Article from

In the Public Interest

January 2016
Issue 12

Employer-Sponsored Health Insurance Under the ACA
Impacts from the Cadillac Plan Excise Tax

By Paul R. Houchens

**In omnibus spending legislation pending at the time of this publication, the Cadillac plan excise tax's scheduled implementation date is delayed until 2020. Additionally, the legislation proposes the tax will now be deductible from an employer's gross income.*

Beginning in 2018, the Patient Protection and Affordable Care Act (ACA) introduces an excise tax on the value of high-cost employer-sponsored health insurance plans. The tax, known commonly as the "Cadillac plan excise tax," has the potential to change the dynamics of the employer-sponsored insurance (ESI) market for approximately 150 million Americans who are receiving health insurance benefits.[1] From a social insurance perspective, the Cadillac plan excise tax is a major change to U.S. tax policy, introducing federal taxation to employer-sponsored health benefits for the first time since the 1920s.[2] This article discusses the structure of the Cadillac plan excise tax and the potential effects of its implementation.

The basic structure of the Cadillac plan excise tax and developing regulatory framework

The Cadillac plan excise tax, scheduled to be implemented in taxable years after Dec. 31, 2017, is defined by Section 9001 of the ACA.[3] The tax was included in the ACA to serve two purposes:[4]

Raise federal revenue to offset expenditures related to ACA insurance coverage expansion, including Medicaid expansion and premium assistance in the insurance marketplace.

Slow the growth in health care costs by incentivizing employers to offer less generous benefits. As stated by the Congressional Research Office, many economists believe the current ESI tax exclusion "encourages the overconsumption of health benefits."

The following section provides a basic overview of the Cadillac plan excise tax structure and the developing regulatory framework.

What is specifically being taxed?

Employer-sponsored health insurance that has an "applicable coverage" cost per employee that exceeds the coverage limits defined by Section 9001 of the ACA. Applicable coverage includes not only the cost of the insurance benefit (both employer and employee costs), but also employer and employee contributions to health reimbursement arrangements (HRAs), health savings accounts (HSAs), and flexible spending accounts (FSAs).[5]

What are the coverage limits for the Cadillac plan excise tax and how will they change in the future?

For calendar year 2018, applicable coverage cost that exceeds $10,200 per employee for single coverage, or $27,500 for non-single coverage.[6] These amounts are indexed by the Consumer Price Index for all Urban Consumers (CPI-U) plus 1 percent in 2019 and, thereafter, only by the CPI-U.[7] The Congressional Budget Office (CBO) estimates the CPI-U to grow at 2.4 percent annually from 2019 through 2025.[8] Historically, growth in ESI premiums has exceeded the forecasted CPI-U growth rate. For example, Milliman's Medical Index, which tracks the cost of an average preferred provider organization (PPO) plan for a family of four, has experienced annual growth rates between 5 percent and 7 percent in the last five years.[9]

How is the tax calculated?

To the extent an employer's cost of applicable coverage exceeds the tax's coverage limits for a given calendar, the excise tax amount is 40 percent of the applicable coverage cost that exceeds the coverage limit. For example, if the cost of applicable coverage for single coverage is $12,000 in 2018, the tax amount will be calculated as:

($12,000 - $10,200) x 40% = $720 excise tax amount

Note that the $10,200 is the 2018 single, unadjusted coverage limit.

The Cadillac plan excise tax amount is not deductible from an employer's gross income.[10]

How are employees grouped together for the purpose of determining the applicable coverage cost per employee?

Rather than calculating the average health insurance cost across all benefit options that an employer may offer, Internal Revenue Service (IRS) guidance suggests that the applicable coverage cost per employee will be determined for "similarly situated" employees.[11] Similarly situated employees would be defined first by benefit package and then split into employees with single or non-single coverage. For example, if an employer offered a PPO and a health maintenance organization (HMO) benefit option, the cost of applicable coverage would be determined (at a minimum) for four groups of similarly situated employees:

1. Single/PPO

2. Non-Single/PPO
3. Single/HMO
4. Non-Single/HMO

The IRS is considering guidance that would allow employers to further disaggregate employees by factors such as geographic location, job classification, and collective bargaining status.[12]

From a social insurance perspective, the Cadillac plan excise tax is a major change to U.S. tax policy, introducing federal taxation to employer-sponsored health benefits for the first time since the 1920s.

