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CAPPING THE HEALTH INSURANCE TAX EXCLUSION

The consequences vary greatly across states and regions

BY ELISE GOULD

Employer-sponsored health insurance plans are the predominant form of coverage in the United States. Nearly 63% of Americans under age 65 have employment-based coverage through the workplace, either as an employee, dependent, or retiree (Gould 2008). Employment-based insurance is effective because workplaces can pool large groups of people along dimensions unrelated to health, ensuring more predictable medical costs and allowing insurers to take advantage of the economies of scale.

Under current law, employer contributions to health insurance premiums are excluded, without limit, from workers' taxable income. Employee contributions are excluded if the employees work at firms with "cafeteria plans," that is, plans that allow employees to choose between taxable and nontaxable fringe benefits.

Subsidizing compensation paid in the form of health insurance encourages employers to offer this benefit and thus increase the number of insured Americans. Nevertheless, proposals to end or cap this tax exclusion are emerging in the discussions of how to pay for health care reform. Capping the tax exclusion would alter the market for employer-sponsored health insurance. A cap has the potential to reduce both the quality and quantity of insurance available through the workplace. At the very least, those workers who receive health premium contributions that exceed any proposed cap could see an increase in their tax liability.

Some argue that a cap would primarily affect those with the most generous coverage, but that is not the whole story. Previous research shows that taxing high-priced health coverage is not the same as taxing high-value health coverage. Previous research finds that taxing expensive health coverage heavily burdens two groups: workers in small firms, and workers in employer pools with higher health risks, such as firms with a high share of older workers (Gould and Minicozzi 2009). Other research illustrates how family policy holders might be more likely to have

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plans that exceed the cap if the cap level does not accurately reflect the health insurance marketplace (Gould 2009).

What has yet to be examined is how cross-state variations in health costs change the likelihood of being directly affected by a tax cap. While some research has looked at regional variation in health insurance premiums and health care costs, even less research has examined regional variation in the share of the enrollee population likely to be affected by a cap in the employer exclusion (though Dorn (2009) has come the closest). This Issue Brief attempts to fill that gap.

Average premiums across states

Using the Medical Expenditure Panel Survey – Insurance Component (MEPS-IC), **Table 1** displays the average total premiums in each state for single and family plans per enrolled employee at private-sector establishments that offer health insurance. In 2006, the average

TABLE 1

Average premium per enrolled employee (single and family plans), by state, 2006

	Single plan	Family plan		Single plan	Family plan
United States	$4,118	$11,381	*Missouri*	$3,958	$11,171
Alabama	3,943	10,571	*Montana*	4,144	11,068
Alaska	4,539	12,198	*Nebraska*	3,890	10,777
Arizona	4,280	11,549	*Nevada*	3,583	9,746
Arkansas	3,567	9,928	*New Hampshire*	4,622	12,686
California	4,036	11,493	*New Jersey*	4,471	12,233
Colorado	4,024	11,195	*New Mexico*	4,037	11,279
Connecticut	4,402	12,416	*New York*	4,605	12,075
Delaware	4,712	12,601	*North Carolina*	4,027	10,950
District of Columbia	4,540	12,262	*North Dakota*	3,787	10,060
Florida	3,936	11,046	*Ohio*	4,054	10,967
Georgia	3,873	10,793	*Oklahoma*	3,967	10,592
Hawaii	3,549	9,426	*Oregon*	4,122	11,613
Idaho	3,573	10,775	*Pennsylvania*	4,277	11,794
Illinois	4,245	11,781	*Rhode Island*	4,595	11,934
Indiana	3,989	11,454	*South Carolina*	4,013	10,956
Iowa	3,916	10,550	*South Dakota*	3,938	9,875
Kansas	3,833	11,048	*Tennessee*	3,747	9,996
Kentucky	3,791	9,864	*Texas*	4,133	11,690
Louisiana	3,938	10,796	*Utah*	3,849	10,975
Maine	4,663	12,363	*Vermont*	4,322	11,631
Maryland	3,930	11,272	*Virginia*	4,091	11,497
Massachusetts	4,448	12,290	*Washington*	4,056	11,423
Michigan	4,446	11,452	*West Virginia*	4,349	11,282
Minnesota	3,981	11,395	*Wisconsin*	4,241	11,658
Mississippi	3,704	9,769	*Wyoming*	4,605	12,087

NOTE: Private industry only.

