The Excise Tax on High-Cost Employer-Sponsored Health Coverage: Background and Economic Analysis

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Summary

Beginning in 2018, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) imposes a 40%, nondeductible excise tax on the value of applicable employer-sponsored health coverage above specific dollar thresholds. In 2018, these thresholds are $10,200 for single health coverage and $27,500 for non-single (e.g., family) coverage. The thresholds are adjusted for eligible retirees, workers in certain high-risk professions, and plans whose demographics differ from the national workforce.

This excise tax on high-cost employer-sponsored coverage, commonly referred to as the *Cadillac tax*, is intended to raise revenue and reduce the growth of aggregate health care costs. Particularly, the Cadillac tax effectively counteracts part of the tax exclusion for employer sponsored insurance (ESI), which many economists believe encourages the overconsumption of health benefits.

The Cadillac tax is estimated to raise $3 billion in 2018 and is projected to collect higher amounts of revenue each year through 2024. More plans are projected to be subject to the tax over time, because the Cadillac tax threshold is adjusted annually for inflation with the Consumer Price Index, which generally has been below the rate of growth in insurance premiums. Over the first eight years of implementation, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that the tax will raise $87 billion in revenue.

As the 2018 implementation date draws closer, congressional interest in the tax has increased. For example, the Ax the Tax on Middle Class Americans' Health Plans Act (H.R. 879) and the Middle Class Health Benefits Tax Repeal Act (H.R. 2050) would specifically repeal the Cadillac tax. Opponents of the Cadillac tax argue that the tax unfairly targets certain employers' health plans because their workforce has higher health care risks. Some organized labor groups also oppose the tax because they collectively bargained for workers to receive more compensation through health benefits instead of higher wages. Proponents of the Cadillac tax argue it will help to slow the growth of national health care costs by increasing the price of excess health benefits.

Based on an analysis of employer plans in the 2013 Medical Expenditure Panel Survey Insurance Component (MEP-IC) dataset, 10.2% of single and 6.0% of non-single insurance premiums could exceed the Cadillac tax threshold in 2018 (assuming premiums grow at the same rate as their five-year averages). By 2028, 24.7% of single and 19.1% of non-single premiums could be subject to the tax. These estimates do not assume any plan modifications to avoid the tax and do not include contributions to health-related savings or reimbursement accounts. The share of plans that could be subject to the tax is sensitive to projections in premium growth rates.

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Introduction

Beginning in 2018, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) imposes a nondeductible 40% excise tax on the value of *applicable employer-sponsored health coverage* above specific dollar thresholds. In 2018, these thresholds are $10,200 for single health coverage and $27,500 for non-single (e.g., family) coverage.

This excise tax on high-cost employer-sponsored coverage, commonly referred to as the *Cadillac tax*, was an important feature of the ACA for two primary reasons. One, the tax was among several revenue-raising provisions in the ACA meant to raise revenue to offset the cost of other ACA provisions (e.g., the financial subsidies available through the health insurance exchanges). Two, the tax was among several provisions intended to reduce the growth of national health care costs. Particularly, the tax is intended to target higher-cost "Cadillac" health plans (which are characterized as having more generous coverage or lower cost-sharing requirements than average health plans) and to counteract the income tax exclusion for employer-sponsored insurance's (ESI) incentives. Many economists believe ESI incentives result in the overconsumption of health benefits, resulting in upward pressure on health care costs.

Proponents of the Cadillac tax point out that employer-sponsored plans are the single largest source of health insurance coverage for the non-elderly in the United States and that the current, unlimited ESI tax exclusion (the single largest tax expenditure in the Internal Revenue Code) tends to benefit higher-income individuals more than lower-income individuals.

Critics of the Cadillac tax voice concerns that it might lead insurers to redesign their plans. Some employers claim that the tax imposes an unfair burden on their workforce because of the demographic traits of that workforce or the location of the business—not due to the generosity of their health plans. Some organized labor groups have also opposed the tax because they have negotiated collective bargaining contracts such that their members receive a larger share of their compensation in the form of health benefits in lieu of higher wages. According to these groups, the tax could disrupt these contracts such that employers' costs could increase (in the form of higher prices of the goods and services that the employers provide) or workers could bear the additional burdens of the tax (in the form of lower total compensation).

In the 114th Congress, the Ax the Tax on Middle Class Americans' Health Plans Act (H.R. 879) and the Middle Class Health Benefits Tax Repeal Act (H.R. 2050) would specifically repeal the Cadillac tax.[1]

This report gives a brief description of the Cadillac tax. It discusses the legislative origins of the tax and provides an analysis of the revenue effects of the tax. It then analyzes health insurance premium data to provide insights into what share of health insurance plans could exceed the Cadillac tax threshold and how the threshold could affect more health plans over time. This report also analyzes the Cadillac tax using standard economic criteria of efficiency, equity, and administrative simplicity.

This report is based on interpretation of the statute, and it does not consider how future regulations could affect the impact of the tax. For more detailed description of the administration of the tax, see CRS Report R44147, *Excise Tax on High-Cost Employer-Sponsored Health Coverage: In Brief*, by Annie L. Mach.

[1] H.R. 879, the Ax the Tax on Middle Class Americans' Health Plans Act, would also repeal certain health coverage cost reporting requirements in Internal Revenue Code (IRC) §6051(a).

Description of the Tax

The ACA will impose a 40% tax on the value of *applicable employer-sponsored coverage* above a specified dollar threshold, also referred to as the *excess benefit*, beginning in 2018.[2] Applicable employer-sponsored coverage includes, but is not limited to, the following items that are subject to preferential tax exclusions:

- premiums for accident or health coverage paid by the employer or employee, and
- certain contributions to tax-advantaged accounts, such as flexible spending accounts (FSAs) and health savings accounts (HSAs).

Additionally, employer-sponsored health coverage that is paid by the employee with after-tax dollars (i.e., not subject to tax exclusion) could be included as applicable coverage.[3]

The excess benefit is calculated as the difference between the value of applicable employer-sponsored coverage and the applicable threshold level. The excess benefit is based on the aggregate cost of all employer-sponsored coverage (unless excepted). Two different thresholds apply: one for workers with single coverage, and one for workers with non-single coverage (e.g., family plans or self plus one plans).

The tax specifically does not apply to ("excepts") coverage such as long-term care insurance, stand-alone dental and vision insurance, liability insurance, and accident and disability benefits.[4] Plans provided by public employers are not excepted, and health benefits of public employees could be subject to tax.

Employers will be responsible for calculating the Cadillac tax owed for each employee's employer-sponsored coverage, as well as the share attributable to each coverage provider.[5] The tax is levied on *coverage providers*, which in some cases will be the health insurance companies that issue the employer-sponsored plans and in some cases will be the employer.[6]

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[2] In other words, the tax only applies to the amount of coverage exceeding the threshold.

[3] See IRC 4980I(d)(1)(A) through (D): The term "'applicable employer-sponsored coverage' means ... coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer provided coverage ... without regard to whether the employer or employee pays for the coverage." Additionally, Treasury and the Internal Revenue Service (IRS) have further clarified this interpretation in a request for information. See IRS, *Notice 2015-16*, February 23, 2015, at http://www.irs.gov/pub/irs-drop/n-15-16.pdf: "Section 4980I(d)(1)(C) provides that coverage that meets the basic definition of applicable coverage is applicable coverage 'without regard to whether the employer or employee pays for the coverage.' In addition, coverage that otherwise meets the definition of applicable coverage is applicable coverage without regard to whether the employer provides the coverage (and thus the coverage is excludable from the employee's gross income) or the employee pays for the coverage with after-tax dollars."

[4] For a full list of exceptions, see IRC §4980I(d)(1)(B). For more detailed list of health benefits that could be subject to the Cadillac tax and information on areas in which Treasury intends to issue regulations, see IRS, *Notice 2015-16*, February 23, 2015, at http://www.irs.gov/pub/irs-drop/n-15-16.pdf.

[5] See p. 4 in ibid.; IRS, *Notice 2015-52*, July 30, 2015, p. 7, at http://www.irs.gov/pub/irs-drop/n-15-52.pdf; "Excise Tax on 'Cadillac' Plans," *Health Affairs*, September 12, 2013, at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=99; National Insurance Services, Inc., "Cadillac Tax on High-Cost Health Coverage," Health Care Reform legislative brief, at http://www.nisbenefits.com/ppaca/18-Legislative%20Brief%20Cadillac%20Tax%20on%20High%20cost%20Health%20Coverage%20102213.pdf; and Cigna, Cadillac Tax Fact Sheet, January 2015, at http://www.cigna.com/assets/docs/about-cigna/informed-on-reform/cadillac-tax-fact-sheet.pdf.

[6] IRC Section 4980I(c).

The excise tax is nondeductible from the insurer's gross income (or the employer's gross income, in cases where the employer self-insures).[7] This treatment is unlike some other deductible excise taxes (such as the excise tax on medical device manufacturers) but similar to other ACA revenue-raising provisions (such as the annual fee on health insurance providers).

General Thresholds

In 2018, the threshold for calculating excess benefits will be $10,200 for single coverage and $27,500 for non-single coverage.[8] Employees in multiemployer (e.g., union) coverage will be subject only to the non-single thresholds.

In 2019, the base threshold of $10,200 (single) and $27,500 (non-single) will be indexed to the annual change in inflation, as measured by the Consumer Price Index for All Urban Consumers (CPI-U), plus one percentage point.[9] In years 2020 and beyond, the threshold will be further adjusted using only annual changes in the CPI-U. In all instances, the inflation adjustments will be rounded to the nearest multiple of $50.

Exceptions to the General Thresholds

There are several exceptions to the general thresholds. First, the thresholds are higher for retired individuals aged 55 and older who do not qualify for Medicare. For eligible plans, the threshold increases by $1,650 to $11,850 for single coverage and by $3,450 to $30,950 for non-single (or *family*) coverage.[10]

Second, there is an adjustment for certain high-risk occupations. To be eligible for the occupation exception, the plan must cover employees involved in the repair or installation of electrical or telecommunication lines, law enforcement, fire-protection activities, out-of-hospital emergency medical care (e.g., paramedics), longshore work, construction, mining, agriculture (not including food processing), forestry, and fishing industries.[11]

The same inflation adjustment used for the standard calculation of the Cadillac tax is used to adjust these modified thresholds over time.

Third, employers may also adjust the cost of the health insurance coverage if their workforce differs substantially, in terms of age and gender, from a national risk pool.[12] Regulations in this area could affect the share of plans that are subject to the tax.