Will the applicable coverage limits be adjusted for any employer demographic factors?

Yes, the coverage limits will be adjusted for employees who are in high-risk professions and members who are pre-Medicare retirees.[13] Further, the coverage limits will be adjusted upward if the age and gender characteristics of an employer's workforce are different from those of the national workforce.[14] For example, if an employer employed only 60-year-olds, the coverage limit thresholds would be much higher than the 2018 standard $10,200 and $27,500 limits. Because of the permissible age and gender adjustment, the determination of whether or not an employer's health benefit options are subject to the tax in 2018 may be dependent on the age/gender demographics of each set of similarly situated employees.

IMPACTS FROM THE CADILLAC PLAN EXCISE TAX

How many employers may be subject to the tax?

Estimating the impact of the tax is a difficult endeavor for several reasons, including:

- Forecasting future premium trends,
- Lack of information related to employee age/gender demographics in ESI survey data, and
- Employers may modify existing benefit options to avoid hitting the tax.

With these caveats, estimates from the Kaiser Family Foundation (Kaiser) indicate that 26 percent of employers may have at least one single benefit option subject to the Cadillac plan excise tax in 2018, based on a 5 percent growth in employer premiums from 2015 through 2018.[15] The Agency for Healthcare Research and Quality (AHRQ) estimated 10 percent of the national share of single coverage premium would be subject to the tax in 2018.[16] Both entities estimate that the number of employers impacted by the tax will increase steadily over time as health care inflation outpaces CPI-U.

The CBO and the Joint Committee on Taxation (JCT) have estimated that only one-fourth of the $87 billion expected to be generated by the tax in its first eight years of existence will be generated by direct tax receipts. Three-fourths of the $87 billion in estimated revenue is expected to be generated from employers shifting compensation to wages (thus increasing taxable income) while decreasing the richness of health care benefits to avoid the excise tax.[17]

Regional impacts may vary

While the Cadillac plan excise tax provisions contain adjustments for high-risk professions, pre-Medicare retirees, and age/gender characteristics of employees, the statute does not adjust for other factors that may influence insurance costs, other than benefit design, including:

- Underlying provider reimbursement levels in the employer's geographic location,
- Employee health status (other than factors related to age and gender), and
- Administrative costs and other non-benefit expenses included with ESI coverage.

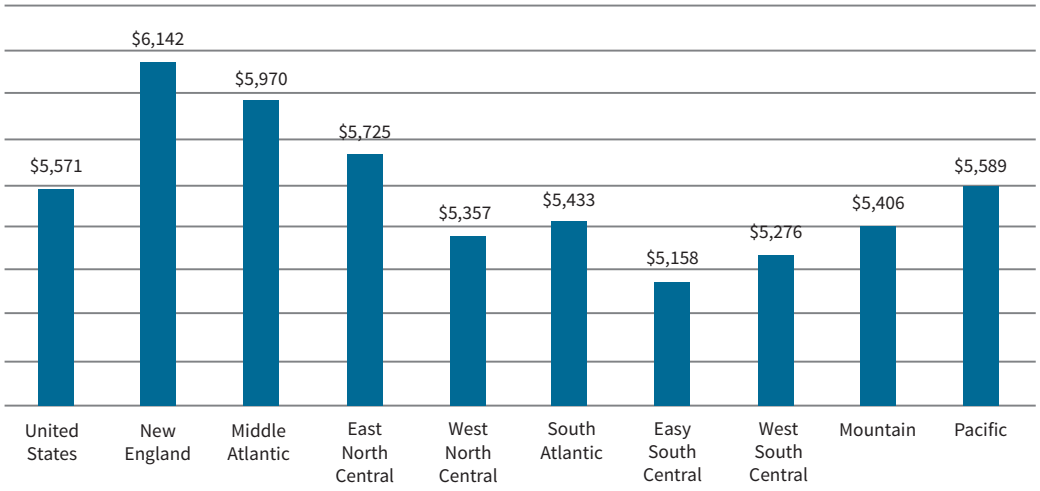
The combination of these factors may result in Cadillac plan excise taxes varying significantly across the country. To illustrate this potential variance, Figure 1 provides average regional (defined by the U.S. Census Bureau) premiums for single private-sector ESI coverage in 2013 from the Medical Expenditure Panel Survey.[18]

