

CBO TESTIMONY

Statement of
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on
The Tax Treatment of
Employment-Based Health Insurance

before the
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NOTICE

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Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before you today to present some of the analysis included in the recent Congressional Budget Office (CBO) study *The Tax Treatment of Employment-Based Health Insurance*. My testimony this morning will focus on the nature of the tax subsidy for employment-based health insurance and on issues raised by hypothetical limits, or caps, on the subsidy. I will also include issues raised by tax caps in the context of proposed reforms in the health insurance market.

I want to emphasize at the outset that my discussion pertains to only one aspect of the market for health care. It does not analyze any specific proposal to reform the health care market. Instead, it addresses the contribution that tax policy makes at present and might make in the future.

INTRODUCTION

As this Committee well knows, the exclusion from tax of employer contributions toward their employees' health insurance is an exception to the general tax policy principle that compensation should be taxable regardless of its form. Because compensation paid in the form of health insurance is not subject to income and payroll taxes, it receives an implicit tax subsidy compared with compensation paid in cash. The subsidy has the beneficial effect of cushioning workers against the high costs of health insurance and health care.

At the same time, it reduces incentives for workers and their employers to seek out the most cost-effective health insurance options. Therefore, the tax subsidy itself contributes to the high cost of health insurance.

I would like to make four key points about the subsidy:

- o Employees pay for "employer-provided" health insurance through lower wages. Thus, a subsidy on employment-based health insurance directly translates into increased demand for insurance by employees.
- o The tax subsidy provides uneven benefits: it helps those with employment-based insurance, but not those without; it lowers the labor costs of firms that can afford to provide the tax-free fringe benefit, but not those that cannot afford insurance.
- o A limit, or cap, on the exclusion would provide incentives for cost containment by reducing the amount of insurance purchased and would reduce the unevenness of the present system, but could be hard to administer.
- o The effect of a cap on those currently with and without insurance depends, in the short run, on how the revenue gained is spent and, in

the long run, on how well the cap and accompanying market reforms can contain health care costs and maintain the quality of care.

HOW THE SUBSIDY WORKS

The exclusion from tax of employer contributions toward their employees' health insurance creates a price subsidy for health insurance. An employee who earns income in the form of health insurance avoids the income and payroll taxes that would be due if the compensation were paid in the form of cash. The additional compensation also escapes the employer's share of payroll taxes. As a result, the price of employment-based health insurance is reduced substantially by the tax savings--by an average of 26 percent in 1994.

If employers provided health insurance as a gift to their employees, then the tax exclusion might not matter much. A key point to understand, however, is that health insurance is not a gift, but something employees pay for with reduced wages. Even the most generous employer cannot for very long pay its employees more than the value of what they produce. Competitive pressures would force the employer either to reduce compensation or eventually go out of business. Thus, when an employer chooses to pay for health insurance, it has to reduce compensation in other forms. As the price of that health insurance increases, wage growth lags to compensate.

Because health insurance is costly and valued by many, competitive pressures drive employers to provide the insurance that their employees want and are willing to pay for with reduced wages. If an employer offered a mix of benefits and take-home pay that did not match the preferences of its employees, it would find that it was paying more to attract and keep employees than a competitor whose compensation mix more closely matched its employees' preferences. Competitive pressure also forces employers to act as the employees' agents in selecting appropriate health insurance.

In this context, the price subsidy resulting from the tax exclusion has two contradictory effects. The positive effect is that it encourages people to be insured. Employees demand health insurance from their employers in part because they have to pay only part of the cost. Employers, acting as their agents, thus have a strong incentive to provide insurance to their workers. The negative effect is that employees are much less sensitive to the price of health insurance than they would be if they had to pay full cost. Employers thus find that their employees resist efforts to control costs more than they would without a subsidy. For example, employees might prefer a fee-for-service health insurance plan with access to specialists on demand when the price of insurance is subsidized. Yet, when they have to pay the whole cost, they are more apt to choose a health maintenance organization (HMO) in which primary care physicians control access to specialists.

Comprehensive insurance also influences the choices people make when they get sick in ways that hinder efforts to control costs. Many drugs and treatments provide great benefits relative to their costs, but some do not. Because people with comprehensive insurance pay little or none of the costs of treatment, they may be more receptive to treatments of unproven efficacy or of high cost relative to the benefits they confer. Insurers try to control the demand for services of low value, but they can do so only if the premium savings they offer are worth the perceived costs to their customers. The tax exclusion leads employees to undervalue the savings in premiums and resist efforts by insurers to manage care aggressively to reduce cost.