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[7] Although the cost of the tax, itself, is nondeductible, IRS has issued regulations defining which costs "attributable the tax" are excluded from the calculation of the "applicable coverage" tax base. This would include higher costs charged by third-party insurers to account for higher income tax payments resulting from receipts on plans subject to the tax. See IRS, *Notice 2015-52*, July 30, 2015, p. 7, at http://www.irs.gov/pub/irs-drop/n-15-52.pdf.

[8] *Employee-plus-one* plans, which typically provide coverage for an employee and a spouse, would be subject to the non-single coverage threshold. In other words, the Cadillac tax threshold for non-single plans does not distinguish between these employee-plus-one plans and family coverage. Additionally, statute requires that the 2018 thresholds are adjusted by the health cost adjustment percentage, which is a one-time upward adjustment if premium growth in the Blue Cross Blue Shield (BCBS) Standard Plan offered through the Federal Employees Health Benefit (FEHB) program exceeds a certain percentage. It is unlikely that the 2018 thresholds will be subject to the adjustment, so this report does not consider the impact of the potential adjustment when discussing the 2018 thresholds.

[9] IRC §4980I(b)(3)(C)(v).

[10] IRC §4980I(b)(3)(C)(iv).

[11] IRC §4980I(f)(3). See the IRC for specific definitions of each profession.

[12] The FEHB BCBS Standard plan is used to make age and gender adjustments. See IRC Section 4980I(b)(3)(C)(ii). (continued...)

Legislative Background

The legislative history of the Cadillac tax is rooted in efforts to limit the effects of the long-standing income tax exclusion for employer-sponsored insurance (ESI). Before discussing the specific legislative origins of the Cadillac tax, it is important to briefly review the legislative history of the ESI tax exclusion.[13]

Brief History of ESI Tax Exclusion

Since the 1920s, ESI benefits have been excluded from federal income tax. The Stabilization Act of 1942 (P.L. 77-729) further encouraged this practice through its wage controls during World War II. With wages—but not benefits—frozen, more firms began offering health benefits to attract employees. After the war, the exclusion remained in place and firms continued to offer health benefits as a fringe benefit. In 1954, the exclusion was codified in the Internal Revenue Code. ESI coverage rates have leveled off or even declined slightly since the 1960s, in part due to the creation of major programs to cover the health benefits for the poor and elderly (and subsequent expansions of such benefits).[14]

Still, ESI coverage plays a large role in the modern economy. First, employer-sponsored plans provide the largest single source of health coverage for the non-elderly population in the United States. As of 2012, 65.8% of the non-elderly population (175.4 million people) were covered by private health insurance.[15] Of that total, 88.9% (156.0 million people) were covered by an employer-sponsored plan. Second, the exclusion has become the largest single tax expenditure in the Internal Revenue Code. For FY2015, the Joint Committee on Taxation (JCT) estimates that the ESI tax exclusion is the single largest federal tax expenditure—$150.6 billion.[16]

(...continued)

For further clarification regarding multiple employers under common control (e.g., multiple franchises owned by the same individual), see IRC Section 4980I(f)(9). Statute requires that the 2018 thresholds be adjusted by the health cost adjustment percentage. The health cost adjustment percentage is a one-time upward adjustment based on premium growth in the FEHB BCBS Standard plan. The 2018 dollar limits will be adjusted upward if premium growth in the BCBS Standard plan is more than 55% between 2010 and 2018. It is unlikely that the 2018 thresholds will be subject to the adjustment, so this report does not consider the impact of the potential adjustment when discussing the 2018 thresholds. For more discussion, see IRS, *Notice 2015-52*, July 30, 2015, p. 7, at http://www.irs.gov/pub/irs-drop/n-15-52.pdf.

[13] For a more in-depth discussion, see CRS Report R40834, *The Market Structure of the Health Insurance Industry*, by D. Andrew Austin and Thomas L. Hungerford.

[14] For more background, see *Employment and Health Benefits: A Connection at Risk*, ed. Marilyn J. Field and Harold T. Shapiro (Washington, DC: National Academy Press, 1993), p. 27.

[15] Employee Benefit Research Institute (EBRI), *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2013 Current Population Survey*, EBRI Issue Brief #390, September 2013, at http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=5272. Although EBRI has yet to update this analysis for 2013 data, the U.S. Census Bureau has published 2013 coverage data for "working-age adults" (aged 19 to 64) in Jessica C. Smith and Carla Medalia, *Health Insurance in the United States: 2013 (Current Population Reports)*, U.S. Census Bureau, September 2014, at https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf.

[16] Joint Committee on Taxation (JCT), *Estimates of Federal Tax Expenditures for Fiscal Years 2014-2018*, JCX-97-14, August 5, 2014, p. 31, at https://www.jct.gov/publications.html?func=startdown&id=4663. Note that the tax expenditure is only calculated based on losses to income tax revenue. It does not include revenue lost from payroll taxes for Social Security and Medicare if this form of compensation was taxed like wages.

Economic Impact of ESI Tax Exclusion in Brief

Economists note that the ESI tax exclusion can both increase and decrease economic efficiency as well as decrease the perceived "fairness" or equity of the income tax. Incentives for ESI could enhance economic efficiency because ESI provides a risk-pooling mechanism that is unrelated to health factors among the working population. Further, ESI could reduce health costs through increased bargaining power and decreased administrative costs.[17] In contrast, studies have concluded that the tax exclusion for ESI encourages greater health care consumption than would be the case without a tax preference, thus generating an economically inefficient outcome.[18]

In addition to the debate over economic efficiency, the ESI tax exclusion changes the burden distribution of the income tax. Generally, the ESI exclusion is regressive, since the exclusion is more valuable to those in higher income brackets.[19] Individuals who obtain coverage outside of an employer-sponsored plan or uninsured workers generally do not benefit from the ESI tax exclusion.

Congressional Discussions on Reforming the ESI Tax Exclusion

Economists and policy experts discussed the merits and potential options for eliminating the ESI tax exclusion over the course of a three-session Senate Finance Committee roundtable discussion held in spring 2009 (one year before enactment of the ACA).[20] In one opening statement, Senate Finance Chairman Max Baucus said

> We should also look at the current tax treatment of health care. I know that there is some controversy about doing so. Some do not want to modify the current unlimited exclusion for employer-provided health care, and I agree that we are not going to eliminate that exclusion. But the current tax exclusion is not perfect. It is regressive and often leads people to buy more health coverage than they need…We should look at ways to modify the current tax exclusion so that it provides the right incentives, and we should look to ways to make it fairer and more equitable for everyone.[21]

Members of the Senate Finance Committee and a bipartisan panel of health care experts discussed several issues within the context of limiting or eliminating the ESI tax exclusion in 2009, including

[17] For more explanation about the rationale of the employer-sponsored insurance (ESI) system, see CRS Report R43181, *The Affordable Care Act and Small Business: Economic Issues*, by Sean Lowry and Jane G. Gravelle. The benefits to ESI have become less pronounced after enactment of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), in part due to the new insurance exchanges, market reforms, premium tax credits, and cost-sharing subsidies.

[18] See Jonathan Gruber and James M. Poterba, "Tax Subsidies to Employer-Provided Health Insurance," in *Empirical Foundations of Household Taxation*, ed. Martin Feldstein and James Poterba (Chicago, MA: University of Chicago Press, 1996), pp. 135-169.

[19] The degree of regressiveness is reduced, however, when the exclusion from payroll taxes, which are partially capped for higher-income earners, is considered. Further, when measured as a share of after-tax income, the ESI exclusion is fairly flat for lower- and middle-income earners, and decreases for higher-income earners. Since health insurance premiums do not tend to rise much with income, the distribution of ESI exclusion benefits is flatter than the distribution of income. See Congressional Budget Office (CBO), *The Distribution of Major Tax Expenditures in the Individual Income Tax System*, Washington, DC, May 2013, at https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/43768_DistributionTaxExpenditures.pdf.

[20] U.S. Congress, Senate Committee on Finance, *Roundtable Discussion on Expanding Health Care Coverage*, 111th Cong., 1st sess., May 5, 2009, pp. 114-167, at http://www.finance.senate.gov/hearings/hearing/?id=d8c677d4-fa54-11f2-1c31-64fbd9076f32.

[21] Ibid., p. 115.

- limiting the exclusion for certain taxpayers above a particular income;
- limiting the exclusion for the value of plans over a percentile of the average actuarial value of employer-sponsored plans;[22]
- adjusting any limit for regional difference in plans or for age of the workforce;[23]
- what types of health benefits should be tax preferred (e.g., HSAs, FSAs);[24] and
- how to adjust the limit over time.[25]

Legislative Origins of the Cadillac Tax

The idea of the Cadillac tax emerged in legislation as part of the chairman's mark of the America's Healthy Future Act of 2009, the Senate Finance Committee's draft bill for health care reform, released on September 16, 2009.[26] This first version of the Cadillac tax would have taxed insurance policies with excess benefits above a threshold ($8,000 for single plans and $21,000 for family plans) at a rate of 35% beginning in 2013.[27] The Congressional Budget Office (CBO) and the JCT estimated that the provision would have raised $215 billion over the budget window from 2010 to 2019 (i.e., within the first seven fiscal years of implementation). The threshold would have been adjusted for inflation in 2014 and beyond. This version of the bill also included a three-year transition rule that would have increased the threshold for the 17 highest-cost states.

On September 22, 2009, the modified chairman's mark was released, and the Senate Finance Committee began to mark up the bill over seven days.[28] The modified mark increased the Cadillac tax rate to 40%, but it adjusted the threshold in 2014 and beyond for changes in inflation plus one percentage point. The initial threshold amounts were not modified. The Cadillac tax provision in the modified mark was estimated by CBO and JCT to raise $201 billion over the budget window (i.e., $14 billion less than the initial version).

On December 19, 2009, CBO and JCT released analysis of S.Amdt. 2786, a substitute for the House-passed Affordable Care Act (H.R. 3590). The version of the Cadillac tax in this bill had

[22] Ibid., p. 125. See comments by Senator Max Baucus: "we can dial this any way we want. Basically my understanding is that the average in business is about the 75th or 76th percentile of actuarial value that companies now provide for their employees."

[23] Ibid., p. 142. This was an issue of reoccurring economic and legal interest during the roundtable session. Most notably, Dr. Len Burman, Director of the Urban Institute's Tax Policy Center, suggested that "if you could design an efficient health insurance plan and figure out what costs would be in each state and tie a cap to that, that would be the ideal cap. A second-best measure might be to take something like the lowest-cost plans in the Federal Employees Health Benefit Program, which vary across States, and you could tie the cap to that."

[24] For the discussion on flexible savings accounts (FSAs), see ibid., pp. 133-134. For the discussion on health savings accounts (HSAs), see ibid., pp. 150-151.

