RESEARCH REPORT

Building a Better "Cadillac"

Henry J. Aaron
BROOKINGS INSTITUTION

Linda J. Blumberg
URBAN INSTITUTE

Paul B. Ginsburg
BROOKINGS INSTITUTION

Stephen Zuckerman
URBAN INSTITUTE

January 2017

URBAN INSTITUTE

USC Schaeffer
Leonard D. Schaeffer Center for Health Policy & Economics

Center for Health Policy at BROOKINGS

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.

ABOUT THE LEONARD D. SCHAEFFER INITIATIVE FOR INNOVATION IN HEALTH POLICY

The Leonard D. Schaeffer Initiative for Innovation in Health Policy is a partnership between the Center for Health Policy at Brookings and the USC Schaeffer Center for Health Policy & Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings.

Contents

Acknowledgments

This report was funded by the Robert Wood Johnson Foundation and the Schaeffer Initiative for Innovation in Health Policy. We are grateful to them and to all our funders, who make it possible for Urban and Brookings to advance their missions.

The authors are grateful for helpful comments and suggestions from Matt Fiedler, John Holahan, Robert Reischauer, Alice Rivlin, and Sylvester Schieber. The views expressed are those of the authors and should not be attributed to the Urban Institute, the Brookings Institution, their trustees, or their funders. Funders do not determine research findings or the insights and recommendations of Urban or Brookings experts.

Executive Summary

The excise tax on high-cost health insurance plans, a provision of the Affordable Care Act (ACA), has the potential to achieve two important goals by curbing the open-ended exclusion of employer-financed health insurance from personal income and payroll taxes. It will reduce the incentive to offer health insurance with features that permit or encourage excessive health care spending. It will also generate revenues that offset the costs of health insurance expansion.

The objective of curbing the employer exclusion has enjoyed bipartisan support among health and public finance economists for decades.[1] Many supporters reason that the unlimited exclusion from personal income and payroll taxes encourages companies to offer, and their employees to select, coverage so generous that people use more health care (in both quantity and price) than is optimal. Others oppose the exclusion because it is regressive, reducing taxes most for high-income households and least for low-income households. The Cadillac tax simultaneously raises revenue progressively and advances the broader objectives of curbing overly generous insurance coverage.

The Cadillac tax has drawn five main criticisms that we address in this paper:

- The tax does not sufficiently allow for variation in health insurance costs by location, business type, worker health status, and other idiosyncratic features of particular businesses or their labor forces. We outline ways to address this problem.
- The indexing rules used to update the threshold at which the tax begins to apply almost certainly will eventually extend the tax to plans that are not unduly generous. We suggest indexing the thresholds based on GDP or GDP plus 0.5 percent instead.
- To avoid the tax, employers may take actions that increase deductibles and other cost-sharing. These steps, in turn, may discourage use of effective health care and/or unduly burden low- and moderate-income households with high medical expenses. This serious problem can be addressed by providing direct financial aid to financially vulnerable people in the form of tax credits, direct assistance through the ACA Marketplaces, or other means.
- Some members of Congress have proposed a cap on the exclusion, instead of an excise tax.[2] In practice, the two approaches are likely to produce similar effects. Either approach would be superior to simple repeal of the Cadillac tax, although we prefer the cap on the exclusion

because it is more straightforward to address the problem of an unlimited exclusion by limiting it, and the cap is likely to be somewhat more progressive.

- The tax would discourage flexible spending accounts because such accounts alone may trigger the tax, regardless of total premiums. A simple solution to this problem is at hand with the Obama administration's recommendation to permit employers to average such deposits over their workforce and add this amount to employer premium costs when computing Cadillac tax liability.

The Cadillac tax was originally scheduled to begin in 2018. On December 3, 2015, Congress voted to suspend implementation for two years. A majority of both houses of Congress seemed to support repeal. Delay won out because repeal would have boosted the deficit much more than postponement did under budget scoring rules. Now, with the election of a president who has pledged to repeal all or most elements of the ACA, even delayed implementation of the tax is in doubt. We believe that a modified version of the Cadillac tax can still play a valuable role both in fostering health care cost containment and in providing revenues to expand coverage, either under a modified version of the ACA or in an alternative that achieves a similar level of coverage.

Building a Better "Cadillac"

Introduction

The "Cadillac tax," a provision of the Affordable Care Act (ACA), is an excise tax on high-cost employer-sponsored health coverage. The tax was intended to partially curb the effects of excluding employer-financed health insurance from personal income and payroll taxes (see box for details on the tax).[3] The tax has two broad purposes:

- to reduce an incentive arising from an unlimited exclusion for employers to offer health insurance with features that permit or encourage excessive health care spending
- to generate revenues that could be used to help offset costs of health insurance expansion or other government spending

The Cadillac tax has drawn five main criticisms:

- The tax does not sufficiently allow for variation in health insurance costs by location, business type, worker health status, and other idiosyncratic features of particular businesses or their labor forces.
- The indexing rules used to update the threshold at which the tax begins to apply may eventually extend the tax to plans that are not unduly generous.
- As employers try to hold down premiums to avoid the tax, they may take actions that increase deductibles and other cost-sharing, which in turn may discourage use of effective health care and unduly burden low- and moderate-income households with high medical expenses.
- A cap on the exclusion from personal income and payroll taxes may work better than an excise tax on insurance. Some congressional Republicans working on plans to "replace" the insurance expansion components of the ACA have discussed a cap on the exclusion to generate revenue to support tax credits for those purchasing individual insurance.[4]
- The tax would discourage flexible spending accounts because such accounts alone may trigger the tax, regardless of total premiums.

