Worth-Arlington	*	*
Miami-Ft. Lauderdale-Miami Beach	0	0
Houston-Sugar Land-Baytown	184	857
Washington-Arlington-Alexandria	*	270
Atlanta-Sandy Springs-Marietta	0	*
Detroit-Warren-Livonia	435	*
Boston-Cambridge-Quincy	378	1,177
San Francisco-Oakland-Fremont	326	*
Riverside-San Bernadino-Ontario	0	*
Phoenix-Mesa-Scottsdale	410	742
Seattle-Tacoma-Bellevue	*	620
Minneapolis-St. Paul-Bloomington	0	*
San Diego-Carlsbad-San Marcos	0	*
St. Louis, MO-IL	*	*
Baltimore-Towson	0	*
Tampa-St. Petersburg-Clearwater	*	504

Source: Author's calculations, AHRQ, 2006 MEPS-IC.

* = the standard error exceeded the difference between the metropolitan area's average premium and the national average.

0 = the metropolitan premium was below the national average.

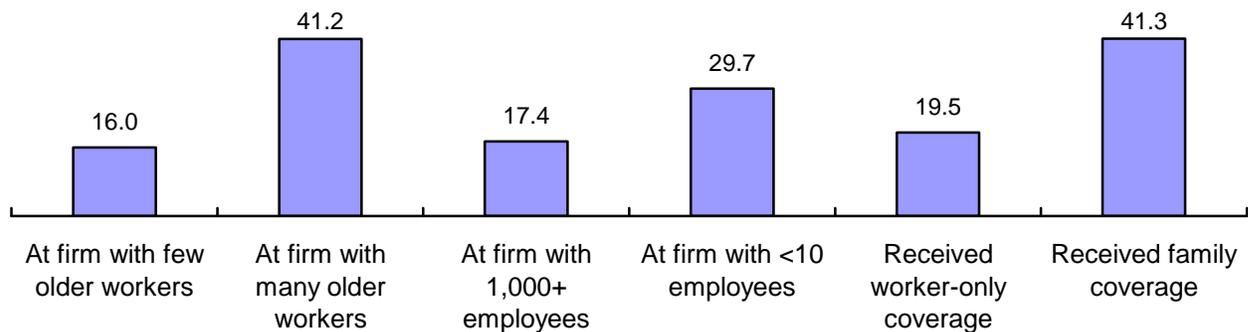
Employee age and health status. In most states, insurers can charge firms different premiums for the same benefits, based on the characteristics of employees at each company. And although self-insured employers do not pay premiums, they pay claims, which likewise vary based on age, health status, and other factors.

According to one recent analysis, the caps on the employer exclusion proposed by the President's Advisory Panel would tax health insurance for 41.2 percent of insured workers at firms where at least 60 percent of workers are age 50 or older. At firms where less than 20 percent of employees are 50 or older, only 16.0 percent would be taxed (figure 1).²

Firm size. The same benefits can cost much more for small companies than for large ones, in significant part because the percentage of premiums that covers insurers' administrative costs is higher in the small- than in the large-group market. As a result, the Advisory Panel's proposed caps would tax 29.7 percent of workers at firms with fewer than 10 employees, compared with 17.4 percent at companies with 1,000 or more workers (figure 1).

Families with children. Depending on the structure of tax caps, families with children can be at an enormous disadvantage. Caps proposed by the Advisory Panel, for example, would tax 41.3 percent of recipients of family coverage. Among workers with single coverage, only 19.5 percent would be taxed (figure 1).³

Figure 1. Percentage of workers receiving ESI who would have been taxed because of a premium-based cap on the employer exclusion, by worker characteristics: 2006



Source: Gould and Minicozzi (2009a).

Notes: This figure shows, for recipients of ESI from their own employers, the application of the tax cap proposed by the President's Advisory Panel on Federal Tax Reform. Firms are classified as having few and many older workers if 50-year-olds make up less than 20 percent and at least 60 percent, respectively, of workers at the company. For firm sizes, this figure shows the extremes of the continuum. The percentage of workers at firms of intermediate sizes who would be taxed on worker-only coverage is as follows: 10–24 employees, 19.2 percent; 25–49 employees, 16.6 percent; 50–99 workers, 19.2 percent; 100–499 workers, 19.4 percent; and 500–999 workers, 24.0 percent.

Administrative complexities

Basing the cap's application on premium payments appears simple. Unfortunately, applying such a cap will involve more complexity than is first evident. Notably, self-insured plans cover 52.8 percent of workers receiving ESI from their employers.⁴ These companies pay health care claims rather than premiums, as indicated above. By the time W-2 statements of income are due in mid-January, self-insured employers do not yet know the costs of claims for the prior calendar year.⁵ Such employers must therefore estimate the value of the coverage they provide to their workers. For example, with premiums for coverage offered to former employees and others under the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA), self-employed firms typically use actuarial valuation to translate estimated claims costs into premium amounts.⁶ In other words, *roughly half of ESI recipients will have the cap applied based on benefit valuation, rather than premium payments, even under an approach that focuses on premiums whenever possible.*

While the Internal Revenue Service (IRS) would presumably develop guidelines for the assumptions used in estimating expected spending while determining whether a self-insured plan exceeded the premium cap, such guidelines would leave significant room for actuarial judgment. This may permit some employers to increase the amount of compensation that can be provided tax free.

Further, employers can adjust pooling arrangements to affect both premiums and estimates of projected claims. For example, many employers now combine active employees and retirees into a single pool. If retirees instead were separated into their own pool, the premiums and per capita claims costs for active employees would drop. Such separate pooling would increase an employer's ability to offer tax-free compensation to recruit essential workers. Retirees would wind up paying a disproportionate share of taxes on employer-sponsored health benefits, but that would not undermine a firm's ability to compete in the labor market. Not only would such gaming reduce caps' ability to yield revenue, it could have collateral, adverse effects on retirees. Similar results would apply when a single employer offered multiple benefit plans, the more

comprehensive of which attracted higher-cost enrollees.⁷ Legislation imposing a premium-based cap would presumably direct the IRS to develop procedural and substantive requirements that limit the opportunity for such employer manipulation, but the risk could not be entirely eliminated.