[25] Ibid., p. 166. See comments by the Gail Wilensky, Senior Fellow at Project HOPE: "As long as it is not indexed to medical expenditures it will begin to have more impact over time."

[26] For the CBO analysis of the preliminary version of the bill, see Letter from Douglas Elmendorf, Director of the Congressional Budget Office, to Hon. Max Baucus, Chairman of the Senate Committee on Finance, September 16, 2009, at http://www.cbo.gov/publication/41265?index=10572.

[27] The chairman's mark also factored tax-excluded spending arrangement and health savings accounts into the calculation of excess benefits like the final provision.

[28] See Senate Committee on Finance, Modifications to the Chairman's Mark "America's Healthy Futures Act of 2009, September 22, 2009, at http://finance.senate.gov/download/?id=900c6417-5bb5-4cc6-a67d-911cac22e35b. On October 7, 2009, CBO and JCT released analysis of the modified chairman's mark of the America's Healthy Future Act. See Letter from Douglas Elmendorf, Director of the Congressional Budget Office, to Honorable Max Baucus, Chairman of the Senate Committee on Finance, October 7, 2009, at http://www.cbo.gov/publication/41335.

higher thresholds ($8,500 singles, and $23,000 family policies) than the Senate version, but retained the higher 40% tax rate and the adjustment for inflation plus one percentage point.[29] This version of the Cadillac tax would remain intact until the ACA was approved by Congress on March 21, 2010.

On March 20, 2010, CBO and JCT released analysis of the Health Care and Education Reconciliation Act (HCERA), an amendment to the provisions in the ACA. In particular, HCERA delayed the implementation of the Cadillac tax from 2013 to 2018 and raised the thresholds ($10,200 for singles, and $27,500 for families). CBO and JCT scored the revised Cadillac tax as raising $32 billion from 2010 to 2019 (i.e., after the first two years of implementation). The House passed the Senate-modified ACA and HCERA on March 21, 2010, and the Senate passed the bill (which eventually became P.L. 111-148) by reconciliation on March 25, 2010.

After enactment, bipartisan concerns emerged. These concerns culminated in a letter organized by Representative Joe Courtney and Representative Tom Cole opposing the Cadillac tax and any provision intended to reduce the benefits associated with the ESI tax exclusion.[30]

Estimated Revenue Effects of the Cadillac Tax

In April 2014, CBO and JCT estimated that the Cadillac tax will raise $5 billion in FY2018 and will collect higher amounts of revenue each year through FY2024.[31] Over the first *seven* years of implementation, CBO and JCT estimated that the tax will raise $120 billion in revenue.[32]

In March 2015, CBO and JCT significantly reduced their most recent estimates of the Cadillac tax to indicate that the tax will raise $87 billion over the first *eight* years of implementation (FY2018 to FY2025).[33] Because premium growth is now projected to be slower, fewer workers are expected to enroll in employment-based insurance plans whose costs exceed the excise tax thresholds specified in the ACA.[34]

In comparison, CBO and JCT estimated in March 2015 that two other provisions in ACA, the employer penalty and the individual mandate, will raise $145 billion and $34 billion, respectively, over the same eight-year period (FY2018 to FY2025). The $3 billion projected to be raised by the Cadillac tax in FY2018 is also small relative to the estimated $172 billion annual tax expenditure associated with the tax exclusion for ESI in that same year.[35]

Official scores indicate that the Cadillac tax will raise revenue directly on applicable plans exceeding the threshold and indirectly through increases in taxable income for employers that

[29] See Letter from Douglas Elmendorf, Director of the Congressional Budget Office, to Hon. Harry Reid, Majority Leader of the US Senate, December 19, 2009, at http://www.cbo.gov/sites/default/files/12-19-reid_letter_managers_correction_noted.pdf.

[30] See Letter from Reps. Joe Courtney and Tom Cole to Members of the Senate Finance Committee and House Ways and Means Committee, November 4, 2011.

[31] CBO, *Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline*, March 9, 2015, at https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.

[32] CBO, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act*, April 2014, p. 2, at https://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf.

[33] CBO, *Updated Budget Projections: 2015 to 2025*, March 2015, at https://www.cbo.gov/sites/default/files/cbofiles/attachments/49973-UpdatedBudgetProjections.pdf.

[34] Ibid., p. 9 and 19.

[35] JCT, *Estimates of Federal Tax Expenditures for Fiscal Years 2014-2018*, JCX-97-14, August 5, 2014, p. 31, at https://www.jct.gov/publications.html?func=startdown&id=4663.

reduce health benefits and increase wages. Roughly one-quarter of the revenue gain stems from excise tax receipts, and roughly three-quarters stems from a net increase in employees' taxable compensation and, to a lesser extent, in employers' deductible expenses.[36] This assessment assumes that employers will shift compensation over time from health benefits to wages to reduce or avoid the Cadillac tax.

Share of Plans with Insurance Premiums Exceeding the Tax's Threshold

This section of the report analyzes insurance premiums to provide insights into what share of insurance premiums exceed the Cadillac tax threshold. These premiums are a major component of health plan coverage as defined by ACA, but they are not the only component of coverage. Thus, the Cadillac tax could affect more health plans over time than estimated here if all components of applicable coverage are included. Note that the estimates also assume no further changes are made by employer providers to avoid or reduce exposure to the tax. Other studies are reviewed in the **Appendix** of this report.

In June 2015, the Congressional Research Service (CRS) requested that the Department of Health and Human Services' (HHS's) Agency for Healthcare Research and Quality (AHRQ) estimate the share of premiums that could have a health insurance premium greater than the applicable Cadillac tax threshold. At the request of CRS, AHRQ used the 2013 Medical Expenditure Panel Survey Insurance Component (MEP-IC) dataset, which is a sample of plans provided by 39,216 private-sector establishments and public employers.[37] CRS provided AHRQ with Cadillac tax thresholds adjusted for CBO's projected annual changes in the CPI-U between 2018 and 2038.[38] CRS then asked AHRQ to simulate the growth of insurance premium values offered by employers in the MEPS-IC data. These scenarios are based on different historical trends exhibited by the cost of the average insurance premium found the Kaiser Family Foundation's (KFF's) and the Health Research & Educational Trust's 2014 Employer Health Benefits Survey.[39] The scenarios include

- "Lower Growth": assuming an annual growth rate in average insurance premiums of 4.6% for single coverage and 4.7% for family coverage, based on a five-year average of trends within the KFF data.
- "Moderate Growth": assuming an annual growth rate in average insurance premiums of 5.0% for single coverage and 5.4% for family coverage, based on a 10-year average of trends within the KFF data.

[36] CBO, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act*, April 2014, p. 13, at https://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf.

[37] Agency for Healthcare Research and Quality, "MEPS-IC Sample Size," at http://meps.ahrq.gov/mepsweb/survey_comp/ic_sample_size.jsp.

[38] Annual changes in the Consumer Price Index for All Urban Consumers (CPI-U) were taken from CBO's *Long-Term Budget and Economic Outlook*. For more information, see the **Appendix**.

[39] The Kaiser Family Foundation (KFF) surveys both private and public employers, but the data limit KFF's ability to analyze public employees. For more information on the sample design of the KFF survey, see Kaiser Family Foundation, "Methodology–2014 Employer Health Benefits Survey," at http://kff.org/report-section/ehbs-2014-methodology/.

- "Higher Growth": assuming an annual growth rate in average insurance premiums of 7.0% for single coverage and 7.4% for family coverage, based on a 15-year average of trends within the KFF data.

The analysis at the state level is provided using only the lower-growth scenario, given the low probability that insurance premium growth by 2018 will increase to rates seen more than a decade ago. In contrast, analyses of the Cadillac tax at the national level are plotted according to all three growth scenarios. While it is uncertain that insurance premium growth will reach the rates in the moderate- to high-growth scenarios, these scenarios illustrate how changes in the actual rate of insurance premium growth can affect the number of premiums subject to the tax.

A full description of the data and methodology used to derive these illustrations appears in the **Appendix**.

Caution should be exercised when interpreting some state results due to potential estimation issues stemming from smaller sample sizes and significant variation in premium amounts in some states.[40]

The estimates of the share of premiums that exceed the Cadillac tax threshold provided in this section of the report should not be conflated with analysis of how many plans could actually be subject to the Cadillac tax. This analysis only includes insurance premiums and does not include the costs of other types of coverage that count toward the threshold (e.g., certain contributions to FSAs and HSAs).[41]

Additionally, any estimate of the share of premiums affected by the Cadillac tax is subject to a number of uncertainties.

- First, the growth rate of premium costs has generally been declining in recent years.[42] The analysis in this report models different assumptions in the potential growth of health care costs. Additionally, the analysis in this section of the report does not imply that each scenario is equally likely; rather, this analysis illustrates how sensitive estimates of the Cadillac tax are to inflation projections. Estimates of the impact of the tax using older data could overestimate the actual increase in average health insurance costs in more recent years. Future insurance premium growth rates could continue slowing, or could deviate from the trends used here.
- Second, it is uncertain how employers will respond (or have already responded) to the tax.[43] Since the tax was enacted in 2010, some employers have already

[40] The reliability of the sample mean relative to the actual population mean (the standard error of the mean) and the variability or precision of the measurement (the relative standard error) are different for each state. For example, a standard error of the mean (SEM) of 1% indicates that the standard deviation is 1% above or below the sample mean. Estimates with lower relative standard errors (RSE) can be said to have a more precise measurement, because they have proportionately less sampling variation around the mean. Estimates where the RSE is greater than 30% are omitted from this report's analysis because they are considered statistically unreliable, as per the standards set forth in Richard J. Klein et al., "Health People 2010 Criteria for Data Suppression," Center for Disease Control (CDC), National Center for Health Statistics, Healthy People 2010, July 2002, at http://www.cdc.gov/nchs/data/statnt/statnt24.pdf.

[41] Some studies have tried to incorporate these benefits into estimates of the impact of the Cadillac tax (See the description of Herring and Lentz, 2012, in the **Appendix**). It is uncertain how data on these benefits in a world before the Cadillac tax might be representative of a world after the tax is implemented. Contributions to these accounts are easier to adjust than changes in annual premiums. These other accounts could lead to excess benefits above the Cadillac tax threshold (thereby making more plans subject to the tax) or they could allow some employees on the margins of the threshold to reduce their contributions to a level that their total excess benefits would not rise above the threshold.

[42] See **Table A-1**.

[43] For anecdotal evidence of one employer, Harvard University, already making changes to its employee health plans, (continued...)

begun to offer less generous plans (thus, some behavioral effects would already be contained within observed data).[44] For example, employers could offer a high-deductible health plan, which might be less likely to cross the threshold than their traditional PPO/HMO plan. The analysis in this section assumes that employers do not take any actions to adjust the plans offered to employees.