The average premium cost ranges from $5,158 in the East South Central region to $6,142 in the New England states, a percentage difference of nearly 20 percent. Given equal benefit designs, employers in high-cost states may be more likely to hit the excise tax coverage limits in 2018.

Employer reaction to the Cadillac plan excise tax

As stated previously, the Cadillac plan excise tax is intended to incentivize employers with high-cost health insurance options to provide less expensive health insurance benefits. While there are a number of means for an employer to achieve a reduction in health plan expenses, many employers review offered benefit designs (deductibles, coinsurance, copays, etc.) on an annual ba-

Figure 1
2013 Composite Private Sector Single Premiums
Medical Expenditure Panel Survey - U.S. Census Region



Note: Premium value variance may be attributable to demographic and benefit design differences between regions.

sis to create sustainable health care expense trends. For employers with high-cost insurance, the tax places an even greater value on reducing or mitigating health care trend increases. To the extent that future health care trends outpace general inflation, the excise tax may result in employee cost sharing increasing at a faster rate than historically observed. The 2015 Kaiser Employer Health Benefits Survey reported that, among large firms (200 or more workers), 13 percent of the firms have made changes to benefit design or coverage to decrease the likelihood of exceeding the excise tax coverage limits in 2018.[19]

For employers in collective bargaining agreements, it may be necessary to do a more long-term analysis of the potential impact from the Cadillac plan excise tax. Such an employer may not have the ability to make annual benefit design changes, making it optimal to estimate the effects of the tax during contract negotiations.

Because the excise tax provisions do not contain any adjustment for employee morbidity, other than age and gender demographics, the tax also implicitly places a greater value on an employed population's health status. All else equal, an employer with a relatively healthy workforce will be less likely to hit the excise tax coverage limits than an employer with a workforce in relatively poor health. Therefore, the excise tax provisions may result in higher investment in population health management by employers, as the potential return on investment will be higher beginning in 2018.

Despite the introduction of the Cadillac plan excise tax in 2018, the proportion of large employers offering ESI, 95 percent in 2013,[20] may remain high for several reasons:

- **Majority of individuals with ESI are not eligible for marketplace premium assistance.** On a national basis, it is estimated that more than 50 percent of non-elderly individuals with ESI had household incomes above 400 percent of the federal poverty level, making them ineligible for any premium assistance in the insurance exchanges.[21]
- **ACA employer mandate.** The ACA introduces an employer mandate penalty of approximately $2,000 per each full-time employee if a large employer fails to offer health insurance coverage to its full-time employees.[22]
- **ESI tax exclusion.** With the exception of introducing the ESI Cadillac plan excise tax, the ACA maintains the ESI tax exclusion, which allows employers to offer health insurance benefits as a nontaxable benefit to employees. The tax exclusion, estimated at $151 billion in federal fiscal year 2015, is the single largest federal tax expenditure.[23] The ESI tax exclusion is most valuable for higher-paid employees. For example, a $10,000 health insurance benefit would provide an employee in the 10 percent marginal tax rate bracket with $1,000 in tax savings. However, an employee in the 35 percent marginal tax rate bracket would receive $3,500 in tax savings.

Employee decision making

To the extent that households with ESI are faced with higher cost-sharing requirements under their insurance plans, the demand for health care price transparency may increase as a greater number of Americans will be exposed to significant cost sharing under their health plans. Resources and tools offered by insurers or third-party vendors to evaluate the cost of health care services

may become standard features of many employer-sponsored plans.