At a more mundane level, caps would impose new duties on employers to record and report premium contributions for each covered worker, dependent, and retiree. The work involved may not be trivial, given all the changes that take place with employees and their families during the year: new hires, terminations, marriages, divorces, births and adoptions, children “aging out” of coverage, and so on.

The meaning of actuarial value

The previous section of this report described the equity problems that appear inherent in a purely premium-based cap and identified some administrative challenges. The remainder of this paper asks whether those equity problems can be avoided, without significant further increases in complexity or other administrative problems, by defining the cap in terms of actuarial value. This approach would seek to base taxation on the comprehensiveness of covered benefits, rather than employer premium payments.

To determine actuarial value, highly trained actuaries estimate likely claims costs for given benefits, considering both covered services (including limits on total benefit amounts) and the out-of-pocket cost-sharing imposed on enrollees. The latter factor encompasses deductibles, coinsurance, co-payments, and annual or other limits on the amount of cost-sharing that enrollees can incur. Actuarial estimates are based on complex datasets and assumptions about such topics as enrollee characteristics; whether to consider the impact of cost-sharing on use and, if so, how to estimate that effect; and the demand for and the cost of particular services.

How current law uses actuarial value and similar concepts

Actuarial value plays a central role in several major health programs. In addition to COBRA, the Children’s Health Insurance Program (CHIP) and Medicare Part D both use actuarial value. Also, employer-sponsored group life insurance is excluded from taxation up to a capped amount, and the extent to which employees receive taxable income is based on imputed value rather than simple employer premium payments.

Actuarial value in CHIP

Actuarial value is included in CHIP’s definition of covered benefits. States have the option to implement CHIP by extending Medicaid to previously ineligible children, but most states rely, in whole or in part, on a separate CHIP plan. Such a separate plan covers benefits with an actuarial value no less than the value of benchmark coverage. A state taking this approach may use as its benchmark either the Blue Cross/Blue Shield standard option for federal employees, state employee health coverage, or the most widely subscribed health maintenance organization serving privately insured state residents.

Such a state is not obliged to provide precisely the same benefits as under the benchmark plan. Rather, some benefits can be more generous and others less so, as long as the total estimated claims costs are at least as high as under the benchmark package.

In addition to providing an *overall* actuarial value equal to or greater than that of the benchmark plan, CHIP coverage must meet separate actuarial value tests that apply to *particular benefits*. If the benchmark package covers prescription drugs, vision care, hearing care, or mental health

services, the actuarial value of CHIP's coverage of such a service must be at least 75 percent of the service's actuarial value in the benchmark plan.

A state taking this approach to covered benefits must attach to its state plan an actuarial report prepared by a member of the American Academy of Actuaries. The report must use generally accepted actuarial principles and methodologies, applying standardized utilization and price factors and a standardized population that is representative of the population being served. The same assumptions must apply equally in evaluating the benchmark plan and the state's CHIP benefits. All together, seven states use this actuarial value approach to defining covered benefits (American Academy of Pediatrics 2008).

Actuarial value in Medicare Part D

Actuarial value defines Medicare Part D coverage of prescription drugs in three different ways.

First, insurers can offer "alternative prescription drug packages" instead of standard Part D plan design if the actuarial value of such alternatives is equal to or greater than standard coverage.⁸ Under Medicare Part D's standard benefits,⁹

- Beneficiaries pay 25 percent coinsurance on prescription drugs above the standard deductible (\$275 for 2008) and below the Initial Coverage Limit, or ICL (\$2,510 for 2008).
- Medicare provides no coverage above the ICL until the beneficiary incurs a specified level of True Out of Pocket (TrOOP) costs (\$4,050 for 2008).
- Above the TrOOP level, the beneficiary pays 5 percent coinsurance, and Medicare pays for the remainder of covered drug costs.

When coinsurance payments differ for an alternative plan and standard benefits, the expected costs of the alternative plan must equal or exceed those under the standard package for two sets of claims: those between the deductible and the ICL, and those above the TrOOP limit.

If the alternative plan changes more than coinsurance amounts, expected claims must equal or exceed those under the standard plan as calculated under each of the following scenarios, some of which are explicitly hypothetical:

- both with and without taking into account federal reinsurance subsidies (a methodology that, among other things, prevents alternative benefit designs from increasing the cost of such subsidies); and
- for three different enrollee groups:
 - all expected enrollees in the plan;
 - enrollees whose costs exceed the ICL; and
 - enrollees whose costs exceed the TrOOP limit. The latter two populations are tested to prevent alternative benefit designs from increasing the generosity of coverage for healthy enrollees at the expense of those with greater needs.

Second, when employers provide retired Medicare beneficiaries with prescription drug coverage, such employers can qualify for tax-free Medicare subsidies if the employer's prescription drug benefits pass both a gross and a net test of actuarial equivalence. The gross test requires that the expected value of covered claims for prescription drugs must be at least as high as under the standard Medicare drug benefit. The net test requires that the amount paid by the employer must be no less than the average amount paid by Medicare for Part D. Detailed rules explain how to make these calculations when employers supplement Medicare coverage, when firms offer multiple plans that are used by different retirees, when employer coverage of prescription drugs is combined with coverage of other benefits, and so on.¹⁰

Third, late enrollment penalties apply if a Medicare beneficiary delays enrolling in Medicare Part D, unless the beneficiary has “creditable drug coverage” between first qualifying for Medicare and enrolling in Part D. If a plan meets the above-described gross value test for retiree coverage, it constitutes creditable drug coverage, and an enrollee in such a plan is not penalized for later switching into Part D.