The Cadillac tax was originally scheduled to begin in 2018. On December 3, 2015, Congress voted to suspend implementation for two years. A majority of both houses of Congress seemed to support repeal. Delay won out because repeal would have boosted the deficit much more than postponement did under budget scoring rules. Now, with the election of a president who has pledged to repeal all or most elements of the ACA, even delayed implementation is in doubt. We believe that a modified version of the Cadillac tax can still play a valuable role in providing revenues to expand coverage, either in a modified version of the ACA or in an alternative that achieves a similar level of coverage.

The objective of curbing the employer exclusion has enjoyed bipartisan support among health and public finance economists for decades.[5] Many supporters reason that unlimited exclusion from personal income and payroll taxes encourages companies to offer, and their employees to select, coverage so generous that people use more health care (in both quantity and price) than they would otherwise. Others oppose the exclusion because it is regressive, reducing taxes most for high-income households and least for low-income households. The Cadillac tax simultaneously raises revenue progressively and advances the broader objectives of curbing overly generous insurance coverage.

This paper addresses criticisms of the Cadillac tax and proposes the following improvements to achieve the core goals of the policy.

Recommendations

Allowing for Variation in the Costs of Coverage

The Cadillac tax is designed to apply above separate premium thresholds for single coverage and family coverage. A few high-cost states have somewhat higher thresholds for plans that insure retirees ages 55 and older or workers in high-risk industries specified in the ACA. Thresholds may also differ based on the age and sex composition of a company's workforce.[6] Making such adjustments is administratively straightforward because of the wealth of data available for computing expected health cost differences by age and sex.

Adjustments by state and industry are considerably more complicated. Breadth of coverage varies significantly, in part because of differences in worker health status. Health care spending also differs regionally because of variation in the prices of medical care inputs and in medical practice patterns.

Both industry and regional adjustments warrant close attention. Industry adjustments beyond those specified in the ACA may be appropriate if data support them.

POTENTIAL ADJUSTMENT FOR EMPLOYER SIZE

Premiums vary with the size of the insured group because administrative costs per insured person are higher for small groups than for large groups. The ACA explicitly recognizes the variation in health care premiums by size of employer group in its rules for medical loss ratios.[7] For plans serving groups of 51 or more employees, insurers may retain up to 15 percent of premiums for purposes other than claims and activities to improve health care quality. For plans serving 50 or fewer employees, insurers may retain up to 20 percent of premium income for these purposes. Large employers typically have loading charges substantially lower than the 15 percent maximum (CRS 1988). An adjustment allowing for variation in administrative expenses by employer size should be built into the Cadillac tax.

POTENTIAL ADJUSTMENT FOR GEOGRAPHIC DIFFERENCES

After Congress delayed implementation of the Cadillac tax from 2018 to 2020, the Obama administration proposed in its 2017 budget to introduce a modicum of regional variation in the thresholds above which the Cadillac tax applies (Furman and Fiedler 2016). Specifically, the administration proposed that the tax be imposed above the *greater* of the original threshold—$10,200 for individuals and $27,500 for families (updated to 2020 using the consumer price index for all urban consumers [CPI-U] plus 1 percent in 2019)—or the cost of the ACA's nongroup Marketplace gold plan coverage for each state or substate geographical area.[8] (The proposal actually sets the alternative threshold for self-only coverage at $^{8}/_{7}$, or 114 percent, of the premium of the statewide average for each age and county of the lowest-cost silver plan offered through the ACA Marketplaces, a measure designed to approximate premiums for gold-like 80 percent actuarial value coverage.) This change would immediately lower the number of plans to which the Cadillac tax applies. It would also slow the expansion of the tax's reach because gold-level premiums would be expected to rise with health care spending, which has increased considerably faster than the CPI-U.

Whether the Obama administration's plan adjusts the thresholds in the "right" areas is unclear. Neither the level nor the rate of change of premiums in the nongroup market—which generates the premiums that would set the thresholds—is necessarily closely linked to premiums that employers face. The correlation across states between the average employer premium within each state and the ACA premium that the 2017 budget would use as an alternative to the current Cadillac tax thresholds is 0.43, based on data from Marketplaces and the Medical Expenditure Panel Survey Insurance Component

analyzed by the Urban Institute. This means that state-to-state variation in Marketplace premiums accounts for just 18.5 percent ($0.43^2 = 0.185$) of the variation in average employer premiums.

This estimate actually overstates the correspondence between ACA premiums and individual company premiums for employer-sponsored health insurance; statewide averages obscure the considerable variation in premiums across individual companies. Costs for companies that self-insure are specific to each company (aside from costs pooled via reinsurance). Some businesses buy coverage from insurance companies with premiums based on area averages adjusted for the idiosyncratic loss experience of each company.

A deeper question for any effort to curb "excess" premiums is what factors causing regional or industrial variation in health costs *should* be discouraged. If such variation results from health care that is medically excessive or from needlessly high prices (for example, from hospital prices inflated by a large hospital group with monopoly power or from very broad provider networks), then adjusting the Cadillac tax for such variation would work *against* the purposes of the tax. On the other hand, if premium variations arise from "legitimate" causes, such as differences in average health status across employer groups or regional variation in the prices of medical inputs, adjustments in Cadillac tax thresholds based on such factors would make the tax fairer and support the objectives of the tax.