WHO BENEFITS FROM THE PRESENT SUBSIDY?

Like any tax subsidy, the tax exclusion for employment-based health insurance affects people and businesses in different ways. People who are uninsured or who purchase their own insurance receive no benefit at all. Even among the insured, the benefits of the tax exclusion vary widely. As for businesses, the exclusion tends to lower labor costs of large firms relative to labor costs of small firms.

Horizontal Equity

A basic principle of tax policy--called horizontal equity--holds that people with the same ability to pay tax should pay the same amount of tax. Like other tax preferences, the tax exclusion violates this principle. People with employment-based health insurance pay less tax than do otherwise similar people without insurance. Self-employed people and those who are out of the work force receive no benefit from the tax exclusion. (Before 1994, the self-employed could deduct 25 percent of their premiums from taxable income.) People whose employers provide more expensive health insurance coverage receive a greater benefit than people with less generous coverage. People whose employers pay a larger share of their health insurance premiums receive a greater benefit than people whose employers pay a smaller share.

Coverage by employment-based health insurance varies widely within income groups (see Table 1 on page 22). For example, only 8 percent of families with yearly incomes below \$10,000 receive health insurance at work. As incomes increase, more and more people are covered by employment-based insurance. Nevertheless, in every income group, significant minorities are not covered. Among families with incomes of more than \$200,000 a year, the prevalence of employment-based insurance drops because a significant proportion of that group is made up of either self-employed people or those who are not employed.

Among insured people, employers' contributions for health insurance vary substantially within each income group. Some of the variation reflects different levels of generosity of health insurance coverage; some reflects differences in the share of premiums paid by employers. Furthermore, the cost of health insurance coverage varies substantially by region. Those differences arise from both variations in overall costs of living and variations in patterns of medical practice.

Vertical Equity

According to another principle of tax policy--called vertical equity--people with more ability to pay should pay more tax than those with less ability to pay. This principle has been applied to policies like the tax exclusion for health insurance, but the principle can be misleading when applied to only one component of tax law such as the tax exclusion. The reason is that the net distributional effect of any tax provision depends on how it is financed; that is, how it fits into the overall distribution of taxes.

Both the likelihood of being insured and the amount of the premiums from employment-based health insurance that are excluded from taxation increase with family income. The average premiums for families with income

of less than \$20,000 a year will be under \$2,400 in 1994, whereas the average premiums for families with income of more than \$50,000 will be more than twice that amount (see Table 1). The differences in premiums reflect several factors. Higher-income families are more likely to be covered by multiple policies and to have family rather than self-only coverage. Lower-income families are more likely to have been employed for only part of the year and thus to be covered for only that part.

The average employer's share increases with income, but only slightly. It rises from about 83 percent for families with less than \$10,000 of income to about 89 percent for families with income of more than \$200,000. Because the income tax is progressive, the benefit of the tax exclusion is greatest for high-income people. Families in the lowest-income group receive an average income and payroll tax subsidy worth 11 percent of their premiums, compared with a subsidy of 33 percent of the premiums for the highest-income group.

However, for lower-income families who receive health insurance through their employers, the subsidy constitutes a larger share of their income than it does for higher-income families with such coverage. The average subsidy is almost 3 percent of after-tax income for low-income families who are covered by employment-based health insurance, compared with less than 1 percent for the highest-income families. As a result of differences in partici-

pation rates in health insurance, the average tax subsidy is roughly proportional to after-tax income for most of the population (with incomes between about \$20,000 and \$100,000).

Finally, one might want to target a subsidy toward lower-income households for reasons other than vertical equity. Low-income working people are the least likely to be insured, both because health insurance is unaffordable for them and because they know that they can receive free emergency care at hospitals if they need it. The tax exclusion, however, provides the greatest benefit to the higher-income households that would be most likely to obtain insurance even if the subsidy did not exist and relatively little benefit to low-income households.