- Third, this report does not take into consideration how regulations could affect implementation of the tax. Treasury and IRS could issue regulations clarifying the benefits potentially subject to tax, safe harbors for employers, and modifications in various cost adjustments (e.g., under the workforce age and gender provision). Regulations in these areas could reduce (or increase) the number of plans subject to the tax.

2018

Figure 1 and **Figure 2** depict the share of single and non-single plans, respectively, with premiums that could exceed the tax in 2018, by state.

As shown in **Figure 1**, approximately 10.2% of single premiums, nationally, could be subject to the tax in 2018. As shown in **Figure 2**, approximately 6.0% of non-single premiums, nationally, could be subject to the tax in 2018.

It should be noted that the following figures do not provide insight into what share of a plan's health benefits is subject to tax or the amount by which the plan exceeds the threshold. Only the portion of health benefits in excess of the threshold is subject to tax. Additionally, these figures do not quantify how many enrollees in these plans could be affected.

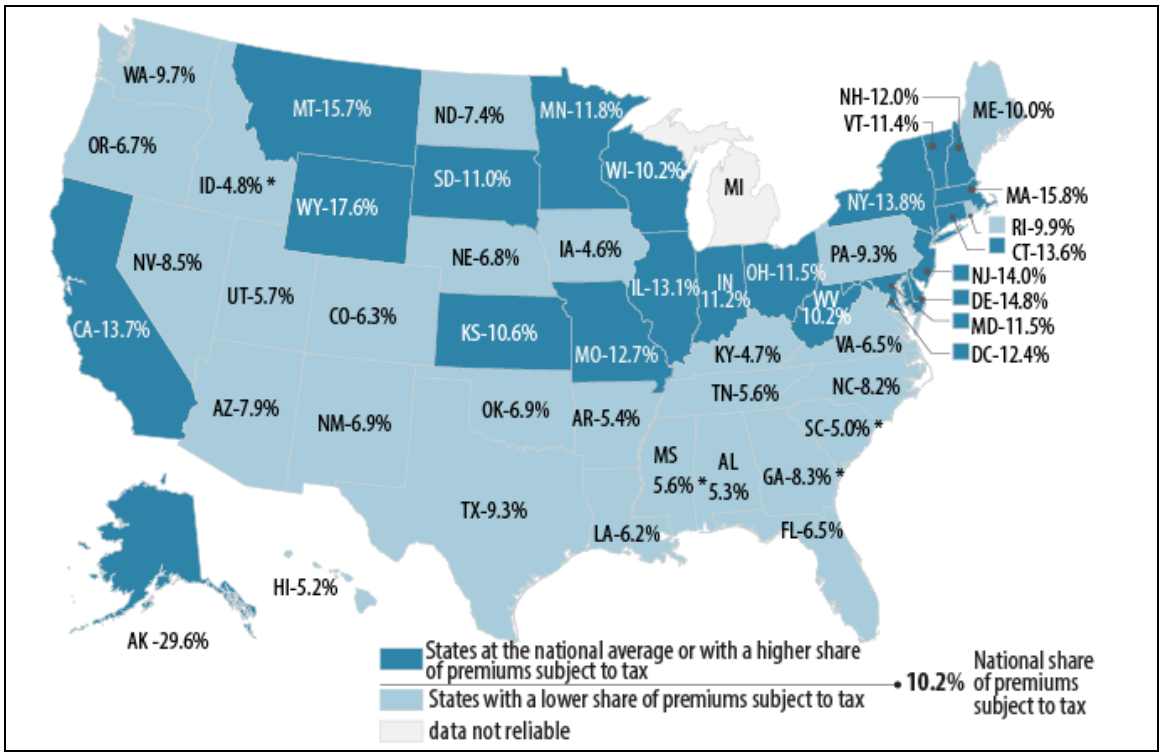
(...continued)

see Robert Pear, "Harvard Ideas on Health Care Hit Home, Hard," *New York Times*, January 5, 2015, at http://www.nytimes.com/2015/01/06/us/health-care-fixes-backed-by-harvards-experts-now-roil-its-faculty.html.

[44] The JCT's analysis of the tax assumes that, over time, employers will offer less generous health plans in exchange for higher wages.

Figure 1. Percentage of Employer-Sponsored, Single Premiums Estimated to Exceed the Cadillac Tax Threshold in 2018, by State

(under the assumption of 4.7% annual premium growth, in individual plans)

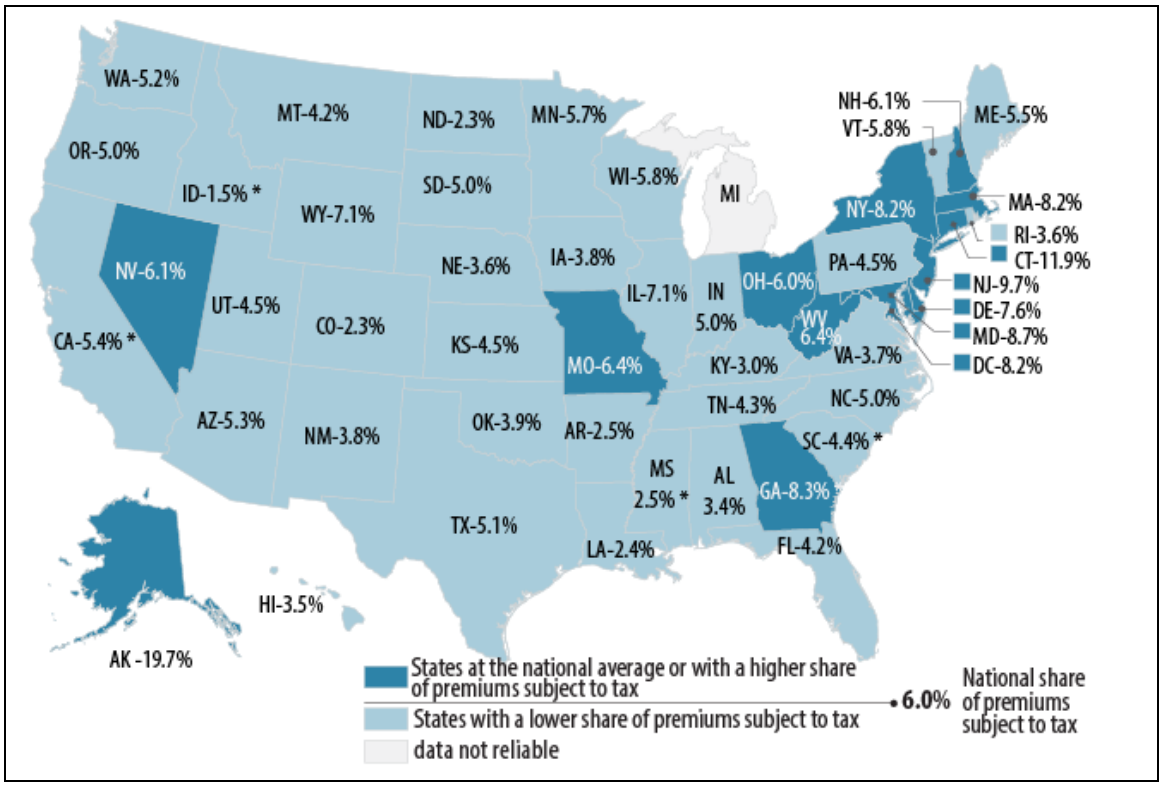


Source: U.S. Department of Health and Human Services (HHS), Agency for Healthcare Research and Quality (AHRQ) analysis of 2013 Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) data provided to the Congressional Research Service (CRS) in June 2015.

Notes: All reported values have a standard error (SE) of less than 2% and a relative standard error (RSE) of less than 30%. Caution should be taken when interpreting the results with an asterisk (*), which denotes an RSE of greater than 25%. Any estimate with an RSE greater than 30% is considered unreliable and omitted from this graphic. Reported values are weighted by the number of plans in the data sample. This graphic does not take into account any exceptions to the general Cadillac tax threshold for certain "high-risk" professions or for employers with workforces that differ from the age and gender profile of the national risk pool. See report text for more details.

Figure 2. Percentage of Employer-Sponsored, Non-Single Premiums Estimated to Exceed the Cadillac Tax Threshold in 2018, by State

(under the assumption of 4.6% annual premium growth, in family plans)



Source: AHRQ analysis of 2013 MEPS-IC data provided to CRS in June 2015.

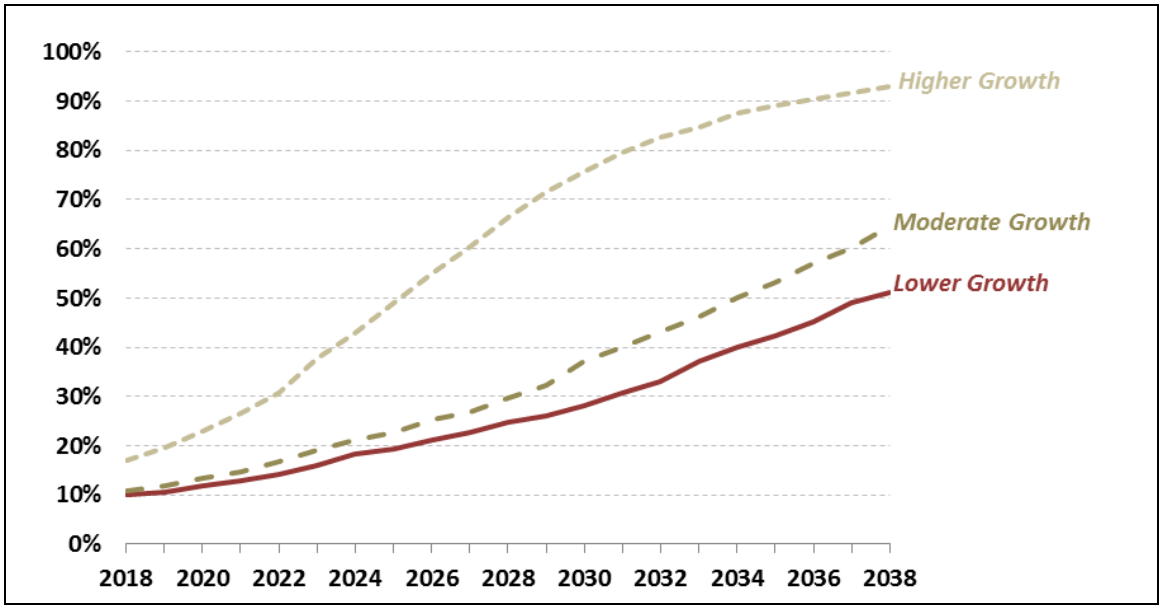
Notes: All reported values have a standard error (SE) of less than 2% and a relative standard error (RSE) of less than 30%. Caution should be taken when interpreting the results with an asterisk (*), which denotes an RSE of greater than 25%. Any estimate with an RSE greater than 30% if considered unreliable and omitted from this graphic. Reported values are weighted by the number of plans in the data sample. This graphic does not take into account any exceptions to the general Cadillac tax threshold for certain "high-risk" professions or for employers with workforces that differ from the age and gender profile of the national risk pool. See report text for more details.