In summary, regional or industrial variation in the Cadillac tax threshold is *analytically* justified if (1) it targets the "right" sources of variation in premium costs and (2) sufficient data are available to make the adjustment fairly. Even if these conditions are not fully satisfied, an imperfect adjuster, such as that proposed in Obama's 2017 budget, may attenuate political opposition and preserve an imperfect instrument, such as the Cadillac tax, that can do more good than harm.

We are aware of only one currently available geographic adjustment algorithm that meets this analytic standard. The Centers for Medicare & Medicaid Services (CMS) use local wage levels and certain other input prices to adjust some reimbursements to hospitals and other providers.[9] The CMS adjusters have been criticized (MaCurdy et al. 2009), and the agency has modified them periodically. CMS does not adjust for regional variation in practice patterns or illness intensity.

We believe that regional adjustment in Cadillac tax thresholds based on input prices is more consistent with the stated purpose of the tax than are adjustments based on premiums, which also vary by practice patterns—the very behavior that the Cadillac tax is intended to influence. The bottom line is that it is hard to be sure whether adjusting the threshold above which the Cadillac tax applies (other than for input price variations) is a move in the right direction. These doubts apply to the Obama administration's proposed use of ACA nongroup gold-level premiums as an adjuster.

POTENTIAL MODIFICATION TO ACCOUNT FOR HEALTH STATUS VARIABILITY ACROSS EMPLOYERS

For small-group plans in the fully insured market (those serving firms with 50 or fewer workers), variability in employee health status has been addressed by an ACA provision on modified community rating.[10] Specifically, all plans face the same premiums for workers of the same age and tobacco use status, regardless of the claims experience of the group. Although many small employer plans were given additional time to meet ACA rules, this extension will have ended before the date that the Cadillac tax is now scheduled for implementation. However, managers of small-group plans with below-average risks may try to lower their premiums by self-insuring and buying stop-loss insurance to protect themselves against the risk that in some years, one or a few very sick employees or dependents could accrue health costs beyond what they can absorb (Buettgens and Blumberg 2012; Jost and Hall 2013).[11] The ACA's modified community rating rules do not apply to self-insured employer plans. Movement of employers with healthier workforces to self-insurance could lead to higher premiums for those employers remaining under modified community rating rules in the fully insured market, and the Cadillac tax would compound the impact.

We believe that this issue must be addressed and that the Cadillac tax implications add to the urgency. Discussion of policy remedies is beyond the scope of this paper, but the National Association of Insurance Commissioners developed one option in its Stop-Loss Insurance Model Act. This approach would set floors for self-insurance stop-loss deductibles (also known as attachment points), reducing the incentive for small firms to self-insure by increasing the financial risk of doing so (Chollet 2012; NAIC 2015). Other approaches may address this issue specifically in the context of the Cadillac tax, but we believe that policies should tackle the underlying problem rather than mitigate an additional undesirable effect.

Among larger employers, which do not have ACA modified community rating, the Cadillac tax would affect those with less healthy workforces disproportionately (after adjustment for age and sex). This is likely to be a more significant problem for medium-sized employers than for large employers; the larger the employer risk pool, the more likely that risk pool is to mirror the risk of the broader employed population in the area. Because data on health status variation across employers is limited, we cannot gauge the magnitude of the problem, and we do not have solutions beyond the Cadillac tax provision of higher limits for "high-risk professions," although we recognize this as an issue worthy of additional analysis.

Using a Better Index to Update Thresholds

The ACA stipulates that the ceilings on per worker health insurance premiums above which the Cadillac tax applies will be based on the consumer price index for urban residents, or CPI-U. Over any extended period, insurance premiums closely track the growth of per person health care spending. From 1965 to 2006, annual growth of per capita health care spending was 4 percentage points higher than annual increase in the CPI-U. Between 2006 and 2015, that gap narrowed to 1.6 percentage points, which is still substantial. Growth of per person health care spending likely will continue to exceed growth of consumer prices. For that reason, growth of health insurance premiums is almost as likely to exceed growth of the CPI-U. Thus, the Cadillac tax will almost certainly apply to ever more insurance plans, and the wider the gap, the faster the "bite" of the tax will spread to more plans and hit larger portions of the premiums it affects. Obama administration analysts estimated that initially only 7 percent of employees and 1 percent of health expenditures would be affected by the tax (US Department of the Treasury 2016).[12]

Because the gap between growth of per person health care spending and insurance premiums and growth of consumer prices is likely to persist, current indexing rules mean that the Cadillac tax will apply to growing proportions of insurance plans, employees, and premiums.[13] Whether such tax creep is desirable depends on one's answers to a number of questions: (1) Should the linkage of health insurance to employment, which is strongly encouraged by the exclusion from tax of employer-financed health coverage, be gradually phased out? (2) If so, is gradually narrowing the exclusion the best way to achieve that goal? (3) To what extent would shifting to the insured an increased proportion of the cost of care at time of use promote cost consciousness and lower the growth of spending without causing people to forgo needed care?

The answers to these questions should determine one's views on whether the long-term use of the CPI-U to index the Cadillac tax ceilings is a flaw or a virtue. The express purpose of the Cadillac tax is to prod employers to redesign insurance plans to control health care spending by administrative methods and by increasing covered employees' sensitivity to the cost of health care. We view the choice of the CPI-U over a standard tied more closely to health spending as a less-than-transparent transition strategy. Drafters of the provision may have intended the tax to eventually affect 20 or 25 percent of employees but initiated the process at a threshold affecting only 7 percent to make the policy more politically feasible. Using a threshold index that is likely to increase less than premiums could achieve this outcome over many years.