SOURCE: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey-Insurance Component.

premiums were $4,118 for single plans and $11,381 for family plans.

Average premiums vary substantially across states. For single plans, premiums range from $3,549 to $4,712. This range of $1,163 translates into a 33% increase in premium from the least-expensive state (Hawaii) to the most-expensive (Delaware). The least expensive average family plan premium is also found in Hawaii at $9,426, while the most expensive is $12,686 in New Hampshire. Similar to single plans, family plan premiums vary by 35% from lowest to highest, a range of $3,260.

In additional to substantial cross-state variation in average premiums, Dorn (2009) finds substantial within state variation. Intrastate area premiums differ by as much as 28% for single plans and 38% for family plans.

State-by-state comparison of the share of premiums above a proposed cap

In this section, we examine a recent, well-know proposal to cap the tax exclusion and look at how many single and family plans would be directly impacted. To best assess how enrollees in different states may be affected, we use this proposal's cap along with data from the Medical Expenditure Panel Survey–Insurance Component (MEPS-IC) in order to separate out the tax-preferred portion of the premium from the total premium.

In 2005, President Bush established a bipartisan panel to recommend reforms that would make the tax code "simpler, fairer, and more pro-growth." In its final report, the President's Advisory Panel on Federal Tax Reform, (henceforth called the Tax Reform Panel) recommended substantially changing the tax subsidy for employment-based health insurance by setting a limit on the premium amount that could be excluded from an individual's taxable income.

In November 2005, the Tax Reform Panel recommended several changes to the tax treatment of health insurance. The most prominent recommendation was to set a cap on the income and payroll tax exclusion for employer and employee contributions to health insurance premiums. Thus premiums in excess of the fixed dollar limit (which varies by type of coverage) would be included in taxable income and subject to payroll taxes. The Panel set the exclusion limit at the average cost of health coverage in 2006. The proposed maximum exclusion was $5,000 for single plans and $11,500 for family plans, including employee-plus-one plans.

While this proposal may differ in particular cap value from proposals currently being discussed, the results from this analysis are not limited to the proposal in question. Similar proposals may impact a higher or lower share of enrollees, but the overall pattern of variation across states will be consistent.

As shown in **Table 2**, the percentage of enrollees directly affected by the cap differs substantially across states. On average, 19.5% of single plan enrollees would be affected compared with 41.4% of family (including plus-one) plan enrollees. The likelihood of being above the single plan cap varies from 5.3% in Hawaii to 42.6% in Alaska. Over 30% of those with single plans would be directly affected in the District of Columbia, Rhode Island, Maine, and New Hampshire.

The likelihood of being above the family plan tax-exclusion cap has even wider variation across the states, from 17.2% in Utah to 63.8% in the District of Columbia. Over 50% of enrollees with family plans would be directly affected in New Hampshire, Connecticut, New Jersey, Maine, Vermont, Alaska, Delaware, and Massachusetts.

The higher likelihood of family plans crossing above the tax-exclusion cap results from the Tax Reform Panel's failure to accurately reflect the relative prices of single and family premiums. Van de Water (2009) asserts that this can be easily rectified by setting a cap at a particular percentile in the distribution for each coverage category (individual, family, etc.). But creating separate caps for different types of coverage would not remedy the wide variation in how many enrollees would be affected across different states.