Evenhanded Treatment of Business

An important objective of tax policy is to minimize distortions among firms and industries. The tax exclusion violates this principle in a subtle way. Because it subsidizes one form of compensation that only some firms can afford to provide, it lowers labor costs for those firms relative to other firms. Large firms can generally provide health insurance at much lower costs than small firms or individuals and would thus be likely to sponsor health insurance for

their employees even if there were no subsidy. Small firms typically face much higher costs and, therefore, tend to pay all compensation in the form of cash or other fringe benefits. The tax subsidy for employment-based health insurance makes the compensation package of the large firm more attractive to most employees than the all-cash package offered by smaller firms, giving large firms an advantage in hiring. Even if a small firm decides to offer health insurance to its employees in response to their demand for the subsidized form of compensation, it is at a disadvantage relative to a large firm because it costs more for a small firm to offer the same amount of insurance coverage than a large firm.

The distortion in relative labor costs induced by the subsidy tends to help large firms at the expense of small ones. Furthermore, the net effect of the distortion is to lower economic productivity.

Long-Run Effects

Over the long run, some of those who benefit from the tax exclusion may also bear some of its cost. The tax exclusion raises health care costs for everyone, including those who directly benefit from the subsidy. As a result, it exacerbates the problems of the uninsured and raises insurance costs for the

insured. The revenue losses that result from the exclusion contribute to higher deficits, higher taxes, or reduced government services, which ultimately affect everyone. In sum, even the apparent beneficiaries of the tax exclusion might be better off eventually if the subsidy were curtailed.

TAX CAPS

A tax cap would reduce the tax subsidy for employment-based health insurance by limiting the premiums not subject to taxes. The limit would encourage employees and employers to choose more cost-effective health insurance while still retaining an incentive for employers to provide health insurance. Moreover, a tax cap would raise revenues that might be used to expand access to health care for those who are currently uninsured. Implementing a tax cap, however, would be difficult.

Employer Versus Employee Caps

Some current proposals for health care reform would limit the amount of health insurance premiums that employers could deduct from their corporate taxable income. Others would include in the taxable income of employees the portion of health insurance premiums that exceeds a cap. Another alternative

is to impose an excise tax on premiums in excess of the cap. What difference does it make which option is adopted? What advantages are there to one approach versus another?

Under established tax policy, health insurance premiums are a component of employee compensation, just like cash wages, and thus constitute income to employees and a legitimate deductible business expense for employers. Nonetheless, each of the alternative cap mechanisms would help to constrain the amount of employment-based health insurance premiums. Imposing the cap on employers has some practical advantages. For example, because there are many fewer business returns than individual income tax returns, limiting the deduction for employers against their taxable income may reduce the costs of complying with the income tax compared with a limit at the individual level. An excise tax has an additional advantage: it would provide the same incentive to limit health insurance contributions for state and local governments and nonprofit businesses as it would for businesses that are subject to income tax.

Employer and employee caps can have similar effects on incentives and tax revenues over the long run, because all of the approaches provide an incentive for employers to reduce their contributions to the amount of the cap. For example, suppose that the cap on premiums was set at the average

premium employers currently pay. Under either an employer or employee cap (or an excise tax near the level of individual and corporate tax rates), employers whose premiums were near the cap would have a strong incentive to seek out health insurance policies that could be purchased for the cap amount. Over time, lower premiums would be passed along to employees in the form of higher wages and other fringe benefits. Thus, any tax penalty on employers would not be binding for long. The taxable income of employees would increase by the same amount under all three tax options.

If the cap was set so low that most employees continued to demand insurance that costs more than the cap, the ultimate response of employers and employees would be more complex. The employer facing an excise tax or limit on deductibility could reduce its contribution to the level of the cap and increase wages by the difference in premium contributions; alternatively, the employer could pay the tax and reduce wages so that the overall after-tax cost of compensation was unchanged. The choice would depend on whether the average individual's rate for income and payroll taxes (net of the value of additional Social Security benefits) is more or less than the employer's tax imposed on excess premiums. If individuals would have to pay more in taxes than the firm, then the firm would tend to pay the penalty and pass the cost on to workers by reducing wages.

Fixed-Dollar Caps Versus Fixed-Benefit Caps

The simplest kind of cap to define would be in terms of fixed-dollar limits that might vary by type of coverage (self-only versus family, for example), but not by individual circumstances. Such a fixed cap would have a disproportionate effect on people who live in areas with higher-than-average medical costs or who work for small firms that face high premiums because of the poor health of employees or their families.

