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The Cadillac Tax Do-Over Challenge

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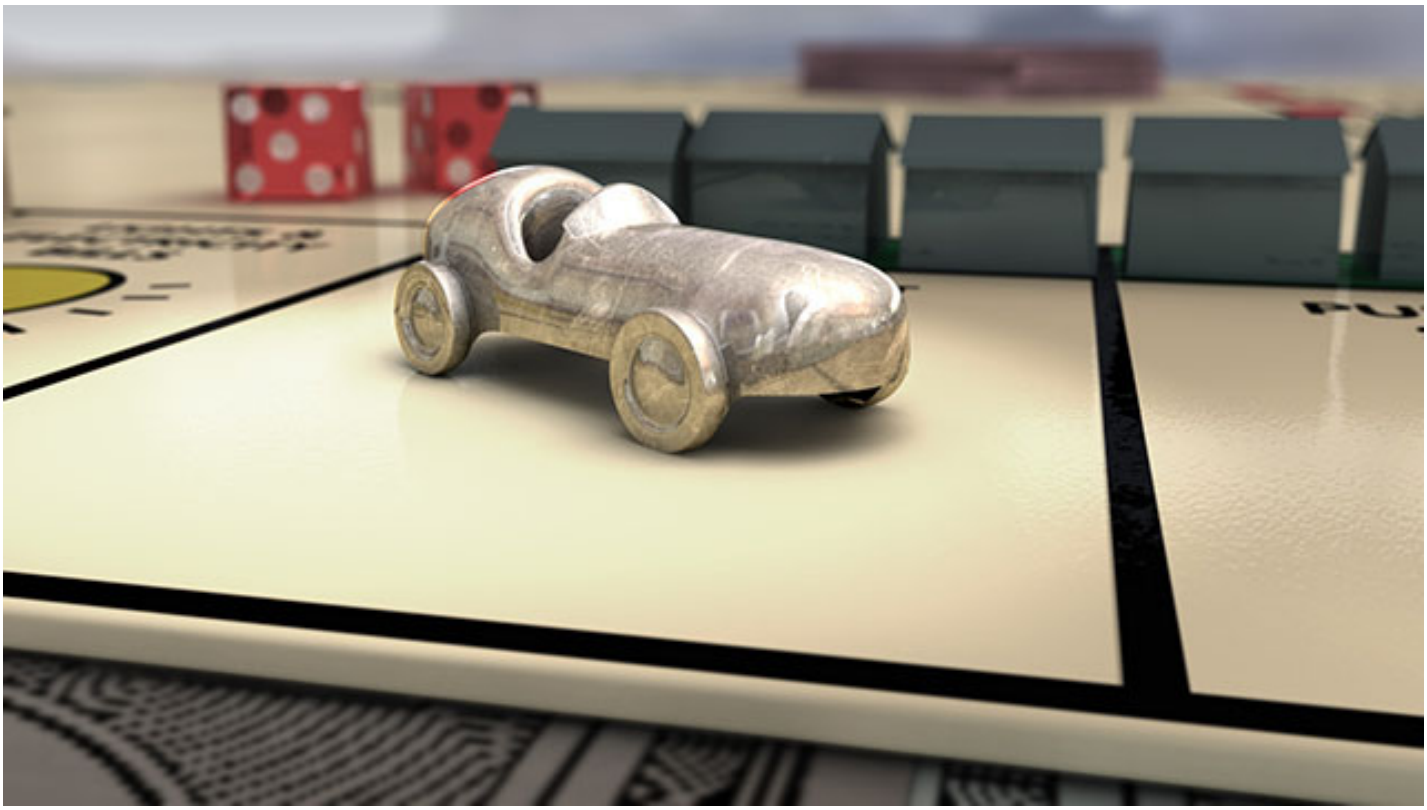

In the midst of intense negotiations over federal spending, a coalition including business groups and health plan sponsors last month helped push a repeal of the Affordable Care Act's (ACA's) "Cadillac" high-cost health plan tax through the House. In a letter to Senate leaders, a group of prominent health economists and budget analysts underscored previous warnings "to take no action to weaken, delay, or reduce the Cadillac tax until and unless [Congress] enacts an alternative tax change that would more effectively curtail cost growth." The letter does not offer an alternative. How Congress and the Trump

administration handle this issue may be a key to the stability and viability of job-based health insurance as well as the economic well-being of millions of US workers.