However, we do not believe that indexing with CPI-U is a wise policy unless it is limited to a few years. Using an unsustainable index and relying on future Congresses to switch to a more suitable long-term index at the right moment is not a good strategy, as we saw in the 1997 sustainable growth rate provision, which took almost two decades to correct. Instead, we suggest that policymakers convert to an index based on GDP either at the beginning of a Cadillac tax or after a limited number of years. Although discussions during the previous decade often cited GDP plus 1 percent as a suitable target for health spending growth, the low spending trend of the last few years suggests that GDP or GDP plus 0.5 percent might be a better goal.

We believe that the reach of the current tax is reasonable. But we are equally convinced that the current indexing rules will ultimately force employers either to drop sponsorship of health insurance or to impose highly onerous cost-sharing on workers. We take no position here on whether ending employer-sponsored health insurance might become desirable at some time in the future, but we acknowledge the problems created by linking access to health insurance to one's place of employment. This linkage means that job loss or job change may interrupt health insurance coverage.

However, stable diverse pools are essential for the operation of private health insurance. At present, such pooling occurs most consistently and effectively through the workplace. Most workforce participants and their families receive insurance through employment-based coverage. Though the ACA's insurance market reforms have increased risk pooling through nongroup insurance markets, these pools have not yet reached a stable equilibrium in a significant number of geographic areas; this can be observed in large annual premium increases and decreasing insurer competition. Further policy changes likely will be necessary to correct market challenges in these areas. *Until those markets are strengthened and stabilized or until some other pooling mechanism becomes administratively and politically feasible, workplaces must remain a secure source for health insurance risk pooling.* The risks associated with undermining employer-based insurance are much greater in an environment in which significant portions of the ACA are repealed.

Providing Direct Aid to Financially Vulnerable People

An excise tax (or an exclusion cap) could change the structure of health insurance in three ways:

- **Benefit design.** The proportion of the cost of services used that insurance pays for can be reduced by boosting deductibles, copayments, and coinsurance; by reducing covered benefits;

and/or by varying payments or disallowing them altogether based on analysis of the medical value of care.

- **Administrative procedures**. Insurers could introduce administrative methods to reduce health care use, such as requiring prior authorization for certain services or selectively contracting with providers who use costly therapies sparingly.
- **Network design.** Insurers could negotiate reduced prices from providers and deny reimbursement or charge higher cost-sharing for other providers. They could also require tiered formularies to discourage use of drugs judged to be less effective or costlier than available alternatives.

To the extent that these measures lower provider prices or reduce the use of care, they may not increase, and in some cases may decrease, out-of-pocket spending. But narrowing covered services and raising deductibles, copayments, and coinsurance may add to out-of-pocket costs, especially for seriously ill patients. Out-of-pocket costs may increase as well if narrow provider networks lead to more use of out-of-network providers with higher cost-sharing requirements. Cost-sharing increases can have the opposite effect, at least in the short run, by discouraging people from initiating care. Added out-of-pocket expenses can cause those with low or moderate incomes to forgo needed care or incur heavy debt burdens. Some of the money the Cadillac tax raises should be devoted to solving some of the problems that it can be expected to create. The question is how best to do that.

TAX CREDITS

Some of the revenue raised by the Cadillac tax (or a cap on the tax exclusion for employer coverage) could be used to help defray out-of-pocket medical expenses for those with low or modest incomes. During her presidential campaign, Hillary Clinton proposed a refundable income tax credit of up to $2,500 per person ($5,000 per family) to help defray out-of-pocket health care costs in excess of 5 percent of income.[14] The credit would be available to people who are not eligible for Medicare and who do not claim medical expenses as an itemized deduction on their personal income tax returns.

The credit would provide considerable relief to some, but it has a few shortcomings. For all filers, help would be delayed until the succeeding year when tax returns are filed. Most upper-middle-class filers can afford to pay more than 5 percent of income out-of-pocket for health care. But for lower-middle-income filers or those with meager liquid savings, the payment delay could cause significant hardship. Securing the aid would require additional record keeping. Some people would have to file tax returns who otherwise would not have to do so. Moreover, a $2,500 credit would not adequately

address the added out-of-pocket expenses for patients with very serious illnesses who are covered by employer plans providing very limited coverage or even bronze- or silver-like coverage.

ACA INSURANCE MARKETPLACES

Protection from large out-of-pocket medical expenses could be provided instead through the health insurance Marketplaces established under the ACA. The Marketplaces could be used in one of two ways. First, they could be used to determine eligibility for out-of-pocket assistance with the same income determination process currently used for advanced premium tax credits and cost-sharing reductions. A person deemed eligible for an out-of-pocket cost subsidy could be provided with an electronic mechanism (similar to a supplemental insurance card for a specified benefit amount) that could be used to pay providers for care as it is incurred.

Alternatively, the ACA Marketplaces could be used as the source of coverage for workers offered employer-based insurance with high cost-sharing requirements relative to the worker's income. This approach would require easing the firewall between employer-based coverage and Marketplace coverage, but it could simplify administration of the assistance. For example, workers whose employers offer them coverage for which the out-of-pocket maximum exceeds a specified percentage of the worker's income could opt to enroll themselves and their dependents in Marketplace coverage instead. These eligible workers would be entitled to the same premium assistance and cost-sharing reductions provided to other Marketplace enrollees, and their employers would be required to make premium contributions to the Marketplace consistent with their contributions to other workers enrolling in the company's plan.