Alternatively, caps could be defined in terms of the cost of a fixed package of health insurance benefits. This approach could be implemented under a system of managed competition, but probably would be infeasible without such a structure. The trade-off in this case is that the health insurance purchasing cooperatives that would be set up in the managed competition model would be costly to operate and would remove control from individuals and firms over their health insurance, thereby diminishing their incentives to try to control costs.

"Pure" managed competition would channel all health insurance purchases through purchasing cooperatives. Under this hypothetical system, the tax cap would be set equal to the premium paid for the low-cost plan--covering a defined set of health benefits--offered through the cooperative. This

approach has certain advantages. All taxpayers would be able to receive a tax subsidy on the same level of health insurance coverage. The choice among alternative plans and provider networks would be unsubsidized because any additional premiums above the low-cost plan would be paid out of after-tax dollars. Moreover, since the cooperative would negotiate all prices, it would be straightforward to determine the premium paid on behalf of each employee and to compare it with the relevant cap levels.

This approach has a cost: the structure of purchasing cooperatives requires a substantial amount of administrative apparatus, which adds to the overall cost of health care. In addition, individual employers and their employees would lose much of their stake in the design and administration of health insurance since, with few exceptions, they would be so small that their own behavior would be insignificant to the premiums charged to the cooperative. Managed competition promises other savings, however, and it might well reduce the overall cost of health care.

Weighed against the administrative apparatus of a system of purchasing cooperatives is the administrative apparatus required by employers that manage their own health insurance systems. First of all, in today's health insurance market or any system in which some employers managed the insurance for their employees, setting caps that depend on the cost of a fixed

set of benefits would be difficult at best. The Internal Revenue Service (IRS) would require information that is currently unavailable, such as accurate measures of regional variation in prices, and actuarial measures of the cost of a hypothetical package of health insurance benefits for each firm. Even if the cap levels were set as fixed dollar levels that varied only by the type of health insurance coverage, companies would have a strong incentive to try to characterize excess health insurance benefits as company overhead. They might also be inclined to reallocate them among different branches so as to minimize the amount that seems to exceed the cap. In turn, the IRS would have a very difficult job of trying to verify that health insurance benefits were accurately measured and allocated among enterprises in the firm.

Some variations of managed competition would combine purchasing cooperatives for smaller employers and individuals with management of health insurance outside the system by larger employers. The advantage of such an approach is that it allows large employers--who might be better able to control their own health care costs than would a purchasing cooperative--to manage their own health plans. The cost of this approach is that it retains the administrative apparatus of purchasing cooperatives for small firms and the inevitable problems of enforcement and compliance for larger firms.

Distributional Effects of an Illustrative Tax Cap

The Congressional Budget Office (CBO) has simulated a set of fixed-dollar caps to illustrate the nature and range of redistributive effects under a tax cap. The simulations assume the following limits on the amount of health insurance premiums that could be excluded from individuals' taxable income (for both income tax and payroll taxes): \$4,000 for joint returns, \$3,400 for head-of-household returns, and \$1,600 for single returns. Those levels correspond roughly to the typical employer share of the premium for health insurance plans for different size families in 1994. For those families with less generous health insurance policies, the caps would have no immediate effect on their behavior. Those families with policies that exceeded the caps would have an incentive to demand less comprehensive health insurance over time.

Employers would have two possible responses to caps on the tax exclusion. They could scale back their health insurance premiums to the caps, in which case employees would gradually receive increases in taxable wages and other fringe benefits. Or they could continue to provide the same health insurance policies, in which case the portion of the premiums that exceeded the caps would be included in taxable income.

Except for a small amount of shifting of funds into other fringe benefits, the net effects on federal tax revenues of the two behavioral responses by employers would be nearly identical. Taxable income and the payroll tax base would increase in both instances by almost the same amount that current health insurance premiums exceeded the caps. (Taxable wages would not increase dollar for dollar because employers would have to pay Social Security taxes on the additional taxable wages. That increase in the employer payroll tax is assumed to be passed on to workers in the form of slightly lower wages.)

The illustrative caps would raise tax liabilities for 1994 by about \$18.9 billion--\$12.4 billion in income taxes and \$6.4 billion in Social Security payroll taxes (see Table 2 on page 24). The average change in tax liability as a result of imposing the illustrative caps increases with income and goes from virtually no change in the lowest-income group to a \$540 increase in the group with incomes between \$100,000 and \$200,000.

The increases in tax liability suggest that every income group would be worse off under tax caps, but that is a very misleading impression. The \$18.9 billion of additional revenue could be used to make some people better off, but the exact distributional consequences would depend on how the additional revenues were used (see Table 2).