Twice delayed, the ACA's High Cost Plan Excise Tax in 2022 will begin imposing a 40 percent surcharge on the value of health benefits exceeding a threshold projected to be about $11,200 for self-only and $29,750 for family coverage. Opponents of the tax, including unions that have bargained for generous benefits, see it as a blunt instrument that unfairly targets plans whose costs are high due to causes beyond the control of the people running them. Health plans can be expensive for many reasons including covering a disproportionate percentage of sicker, older people and paying for services in regions with high medical costs.

The Cadillac plan tax serves intertwined purposes in the ACA's drive to increase health coverage. By penalizing high-cost benefits, it raises revenues that can be used to cover more people. More important, it is intended to counter hyper-inflationary features of the US health care system, including an imbalance embedded in the tax code that provides an incentive for employers to offer employees ever-more-costly health benefits instead of higher wages. Since the 1950s, employer contributions for health benefits have been tax exempt for workers, while wages are taxed. Most health economists think this is a bad idea, especially since commonly shared resources paid for by third parties, such as health benefits, are prone to rise in cost at a greater rate than wages or goods and services in general. The Congressional Budget Office (CBO) estimates that the Cadillac tax repeal passed by the Democrat-led House—by a whopping 419 to 6 margin—will cost the Treasury $197 billion over a decade. Repeal also has strong support in the Republican-led Senate. Although many members of Congress and the White House often protest loudly that health care costs are way too high, hardly anyone on the Hill has uttered a peep about the consequences of scrapping the tax.

The Committee for a Responsible Federal Budget (CRFB) has played a lead role in opposing repeal of the Cadillac plan tax without replacement and published the experts' letter to the Senate. Using CBO numbers along with its own, the CRFB offers price tags on several ways to replace the Cadillac plan tax by reducing the tax exclusion of employee health benefits.

The fate of the Cadillac tax—and any changes to the tax treatment of health benefits that might replace it—also raises important equity issues. Exempting employer contributions from taxation has been criticized as unfairly favoring higher-paid employees because the higher a tax bracket, the greater the monetary value of the tax break. Because of the tax exclusion, company executives, in effect, pay about 60 cents for each dollar of health benefits they receive, while minimum-wage workers pay roughly 90 cents.

Over time, tax exemptions can exacerbate economic inequality as they drive up benefit costs—especially during periods of widening income disparity. Employers now face the challenge of designing health benefits and compensation packages that can meet the needs and desires of both professional couples pulling down $500,000 and single parents making $20,000. A $25,000 family plan looks a lot different to a doctor and lawyer raising two kids than to a home health aide or hotel clerk struggling to send kids to school and make ends meet. For a professional couple, the total cost of health coverage may equal about one-fortieth of income. For the lower-paid, who typically have little leverage to influence their compensation, what employers spend in wages may be in the same ballpark as the cost of their health benefits.

Alternative: Reduce Or Eliminate The Tax Exemption For Health Benefits

The Cadillac tax would be levied on health plans, which are legal entities through which employers and unions provide benefits to employees. Its impact on employees would be indirect and depend on how firms and health plan managers respond to the tax in offering and designing benefits. Many of the alternatives to the Cadillac tax that have been proposed instead involve curtailing the tax exemption received by employees, which would impact them more directly.

In a December 2018 paper, the CBO laid out key design choices for replacing the Cadillac tax as well as estimates of the cost impact of specific options. The general design choices include: eliminating the tax exclusion from income or payroll taxes, or both; eliminating tax exemption of the value of all health benefits or a portion; and retaining tax exemption up to an income limit with tax breaks phased down for higher-income people. The CBO paper provided three illustrative cost estimates for capping the tax exclusion (summarized below), but none for progressively limiting the exclusion by income.

Estimate 1

The first would replace the Cadillac tax with a limit on income and payroll tax exclusions set at the average premium cost. Starting in 2022, contributions that exceeded $7,800 a year for individual coverage and $18,500 for family coverage would be included in employees' taxable income. Tax thresholds would be indexed, but at a lower rate than projected health care costs. The same limits would apply to the deduction for health insurance available to self-employed people. Because the limits would be lower than the thresholds scheduled to take effect for the current excise tax—for example, $11,200 for individual coverage in 2022—overall federal tax subsidies would be lower as well. As a

result, employers would offer less coverage, and more employees would be uninsured or receive subsidized coverage in the exchanges or from Medicaid.