Procedural requirements include the following:

- With actuarial valuation that applies to alternative benefits, the actuary must maintain, for at least 10 years, complete and detailed records from which another experienced actuary could replicate the calculation. The actuary must also certify that “the entire bid is in compliance with the appropriate laws, rules, and instructions” and clearly disclose the relationship between the certifying actuary and the plan sponsor.
- An actuary who wrongly attests that an employer plan has sufficient actuarial value to qualify for Medicare subsidies of retiree coverage can be liable under the federal False Claims Act to repay those subsidies to the federal government.
- The actuarial analysis must be done or overseen by a member of the American Academy of Actuaries who meets the applicable requirements for education, experience, and continuing education. The Centers for Medicare and Medicaid Services require adherence to generally accepted actuarial principles and mandate use of common beneficiaries and methodologies in testing both the standard plan and the plan subject to actuarial valuation.

Using imputed value for group life insurance

When employers provide group term life insurance as a fringe benefit, the first \$50,000 in insurance is exempt from income and payroll taxes. The amount above that threshold counts as taxable income. However, according to a section of the Internal Revenue Code dating from the 1960s, the extent to which an employee receives taxable income is imputed “on the basis of uniform premiums (computed on the basis of 5-year age brackets) prescribed by regulations by the Secretary.”¹¹

Applying regulatory formulas¹² to derive a “uniform premium table,” the 2009 IRS handbook for employers directs them to impute the value of group life insurance based on the employee’s age, the generosity of covered benefits (defined by the amount the policy pays in the event of death), the amount (if any) the employee contributed toward coverage, and the number of months during the year for which the worker was enrolled (IRS 2009). If the insurance exceeds \$50,000 in value, the excess is included as taxable income on employees’ W-2 forms. For our purposes, the key point is that, with this longstanding cap on the exclusion of employer-sponsored insurance, workers are taxed based on the imputed value of covered benefits rather than employer cost.

Using actuarial value to define the amount of health coverage that is excluded from taxation

As the previous section suggests, lawmakers have often incorporated actuarial value tests into the design of major health legislation, carefully structuring them to achieve multiple, sometimes subtle policy goals. Policymakers have also capped the tax exclusion for group life insurance based on uniform national methods for imputing value, rather than simple premium payments made by employers.

Building on that background analysis, this section describes how actuarial value, calculated based on the expected claims costs of just one nationally representative population, could determine whether employer-sponsored insurance is excluded from taxation. The section also

analyzes some potential disadvantages of an actuarial value approach. Other possible methods for structuring an actuarial value cap are explored in the appendix.

The basic concept

Actuarial value could be calculated based on the expected claims cost for the benefits covered by an employer, assuming use by a nationally representative population. This approach singles out for taxation only the most generous of covered benefits. Utterly irrelevant to tax liability are the age and health status of employees at a particular firm, the administrative loading in premiums, regional variations in health care costs, and how dependent coverage is categorized.

To illustrate the difference between defining the cap based on premiums and defining it based on nationally calculated actuarial value, consider four firms: Limited-Lucky, Limited-Unlucky, Generous-Lucky, and Generous-Unlucky. The two Limited firms offer their employees comparatively limited benefits that, for single coverage, would cost \$3,840 for a nationally representative group of workers. The two Generous companies buy a more comprehensive plan, which would charge premiums of \$5,760 for a nationally representative group of workers.

At the two Lucky firms, the combination of location, worker characteristics, and firm size drops premiums 40 percent below what they would be for a nationally representative population. Limited-Lucky and Generous-Lucky thus pay \$2,304 and \$3,456, respectively, per insured worker. By contrast, those same factors work against the Unlucky companies, which pay premiums 40 percent above the amounts that would be charged for a nationally representative population. Limited-Unlucky and Generous-Unlucky thus pay \$5,376 and \$8,064, respectively.

Suppose the employer exclusion for worker-only coverage is capped at \$5,000 a year, roughly 6 percent above the 2008 national average of \$4,704 (Kaiser Family Foundation and Health Research and Educational Trust 2008). If the cap is applied based on premiums, the workers at the Lucky companies will escape taxation, while those at the Unlucky companies will be taxed (table 3). By contrast, if actuarial value based on a nationally representative population determines whether a plan exceeds the cap, only the workers at the Generous companies will be taxed.

Table 3. Capping the employer exclusion based on cost vs. actuarial value: effects on workers at various hypothetical firms

Employer	Premium	Actuarial value	Taxable income per worker	
			Capped based on premium	Capped based on actuarial value
Limited-Lucky	\$2,304	\$3,840	\$0	\$0
Limited-Unlucky	\$5,376	\$3,840	\$376	\$0
Generous-Lucky	\$3,456	\$5,760	\$0	\$760
Generous-Unlucky	\$8,064	\$5,760	\$3,064	\$760

Note: The table shows amounts for worker-only coverage, assuming a cap on employer-sponsored insurance of \$5,000. Actuarial value reflects expected health care claims for a nationally representative population.

How it could work in practice: one possible approach

Congress could direct the IRS to set a cap for adults and a cap for dependent children, each of which represents the 75th percentile of actuarial value among all enrollees in employer-sponsored coverage. After establishing methodological parameters for actuarial valuation, the IRS would survey employers in 2010 and set those caps for FY 2011. In later years, the cap would increase based on general inflation (CPI-U), thus yielding higher revenue in the future while exerting increasing downward pressure on benefit generosity.¹³

Under this system, a worker’s W-2 form would show how many adults and how many children in the worker’s family received coverage from the employer. If the plan’s actuarial value for adults exceeded the cap by, for example, \$100, the employee would receive \$100 in taxable income for each covered adult. If the plan’s actuarial value for children exceeded the cap by \$50, the worker would realize \$50 in taxable income for each child covered by the plan.

Actuarial value would be based on the estimated cost of the employer’s benefits package if it were used by a nationally representative population. Legislation would direct the IRS to specify, in detail, the datasets and assumptions that actuaries must apply in valuing health benefits. Insurers could thus determine a single actuarial value for each package of covered benefits it sells to firms, since such value would be the same for all purchasing employers. A firm (and its workers) could rely on the insurer’s certification in determining whether a given plan was exempt from taxation and, if not, the amount of taxable income per adult and child enrollee.