2019 and Beyond

Figure 3 and **Figure 4** show the national share of single and non-single premiums, respectively, that could be subject to the Cadillac tax over time. The share of premiums that could be subject to the Cadillac tax is estimated to increase over time, primarily because the growth of inflation in the CPI-U (which is used to adjust the Cadillac tax threshold) is projected to increase more slowly than the historical trends for premium growth.

Figure 3 shows that between 2018 and 2028, the share of single premiums that could be subject to the Cadillac tax increases from 10.2% to 24.7% under the lower-growth scenario. **Figure 4** shows that between 2018 and 2028, the share of non-single premiums that could be subject to the Cadillac tax increases from 6.0% to 19.1% under the lower-growth scenario. For both single and non-single premiums, the share of plans affected by 2028 is higher under the moderate- and higher-growth scenarios.

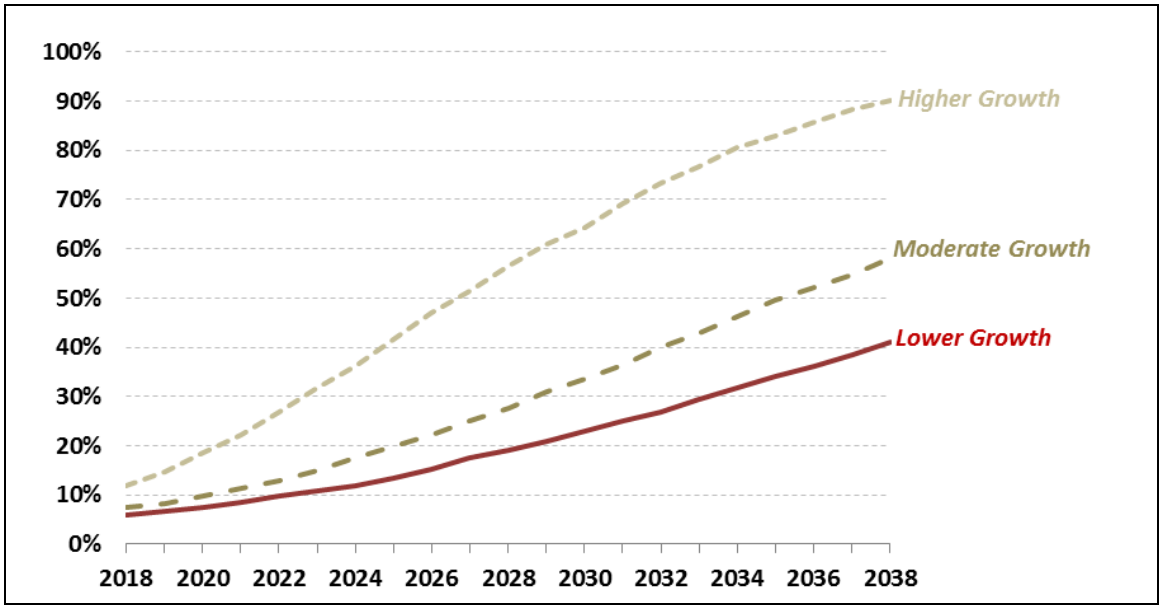
Figure 3. Percentage of Employer-Sponsored, Single Premiums Estimated to Exceed the Cadillac Tax Threshold, Nationally, 2018-2038



Sources: AHRQ analysis of 2013 MEPS-IC data provided to CRS in June 2015; growth rates in the different scenarios are derived from historical average premium values from Kaiser Family Foundation (KFF), *2014 Annual Survey of Employer Health Benefits*, September 10, 2014, at http://kff.org/health-costs/report/2014-employer-health-benefits-survey/; and projections of the Consumer Price Index for All Urban Consumers (CPI-U) from the Congressional Budget Office, *The Budget and Economic Outlook: 2015 to 2025*, January 26, 2015, at https://www.cbo.gov/publication/45066.

Notes: "Lower Growth" scenario assumes annual growth in average health insurance premiums of 4.6%, based on a 5-year average in historical trends; "Moderate Growth" scenario assumes an annual growth rate of 5.0%, based on a 10-year average; and "Higher Growth" estimate assumes an annual growth rate of 7.0%, based on a 15-year average. Historical trends are averaged from KFF data. Regarding the tax threshold, trends in the CPI-U are held constant at 2024 levels for years outside of CBO's projection window (i.e., 2025 to 2038). See **Appendix** for more details on methodology. This graphic does not take into account any exceptions to the general Cadillac tax threshold for certain "high-risk" professions or for employers with workforces that differ from the age and gender profile of the national risk pool. See report text for more details.

Figure 4. Percentage of Employer-Sponsored, Non-Single Premiums Estimated to Exceed the Cadillac Tax Threshold, Nationally, 2018-2038



Sources: AHRQ analysis of 2013 MEPS-IC data provided to CRS in June 2015; growth rates in the different scenarios are derived from historical average premium values from KFF, *2014 Annual Survey of Employer Health Benefits*, September 10, 2014, at http://kff.org/health-costs/report/2014-employer-health-benefits-survey/; and projections of the CPI-U from the CBO, *The Budget and Economic Outlook: 2015 to 2025*, January 26, 2015, at https://www.cbo.gov/publication/45066.

Notes: "Lower Growth" scenario assumes annual growth in average health insurance premiums of 4.7%, based on a 5-year average in historical trends; "Moderate Growth" scenario assumes an annual growth rate of 5.4%, based on a 10-year average; and "Higher Growth" estimate assumes an annual growth rate of 7.4%, based on a 15-year average. Historical trends are averaged from KFF data. Regarding the tax threshold, trends in the CPI-U are held constant at 2024 levels for years outside of CBO's projection window (i.e., 2025 to 2038). See **Appendix** for more details on methodology. This graphic does not take into account any exceptions to the general Cadillac tax threshold for certain "high-risk" professions or for employers with workforces that differ from the age and gender profile of the national risk pool. See report text for more details.

Interaction of the Cadillac Tax and a Hypothetical Employer-Sponsored Plan

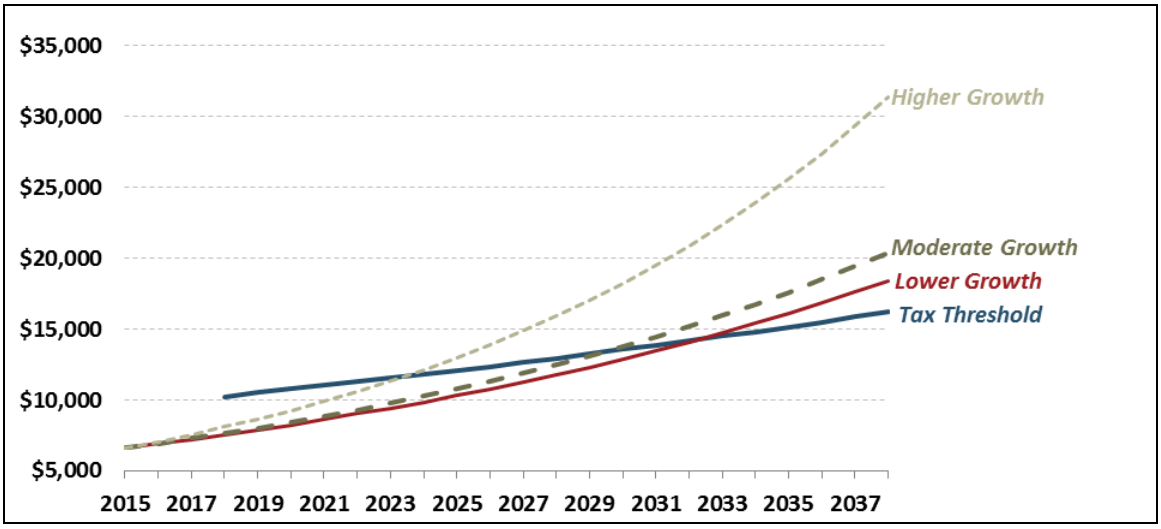
In contrast to the aggregate analysis in **Figure 3** and **Figure 4**, the graphs in this section of the report illustrate how a hypothetical employer-provided plan could be subject to the tax over time. **Figure 5** and **Figure 6** chart a hypothetical, preferred provider organization (PPO) plan for single and non-single coverage, respectively. The plan provides a comprehensive scope of benefits (physician's visits, pharmaceutical, vision, dental, etc.). The major characteristics of this plan are that it has no deductible, charges flat fees for doctor's visits and prescriptions, and does not cover medical care outside of the preferred provider network. For more information on the methodology used to construct this illustration, see the **Appendix**.

The 2015 premiums are adjusted over time using the same three growth scenarios used in previous figures.

As shown in **Figure 5**, this hypothetical employer-provided single plan would be subject to the Cadillac tax in 2033 under the lower-growth scenario. In the moderate- and higher-growth scenarios, the hypothetical plan would be subject to the tax in an earlier year. As shown in **Figure**

6, the non-single plan would be subject to the Cadillac tax in 2038 under the lower-growth scenario (or earlier under the moderate- or higher-growth scenarios).