For example, if policymakers intended to limit only the incentive to overconsume health insurance, they could reduce taxes in such a way that, on average, each income group would be unaffected. Thus, within each group, people without insurance or people whose insurance was below the caps would benefit relative to people with above-average insurance coverage. This approach would reduce the disparity in tax treatment between those with insurance and those without.

To illustrate the possible redistributive effects of such policies, suppose the additional revenues were spent so as to benefit all taxpayers equally. CBO simulated this option as a lump-sum rebate of \$153 per nondependent tax return. Under this scenario, families with incomes of less than \$10,000 would have an average net gain of \$150, and the average family with income between \$100,000 and \$200,000 would lose \$320 (see Table 3 on page 25). Families with employment-based insurance would pay about \$7 billion more in taxes to the benefit of those without employment-based insurance.

As explained earlier, one of the objectives of tax policy is to treat people who start out in similar positions the same way. Tax caps advance this objective of horizontal equity if "positions" are measured in terms of income. With an unlimited tax exclusion, otherwise similar people can face much different tax liabilities based on how much their employers contribute toward

their health insurance premiums, if at all. Imposing caps by itself reduces the variability of tax liability that the tax exclusion creates. Redistributing the additional revenues that the caps generate in favor of the uninsured and underinsured could reduce the inequity still further.

CONCLUSIONS

The present unlimited tax exclusion for employment-based health insurance has helped many people obtain health insurance, but it has also contributed to the high cost of health care by discouraging the purchase of cost-effective health insurance. The tax subsidy also provides uneven benefits, helping insured working people, but it provides no benefit to the uninsured and those who purchase their own insurance. It provides the largest subsidies to those who are most likely to obtain insurance even without a subsidy. And the subsidy is only valuable to those firms that can afford to sponsor health insurance for their employees, so it gives these firms an advantage in hiring employees compared with other firms.

A tax cap would heighten workers' consciousness of the cost of health insurance and is thus an important element of market-based approaches to control the cost of health care. Whether the cap is imposed on employers or on employees, employees will ultimately bear the cost of any cap and would

have a similar incentive to reduce their spending on health insurance in either case. The revenues generated could also be used to advance other aims, such as reducing the number of people without insurance.

A tax cap could improve the functioning of the market for health care. But this improvement would entail costs: either in the form of administrative and compliance costs--if the cap is implemented completely through the tax system--or in the form of the costs of setting up and running a system of purchasing cooperatives. Moreover, tax caps that do not account for unavoidable differences in the cost of health care--for example, because of differences in health status or place of residence--could be seen as unfair.

In the short run, a tax cap would increase the taxes of those with generous employment-based insurance, although the overall effect on taxpayers would depend on how the additional revenues were distributed. In the longer run, however, if a tax cap contributes to successful health care cost containment, many people who face a higher tax burden could ultimately be made better off.

TABLE 1. PREMIUMS AND TAX SUBSIDIES FOR FAMILIES WITH EMPLOYMENT-BASED HEALTH INSURANCE, BY INCOME

Income (Dollars) ^a	Percentage of Families in Income Class	Average Premium (Dollars) ^b	Employer Share of Premium (Percent) ^b	Average Subsidy (Dollars)	Tax Subsidy as a Percentage of Premiums ^b
1 to 9,999	8	1,830	83	190	11
10,000 to 19,999	34	2,370	80	450	19
20,000 to 29,999	62	3,080	84	800	26
30,000 to 39,999	78	3,650	84	900	25
40,000 to 49,999	85	4,370	86	1,090	25
50,000 to 74,999	89	5,080	87	1,320	26
75,000 to 99,999	91	6,010	87	1,740	29
100,000 to 199,999	89	6,410	88	1,910	30
200,000 or More	76	5,530	89	1,830	33
All Incomes ^c	61	4,310	86	1,130	26

(Continued)

TABLE 1. CONTINUED

Income (Dollars) ^a	Average After-Tax Premium	Tax Subsidy as a Percentage of After-Tax Income		After-Tax Premium as a Percentage of After-Tax Income
		Families with Employment-Based Health Insurance	All Taxpayers	
1 to 9,999	1,640	2.9	0.2	25
10,000 to 19,999	1,920	3.0	1.1	13
20,000 to 29,999	2,280	3.5	2.2	10
30,000 to 39,999	2,750	2.9	2.3	9
40,000 to 49,999	3,280	2.8	2.4	9
50,000 to 74,999	3,770	2.6	2.3	7
75,000 to 99,999	4,270	2.5	2.2	6
100,000 to 199,999	4,500	1.8	1.6	4
200,000 or More	3,710	0.5	0.4	1
All Incomes ^c	3,190	2.4	1.9	7

SOURCE: Congressional Budget Office.