Further, detailed IRS specifications would allow many benefits packages to have their actuarial value calculated based entirely on formula. In effect, a self-insured employer could input the details of covered benefits and, as long as such benefits were relatively typical, receive an actuarial value estimate.¹⁴

If a self-insured employer wished to offer an innovative benefit design, the firm would need to obtain a customized actuarial valuation. As examples of such innovation, some employers offer financial rewards to employees who participate in recommended wellness programs, others provide services through health clinics located at the work site, and others implement “value-based insurance design” strategies to lower or eliminate out-of-pocket costs for particular services offered to enrollees with certain chronic conditions.

Actuarial valuations of innovative benefits would not create a large new burden on employers, since under the status quo companies offering such benefits must already undertake actuarial analysis to project the resulting costs. And while the valuation of innovative benefits to determine whether they exceed the cap would involve actuarial judgment, the risk of employer gaming would not exceed that already present with self-insured plans under a premium-based approach to the cap. Not only would actuarial valuations be bounded by IRS-specified

methodologies, generally accepted actuarial principles, and the actuarial profession's self-regulation (including codes of professional conduct, qualification standards, and formalized disciplinary procedures), mischief could be further deterred through procedural requirements like those applied in Medicare Part D. For example, policymakers could impose significant liability for wrongful valuation, require actuaries to disclose all relevant financial interests and meet specific standards related to record-keeping and retention, and insist on the use of members of the American Academy of Actuaries who have pertinent training and experience.

Trade-offs with an actuarial value approach

Using actuarial value rather than premiums to decide whether an employer's plan exceeds a cap would have two major disadvantages. First, employers would gain no tax advantage from lowering cost through methods other than benefit reductions. For example, if an employer with unusually generous benefits reduced health care costs through tough negotiations with insurers, tightly limiting provider networks, or workplace incentives that increased exercise and reduced obesity, the resulting cost reductions would not lower taxes for workers at the firm.

This is not a problem of employer motivation to reduce spending. Today's employers are highly motivated to control health care costs, even though success in such efforts yields no tax advantages.

Rather, the issue involves equity. Some may view it as unfair that the same tax rates apply to the employees of two firms offering identical benefits even if one firm controls costs using socially useful initiatives, such as efforts to improve workers' health. That result is inevitable, however, with any policy approach that singles out unusually generous benefits for taxation, regardless of all other factors. By definition, that makes irrelevant to taxation not just such things as firm size and the health status of covered workers but also employers' tough bargaining and wellness programs.¹⁵

Second, it may be hard to explain this approach and justify it to the public. Although actuarial value plays a major role in health coverage programs, that role is largely invisible to most people. That would surely change if workers' health benefits were taxed based on actuarial value.

Of course, this challenge will also be present with self-insured employers under a premium-based cap. As noted above, these employers do not pay premiums, so actuarial valuation will be needed to determine whether their workers are taxed. That said, the communication challenge might be greater if such valuation applied to all ESI recipients, rather than half of them.

On the other hand, the above-described, decades-old cap on the tax exclusion for group life insurance shows that complex imputations of value to determine taxation levels need not be fatal to public acceptance. In applying actuarial value to cap the employer exclusion for health insurance, policymakers could explain that taxation will apply only to unusually comprehensive benefits; and that to make such taxation fair, all employers in the United States will have their benefits assessed under the same rules. As a result, no one will be taxed based on such things as the age and health status of covered workers, geography, and so on. But no matter how adroitly the policy is communicated, it may seem more abstract and confusing than would a tax based on the amount of money employers spend on their employees' behalf.

Using a premium-based cap, but adjusting it to compensate for geography and other factors

Some federal policymakers are considering avoiding the inequities described above by adjusting a premium-based cap to compensate for factors like age, firm size, and geography (Senate Finance Committee 2009).

As with an actuarial-value approach, such adjustments could be relatively straightforward for the employer to apply but complex in behind-the-scenes calculations. Such calculations would include the following elements:

- Given the rapid pace of change in insurance markets, new adjustments would be needed annually (or at least biennially).
- For small firms, each state would need its own table showing how to adjust premiums based on firm size, age, gender, and other factors affected by the state's small-group market rules.
- Firms too large to be governed by state small-group rules would need different tables showing how to adjust premiums based on firm size, worker age, gender, and so on.
- Geographic adjustments would need to take place by substate areas. Adjusting by state would not suffice because of significant intrastate variation. In the median state, average ESI premiums in the highest region exceed those in the lowest region by 15 and 12 percent for single and family coverage, respectively (table 4). In 13 states, such differences for either single or family coverage are 20 percent or more. To prevent untoward distortions of firm location decisions, geographic adjustments could apply based on the area of residence of each covered individual, rather than the work site.
- Deriving annual or biennial substate geographic adjustment factors would require significantly expanding existing surveys. Current premium surveys do not take large enough samples from which to derive reliable annual estimates by state, much less by small substate areas. And analysts would need to either disentangle the effect of geography on premiums from possible local differences in typical covered benefits or develop highly localized surveys of underlying health care costs.
- The firm's industry would need to be taken into account in adjusting premiums, thereby compensating for the differences in the proportion of workers with above-average health risks at certain types of companies. For example, among mining and manufacturing firms in 2007, 6.4 percent of covered employees were in fair or poor health, compared with 3.9 percent at information technology and communications companies.¹⁶
- To avoid inequities like those that would affect the President's Advisory Panel proposal, separate caps would be needed for each type of dependent coverage, including self-plus-one, family, and so on. As such categories evolve in the private market, the caps would also need to evolve.

Those procedures would allow the development of adjustment tables unique to each state. An employer would thus input firm size, industry, and information about the age, gender, and residence of each enrollee, along with the category of coverage received by dependents. Based on the formulas applicable in the state, the employer would receive adjustment factors that convert the premium paid for coverage of a worker and his or her dependents into an amount stated on the worker's W-2 form. The worker would be taxed on any amount above the cap. Special rules would be needed to cover multistate firms. In the case of self-employed plans, this entire process would be preceded by actuarial valuation that translates the company's claims costs into an estimated premium value.