Likelihood of exceeding cap after accounting for other factors

While the analysis described in the previous section is useful, a better analysis would control for other factors that might affect the size of a premium across states. For instance, industry or union penetration may explain some of the variation in premiums across states. Controlling for these factors (in a logit regression model) allows us to tease

TABLE 2

Share of single and family premiums subject to tax exclusion cap, by state, 2006

	Single plan	Family plan		Single plan	Family plan
United States	19.5%	41.4%	*Missouri*	15.5%	32.7%
Alabama	13.1	27.4	*Montana*	22.3	30.5
Alaska	42.6	53.5	*Nebraska*	26.3	29.1
Arizona	13.3	25.5	*Nevada*	23.5	39.9
Arkansas	13.6	20.2	*New Hampshire*	31.2	61.1
California	16.3	36.0	*New Jersey*	23.1	56.9
Colorado	16.9	48.0	*New Mexico*	12.9	35.6
Connecticut	25.0	59.2	*New York*	20.3	48.0
Delaware	24.9	50.9	*North Carolina*	14.6	49.7
District of Columbia	36.7	63.8	*North Dakota*	12.3	24.4
Florida	18.7	48.3	*Ohio*	19.9	32.6
Georgia	14.0	30.1	*Oklahoma*	21.7	36.1
Hawaii	5.3	21.9	*Oregon*	20.7	45.2
Idaho	12.9	33.9	*Pennsylvania*	20.2	43.1
Illinois	25.0	46.8	*Rhode Island*	36.4	46.7
Indiana	16.0	42.1	*South Carolina*	18.1	35.7
Iowa	16.6	28.5	*South Dakota*	8.9	39.0
Kansas	18.5	32.8	*Tennessee*	19.4	41.9
Kentucky	15.6	37.7	*Texas*	23.2	40.7
Louisiana	12.9	41.7	*Utah*	7.5	17.2
Maine	32.1	53.7	*Vermont*	23.2	53.7
Maryland	14.6	37.6	*Virginia*	22.8	46.2
Massachusetts	27.9	50.0	*Washington*	13.5	48.9
Michigan	23.5	31.5	*West Virginia*	21.2	32.6
Minnesota	23.3	44.1	*Wisconsin*	24.8	44.4
Mississippi	13.5	33.5	*Wyoming*	25.5	38.4

NOTE: Includes private industry and state and local governments.

SOURCE: Calcuations provided by the Agency for Healthcare Research and Quality using data from the Medical Expenditure Panel Survey Insurance Component.

out the "pure" state-level affects. (Refer to Gould and Minicozzi (2009a) for a complete discussion of covariates used in the full regression model.) Even after controlling for these other factors, the coefficient estimates for the state indicators vary in sign and significance, as shown in **Appendix Table 1**.

The magnitudes of the logit model coefficient estimates are easiest to interpret if we define a "typical" establishment and then alter the state to see how the likelihood of enrollees being subject to the tax changes. A prototypical establishment is one that takes on the most common values for a set of establishment- and firm-level characteristics (again see Gould and Minicozzi (2009a)).

Using this common set of characteristics, we can vary just the state to see how the likelihood of premiums exceeding the cap changes by location. **Table 3** illustrates the wide variation in this likelihood, providing specific points in the distribution of single and family plans for comparison.

TABLE 3

Likelihood of exceeding exclusion cap, by state

	Percentage-point deviation from the median			
	Single plans		*Family plans*	
Bottom	-8.4	*(Hawaii)*	-13.5	*(Utah)*
10th percentile	-4.8	*(North Dakota)*	-9.5	*(Arizona)*
25th percentile	-2.6	*(Idaho)*	-4.7	*(Kansas)*
50th percentile	0.0	*(Pennsylvania)*	0.0	*(Wyoming)*
75th percentile	2.3	*(Connecticut)*	5.1	*(Oregon)*
90th percentile	4.6	*(D.C.)*	13.6	*(Vermont)*
Top	13.9	*(Alaska)*	21.5	*(New Hampshire)*
Top - Bottom	22.3		34.9	
90th - 10th	9.4		23.1	
75th - 25th	4.9		9.8	

NOTE: Median predicted probability for prototypical characteristics is 0.109 for single plans and 0.236 for family plans. Prototypical establishment is a professional services, incorporated for-profit firm with at least 1,000 employees and a union penetration of less than 20%, in existence at least 20 years, less than 20% of their workforce over age 50 and less than 20% part-time, 20-39% of the workforce female, and with an average wage rate of $37,000.