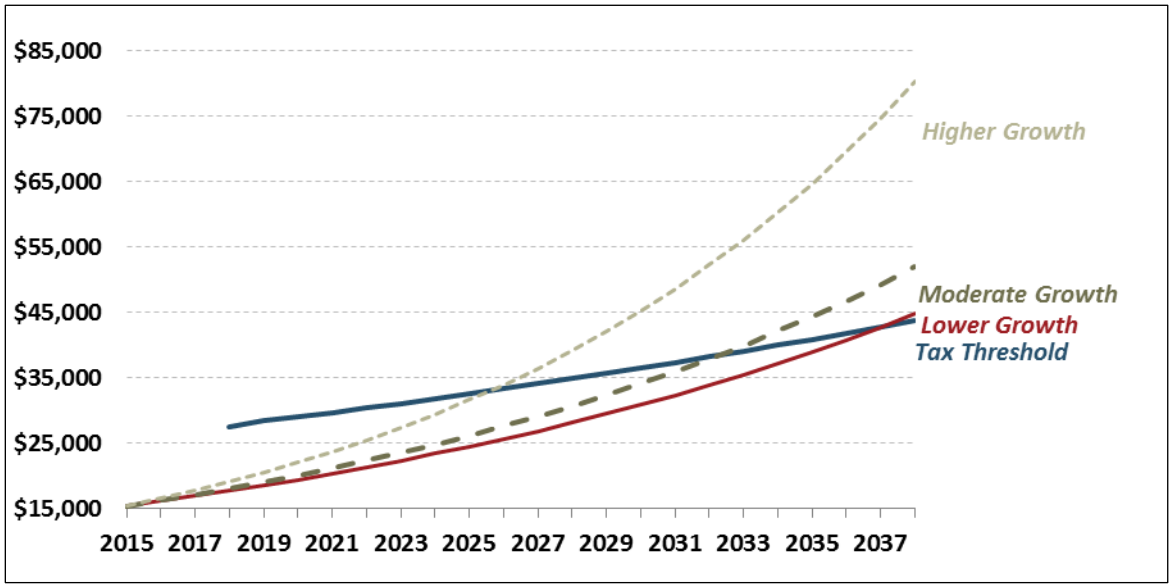
Figure 5. Illustration of the Long-Term Interaction of the Cadillac Tax Threshold and the Premium for a Hypothetical Employer-Provided Single Plan



Sources: CRS analysis of historical average premium values from KFF, *2014 Annual Survey of Employer Health Benefits*, September 10, 2014, at http://kff.org/health-costs/report/2014-employer-health-benefits-survey/; and projections of the CPI-U from the Congressional Budget Office (CBO), *The Budget and Economic Outlook: 2015 to 2025*, January 26, 2015, at https://www.cbo.gov/publication/45066.

Notes: "Lower Growth" scenario assumes annual growth in average health insurance premiums of 4.6%, based on a 5-year average in historical trends; "Moderate Growth" scenario assumes an annual growth rate of 5.0%, based on a 10-year average; and "Higher Growth" estimate assumes an annual growth rate of 7.0%, based on a 15-year average. Historical trends are averaged from KFF data. Regarding the tax threshold, trends in the CPI-U are held constant at 2024 levels for years outside of CBO's projection window (i.e., 2025 to 2038). See **Appendix** for more details on methodology.

Figure 6. Illustration of the Long-Term Interaction of the Cadillac Tax Threshold and the Premium for a Hypothetical Employer-Provided Non-Single Plan



Sources: CRS analysis of historical average premium values from KFF, *2014 Annual Survey of Employer Health Benefits*, September 10, 2014, at http://kff.org/health-costs/report/2014-employer-health-benefits-survey/; and projections of the CPI-U from the CBO, *The Budget and Economic Outlook: 2015 to 2025*, January 26, 2015, at https://www.cbo.gov/publication/45066.

Notes: "Lower Growth" scenario assumes annual growth in average health insurance premiums of 4.6%, based on a 5-year average in historical trends; "Moderate Growth" scenario assumes an annual growth rate of 5.0%, based on a 10-year average; and "Higher Growth" estimate assumes an annual growth rate of 7.0%, based on a 15-year average. Historical trends are averaged from KFF data. Regarding the tax threshold, trends in the CPI-U are held constant at 2025 levels for years outside of CBO's projection window (i.e., 2026 to 2038). See **Appendix** for more details on methodology.

Interaction of the Cadillac Tax and Small Group and Small Business (SHOP) Insurance Exchange Plans

In addition to the general effect of applying to more employer-sponsored plans, the tax, left unadjusted, could also affect small group plans. Small group plans include the employer-sponsored plans that are part of the Small Business Health Options Program (SHOP) exchanges.[45] SHOP exchanges are marketplaces where small employers can purchase health insurance plans from health insurance issuers. This effect could reduce the incentive for businesses to offer plans in the SHOP exchanges, if it is less expensive for their employees to obtain similar coverage in the individual exchanges (or the workers could forgo health insurance and potentially face the individual mandate penalty).[46] If an employer with at least 50 full-time-equivalent (FTE)

[45] The Cadillac tax only applies to employer-sponsored plans. Thus, plans purchased by individuals in the marketplace would not be subject to the Cadillac tax. For more information on the SHOP exchanges, see CRS Report R43771, *Small Business Health Options Program (SHOP) Exchange*, by Annie L. Mach.

[46] For more background, see CRS Report R41331, *Individual Mandate Under the ACA*, by Annie L. Mach, and CRS Report R43181, *The Affordable Care Act and Small Business: Economic Issues*, by Sean Lowry and Jane G. Gravelle. Individuals without ESI could face additional economic incentives to not purchase health care, because health coverage purchased by individuals (in individual markets, like the exchanges) is not subject to the same, tax-excluded status as ESI. Under current tax law, taxpayers may only deduct contributions to their health premiums if they itemize tax (continued...)

employees does not offer at least a *bronze plan*, defined as having an actuarial value of 60%, and at least one worker receives a tax credit or subsidy in the individual exchanges, then the employer could be subject to the ACA's employer penalty.[47]

National data on average premiums in the SHOP exchanges is limited, and only plan-specific premium data is available from official sources.[48] With this said, it is unlikely that these less generous plans in the SHOP exchanges will be subject to the Cadillac tax in the foreseeable future, given that the silver- and bronze-level plans in the SHOP are less generous than the hypothetical plan analyzed in the "Interaction of the Cadillac Tax and a Hypothetical Employer-Sponsored Plan" section this report.

Economic Analysis

This section analyzes the Cadillac tax using standard criteria for evaluating tax policy: economic efficiency, equity, and administrative simplicity. However, because the Cadillac tax is often compared to limits on the tax exclusion for ESI under current law, the two policies are also compared.

Economic Efficiency

The health care sector contains many sources of market failures, some of which create economic inefficiencies.[49] The inefficiency that is most directly related to the Cadillac tax is the moral hazard issue of those with health insurance. In general, insured individuals spend more on medical care than they would without insurance. More demand for medical care raises the price of medical care, and insurance and cost-sharing subsidies could insulate individuals from the full cost of their health-related decisions.[50] Incentives that encourage insurance consumption, such as the ESI tax exclusion, can increase these inefficiencies in the market for medical care.[51] The Cadillac tax is intended in part to reduce this source of inefficiency.

(...continued)

deductions and their total medical and dental costs are greater than 10% of their adjusted gross income.

[47] For more information, see CRS Report R43981, *Affordable Care Act (ACA): Employer Shared Responsibility Determinations and Potential Penalties*, by Julie M. Whittaker.

[48] In contrast, official summaries of average premiums on the individual health exchanges are available in publications, such as Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS), *Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace*, January 8, 2015, pp. 16-17, at http://aspe.hhs.gov/health/reports/2015/premiumreport/healthpremium2015.pdf. ASPE only analyzes premiums from 35 states that are *not* state-based exchanges. For a more in-depth discussion of ASPE's methodology, including its weighting techniques, see the notes to Table 10 in *Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace*.

[49] Some of these inefficiencies are summarized in Joseph Stiglitz, *Economics of the Public Sector*, 3rd ed. (New York: Norton), pp. 300-330; and Executive Office of the President, Council of Economic Advisers, *The Economic Case for Health Care Reform*, June 2009, pp. 9-17, at https://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf.

[50] Joseph Stiglitz, *Economics of the Public Sector*, 3rd ed. (New York: Norton), p. 315.

[51] ESI can also reduce other inefficiencies in the health care market. For more discussion, see CRS Report R43181, *The Affordable Care Act and Small Business: Economic Issues*, by Sean Lowry and Jane G. Gravelle.

Economic Incidence of the Tax

For the purposes of the Cadillac tax, there are two important levels of analyzing who bears the economic burden of the tax. First, there is a determination of how the added costs of the Cadillac tax are passed along from the plan administrator to covered employees. Second, there is a determination of which share of this cost is borne by employees versus medical care providers (e.g., hospitals, doctors, drug companies).

It can be expected that much of the economic burden of the Cadillac tax will be passed along to labor, much like any other partial tax on a factor of production.[52] This analysis is for employers that offer "Cadillac" health plans as part of their total employee compensation package. Since the tax increases the relative cost of one form of labor compensation (health benefits), it follows that the tax will shift the mix of compensation offered by some employers more toward wages (which become relatively less expensive after the tax is enacted).

Higher wages are likely preferable for most workers, since health benefits above the tax threshold are subject to a marginal tax rate of 40% plus any insurer markups to offset higher income tax payments due to the higher, post-Cadillac tax price of health benefits. In contrast, most workers will be facing a marginal tax rate on wages less than the top income tax rate of 39.6% plus the 7.65% employee portion of the payroll tax.[53] Some workers, who are more risk-averse and value the after-tax value of an additional one dollar of health benefits versus wages, may still want to retain their health plans even if part of the plan is subject to the Cadillac tax.[54]

This analysis, above, reflects the *long-term* effects on labor markets. In the short run, wages are sometimes "sticky" and bound by the terms of particular contracts or labor agreements. Indeed, some industries that have rigid labor contracts might be slower to adjust than others. With this said, some employers negotiating multi-year, collective bargaining agreements might already be trying to price the effects of the tax into labor contracts prior to 2018.

Effects on the Market for Medical Care

The Cadillac tax's effects on the mix of compensation taken up by employees also have effects on the market for medical care, depending on the sensitivity of producers and consumers to changes in price.

A standard supply and demand market framework can used to better understand how the Cadillac tax could affect the market for medical care. The demand for most goods and services is inversely related to the price of that good, such that consumers demand less of a good or service when prices are higher. In contrast, the supply of most goods and services is positively related to price, such that suppliers produce more of a good or service when prices are higher.

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[52] For a similar comparison, see the incidence analysis of the federal payroll tax in Harvey S. Rosen, *Public Finance*, 7th ed. (New York, NY: McGraw-Hill Irwin, 2005), pp. 285-287.

[53] This is a very simplified calculation of comparing marginal tax rates, and does not take into consideration other factors, such as: the cap on wages subject to the Social Security part of the federal payroll tax, any state and local income tax rates, or any federal deductions for state and local taxes paid. For more detailed analysis on the incidence of the tax, see CRS Report R44159, *The Excise Tax on High-Cost Employer-Sponsored Health Insurance: Estimated Economic and Market Effects*, by Jane G. Gravelle.

[54] According to the Joint Committee on Taxation (JCT), most employers and workers will shift to plans that are not subject to the Cadillac tax. See Letter from Thomas A. Barthold, Chief of Staff, Joint Committee on Taxation, to the Hon. Joe Courtney, U.S. House of Representatives, October 16, 2009, p.2. This assumption was reaffirmed in CBO, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act*, April 2014, p. 13, at https://www.cbo.gov/publication/45231.