Table 4. Intrastate area differences in average premiums for single and family ESI: 2006

	Number of areas within state	Premium variation			
		Single		Family	
		Dollars	Percent	Dollars	Percent
Median state	2	\$607	15%	\$1,354	12%
Alabama	2	*	*	\$872	8%
Alaska	2	\$512	12%	*	*
Arizona	2	\$875	24%	\$2,456	25%
Arkansas	2	*	*	*	*
California	7	\$828	22%	\$3,236	31%
Colorado	2	\$249	6%	\$1,107	10%
Connecticut	4	\$698	17%	\$1,772	15%
D.C.	1	*	*	*	*
Delaware	2	\$700	17%	*	*
Florida	4	*	*	\$1,117	10%
Georgia	2	\$246	7%	*	*
Hawaii	2	\$341	10%	\$681	8%
Idaho	2	\$190	5%	\$1,439	15%
Illinois	2	\$360	9%	\$1,000	9%
Indiana	2	\$232	6%	*	*
Iowa	2	*	*	*	*
Kansas	3	\$341	9%	\$2,399	23%
Kentucky	2	*	*	\$899	9%
Louisiana	2	*	*	\$786	7%
Maine	2	\$638	15%	*	*
Maryland	3	\$607	16%	*	*
Massachusetts	2	\$165	4%	\$1,354	12%
Michigan	2	*	*	*	*
Minnesota	2	*	*	\$815	7%
Mississippi	2	\$294	8%	*	*
Missouri	3	*	*	\$2,521	25%
Montana	2	*	*	\$1,066	10%
Nebraska	2	\$732	22%	\$2,132	24%
Nevada	2	\$809	24%	\$2,238	24%
New Hampshire	3	\$860	20%	\$1,464	12%
New Jersey	2	*	*	*	*
New Mexico	2	\$966	27%	\$1,546	15%
New York	2	\$719	17%	\$2,503	24%
North Carolina	2	*	*	\$737	7%
North Dakota	2	\$704	21%	\$1,021	11%
Ohio	4	\$1,024	28%	\$1,381	13%
Oklahoma	3	*	*	\$3,327	38%
Oregon	2	\$341	9%	\$1,137	10%
Pennsylvania	3	\$180	4%	\$535	5%
Rhode Island	1	*	*	*	*
South Carolina	2	*	*	*	*
South Dakota	2	*	*	*	*
Tennessee	3	\$986	22%	\$3,161	36%
Texas	4	\$629	17%	\$1,331	12%
Utah	4	*	*	\$1,481	15%
Vermont	2	\$179	4%	\$1,545	15%
Virginia	3	*	*	\$599	5%
Washington	2	*	*	\$1,302	12%
West Virginia	2	\$270	6%	*	*
Wisconsin	2	\$628	15%	*	*
Wyoming	2	*	*	\$1,780	17%

Source: Author's calculations, AHRQ, 2006 MEPS-IC.

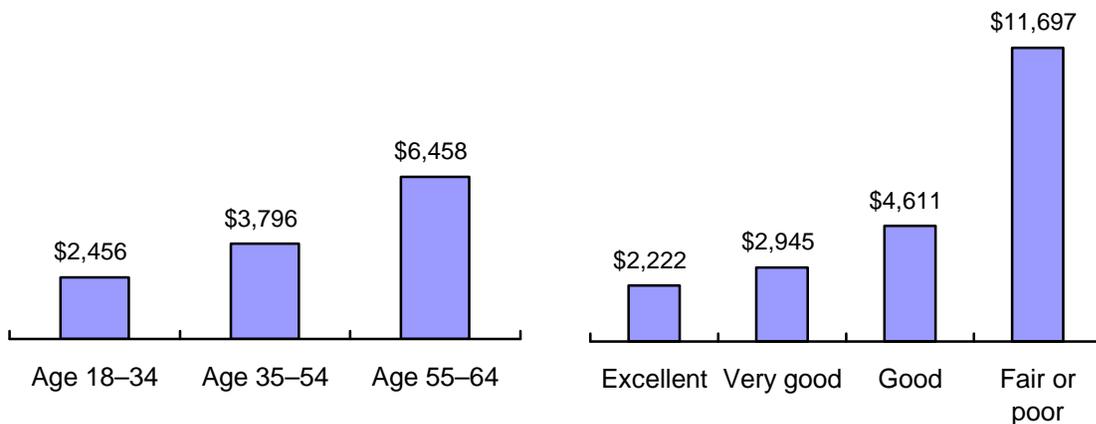
* = the standard error for the highest or lowest premium among state areas exceeded the difference between premiums.

Notes: The median state was calculated based on states with listed dollar results, excluding states where standard errors exceeded differences.

Compared with an actuarial value approach, policymakers would not achieve major gains in simplicity by using objective factors to adjust premium costs. Either way, employers would complain about administrative burdens (and in both cases, such burdens would be minor, relative to both the revenue gains of capping the employer exclusion and the remaining value of the exclusion, post-cap). A premium adjustment method may be a little easier to explain, since the analysis begins with actual costs incurred by the employer, but communication challenges would surely remain significant.

The most serious problem with this approach is its inability to compensate for differences in health status, which can greatly affect health care costs despite adjustments for age, gender, geography, and industry. Average 2006 health care costs ranged from \$2,222 for workers in excellent health to \$11,697 for those in fair or poor health (figure 2). This significantly exceeded age-based variation, which extended from \$2,456 for workers age 18–34 to \$6,548 for workers age 55–64.