SOURCE: Author's calculations based on logit regressions provided by the Agency for Healthcare Research and Quality using data from the Medical Expenditure Panel Survey Insurance Component.

This analysis shows that Pennsylvania lies in the middle of the spread when it comes to the share of single-plan enrollees that would be affected by a cap. Enrollees in Hawaii are least affected whereas those in Alaska are 22.3 percentage points more likely to be affected than those in Hawaii. While the variation remains at all points in the distribution, the likelihood of being affected for the majority of enrollees in the prototypical establishment across states falls within 5 percentage points of each other.

The results for family plan enrollees are similar to those with single plans, yet even more disperse. The lowest likelihood occurs in Utah, and the highest in New Hampshire, resulting in a spread of nearly 35 percentage points. The range from the state at the 90th percentile to the 10th is 23.1 percentage points, over twice as wide as what was found among single plan enrollees.

While there is a wide distribution across and within states in terms of the size of tax-preferred premium and thus likelihood of being directly affected by a cap, there is a fair amount of "noise" or variability in any state measure in a given year. Weighting the state-level likelihoods by the number of those under age 65 with employer-sponsored insurance in the combined 2006-07 years (see **Appendix Table 2**) allows for a measure of regional variability. **Table 4** aggregates the state-level results to create this regional measure of variability in the likelihood of exceeding the cap value.

As before, a "typical" establishment is used to generate these predicted probabilities. The levels found in Table 4 are specific to the prototype chosen and does not reflect the range or even the average likelihood within each state; it is simply used to illustrate the variability across states or regions.

A single-plan enrollee in a typical establishment in the Northeast would have a 11.5% likelihood of exceeding the cap. The likelihood falls to 8.6% for an enrollee in the West. Much of the variability in the state-level results disappears when aggregating up to the regional level of analysis. Even at the level of regional sub-groupings (with nine categories), the highest likelihood is in New England, with a 15.2% likelihood, and the lowest is in the Pacific, with an 8.5% likelihood.

Family-plan enrollees experienced slightly more variability, from a high likelihood of 30.3% in the Northeast down to 21.7% in the West. Among the sub-regions, New

TABLE 4

Regional differences in likelihood of exceeding exclusion cap

	Single plans	Family plans
NORTHEAST	**11.5%**	**30.3%**
New England	15.2	34.6
Middle Atlantic	10.1	28.7
MIDWEST	**11.8**	**22.4**
East North Central	12.4	23.4
West North Central	10.2	19.9
SOUTH	**10.7**	**24.4**
South Atlantic	9.7	22.2
East South Central	10.3	25.5
West South Central	12.1	23.3
WEST	**8.6**	**21.7**
Mountain	8.6	19.9
Pacific	8.5	22.5

SOURCE: Author's calculations based on logit regressions provided by the Agency for Healthcare Research and Quality using data from the Medical Expenditure Panel Survey Insurance Component weighted by ESI enrollments in each state.

England is still the highest with a 34.6% likelihood. Mountain and West North Central tie for the lowest likelihood of being affected among family plan enrollees at 19.9%.

Crafting policy

This paper finds nontrivial regional variation in the likelihood of an enrollee being affected by a cap on the share of employer-sponsored insurance that is excluded from taxes. While the regression analysis includes a set of establishment-level characteristics, premiums may vary across states for multiple reasons not controlled for in the empirical model. These factors include the cost of living, supply of doctors, and state mandates. Given all of these factors, what can and should be done to address this variability?