In a world without insurance, consumers face the full price of medical care and demand an amount of medical care. When insurance is introduced, individual consumers pay a share of their full medical care costs and then demand a higher amount of medical care at this insurance-subsidized price. Other subsidies for health insurance, such as the ESI tax exclusion, further contribute to reductions in the price faced by consumers. After introducing insurance (and any other subsidies), the quantity of medical care demanded is higher than it would have been absent insurance or other cost-sharing or cost-reduction incentives.

The Cadillac tax is designed to increase the price of medical care above the tax's threshold, such that the price of this care to consumers is closer to the full (or true) cost of their medical care. On net, the demand for medical care after imposing the tax is still above the quantity demanded under the full market price (since insurance and subsidies still exist), but less than the quantity demanded after incorporating the effects of insurance and subsidies without the tax. In practice, the tax increases the cost-sharing burden on consumers for medical care over the threshold for those employees and employers who choose to reduce insurance coverage. For plans that are modified in order to avoid the tax, these cost-sharing increases could come in a variety of forms of higher out-of-pocket costs (e.g., higher co-payments, deductibles, or other features).

It is this decrease in medical care spending that will purportedly lead to reduced costs in the overall medical care market, relative to a world without the tax. As medical care above the threshold level becomes more costly, spending on medical care will decrease and spending on other commodities will increase.

The exact magnitude of this market change is unknown. First, the underlying data on the growth of health care spending are changing. If the growth of insurance costs continues to increase at a pace less than recent historical trends, then it is likely that the Cadillac tax will affect fewer plans than projected (and result in fewer savings on medical care expenditures). Additionally, the size of the change in the market depends on how responsive consumers and producers are to changes in price.[55] As discussed in CRS Report R44159, *The Excise Tax on High-Cost Employer-Sponsored Health Insurance: Estimated Economic and Market Effects*, by Jane G. Gravelle, the Cadillac tax, under certain assumptions, could lead to an overall decline in national health expenditures of 0.6%-0.9% in 2018 and by 2.5%-3.6% in 2024. In other words, the tax could result in a gross reduction of $7.6-$11.0 billion in national health expenditures in 2018 and $41.0-$60.3 billion by 2024.

Repealing or capping the tax exclusion for ESI could have effects on economic efficiency similar to those of the Cadillac tax. However, there could be efficiency tradeoffs to consider when looking at options for implementing such a cap. A major administrative issue impeding the taxation of employer-sponsored health care benefits is measuring the imputed value of health benefits received. Some measures of a health plan's value are now available on an employee's W-2 form, but this amount could be closer to an average cost per worker across an employer's workforce and does not necessarily represent the *ex post* health benefits received by the particular

[55] An elasticity of demand for insured health services of -0.2 is commonly referred to in the health economics literature. In other words, a 10% increase in the price of medical care leads to a 2% decline in the quantity of health care demanded by consumers. For example, see Su Liu and Deborah Chollet, *Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature*, Mathematica Policy Research, Inc., March 24, 2006, at http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf. Although some economists caution the use of a single elasticity to describe all medical spending, studies of different types of medical care often find demand to still be relatively inelastic (i.e., less than 1.0 in absolute value terms). The supply responses are expected to be relatively elastic (greater than 1.0). For further discussion of the supply elasticities, see CRS Report R44159, *The Excise Tax on High-Cost Employer-Sponsored Health Insurance: Estimated Economic and Market Effects*, by Jane G. Gravelle.

taxpayer.[56] If workers were subject to taxation on the full cost of their health benefits received, then higher-risk workers would face a higher tax penalty under an ESI tax exclusion cap. These workers are more likely to be elderly or other groups more likely to use health care. If workers were subject to an approximate measure of health benefits, such as the average benefit received across an employer's workforce, then relatively healthy workers would subsidize less healthy workers. Although the latter case might be desirable under a social insurance principle, it could raise issues about equity across different types of taxpayers.

Equity

Mermin and Toder (2015), researchers at the Tax Policy Center, find that if the Cadillac tax were repealed and premiums reverted back to their pre-Cadillac tax levels, taxpayers with incomes between $50,000 and $200,000 would experience a 0.3 percentage point decrease in their average tax rate by 2025 compared to current law (that assumes the Cadillac tax comes into effect in 2018).[57] Taxpayers below and above this income range would experience a smaller change in their average tax rate. These distributional effects are similar to previous analyses of the tax.

JCT analyses of preliminary versions of the Cadillac tax indicate that the tax's effects are primarily concentrated among middle- and upper-middle-income taxpayers. JCT modeled the distributional effects of earlier versions of the Cadillac tax found in the America's Healthy Future Act of 2009 (S. 1796), as reported by the Senate Finance Committee in October 2009, and the version of the Affordable Care Act (H.R. 3590) passed by the House in December 2009.[58] In summary, analysis of the more recent, House-passed version showed that the tax resulted in an increase, at most, of 0.1 percentage points in the average tax rate (defined as federal taxes paid divided by adjusted gross income) within a particular income range in the first year of implementation, and up to a 0.3 percentage points in the average tax rate within a particular income range in the seventh year of implementation.[59] In the House-passed version, the largest change in average tax rates (0.3 percentage points) was estimated to occur among taxpayers with incomes between $50,000 and $200,000.

Distributional analysis of the ESI tax exclusion indicates that it is regressive (and repealing the ESI tax exclusion would increase progressivity).[60] The tax benefits of the exclusion tend to

[56] For a discussion of the problems associated with imputing income from employer health benefits see Stan Dorn, *Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible?*, June 2009, at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411894-Capping-the-Tax-Exclusion-of-Employer-Sponsored-Health-Insurance-Is-Equity-Feasible-.PDF.

[57] See Gordon Mermin and Eric Toder, *Distributional Impact of Repealing the Excise Tax on High-Cost Health Plans*, Tax Policy Center, July 2015, at http://www.taxpolicycenter.org/UploadedPDF/2000315-Distributional-Impact-of-Repealing-the-Excise-Tax-on-High-Cost-Health-Plans.pdf. For a separate attachment, see Table T15-0103, at http://taxpolicycenter.org/numbers/Content/PDF/T15-0103.pdf.

[58] For analysis of the Senate Finance Committee's America's Healthy Future Act of 2009, see Letter from Thomas A. Barthold, Chief of Staff, Joint Committee on Taxation, to the Hon. Joe Courtney, U.S. House of Representatives, October 16, 2009. For analysis of the version of the ACA passed by the House in December 2009, see Letter from Thomas A. Barthold, Chief of Staff, Joint Committee on Taxation, to the Hon. Joe Courtney, U.S. House of Representatives, December 8, 2009.

[59] See Letter from Thomas A. Barthold, Chief of Staff, Joint Committee on Taxation, to the Honorable Joe Courtney, U.S. House of Representatives, October 16, 2009. These exact estimates, however, are likely to be outdated due to newer data regarding inflation, discontinuation of some of the affected insurance policies, changes in current law income tax policy, and other behavioral changes in anticipation of the tax. In addition, the current law tax policy baseline changed since 2009 with the enactment of permanent, marginal income tax rates in the American Taxpayer Relief Act of 2012 (P.L. 112-240).

[60] For example, taxpayers in the top 20% of the income distribution account for 34% of the tax expenditure value for (continued...)

increase with income until the highest income levels (where income grows faster than health benefits). According to Treasury analysis, the ESI tax exclusion results in tax benefits, at most, of 2.4% of after-tax income in 2015.[61] The largest changes in relative income due to the ESI tax exclusion accrue to those with $47,339 and $113,139 in income (i.e., the 60th to 90th percentiles of the income distribution). It is difficult to make a nuanced comparison of the two policies at the upper end of the income distribution, since the income ranges used by JCT and Treasury are different. Overall, though, the ESI tax exclusion's distribution of the tax benefits as a share of after-tax income is roughly similar to the distribution of the Cadillac tax's increases in average tax rates.

The Cadillac tax may be viewed by some as violating the principle of horizontal equity, which states that the tax code should treat like-situated taxpayers similarly. Health premiums are often more expensive for reasons beyond an individual's control. Thus, taxpayers with similar income levels and expected health care consumption could be subject to disproportionate federal tax burdens, simply because their health plans have characteristics that are more likely to trigger the Cadillac tax. For example, higher premiums in certain geographic areas could be due to higher claims rates, riskier industries, differences in health professional practice styles, large distances between care providers, older populations, etc. Furthermore, there might be wide variation in premiums within a particular state.

The Cadillac tax provides a mechanism to adjust, at least in part, for some of the demographic variation in health premiums. First, professionals in certain industries and qualified retirees above 55 years old are subject to a higher threshold. Second, the dollar limits for an employer's plan are increased if the age and gender characteristics of the employer would result in higher premiums than those of the national workforce (as measured by the Federal Employee Health Benefits Program's Blue Cross and Blue Shield standard benefit option). It remains to be seen whether the inflation, age and gender, and other adjustments provided in statute will keep workers with these special circumstances from paying the tax (at least in the short run).

Alternative policies that limit the tax exclusion for ESI might also pose complications for those who wish to promote tax equity. It is difficult to calculate the imputed value of an individual's health benefits, as mentioned in the "Economic Efficiency" section of this report. If workers were taxed the average value of their health benefits (which is how they are currently calculated on workers' W-2s by some firms), then younger and risk averse individuals would effectively be subsidizing older and less risk averse individuals. If the true value of an individual's health benefits were reported on a W-2, it is likely that older workers or workers with higher health risk profiles would receive more health benefits (and be subject to higher income taxes) than younger workers or workers with relatively lower health risk profiles.

(...continued)

the ESI tax exclusion. See Congressional Budget Office, *The Distribution of Major Tax Expenditures in the Individual Income Tax System*, May 2013, pp. 14-15, at https://www.cbo.gov/sites/default/files/43768_DistributionTaxExpenditures.pdf. Generally, a tax exclusion provides a higher tax benefit for those facing higher marginal tax rates (in contrast to a tax credit, which is a dollar-for-dollar offset against tax liability regardless of income). The share of the tax expenditure value for the ESI tax exclusion tends to decline among the highest income earners, though, as income grows faster than health insurance. At the bottom of the income distribution, lower-income workers are more likely to work part-time and are typically not offered employer-sponsored health coverage. Additionally, the Tax Policy Center finds similar distributional effects of limiting the ESI tax exclusion.

[61] U.S. Department of the Treasury, Office of Tax Analysis, *Distribution of Selected Income Tax Expenditures: Tax Benefits as a Share of After-Tax Income*, July 28, 2014, at http://www.treasury.gov/resource-center/tax-policy/Documents/Analysis-and-Research-Selected-Credits-Deductions-Exclusions-2015.pdf.