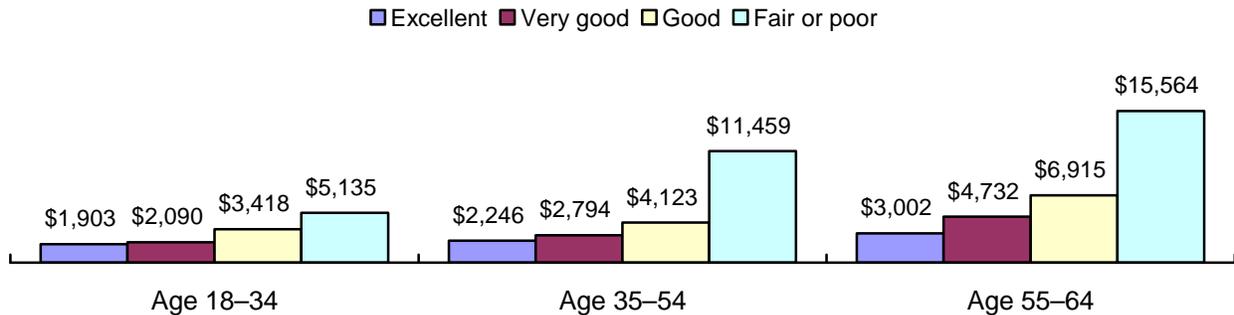
Figure 2. Average health care costs for all privately insured adults under age 65, by age and self-reported health status: 2006



Source: Agency for Healthcare Research and Quality, “Total Health Services-Mean and Median Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2006,” Medical Expenditure Panel Survey component data, generated interactively, May 23, 2009.

In important ways, cost is affected more powerfully by health status than age. Within each age group, privately insured adults of varying health status exhibit significant cost differences. For example, among 55–64-year-olds, 2006 costs were more than five times higher for workers in fair or poor health than for those in excellent health, averaging \$15,564 and \$3,002, respectively (figure 3).

Figure 3. Average health care costs for privately insured adults within various age groups, by health status: 2006

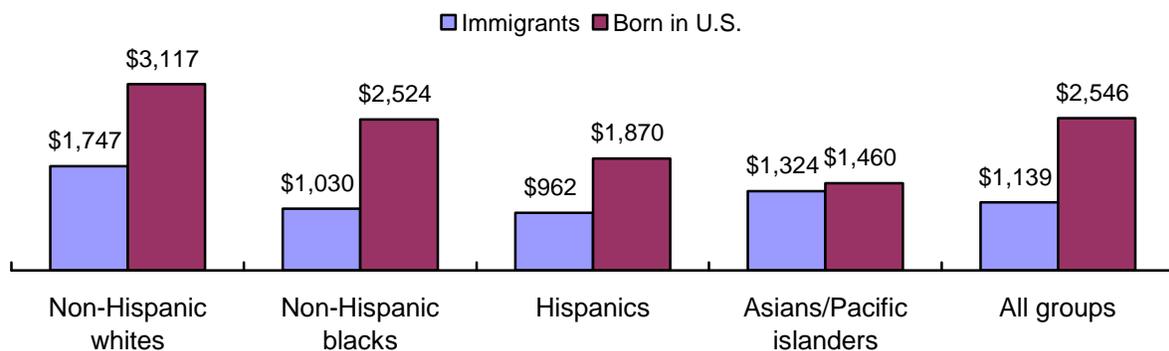


Source: MEPS-HC 2006.

Of course, health status, like age, is an individual characteristic. But at firms with many workers who have health problems, adjustments to a premium-based cap would still leave workers paying more in taxes than they would at companies offering the identical benefits to healthier workers.

An actuarial value cap applied based on premiums, even adjusted for geography, age, and similar factors, could likewise disadvantage employees at companies with mostly American-born workers. A multivariate analysis controlling for age, poverty level, insurance status, and self-reported health status found that health costs were significantly lower in 1998 for immigrants than for people born in the United States, averaging \$1,130 and \$2,546, respectively (figure 4). Within most racial and ethnic groups, immigrants cost much less than people born in the United States (with the sole exception of Asian/Pacific Islanders). As a result, the same benefits could be tax free at companies with mostly immigrant employees but subject to taxation at a competing firm staffed largely by U.S.-born workers.

Figure 4. Average costs for immigrants and U.S. citizens, by racial and ethnic group, adjusted for income, insurance status, age, and self-reported health status: 1998



Source: Mohanty, et al., 2005.

Notes: All differences are statistically significant at the .01 level, except for those involving Asians/Pacific Islanders. The analysis of the effect of immigration status on all U.S. residents also controlled for racial and ethnic status, in addition to the factors described in the figure title.

Some (but not all) of these immigration-based discrepancies would be narrowed by adjusting premiums to reflect geography. However, one important set of health status differences would not be addressed by any suggested adjustment factors. Health care costs at a company can rise dramatically if even a tiny fraction of covered workers, dependents, and retirees experience serious health problems, such as an acute illness or major accident. In markets that allow experience rating, the next year's premiums can rise dramatically. Likewise, such events can significantly increase claims costs for self-insured firms.¹⁷ Serious equity questions would arise if Congress enacted a policy that raised workers' taxes when they or their coworkers experienced catastrophic accidents or major illness.

Conclusion

If policymakers decide to limit the amount of employer-sponsored health insurance that is exempt from federal taxation, they need to decide how to calculate whether a particular plan is "over" or "under" the cap. If the calculation is based on premiums, workers' tax liability will depend on many factors, including the age and health status of workers at the firm, the company's geographic location, and firm size. By contrast, if each plan is evaluated in terms of its actuarial value—that is, the expected claims cost of enrolling a nationally representative population in the plan—only one factor would determine taxation: namely, the generosity of covered benefits. As suggested by prior experience with other legislation, actuarial standards can be defined with enough specificity that a cap on the exclusion of health insurance will be clear and objective in its application.

Put simply, there is no problem-free approach to capping the amount of health coverage that is exempt from taxation. Each method of structuring these caps will create risks and trade-offs. If the country's leaders wish to limit the tax advantages of employer-sponsored health insurance, whether to obtain revenue or to reduce health care spending, using actuarial value to determine the amount of coverage that is exempt from taxation deserves serious consideration.

About the Author

Stan Dorn is a senior research associate at the Urban Institute. For nearly 25 years, he has worked at the state and federal level on health coverage issues, with a particular focus on mechanisms to cover the uninsured. A former senior policy analyst at the Economic and Social Research Institute and managing attorney at the National Health Law Program, Mr. Dorn is widely viewed as one of the nation's leading experts on the intersection of the tax system and health care reform strategies.