Van de Water (2009) argues that the amount of premiums subject to taxes can be adjusted by firm's location, to account for the fact that some covered workers may live in an area with high health care spending or insurance costs. Dorn (2009) suggests setting a cap on the actuarial value of the insurance policy as opposed to the strict premium to account for variation in premium by workforce characteristics (including location). While these solutions may help equalize the burden across states, the fact that some states are much more expensive than other requires additional thought.

Evidence compiled by CBO (2008) on Medicare spending illustrates wide variation in spending and trends in spending across geographical areas. They find that high Medicare spending areas are not associated with better outcomes. In fact, in some cases, high spending is associated with care that is poorer in quality and does not necessarily produce improvements in aggregate health. Fisher et al. (2009) suggest that geographical variation is related to how physicians respond to the availability of technology, capital, and other resources. Better incentives for physicians to treat patients more efficiently and effectively may better slow spending growth. Capping the exclusion is a rather blunt instrument to encourage high cost areas to act more efficiently.

One of the stated goals of the policy of taxing health benefits is to contain the growth rate of costs. Taxing health benefits would not only raise money, advocates say, but it would put pressure on states to lower costs. Therefore, setting a cap based on the actuarial value or adjusting it across states may be at cross-purposes with this objective. Furthermore, as legislators consider putting conditions on

the tax cap or treating states differently, it is important to remember that there is also substantial within state variation in premiums that will make any state-level adjustment uneven and any fully disaggregated adjustment administratively burdensome.

Conclusion

In a climate of substantial budget deficits, the prospect of recouping upwards of $200 billion by taxing some portion of health benefits is enticing. But we should proceed with extreme caution before moving to cap or eliminate the current tax exclusion. In trying to pay for coverage expansions, taxing health care benefits should not be the first place we look, but rather the last, and only after large-scale health reform is in place to cover everyone.

Capping the tax exclusion is enticing to some not only because it would raise money for health reform, but because it might, they argue, contain costs. Proponents argue that taxing benefits would contain costs by encouraging people to buy cheaper, less-comprehensive coverage. The logic is that, if patients have to pay a higher share of the costs of visiting the doctor (through higher deductibles or higher co-payments), then they will consume health care services more cautiously (though it should be noted not necessarily more wisely).

The potential gains in cost containment from taxing health benefits are exaggerated. About 80% of health costs are borne by 20% of the population. Serious cost containment measures should deal with bringing down the costs of the most expensive cases in our system (e.g., managing chronic diseases) by reforming the health care delivery system.

There is no question that a tax cap policy will encourage some to purchase less expensive health insurance, but this isn't necessarily advisable. All else equal, "less expensive" equals "less comprehensive." This is explicitly a policy to drive down the comprehensiveness of health insurance. And as the comprehensiveness or quality of coverage erodes, the out-of-pocket burden increases.

Gabel et al. (2009) recently found that out-of-pocket costs increased by 34% from 2005 to 2007. They conclude that these higher costs are particularly burdensome for people who are sick or have modest incomes. These trends would only expect to worsen under a tax cap policy.

Furthermore, Himmelstein et al. (2009) find that well over half of all bankruptcies are associated with high medical expenses, even more surprising considering that three-fourths of medical debtors actually had health insurance. This is clear evidence that, for even those lucky enough to have health insurance, their coverage is not enough to prevent financial catastrophe.

A policy of taxing health benefits over a certain dollar amount may do great harm to people we should be striving to help.

— (The author wishes to acknowledge CWA for their assistance in funding this research.)

Appendix

APPENDIX TABLE A1

Logit estimates of the likelihood tax-preferred premiums exceed tax exclusion cap, 2006