Increased out-of-pocket medical expenses arising from the Cadillac tax would be indistinguishable from high out-of-pocket medical expenses from any source. One cause of this problem is the so-called family glitch that prevents employees with an unaffordable employer offer of family coverage from entering the Marketplace as long as the offer of individual coverage is deemed affordable (Buettgens, Dubay, and Kenney 2016). Employer-sponsored insurance enrollees may also experience high out-of-pocket expenses for reasons not associated with the various components of the ACA. These problems are beyond the scope of this paper.

Capping the Exclusion

Before the Cadillac tax was enacted, all discussion about curbing the unlimited tax exclusion for employer-financed health insurance centered on eliminating or capping such exclusions under the

personal income and payroll taxes. The Treasury Department study leading up to the Tax Reform Act of 1986 analyzed a proposal to cap the maximum exclusion of employer-financed health insurance at a level that would have preserved the entire exclusion for about 70 percent of workers with employment-based health insurance (US Department of the Treasury 1984, vol. 2). Employer-paid premiums above this cap were to be included in adjusted gross income and in earnings subject to the payroll tax.[15] Two decades later, members of President George W. Bush's Advisory Panel on Federal Tax Reform recommended limiting the exclusion to the average premium for individual and family coverage. To achieve parity between those with employer-financed coverage and those with private nongroup coverage, the panel also proposed identical rules for people without access to employer-financed coverage.

Resistance to an exclusion cap was widespread. Conservatives regarded it as a tax increase. Progressives saw it as a diminution of the appeal of employer-financed health insurance, a fringe benefit dear to organized labor. The excise tax muted opposition from the political left because it could be presented as a tax on insurance companies rather than on individuals. The excise tax's path to enactment is instructive, but under certain assumptions, an excise tax and an exclusion cap will produce identical economic effects. If these assumptions are violated, the effects of the two approaches differ.

Conditions under which the effects of an excise tax and the effects of an exclusion cap are the same. Assume that an exclusion cap and an excise tax apply at the same dollar thresholds. Assume that employers reduce premiums by changing only those plans with premium costs above the thresholds, and that they bring premium costs down exactly to those thresholds. Assume, by convention,[16] that employers care about the *amount* of compensation and less about the *composition*. Both tax provisions would cause employers to shift the savings from curtailing health insurance plans, which are tax-exempt, to wages and salaries, which are taxed at the individual level.

The mix of compensation (wages versus fringe benefits) would change, but the overall amount of compensation would not. Nontaxable compensation would fall; taxable compensation would increase. The increased taxable compensation will generate personal income and payroll tax revenue based on whatever rate applies to each affected individual. The excise tax and the exclusion cap will generate the same revenue, identically distributed. Neither tax will generate any *direct* revenue from penalties on overly costly health insurance. All revenue will be *indirect*, from payroll and income taxes on increased taxable compensation.

In practice, the effects of an excise tax and an exclusion cap would not *be identical*. To the extent that premiums for some insurance plans remain higher than the thresholds, the amount of tax and its

distribution will differ. The excise tax is a flat 40 percent rate under the Cadillac tax; the tax rate under the exclusion cap is the combination of federal and state income tax rates and payroll tax rates.[17]

The difference between a flat rate excise tax and the combined rate of the personal income and payroll taxes is not as substantial as it may appear. The reason is that the combination of the personal income and payroll taxes is generally, but not consistently, progressive. The 12.4 percent Social Security payroll tax applies to earnings (not to capital income) but only up to a ceiling. The earned income tax credit has a phase-out range over which effective marginal tax rates are higher than statutory rates. Similarly, deductions under the personal income tax are phased out for high-income filers. Personal tax rates would also depend on the mix of earned and unearned income.

Of equal or greater importance, employers could react differently to a tax they pay versus a tax their employees pay in their personal tax returns (CBO 2015). Many noneconomists—and more than a few economists—believe that employers will not consistently replace reductions in health insurance premiums with other forms of compensation. Furthermore, any such replacement will not be instantaneous and precise (Blumberg 1999; Gruber 2000).

In preparing revenue estimates for the Cadillac tax, the Joint Committee on Taxation, which supplies Congress with revenue estimates of all tax proposals, posited that most of the revenue from the Cadillac tax would come from shifts in compensation from tax-exempt health insurance to taxable wages and salaries. If this assumption is correct, the amount and distribution of revenue generated by the Cadillac tax and an exclusion cap with the same thresholds would be similar (Blumberg, Holahan, and Mermin 2015). So, too, would be the challenges to fair and effective design, including the question of whether and how to allow for regional and industry differences in health costs and problems from increased cost-sharing for low- and moderate-income families.

In the end, we believe that an exclusion cap is somewhat preferable to the Cadillac tax (or any other excise tax on high-cost plans). Simply put, the most straightforward way to curb distortions caused by *unlimited* exclusion of health insurance from personal tax is to *limit* the exclusion. In addition, to the extent that either penalty applies because employers continue to offer health insurance costing more than the threshold, the exclusion cap will be somewhat more progressive than the excise tax. But either approach is vastly superior to outright repeal or further delay in implementation.