Administrative Simplicity

In general, the tax has created a degree of administrative complexity as employers continue to develop and implement strategies to avoid or minimize their Cadillac tax burden. Meanwhile, the Treasury and IRS are still issuing regulatory guidance on the tax, as of the publication date of this report.[62]

Policies to limit or to cap the tax exclusion for employer-sponsored insurance (ESI) could modify the existing reporting requirement to specify the full range of employer-sponsored health benefits that lawmakers wish to make taxable.[63] Although this option would more accurately report the value of an individual's health benefits, it could create additional compliance costs for employers, employees, and insurance administrators. Additionally, those who would pay the most in taxes under this form of administration could be more likely to need health coverage; increasing the cost of these health benefits could create disincentives for them to utilize insured medical care.

Conclusion

Although it is among one of the last ACA provisions to come into effect, the Cadillac tax is on track to become one of the most salient features of the ACA. The tax is estimated to raise $3 billion in 2018, but annual tax collections are expected to increase to $87 billion by 2026.

Absent significant changes in the trajectory of insurance premium costs or types of health plans offered by employers, the Cadillac tax is expected to apply to a greater share of employer-sponsored health plans over time. Changes in the trajectory of premium costs primarily affect when, not if, the Cadillac tax will apply to most health plans, as they are structured today. If premium costs increase at a slower rate than in recent history, then the share of plans affected by the tax would likely fall below current estimates (and vice versa).

As employers modify the types of health plans that they offer their employees, they are likely to offer more compensation in the form of wages, which are subject to income and payroll taxes, and less in the form of health benefits. This reduction in health benefits could materialize in a number of different ways, many of which would increase the cost-sharing burden of medical care costs on employees.

By increasing out-of-pocket costs for "excess benefits" above the tax's threshold, the tax intends to reduce demand for medical care above a certain insurance premium value. It is this reduction in demand that could reduce the growth rate in national health care spending, relative to a world without the tax.

[62] For more information, see IRS, *Notice 2015-16*, February 23, 2015, at http://www.irs.gov/pub/irs-drop/n-15-16.pdf; and IRS, *Notice 2015-52*, July 30, 2015, at http://www.irs.gov/pub/irs-drop/n-15-52.pdf

[63] For a list of employer-sponsored health benefits are currently subject to reporting, see Internal Revenue Service, "Form W-2 Reporting of Employer-Sponsored Health Coverage," at http://www.irs.gov/Affordable-Care-Act/Form-W-2-Reporting-of-Employer-Sponsored-Health-Coverage. Currently, employers can pick one of multiple ways to calculate the amount of health benefits listed on an individual's W-2, but not all of them measure the actual value of health benefits received by the individual. For more information, see Internal Revenue Service, Notice 2012-9, at http://www.irs.gov/pub/irs-drop/n-12-09.pdf.

Appendix. Analytical Review and Methodology

Selected Studies and Surveys Estimating the Effects of the Cadillac Tax

Prior studies have estimated a range of possible effects of the tax, including the share of private insurance plans that could be subject to the tax, strategies that employers are considering or adopting to avoid the tax, and the revenue raised by the tax.

Herring and Lentz (2012) estimated the number and characteristics of plans that would likely be affected by the tax in 2018 and beyond.[64] The authors projected the excise tax threshold forward, and use data from the 2008-2009 Kaiser Family Foundation (KFF) Employer Health Benefits Survey to estimate the percentage of plans exceeding the excise tax threshold in each year.[65] Employees from both public and private employers are included in the KFF dataset. Multiple estimates are provided, based on various assumptions to insurance premium growth rates (ranging from 4.5% to 7.5% per year). According to Herring and Lentz's analysis, 6.6% of single plans and 6.3% of family-of-four plans are estimated to exceed the threshold in 2018, and 29.4% of single plans and 30.2% of family-of-four plans are estimated to exceed the threshold in 2029 (under an assumption of a premium growth rate of 4.5% per year).[66] Summary statistics for plans exceeding the threshold in 2018 are provided along different plan characteristics (e.g., preferred provider organization versus health maintenance organization, employee characteristics, employer and industry characteristics, and geographic area of the plan).

According to a presentation by Mercer, a business consultancy, on March 16, 2015, 31% of employers surveyed said they would be subject to the tax in 2018 if they made no changes to their current plans.[67] Likewise, 51% of firms surveyed said they would be affected by 2022.[68] Among survey respondents, 48% said they implemented a "consumer-driven health plan" (CDHP), 38% said they were steered more employees into a CDHP, 28% said they raised deductibles of other cost-sharing provisions, and 17% said they dropped high-cost plans. Among survey respondents 48% were considering raising deductibles or other cost-sharing provisions, 34% were considering dropping high-cost plans, 23% were considering implementing a CDHPs, and 22% were considering steering more employees into CDHPs.[69]

In November 2014, the American Health Policy Institute (AHPI) released a study of the potential impacts of the Cadillac tax.[70] Based on a January and February 2014 survey of over 350 large

[64] Bradley Herring and Lisa Korin Lentz, "What Can We Expect from the 'Cadillac Tax' in 2018 and Beyond," *Inquiry*, vol. 48 (Winter 2011), pp. 322-337.

[65] The authors also used data from other sources to model employer contributions to HSAs, HRAs, and FRAs as part of their base of applicable coverage.

[66] Ibid., p. 326.

[67] "Impact of the Excise Tax on Employer Sponsored Coverage," a presentation by Tracy Watts before a lunch panel in the Rayburn House Office Building, March 16, 2015. Data from this presentation was derived from Mercer's 2015 report, *Health Care Reform Five Years In*, and Mercer's *National Survey of Employer-Sponsored Health Plans 2014*.

[68] Just because an employer is "affected" by the tax, though, does not mean that all of their offered plans are affected.

[69] Consumer-driven health plans (CDHPs) include high-deductible health plans with an HSA or health reimbursement account (HRA).

[70] See Tevi D. Troy and D. Mark Wilson, *The Impact of the Health Care Excise Tax on U.S. Employees and Employers*, American Health Policy Institute, November 10, 2014, at http://www.americanhealthpolicy.org/Content/documents/resources/Excise_Tax_11102014.pdf.

companies that are members of the Human Resources Policy Associations, AHPI reported that more than 38% of respondents would be affected by the tax in 2018 unless they made changes to their plans.

Methodology and Detailed Results Estimating the Share of Plans Subject to the Cadillac Tax

To project the Cadillac tax's thresholds over time, the 2018 statutory thresholds of $10,200 (single) and $27,500 (family) in 2018 are inflated for years 2019 to 2024 using the Congressional Budget Office's (CBO) projections of annual changes to the Consumer Price Index for all Urban Consumers (CPI-U).[71] For years 2025 to 2038, the annual growth in the CPI-U in the last year of CBO's projection is held constant.[72] Increases in the actual rate of inflation in the CPI-U reduce the share of premiums subject to the Cadillac tax over time.

Health insurance premiums in the 2013 Medical Expenditure Survey Insurance Component (MEPS-IS) dataset are inflated on an annual basis using three different scenarios based on historical trends in average health insurance premiums are derived from the KFF Annual Employer Survey.[73] As shown in **Table A-1**, the "Lower Growth" scenario averages the annual growth rates over the past 5 years for single and family coverage, respectively; the "Moderate Growth" scenario averages annual growth rates over the past 10 years; and "Higher Growth" scenario averages annual growth rates over the past 15 years.

Table A-1. Assumed Annual Growth Rates in Illustrated Cases of Growth in Average Annual Health Insurance Premiums

Scenario	Historical Trend	Single Coverage	Family Coverage
"Lower Growth"	Last 5 years	4.6%	4.7%
"Moderate Growth"	Last 10 years	5.0%	5.4%
"Higher Growth"	Last 15 years	7.0%	7.4%

Source: CRS analysis of Kaiser Family Foundation (KFF) data.

Notes: "Lower Growth" scenario is averaged over the five-year period from 2010 to 2014, "Moderate Growth" scenario is averaged over the ten-year period from 2005-2014, and "Higher Growth" scenario is averaged over the 15-year period from 2000 to 2014.

Methodology for Estimating a Hypothetical Employer-Provided Premium and the Cadillac Tax Threshold

Figure 5 and **Figure 6** illustrate the intersection between a hypothetical employer-provided insurance premium and the Cadillac tax threshold. This report bases this illustration on the 2015

[71] See CBO, *The Budget and Economic Outlook: 2015 to 2025*, February 2015, p. 6, at https://www.cbo.gov/sites/default/files/45010-Outlook2014_Feb_0.pdf. To derive the 2019 threshold projection, one percentage point is added to CBO's projected annual increase in the CPI-U.

[72] From 2020 to 2025, CBO projects that the CPI-U will grow at an annual rate of 2.3%. For the purposes of the projections in this report, growth in the CPI-U is held constant at an annual rate of 2.3% in years 2026 to 2038. Actual inflation rates could vary.

[73] This data is typically shown as Exhibit 1.11 in the KFF annual publications. For the most recent edition of the report, see Kaiser Family Foundation (KFF), *2014 Annual Survey of Employer Health Benefits*, September 10, 2014, at http://kff.org/health-costs/report/2014-employer-health-benefits-survey/.

premiums from the "basic" option Blue Cross and Blue Shield (BCBS) plan found in the Federal Employee Health Benefits Plan (FEHBP).[74] This plan was chosen for the purposes of this analysis because it is subscribed to by many workers and ample data concerning enrollments and plan characteristics are available.[75]

It is important to note that the figures in this section of the report should be interpreted as illustrations only, and are *not* intended to be a projection of the effects of the Cadillac tax on the FEHBP's BCBS plans over time.[76] The plans represented in the subsequent analysis are also not necessarily representative of the majority of private-sector, employer-sponsored plans.

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[74] For more information of the plan characteristics, see Blue Cross and Blue Shield, "Plan Brochures," at https://www.fepblue.org/en/benefit-plans/benefit-plans-brochures-and-forms/.

[75] The BCBS options had the highest take-up rates among active, non-Postal Service government employees participating in the FEHB in 2014, based on CRS analysis of data provided by the Office of Personnel Management (OPM) on June 4, 2015. In 2014, approximately 32.2% of non-Postal Service, federal employees enrolled in a FEHB single plan and 35.4% of non-Postal Service, federal employees enrolled in a FEHB non-single plan were enrolled in the BCBS basic option. Approximately 32.7% of non-Postal Service, federal employees enrolled in a FEHB single plan and 33.0% of non-Postal Service, federal employees enrolled in a FEHB non-single plan were enrolled in the BCBS standard option.

[76] For example, the annual premium growth in these FEHBP BCBS plans has been lower than the average growth rates exhibited in the KFF data. Additionally, the demographics of the federal workplace could be different than most employers.