	Single plans		Family plans	
Parameter	*Coefficient*	*Standard errors*	*Coefficient*	*Standard errors*
State (baseline WY)				
Alabama	-0.3841	(0.157)**	-0.5197	(0.110)***
Alaska	1.0351	(0.289)***	0.5993	(0.322)*
Arizona	-0.3961	(0.146)***	-0.6301	(0.117)***
Arkansas	-0.3832	(0.194)**	-0.9424	(0.158)***
California	-0.1954	(0.055)***	-0.1854	(0.044)***
Colorado	-0.1074	(0.128)	0.2891	(0.096)***
Connecticut	0.2611	(0.126)**	0.7778	(0.100)***
Delaware	0.474	(0.239)**	0.4977	(0.220)**
District of Columbia	0.4517	(0.182)**	0.6823	(0.189)***
Florida	0.0203	(0.066)	0.2507	(0.058)***
Georgia	-0.2364	(0.107)**	-0.408	(0.082)***
Hawaii	-1.505	(0.338)***	-0.8996	(0.223)***
Idaho	-0.2526	(0.297)	-0.0219	(0.195)
Illinois	0.2678	(0.072)***	0.3132	(0.059)***
Indiana	-0.0638	(0.114)	0.0131	(0.082)
Iowa	-0.0497	(0.169)	-0.4112	(0.122)***
Kansas	0.0463	(0.182)	-0.2823	(0.129)**
Kentucky	-0.1763	(0.142)	-0.0337	(0.102)
Louisiana	-0.4263	(0.156)***	0.0772	(0.113)
Maine	0.5943	(0.202)***	0.6766	(0.194)***
Maryland	-0.3893	(0.124)***	-0.1734	(0.092)*
Massachusetts	0.3245	(0.087)***	0.2967	(0.074)***
Michigan	0.2462	(0.088)***	-0.3886	(0.073)***
Minnesota	0.1875	(0.102)*	0.1556	(0.079)**
Mississippi	-0.1737	(0.200)	-0.0338	(0.153)
Missouri	-0.3396	(0.115)***	-0.375	(0.093)***
Montana	0.0549	(0.309)	-0.3994	(0.300)
Nebraska	0.3835	(0.175)**	-0.6253	(0.140)***
Nevada	0.3049	(0.140)**	-0.0301	(0.141)
New Hampshire	0.8209	(0.200)***	0.9756	(0.194)***
New Jersey	0.1058	(0.087)	0.65	(0.069)***
New Mexico	-0.3811	(0.279)	-0.1683	(0.200)
New York	-0.2059	(0.065)***	0.1475	(0.051)***
North Carolina	-0.1975	(0.097)**	0.4864	(0.077)***
North Dakota	-0.5812	(0.407)	-0.7482	(0.282)***
Ohio	0.0718	(0.084)	-0.2632	(0.062)***
Oklahoma	0.221	(0.151)	-0.1196	(0.129)
Oregon	-0.0577	(0.137)	0.2636	(0.116)**
Pennsylvania	0.046	(0.072)	0.1219	(0.057)**
Rhode Island	0.8022	(0.215)***	0.2133	(0.191)
South Carolina	0.0494	(0.138)	-0.2169	(0.118)*
South Dakota	-0.9591	(0.437)**	-0.0393	(0.235)
Tennessee	0.1878	(0.112)*	0.1659	(0.086)*
Texas	0.278	(0.062)***	0.0644	(0.053)
Utah	-0.8421	(0.283)***	-1.0047	(0.174)***
Vermont	0.2089	(0.327)	0.6494	(0.264)**
Virginia	0.3186	(0.091)***	0.2196	(0.075)***
Washington	-0.5862	(0.122)***	0.3269	(0.098)***
West Virginia	0.2261	(0.225)	-0.2462	(0.192)
Wisconsin	0.3821	(0.105)***	0.2046	(0.080)**

NOTE: Estimates were constructed using relative weighted enrollments. Both regressions include a set of covariates for industry, firm size, firm age, ownership, unionization, percent part-time, percent 50 years or older, percent women, and average annual salary. See Gould and Minicozzi (2009a) for full results. *p<.10 ** p<.05 *** p<.01. Family plans include plus-one plans.

SOURCE: Calcuations provided by the Agency for Healthcare Research and Quality using data from the Medical Expenditure Panel Survey Insurance Component.