Resolving an Unintended Administrative Issue for Flexible Spending Accounts

Employers and employees may use funds deposited in various types of accounts sheltered from personal income tax, payroll tax, or both to pay for health care or health insurance premiums. Typically, these accounts are combined with health insurance sponsored and financed by employers. The three most important such accounts are:

- **Health savings accounts (HSAs).** These accounts are always linked to high-deductible health insurance. Employers and employees may each make deposits up to statutory annual limits. Any portion of those deposits not spent on health care, together with investment earnings on those balances, may be carried forward indefinitely free of tax. Withdrawals are untaxed until age 65 if used for qualified health care spending and after age 65 without restriction on use. Withdrawals used before age 65 for other purposes are taxed as ordinary income.
- **Health reimbursement accounts (HRAs).** These accounts resemble HSAs, except that only employers may make deposits into them and unspent balances revert to the employer when the worker leaves the firm's employment.
- **Flexible spending accounts (FSAs).** These so-called cafeteria plans are accounts authorized by employers into which employees may direct a portion of their compensation up to statutory annual ceilings for health services and child care. FSA funds used for the employee's share of health insurance premiums or other qualified health care outlays are exempt from personal income or payroll taxes. Unlike HSAs or HRAs, unused FSA balances are forfeited if not used in the year when funds are deposited in them, but up to $500 may be carried forward for up to three months.

To compute the base for the Cadillac tax, amounts allocated to any of these three types of accounts are added to premiums for health insurance (see example 3 in box). Given the logic of the Cadillac tax, this procedure is sound and does not introduce any special problems with respect to HSAs and HRAs. The amounts deposited by employers in HSA and HRAs are normally uniform across all covered employees. The same is not true of FSAs. Each worker decides annually whether and how much to deposit into an FSA. These decisions may trigger Cadillac tax responsibility for employers and must be computed on a worker-by-worker basis. This nonuniformity complicates administration for employers who must keep track of those deposits, worker by worker and year by year. To eliminate this administrative hassle, the Obama administration proposed in its 2017 budget that Congress authorize employers to average such deposits over their workforce and add this amount to employer premium

costs when computing Cadillac tax liability. The proposed amendment satisfactorily answers this objection to the Cadillac tax.

Conclusion

The Cadillac tax has significant positive attributes and fixable flaws. It raises considerable revenue in a fairly progressive manner. It will limit a regressive tax benefit that encourages the purchase of overly generous health insurance plans that weaken incentives for insured people to make cost-conscious insurance choices.

Yet the Cadillac tax has some shortcomings. We have described them in some detail: the limited sensitivity of the tax threshold to firm-specific characteristics affecting health care costs (e.g., geographic differences in prices, differences in employee health status), an aggressive indexing approach that would significantly increase the number of firms affected over time, and the potential effect on the financial burdens of low- and middle-income workers and their families. Each can be fixed or attenuated by modifications we have described. Enactment of our recommendations would preserve the tax as an important revenue source and curb the adverse consequences of the current unlimited tax exclusion of employer-financed health insurance.

The goals of the Cadillac tax could also be achieved by a cap on the exclusion of employer-sponsored insurance from personal income and payroll taxation. That approach would require modifications similar to those delineated for the Cadillac tax. We recognize that the responses to a tax that applies at the same rate to all insurance offered by an employer may differ from those to a tax levied in a decentralized manner on individual employees at varying rates. We also understand that disputes over whether an excise tax or an exclusion cap is preferable may be politicized, but in our view these differences are secondary to the benefits from improving incentives for providers and health care users to attend to health costs.

What Is the Cadillac Tax?

The Cadillac tax is a 40 percent excise tax on employer-sponsored health insurance plans. As drafted in the Affordable Care Act, the tax was to take effect in 2018 and apply to plans with single- and family-coverage premiums greater than $10,200 and $27,500, respectively.[a] For retirees ages 55 and older and for employees in high-risk occupations, these thresholds are $1,650 higher for single coverage and

$3,450 higher for family coverage. The 2018 thresholds could be raised if growth in health costs between 2010 and 2018 exceeds thresholds specified in the Affordable Care Act. Starting in 2020, these thresholds and adjustments will increase with the consumer price index for urban consumers. Employers may also adjust the cost of their insurance coverage if their workforce differs substantially by age and sex from a national risk pool.

The base of the tax is the excess in health insurance cost above the thresholds, with the applicable tax computed on a worker-by-worker basis. The base includes premiums for health insurance (but not long-term care insurance, disability insurance, or standalone dental and vision insurance) and the combined contributions by workers and their employers to tax-favored accounts such as flexible spending accounts, health savings accounts, and health reimbursement accounts. The tax is to be levied on coverage providers—that is, insurance companies that sell ordinary health insurance or companies that self-insure.

In December 2015, Congress delayed implementation of the tax until 2020, in the face of opposition from unions and business leaders.[b] As a result, the basic thresholds above which the tax would apply will be slightly increased.

Three examples illustrate computation of the tax:

- **Example 1**. In a particular year, the threshold for the Cadillac tax is $30,000 for family coverage. The actual premium, paid entirely by the employer, is $33,000. The Cadillac tax for that plan in that year would be$1,200 [0.4 × ($33,000 − $30,000)].

- **Example 2.** Same as example 1, except that the employer pays $25,000 and the employee pays the remaining $8,000 from after-tax income. No Cadillac tax is due because only the $25,000 paid by the employer is exempt from income and payroll tax.

- **Example 3**. In the same year, an employer offers its employees a flexible spending account arrangement along with health insurance. The full premium is $31,500 for family coverage. The employer pays $29,000. The worker deposits $2,500 in a flexible spending account to cover the portion of the premium that the employer does not cover. The Cadillac tax for that plan would be $600 {0.4 × [($29,000 + $2,500) − $30,000]}.

[a] According to the Medical Expenditure Panel Survey Insurance Component, the national average employer premium was $5,693 for single coverage and $17,322 for family coverage in 2015, the most recent year with available data.
[b] Jeff Lemieux and Chad Moutray, "About That Cadillac Tax," *Health Affairs Blog*, April 25, 2016, http://healthaffairs.org/blog/2016/04/25/about-that-cadillac-tax/.