NOTE: The table excludes families in which all members are covered by Medicare or Medicaid.

- a. Adjusted gross income reported on tax returns plus certain nontaxable forms of income including employers' contributions to the cost of health insurance premiums and tax-exempt interest.
- b. Premium data are based on the 1987 National Medical Expenditure Survey conducted by the Agency for Health Care Policy and Research of the Department of Health and Human Services.
- c. Includes families with zero or negative income.

TABLE 2. INCREASE IN TAX LIABILITY FOR FAMILIES BEFORE TRANSFERS UNDER THE ILLUSTRATIVE TAX CAPS

Income (Dollars) ^a	Number of Families (Millions)	Increase in Tax Liability			Average (Dollars)
		Income Tax (Millions of dollars)	Payroll Tax (Millions of dollars)	Total (Millions of dollars)	
1 to 9,999	15.3	0	40	40	0
10,000 to 19,999	18.3	170	280	450	20
20,000 to 29,999	16.9	960	760	1,730	100
30,000 to 39,999	13.8	1,190	910	2,090	150
40,000 to 49,999	10.7	1,390	1,000	2,380	220
50,000 to 74,999	17.3	3,360	1,860	5,220	300
75,000 to 99,999	7.5	2,560	880	3,450	460
100,000 to 199,999	5.4	2,320	610	2,920	540
200,000 or More	<u>1.4</u>	<u>480</u>	<u>80</u>	<u>560</u>	410
Total, All Incomes^b	108.1	12,430	6,420	18,850	170

SOURCE: Congressional Budget Office.

NOTES: Families are groups of related people who live together; people not living with relatives are considered one-person families.

CBO's illustrative caps would establish the following limits on the amount of health insurance premiums that could be excluded from taxable income: \$4,000 for joint returns, \$3,400 for head-of-household returns, and \$1,600 for single returns.

The figures in the table assume that the illustrative tax caps are in place in 1994, based on projected levels of income.

- a. Adjusted gross income reported on tax returns plus certain nontaxable forms of income including employers' contributions to the cost of health insurance premiums and tax-exempt interest.
- b. Includes families with negative or zero income.

TABLE 3. CHANGE IN AVERAGE TAX LIABILITY FOR FAMILIES UNDER THE ILLUSTRATIVE TAX CAPS WITH A \$153 REBATE (In dollars)

Income (Dollars) ^a	Rebate per Family ^b	Change in Average Tax Liability			Percentage of Families with Employment-Based Insurance
		All Families	Families with Employment-Based Insurance	Families Without Employment-Based Insurance	
1 to 9,999	160	-150	-120	-160	7
10,000 to 19,999	160	-140	-90	-160	34
20,000 to 29,999	170	-60	0	-170	62
30,000 to 39,999	170	-20	30	-180	77
40,000 to 49,999	180	50	90	-180	84
50,000 to 74,999	190	120	150	-190	89
75,000 to 99,999	210	260	300	-200	91
100,000 to 199,999	220	320	390	-190	89
200,000 or More	190	220	350	-170	76
All Incomes	170	0	110	-170	61

SOURCE: Congressional Budget Office.

NOTES: Families are groups of related people who live together; people not living with relatives are considered one-person families.

CBO's illustrative caps would establish the following limits on the amount of health insurance premiums that could be excluded from taxable income: \$4,000 for joint returns, \$3,400 for head-of-household returns, and \$1,600 for single returns.

The figures in the table assume that the illustrative tax caps are in place in 1994, based on projected levels of income.

- a. Adjusted gross income reported on tax returns plus certain nontaxable forms of income including employers' contributions to the cost of health insurance premiums and tax-exempt interest.
- b. The rebate is assumed to be a refundable tax credit paid to all nondependent tax units. It is computed by dividing the total increase in taxes for families with employment-based insurance by the number of nondependent tax units. The average tax reduction is greater than \$153 because some families have more than one tax unit.