According to the CBO: "This alternative would decrease cumulative federal deficits by $638 billion by 2028…. On a net basis, $51 billion in additional revenues would be collected in 2022, and that amount would grow to $132 billion by 2028. The increasing amount of revenues that would be collected under this alternative would be the result of indexing the exclusion thresholds to the chained CPI-U, which would increase the threshold amounts at a lower rate than the projected growth of health insurance premiums. Over time, that would increase the share of insurance contributions subject to taxation. Those revenues would be slightly offset by $32 billion of additional outlays—the majority of which would be attributable to more people enrolling in subsidized nongroup insurance. By reducing the appeal of employment-based health insurance, it also would cause about 3 million fewer people to have such coverage in 2028 than would have it under current law. Of those people, about 2 million would buy coverage directly through the nongroup market (that is, either in the health insurance marketplaces or from insurers outside of the marketplaces); fewer than 500,000 would enroll in Medicaid; and about 1 million would be uninsured."

In an important detail, the CBO notes that, although the ACA requires large employers to provide health insurance to their employees or pay significant penalties, its estimates assume that few large employers that dropped coverage due to the Cadillac tax, or alternatives, actually would be penalized. (The penalties would generate only a "small amount" of additional revenue.) Why? According to CBO and Treasury economists interviewed for this post, the IRS has not made a priority of enforcing the ACA's employer penalties, and compliance has been sketchy. The employer penalties are one of the main mechanisms in the ACA that incentivizes maintaining employer coverage levels. Congress already has repealed its counterpart, the individual mandate, a change that is projected to increase the number of uninsured by 13 million in 2027. Along with the Cadillac tax, the employer and individual penalties also were important ACA provisions designed to provide revenue to finance coverage expansion.

Estimate 2

The CBO's second alternative would replace the Cadillac tax with a limit on the income and payroll tax exclusions set at the 75th percentile of premiums. This option has less dramatic effects. More benefits are left untaxed. Tax exclusion limits would be higher: $9,900 a year for individual coverage and $25,000 for family coverage. The CBO estimates that the change would increase revenues by $270 billion and outlays by $15

billion and cause slightly more than one million fewer people to have employee health insurance in 2028 than under current law.

Estimate 3

The third CBO option would replace the Cadillac tax with a limit on only the income tax exclusion, set at the average premium amount (as under current law, there would be no limit on the exclusion of payroll taxes). This change would decrease cumulative federal deficits by $438 billion by 2028 and cause about 1.5 million fewer people to have employment-based insurance than would have it under current law.

All three options would have a greater 10-year budget impact than keeping the Cadillac tax. Removing the exclusion from income tax would impact higher-income people more. Removing it from payroll tax would affect lower-income people more.

While these alternatives all would help reduce the budget deficit and offer incentives to slow health benefit cost growth, they raise many policy issues and administrative hurdles for plan administrators and tax administrators. The size of the tax increases would be greater than with the Cadillac tax. The changes would affect people in more plans, but there would still be complaints about the fairness of plans being penalized because of a group's unavoidable high-cost location, risk pool, or age composition. Tax exclusion would still be incentivizing preference for health benefits over wages beneath the tax exclusion limits. In a sense, the new caps would leave plan managers with an incentive to keep pressing on the accelerator, then suddenly pump the brakes when limits are approached.

The CBO notes that exclusion limits could be adjusted for age, sex, and occupation. The Cadillac tax law makes several such adjustments including a higher threshold for some plans covering workers in dangerous occupations.

Adjusting taxation limits for regional cost variation could be of critical importance. Government data sets and models could no doubt generate regional estimates, which could be padded to moderate the impact of uncertainty or error. Regional adjustment could help in setting tax thresholds at the cost of middle-price plans most chosen by middle-income families in a way that lessened concerns over fairness and unintended cost shocks. But all such adjustments would come with added paperwork and administrative complexity, which could undermine acceptance, compliance, and enforcement by firms and tax collectors.

Progressive Taxation Of Employee Health Benefits

Instead of influencing plans to accelerate health spending and then pump the brakes, lawmakers could develop a replacement for the Cadillac tax that would send additional price signals to decision makers in all health plans, while having less negative impact on middle- and lower-paid employees—or at least holding them harmless. As discussed above, one problem with the current Cadillac tax scheme is that the incentive to restrain the growth of benefits directly impacts only plans at the upper extreme. Another issue is that, by taxing the plan or employer, the burden of paying the tax will likely be passed on to low-paid as well as high-paid employees. Lower-paid workers generally have less influence in determining compensation packages and terms of employment. Higher-wage employees are better situated to influence management decisions in designing health benefits. Over time, the aggregate choices of those who are better off set the bar for what's considered to be a socially acceptable benefit package. Heavily subsidized private insurance sets an ever-costlier standard leaving stewards of government programs to plead with Congress and state legislators to keep up.