Notes

1. One hundred one economists signed a letter to Congress in support of the Cadillac tax. "Health Policy Experts' Statement about Excise Tax on High-Cost Plans," Center on Budget and Policy Priorities, open letter, October 1, 2015, http://www.cbpp.org/sites/default/files/atoms/files/cadillac_tax_letter.pdf.
2. "A Better Way: Health Care," Office of the Speaker of the House, June 22, 2016, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf.
3. The term "Cadillac tax" seems to have originated in the report of a tax reform commission appointed by President George W. Bush: "The Panel's objective is to preserve the incentive for firms to maintain health insurance for their employees without encouraging them to provide excessively generous—or 'Cadillac'—health insurance plans" (President's Advisory Panel on Federal Tax Reform 2005, 82).
4. "A Better Way: Health Care"; and Empowering Patients First Act of 2015, H.R. 2300, 114th Cong. (2015).
5. "Health Policy Experts' Statement."
6. In 2015, the Treasury Department issued a request for suggestions on prospective regulations to implement these and other provisions of the ACA. See Karen Levin, "Notice 2015-16," Internal Revenue Service, issued February 23, 2015, https://www.irs.gov/pub/irs-drop/n-15-16.pdf.
7. Minimum medical loss ratios limit the share of a premium that is devoted to administrative costs as opposed to payment of claims and quality improvement. Under the ACA, medical loss ratios in excess of maximums require insurers to pay refunds to enrollees.
8. Because the ACA stipulates that gold and silver plans must cover 80 percent and 70 percent, respectively, of the actuarial cost of coverage for covered services (each +/– 2 percentage points), the $^{8}/_{7}$ multiplier means that the alternative threshold is equivalent to gold coverage. The corresponding alternate threshold for family coverage would be the self-only premium multiplied by the statewide ratio of family to self-only coverage. Other adjustments for sex, age, occupation, and retiree status would be unchanged from the original delineated approach (US Department of the Treasury 2016).
9. Medicare's geographic adjustments cover regional variations in expenses such as clinical and administrative staff salaries and benefits, rent, malpractice insurance, and other costs specified in regulations. As a result, Medicare's Inpatient Prospective Payment System, other institutional prospective payment systems, and the Medicare Physician Fee Schedule all employ geographic adjustment factors.
10. Under the ACA, modified community rating regulations permit insurers to charge small employers premiums that vary by enrollee age (with a maximum of 3:1 variation) and tobacco use (with a maximum of 1.5:1 variation), but premiums for identical coverage cannot vary by any other factors. For example, two employers providing the same coverage to their workers may pay different premiums based on the age distribution of their workers, but they cannot pay different premiums based on the health histories, industry, or gender distribution of their workers.
11. Ashley Williams, "As Self-Funding Increases in Popularity, Two States Step Up to Address Potential Stop-Loss Policy Concerns," *CHIRblog*, March 11, 2016, http://chirblog.org/as-self-funding-increases-in-popularity-two-states-step-up/.
12. The Kaiser Family Foundation estimated that initially 26 percent of *employers* (46 percent of employers with 200 or more workers) would have at least one *employee* affected by the tax (Claxton and Levitt 2015). These seemingly contradictory estimates can be reconciled because some workers in a firm may not be affected by the tax. If a plan's premium does not exceed the tax threshold but one worker or a small number of workers make substantial contributions to their individual flexible spending accounts (FSAs), the tax would apply to

those particular workers but not to other employees covered by the same plan. We lay out issues related to FSAs in a later section.

13. Eventually, it would fall not only on unusually expensive health plans but also on typical coverage. One study found that the proportion of plans that would hit the threshold could more than double over the decade following implementation (Claxton and Levitt 2015, 4).
14. "Hillary Clinton's Plan for Lowering Out-of-Pocket Health Care Costs," Hillary for America, https://www.hillaryclinton.com/briefing/factsheets/2015/09/23/clinton-plan-to-lower-out-of-pocket-health-care-costs/.
15. The reform proposal later submitted by the administration to Congress turned this proposal on its head. It would have retained the entire exclusion except for the *first* $10 per month for individual coverage and $25 per month for family coverage. The administration proposal was flatly inconsistent with the Treasury Department's rationale for curbing the exclusion. Ultimately, Congress did nothing to curb the exclusion in any way.
16. The standard assumption is that employers structure compensation packages to enable them to hire the type of workforce that they seek at the lowest total cost.
17. Some proposed exclusion caps would subject the excess to income tax but not to payroll tax. We see no reason for such a distinction because the object of an exclusion cap is to discourage excessively costly insurance. Furthermore, applying the payroll tax to excess premiums would generate revenue that would help narrow the projected long-term financial shortfall in Social Security, an effect we regard as a distinct plus.

References

Blumberg, Linda J. 1999. "Who Pays for Employer-Sponsored Health Insurance?" *Health Affairs* 18 (6): 58–61.

Blumberg, Linda J., John Holahan, and Gordon Mermin. 2015. "The ACA's 'Cadillac' Tax Versus a Cap on the Tax Exclusion of Employer-Based Health Benefits: Is This a Battle Worth Fighting?" Washington, DC: Urban Institute.

Buettgens, Matthew, and Linda J. Blumberg. 2012. "Small Firm Self-Insurance under the Affordable Care Act." New York, NY: Commonwealth Fund.

Buettgens, Matthew, Lisa Dubay, and Genevieve M. Kenney. 2016. "Marketplace Subsidies: Changing the 'Family Glitch' Reduces Family Health Spending But Increases Government Costs." *Health Affairs* 35 (8): 1167–75.