APPENDIX TABLE A2

Employer-sponsored health insurance coverage for population under 65 years old, by state, 2006-07

State	Percent with coverage	Number with coverage
Nationwide	62.9%	164,477,595
Alabama	65.5	2,586,526
Alaska	59.9	372,489
Arizona	56.8	3,186,250
Arkansas	55.5	1,355,088
California	56.3	18,243,582
Colorado	63.7	2,783,810
Connecticut	72.3	2,179,392
Delaware	70.7	529,375
District of Columbia	61.6	314,985
Florida	58.0	8,778,183
Georgia	62.6	5,375,452
Hawaii	72.5	787,694
Idaho	64.5	837,005
Illinois	67.8	7,630,489
Indiana	70.5	3,922,393
Iowa	70.9	1,809,588
Kansas	65.2	1,544,286
Kentucky	61.3	2,233,565
Louisiana	54.4	1,989,144
Maine	65.0	728,637
Maryland	70.5	3,481,732
Massachusetts	70.5	3,873,080
Michigan	69.5%	6,007,798
Minnesota	71.5%	3,254,361
Mississippi	53.7%	1,377,026
Missouri	64.8%	3,258,943
Montana	58.0	472,267
Nebraska	66.9	1,040,168
Nevada	66.2	1,481,756
New Hampshire	75.4	867,138
New Jersey	69.7	5,230,028
New Mexico	50.7	862,896
New York	62.9	10,419,238
North Carolina	59.1	4,677,646
North Dakota	65.6	353,365
Ohio	68.7	6,817,881
Oklahoma	56.7	1,733,015
Oregon	61.4	2,010,376
Pennsylvania	70.2	7,369,039
Rhode Island	68.7	631,090
South Carolina	61.0	2,289,418
South Dakota	65.3	436,197
Tennessee	60.0	3,122,406
Texas	53.5	11,203,355
Utah	66.8	1,591,346
Vermont	67.0	360,147
Virginia	67.3	4,546,868
Washington	66.5	3,794,330
West Virginia	62.1	970,788
Wisconsin	71.9	3,462,852
Wyoming	65.1	293,125

SOURCE: Author's analysis of the March Current Population Survey, 2007-08.

References

Congressional Budget Office (CBO). 2008. Geographic variation in health care spending.

Dorn, Stan. 2009. *Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible?* Washington, D.C.: Urban Institute.

Fisher, Elliott S., Julie P. Bynum, and Jonathan S. Skinner. 2009. Slowing the growth of health care costs–lesson from regional variation. *The New England Journal of Medicine*, 360(9): 849-852.

Gabel, Jon R., Roland McDevitt, Ryan Lore, Jeremy Pickreign, Heidi Whitmore, and Tina Ding. 2009. Trends in underinsurance and the affordability of employer coverage, 2004-2007. *Health Affairs*, Vol. 28, No. 4. pp. w595-w606.

Gould, Elise. 2008. *The Erosion of Employer-Sponsored Health Insurance*. EPI Briefing Paper #223. Washington, D.C.: Economic Policy Institute.

Gould, Elise. 2009. *How Capping the Tax Exclusion May Disproportionately Burden Children and Families.* Washington, D.C.: Economic Policy Institute and First Focus.

Gould, Elise, and Alexandra Minicozzi. 2009b. Who loses if we limit the tax exclusion for health insurance? *Tax Note*s, Vol. 122, No. 10, pp. 1259-62.

Gould, Elise and Alexandra Minicozzi. 2009a. *Who is Adversely Affected by Limiting the Tax Exclusion of Employment-Based Premiums?* Economic Policy Institute Working Paper Number 281. Washington, D.C.: EPI.

Himmelstein, David U., Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler. 2009. Medical bankruptcy in the United States, 2007: Results of a national study. *The American Journal of Medicine*, Vol. 20, No. 10.

Van de Water, Paul. 2009. *Limiting the Tax Exclusion for Employer-Sponsored Insurance Can Help Pay for Health Reform*. Washington, D.C.: Center on Budget and Policy Priorities.