One way to impart price sensitivity to higher-paid employees while protecting those with lower incomes would be to reduce the value of the tax exclusion for households in higher tax brackets. As with the CBO's options, this is possible to administer now that employers are required to estimate and report the value of health coverage. As illustrated in exhibit 1 below, the threshold for ending full tax exclusion could be triggered by reaching a set wage level or tax bracket, with workers making less still enjoying greater or full tax exclusion. Workers making more would progressively lose a percentage of the tax exclusion as income rose. Such a policy could be implemented gradually.

Exhibit 1: Progressive taxation of employer-provided Medical benefits

Based on a value of **$20,000** in health benefits from all jobs (combined if filing jointly):		
Tax Bracket	**Benefits Tax Rate**	**Benefits Tax Amount**
10%	0%	$0
12%	0%	$0
22%	2%	$400
24%	4%	$800
32%	12%	$2,400
35%	20%	$4,000
37%	25%	$5,000

Source: Karl Polzer, Center on Capital & Social Equity.

In the above exhibit, an individual or joint tax filer received $20,000 in employer-provided health benefits over the year. Filers in the bottom two tax brackets continue to receive benefits tax free, in part to minimize red tape. A tax rate generating a small amount (say in the ballpark of $100) could be applied to the lowest-income workers if policy makers thought it might help send price signals that could help keep cost inflation down while still leaving low-wage employees enough to get by. Those in the 22 percent tax bracket would begin paying a 2 percent tax on their employee benefits, equaling $400. Taxation rates would rise with income: In this example, people in the top bracket would pay a 25 percent health benefit tax of $5,000.

Effectiveness in holding back health care cost inflation would depend on how management would respond to employees' and their families' responses to taxation in determining the relative amounts of wages and benefits, along with plan design features such as cost sharing and benefit packages. To impart price sensitivity, employers could be required to estimate plan costs in advance, withhold expected benefit taxes from paychecks, and communicate to employees about changes made in plan features and costs, and the resulting impact on their taxes. Incentivizing cost control is as much art as science.

The progressive tax rates in the example above would generate much less revenue than the options the CBO explored, even if the incentives were more directly apparent to employees. If needed, a progressive benefit levy on higher-paid employees could be combined with a tax on high-price plans but much smaller than the 40 percent Cadillac tax (perhaps regionally adjusted).

Policy makers are between a rock and hard place. Congress already has kicked the can down the road on implementing the Cadillac plan tax twice, the last time in 2018. In the short run, it may be impossible for policy and budget experts opposing the repeal to hold their ground. Winning the battle will require coming up with an alternative way to send price signals that can moderate health care inflation without major disruptions. That won't be easy. Any curtailment of a limitless tax break will face attacks in the political arena that it's really a tax increase. In the long run, however, the cost-containment war must be won for the US employer-based coverage system to survive. The faster employee health coverage costs spiral upward, the stronger the case for government-priced health care.

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Roger Collier • 16 days ago

Well-researched article, but with a fundamental flaw that's stated explicitly in the final paragraph: "In the long run, however, the cost-containment war must be won for the US employer-based coverage system to survive."

But why do we want it to survive? It encourages excessive coverage and excessive utilization, it unfairly benefits the highest-paid employees, it discourages insurer and provider price competition, it leads to "job-lock," and it creates a divide between the "haves" with employer coverage and the "have-nots" without such coverage.

The Sanders/Warren Medicare for All proposals certainly aren't the solution to our healthcare woes, but ditching our present employer coverage system ought to be the starting point for more enlightened reform.

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jrb ➚ Roger Collier • 10 days ago • edited

And don't forget about the personal choice and freedom-killing agency problems, such as an employer being able to dictate coverage decisions on personal issues such as birth control, that employer group health insurance creates. Questions like these would not even exist if people could choose to purchase their own insurance on the open market absent the tax distortion.

That said, also do not get too hung up on employer groups being allowed to offer benefits. If an employer believes they are really good at it, and that they can do it better than the private, competitive, health insurance industry then they should be welcome to provide it as an enticement to attract and retain employees.

However, my research indicates that there are very few companies and CEOs who believe that providing healthcare benefits is a core competence of their business, and absent the 40-50% tax preference for healthcare benefits over wages, would not choose to provide them. I'm yet to meet a CEO/CFO who says, "I can't wait to address healthcare benefits every year, because we are so good at designing and implementing them, and it is not at all a distraction to running our core business!"

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