CBO (Congressional Budget Office). 2015. *The Budget and Economic Outlook: 2015 to 2025*. Washington, DC: CBO.

Chollet, Deborah. 2012. "Self-Insurance and Stop-Loss for Small Employers." Washington, DC: Mathematica Policy Research.

Claxton, Gary, and Larry Levitt. 2015. "How Many Employers Could Be Affected by the Cadillac Plan Tax?" Washington, DC: Kaiser Family Foundation.

CRS (Congressional Research Service). 1988. *Costs and Effects of Extending Health Insurance Coverage*. Washington, DC: US Government Printing Office.

Furman, Jason, and Matthew Fiedler. 2016. "The Cadillac Tax—A Crucial Tool for Delivery-System Reform." *New England Journal of Medicine* 374 (11): 1008–09.

Gruber, Jonathan. 2000. "Health Insurance and the Labor Market." In *Handbook of Health Economics*, vol. 1A, edited by Anthony J. Culyer and Joseph P. Newhouse, 645–706. Amsterdam: Elsevier.

Jost, Timothy S., and Mark A. Hall. 2013. "Self-Insurance for Small Employers under the Affordable Care Act: Federal and State Regulatory Options." *New York University Annual Survey of American Law* 68 (3): 539–66.

MaCurdy, Thomas, Thomas DeLeire, Karla López de Nava, Paulette Kamenecka, Yang Tan, and Sean McClellan. 2009. *Revision of Medicare Wage Index: Final Report*. Burlingame, CA: Acumen.

NAIC (National Association of Insurance Commissioners). 2015. "Stop-Loss Insurance, Self-Funding, and the ACA." Washington, DC: NAIC.

President's Advisory Panel on Federal Tax Reform. 2005. *Simple, Fair, and Pro-Growth: Proposals to Fix America's Tax System*. Washington, DC: President's Advisory Panel on Federal Tax Reform.

US Department of the Treasury. 1984. *Tax Reform for Fairness, Simplicity, and Economic Growth: The Treasury Department Report to the President*. Washington, DC: US Department of the Treasury.

———. 2016. *General Explanations of the Administration's Fiscal Year 2017 Revenue Proposals*. Washington, DC: US Department of the Treasury.

About the Authors

Henry J. Aaron is the Bruce and Virginia MacLaury Senior Fellow in the Economic Studies program at the Brookings Institution. From 1990 to 1996 he was the director of the Economic Studies program. He initially joined the Brookings staff in 1968. From 1967 to 1989 he also taught at the University of Maryland. In 1977 and 1978 he served as Assistant Secretary for Planning and Evaluation at the Department of Health, Education, and Welfare. He chaired the 1979 Advisory Council on Social Security. During the academic year 1996–97, he was a Guggenheim Fellow at the Center for Advanced Studies in the Behavioral Sciences at Stanford University. He is a graduate of UCLA and holds a PhD in economics from Harvard University.

Linda Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of particular policies. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in states and nationally. Examples of her research include several analyses of competition in nongroup Marketplaces, an array of studies on the implications of the *King v. Burwell* Supreme Court case, analysis of the remaining uninsured, and codirecting 22 state case studies of stakeholder perspectives on ACA implementation. She also led the quantitative analysis supporting the development of a "Roadmap to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.

Paul B. Ginsburg is the director of the Center for Health Policy at Brookings, a senior fellow in Economic Studies at Brookings, and the Leonard D. Schaeffer Chair in Health Policy Studies. Dr. Ginsburg is also Professor of Health Policy at the University of Southern California (USC) and director of public policy at the USC Schaeffer Center for Health Policy and Economics. He leads the Schaeffer Initiative for Innovation in Health Policy, a partnership between Brookings and the USC Schaeffer Center. A Harvard-trained economist and health policy expert, Ginsburg is a MedPAC commissioner and the former president of the Center for Studying Health System Change, an institution he founded in 1995 to conduct research focused on changes to the organization, financing, and delivery of health care in the United States. Prior to founding HSC, Dr. Ginsburg served as the founding executive director of

the Physician Payment Review Commission (now MedPAC), was a senior economist at RAND, a deputy assistant director at the Congressional Budget Office (CBO), and a faculty member of Duke and Michigan State Universities.

Stephen Zuckerman is a senior fellow and codirector of the Health Policy Center at the Urban Institute. He has studied health economics and health policy for almost 30 years and is a national expert on Medicare and Medicaid physician payment, including how payments affect enrollee access to care and the volume of services they receive. He is currently examining how payment and delivery system reforms can affect the availability of primary care services, and studying the implementation and impact of the Affordable Care Act.

Statement of Independence

The Urban Institute strives to meet the highest standards of integrity and quality in its research and analyses and in the evidence-based policy recommendations offered by its researchers and experts. We believe that operating consistent with the values of independence, rigor, and transparency is essential to maintaining those standards. As an organization, the Urban Institute does not take positions on issues, but it does empower and support its experts in sharing their own evidence-based views and policy recommendations that have been shaped by scholarship. Funders do not determine our research findings or the insights and recommendations of our experts. Urban scholars and experts are expected to be objective and follow the evidence wherever it may lead.

The Brookings Institution is a nonprofit organization devoted to independent research and policy solutions. Its mission is to conduct high-quality, independent research and, based on that research, to provide innovative, practical recommendations for policymakers and the public. The conclusions and recommendations of any Brookings publication are solely those of its authors, and do not reflect the views of the Institution, its management, or its other scholars.