About the Urban Institute and the Health Policy Center

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. The Institute's Health Policy Center analyzes trends and underlying causes of changes in health insurance coverage, access to care, and use of health care services by the entire U.S. population.

Researchers address issues that arise from the inevitable trade-offs among health care costs, access, and quality. For more information, see the Health Policy Center's web site, http://www.urban.org/health_policy/, or the Urban Institute's web site, <http://www.urban.org>.

About the WellPoint Foundation

The WellPoint Foundation, Inc. is a private, non-profit organization wholly funded by WellPoint, Inc. Through charitable contributions and programs, the Foundation promotes WellPoint's inherent commitment to enhance the health and well-being of individuals and families in communities that WellPoint's affiliate health plans serve. The Foundation focuses its funding on strategic initiatives that promote the Healthy Generations Program, a multi-generational initiative that targets specific disease states and medical conditions. These disease states and medical conditions include: prenatal care in the first trimester, low birth weight babies, cardiac morbidity rates, long term activities that decrease obesity and increase physical activity, diabetes prevalence in adult populations, adult pneumococcal and influenza vaccinations and smoking cessation. The Foundation also coordinates the company's annual associate giving campaign and provides a 50 percent match of associates' campaign pledges. To learn more about the WellPoint Foundation please visit www.wellpointfoundation.org.

Appendix. Other possible approaches to defining the cap based on actuarial valuation

Expressing actuarial value as a percentage of covered health care costs or by reference to a benchmark plan

Instead of expressing the actuarial value of a given ESI plan in terms of dollars, it could be expressed in terms of the percentage of health care costs covered by an employer health plan. As with the approach described in the body of the report, that percentage could be determined based on estimated use by a nationally representative sample, consistently with IRS methodological specifications. The percentage could be chosen to fit a benchmark plan, such as the most highly subscribed plan used by federal employees.

This approach may have the advantage of aligning with other uses of actuarial value under national health reform. For example, proposals under discussion in the Senate Finance Committee would use such a percentage-based expression of actuarial value to define levels of covered benefits in a health insurance exchange (Senate Finance Committee 2009).

However, this approach makes it more difficult to have a cap that quietly tightens over time. Such increasing strictness results when the cap is based on a dollar figure that rises more slowly than per capita health care costs. If instead the cap is based on a specified percentage of health care costs or on a comparison to a benchmark set of benefits, policymakers will need to be explicit in reducing the future value of tax-preferred benefits.

Estimating actuarial value based on use by covered individuals at each firm

Policymakers could embrace an actuarial value definition of a cap on the employer exclusion without using a nationally representative dataset of enrollees. Instead, actuaries could, as under CHIP and much of Medicare Part D, use the population enrolled in the employer plan to determine actuarial value.

In the unique context of capping the employer exclusion, this more familiar approach has significant disadvantages. Employers' need to hire actuaries, hence their administrative costs, would be much greater; in fact, the demand could exceed the available supply of actuaries. If valuation is affected by plan enrollees, insurers will not be able to certify a fixed actuarial value for each plan they sell in the group market, since the value will change based on the characteristics of each firm's workers. Further, employers could not avoid the need to hire actuaries by using IRS-approved, uniform formulas for calculating the value of typical benefit packages, since no such formulas can exist if value varies by firm.

Policymakers could try to avoid this problem by giving firms a choice. A company could measure the actuarial value of covered benefits by using either a nationally representative population set, the company's covered workers, or perhaps other enrollment data sets. Such a choice could make employer gaming a very serious problem. Health care usage patterns among a company's workers can differ from those of Americans as a whole (or from other enrollee populations). If each firm could choose the applicable enrollee population, that choice (in some cases) could determine whether covered benefits were above or below the cap.¹⁸

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Notes

¹ Of course, geographic variations in premiums reflect multiple factors beyond differences in underlying health care costs, including state rating rules, different employer preferences, and the varying demographic characteristics of area residents.

² These estimates are for worker-only coverage (Gould and Minicozzi 2009b).

³ This inequity results from how the Advisory Panel's proposal addressed dependent coverage. The proposal applies the same cap to all insurance that covers both workers and dependents, and the cap is based on the average cost of all such policies. Of course, that kind of cap has very different effects on various classes of worker-plus-dependent coverage, depending on how many adult and child dependents are included in each class. For example, only 8.2 percent of people in "employee-plus-one" plans would be taxed, a significantly lower proportion than among people with either worker-only or full family coverage (Gould and Minicozzi 2009a).

⁴ Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2006 Medical Expenditure Panel Survey-Insurance Component (Table I.B.2.b.(1)).

⁵ Fronstin (2009) is the source of much of the analysis in this section.

⁶ The COBRA statute imputes a premium based on "a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries, which is determined on an actuarial basis" 26 U.S.C. 4980B(f)(4)(B). As an alternative to such actuarial calculations, an employer can impute premiums for a self-insured plan based on the plan's recent claims experience (as long as neither the plan's enrollees nor covered benefits have changed significantly since the period for which claims data are available).

⁷ A second example involves multiple benefit plans offered by a single employer. The more comprehensive among these plans are likely to disproportionately attract higher-cost enrollees. If all an employer's plans are pooled separately rather than together, those that attract healthier workers will see their premiums or per capita claims costs drop, and premiums will rise for the plans that attract less healthy workers. Plans serving healthier enrollees will thus be able to shield from taxation a greater proportion of covered benefits than will the plans that serve less healthy members. If the employer is seeking to recruit and retain healthier workers while discouraging the hiring of less healthy workers, separate pooling of multiple health insurance options would serve such recruitment and retention goals, which are problematic as a matter of social policy. As with the example in the text, not only would this employer manipulation prevent the cap from achieving its full revenue goals, older workers and those with health problems could experience collateral harm.

Employer gaming might also result if only certain kinds of health care spending counted against the cap. For example, if workplace health clinics did not count, employers could increase their provision of tax-free benefits by shifting health care costs out of insurance and into services provided on site. To avoid such a result, a cap on the employer exclusion, whether based on premiums or actuarial value, will need to encompass all health-related benefits offered by an employer.

⁸ Much of the analysis in this section is taken from the American Academy of Actuaries Actuarial Equivalence PDP/MA-PD Practice Note Work Group (2008) and the American Academy of Actuaries Actuarial Equivalence Retiree Practice Note Work Group (2006).

⁹ Recipients of low-income subsidies are exempted from paying many of these costs.

¹⁰ If an employer offers more than one plan option, each plan must meet this requirement. If the employer offers coverage that supplements Part D, the expected claims under the supplemental policy are subtracted from the gross value of standard Part D coverage.

The net test seeks to ascertain the value of the employer's contribution to prescription drug coverage, comparing it with the federal government's payments for standard coverage under Part D. The latter, benchmark level is calculated by subtracting from the gross actuarial value of the standard package the average beneficiary premium for the applicable year or 25.5 percent (as well as subtracting the value of any coverage the employer offers to supplement Part D, as noted above).

In valuing the employer's contribution to retiree benefits, the simplest case involves an employer that offers one plan that covers only prescription drugs. In that situation, the retired worker's contribution can be subtracted from the plan's gross value to determine its net value. Unlike the gross value test, this net value test can be met (at the employer's option) by aggregating all plans sponsored by the employer. If the employer offers benefits other than prescription drug coverage, the retiree's premium contribution must be allotted between prescription drug benefits and other costs.

¹¹ 26 U.S.C. §79(c).

¹² For the regulatory formulas, see 26 C.F.R. 1.79—1(d)-(f).

¹³ Policymakers could preserve a minimum level of comprehensiveness in tax-advantaged benefits. For example, the cap might be set never to fall below the 50th percentile of actuarial value during the year of IRS survey. Such a “floor” could be defined, for the future, in terms of health care purchasing power (that is, inflated in subsequent years based on increases in per capita health care spending, rather than general inflation).

¹⁴ A similar result was achieved with Section 89 of the Internal Revenue Code, in effect from 1986 through 1989. This provision sought to prevent the discriminatory provision of extra health benefits to highly compensated employees. While the provision as a whole had many problems, the aspect relevant to the current discussion involved the American Academy of Actuaries’ detailed recommendations that made it straightforward for employers and plans to determine the actuarial value of a set of covered benefits, calculated without regard to the characteristics of any particular plan’s enrollees. Clear guidelines made the determination of actuarial value mechanical, in most cases (American Academy of Actuaries 1988). Of course, with greater sophistication of actuarial science and the greater variety of benefits packages today, guidelines allowing unequivocal estimates of actuarial value would be more complex. But by the same token, computers simplify calculation. It should be possible for IRS to specify actuarial assumptions, datasets, rules of valuations, and examples of “safe harbor” benefit packages that allow employers to calculate, on their own, actuarial value for typical combinations of covered benefits.

Many aspects of Section 89 led to its repeal. The provision limited employers’ ability to deny ESI to new hires, part-time employees, and others in the contingent work force. Another factor was the enormous complexity created by the statutory formula. To qualify as nondiscriminatory under Section 89, an employer had to pass either a four-part test or an alternative two-part test. The four-part test required that at least 90 percent of an employer’s employees must be eligible to participate in a health plan at least 50 percent as valuable as the best health plan available to any highly compensated employee; each plan must be available to a group of at least 50 percent non-highly compensated employees; each plan must be nondiscriminatory in its terms and conditions; and on average, coverage provided to non-highly compensated employees under all health plans of the employer must equal at least 75 percent of the average value of coverage provided under all health plans to the employer’s highly compensated employees. The alternative two-part test required that 80 percent of the employer’s employees must actually receive benefits under the plan, and the plan must be nondiscriminatory in its terms and conditions affecting employee eligibility (Barker 1990).

¹⁵ At the risk of introducing further complexity, policymakers might be able to craft a process through which employers could demonstrate the savings they achieved through such innovations. For example, an employer could have an independent underwriter assess the risk level of covered workers and show that the firm experienced significantly lower health costs than one would expect, given covered benefits and the risk level of ESI recipients at the company. Those documented savings could offset any excess of a firm’s actuarial value of covered benefits over the level of the cap.

¹⁶ Urban Institute tabulations of Current Population Survey—Annual Social and Economic Supplement data concerning self-reported health status for workers receiving employer-sponsored insurance from their employers in 2007.

¹⁷ If a self-insured employer purchases reinsurance or stop-loss coverage, a premium-based cap could be structured to reduce the extent of such problems. Claims covered by reinsurance or the stop-loss policy could be excluded in determining the extent to which health benefits received by employees are taxable. (By the same token, the firm’s premiums for reinsurance or stop-loss coverage would be included in potentially taxable health benefits.) Such a policy may distort firm behavior, however. It could encourage firms to buy reinsurance or stop-loss coverage rather than setting aside reserves to cover unexpected claims. It might also encourage firms to buy more reinsurance or stop-loss coverage than they would otherwise prefer.

¹⁸ That risk of gaming would be reduced if firms were required to use the characteristics of their covered workers in determining actuarial valuation, but gaming could remain a greater problem than under an approach that uses a uniform, nationwide data set. That is because calculations based on the characteristics of a firm’s enrollees may involve considerably more scope for the exercise of actuarial discretion. Not only would each firm need to obtain customized actuarial valuations, actuaries may have significant flexibility in selecting the dataset that represents the characteristics of a firm’s employees and dependents, particularly when a company’s claims experience is sufficiently limited that the actuary needs to use an enrollment database that can be analogized to a company’s covered workers, dependents, and retirees.

To be clear, few actuaries would abuse their discretion, given IRS-specified methodologies, professional norms, and the procedural requirements described in the text. But given the risks (albeit modest) inherent in subjective valuation, the overall danger of employer manipulation and error would be greater in a system that, by using firm-specific rather than nationally representative populations to estimate actuarial value, increased both the number of required actuarial valuations and the discretion with which each estimate was developed.