If employer-sponsored health plans become significantly leaner (higher cost sharing), many low-income Americans may prefer to receive health insurance through the insurance marketplaces.

The availability of both premium assistance and cost-sharing subsidies[24] for qualifying households may create situations where total health care expenses (premium and cost sharing) in a marketplace plan are considerably less than coverage offered by an employer. The ACA requires employers to offer a plan with an actuarial value of at least 60 percent (paying 60 percent of health care expenses, on average). In the marketplace, cost-sharing subsidies provide coverage that has an actuarial value of approximately 90 percent for households with income below 200 percent of the federal poverty level (approximately $24,000 for a single individual in 2015).[25]

However, the ACA's structure does not permit individuals who are eligible for employer-sponsored coverage (meeting certain minimum value and affordability standards) to receive premium assistance or cost-sharing subsidies in the marketplace.

Because of these dynamics, some low-income individuals may actually prefer that their employers not offer health insurance. Particularly for small employers that are not subject to the ACA's employer mandate, not offering insurance may be more valuable than offering it to a certain subset of employees.

CONCLUSION

The Cadillac plan excise tax has the potential to significantly impact the characteristics of insurance coverage offered by employers. The tax may be one of the most visible pieces of the ACA, with the potential to affect the health insurance of 150 million Americans. The Cadillac plan excise tax is likely to be a key component of health policy debates as we approach the 2016 presidential election. ■

ENDNOTES

1 Kaiser Family Foundation (Sept. 10, 2014). 2014 Employer Health Benefits Survey: Summary of Findings. Retrieved Oct. 1, 2015, from http://kff.org/report-section/ehbs-2014-summary-of-findings/.

2 Lowry, S. (Aug. 20, 2015). The Excise Tax on High-Cost Employer-Sponsored Health Coverage: Background and Economic Analysis, p. 4. Congressional Research Service. Retrieved Oct. 1, 2015, from https://www.fas.org/sgp/crs/misc/R44160.pdf.

3 Title IX—Revenue Provisions. Subtitle A—Revenue Offset Provisions. Retrieved Oct. 1, 2015, from http://www.hhs.gov/healthcare/rights/law/title/ix-revenue-provisions.pdf.

4 Lowry, ibid., p. 1.

5 See https://www.fas.org/sgp/crs/misc/R44147.pdf for additional details on the benefits and costs that are included in the definition of applicable coverage.

6 Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage: Notice 2015-16, p. 3. Retrieved Oct. 1, 2015, from http://www.irs.gov/pub/irs-drop/n-15-16.pdf.

7 Mach, A.L. (Aug. 14, 2015). Excise Tax on High-Cost Employer-Sponsored Health Coverage: In Brief, p. 5. Congressional Research Service. Retrieved Oct. 1, 2015, from https://www.fas.org/sgp/crs/misc/R44147.pdf.

8 Data and projections in CBO's August 2015 report, An Update to the Budget and Economic Outlook: 2015 to 2025, worksheet 2, Calendar Year. Retrieved Oct. 1, 2015, from https://www.cbo.gov/sites/default/files/cbofiles/attachments/45066-2015-08-EconomicDataProjections.xlsx.

9 Milliman Research Report (May 2015). 2015 Milliman Medical Index, p. 3. Retrieved Oct. 1, 2015, from http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2015-MMI.pdf.

10 Gravelle, J.G. (Aug. 20, 2015). The Excise Tax on High-Cost Employer-Sponsored Health Insurance: Estimated Economic and Market Effects, p. 2. Congressional Research Service. Retrieved Oct. 1, 2015, from https://www.fas.org/sgp/crs/misc/R44159.pdf.

11 Section 4980I, ibid., p. 13.

12 Section 4980I, ibid., p. 14.

13 Section 4980I, ibid., p. 22.

14 Section 4980I, ibid., p. 23.

15 Claxton, G. & Levitt, L. (Aug. 2015). How many employers could be affected by the Cadillac plan tax, Figure 1. Kaiser Family Foundation Issue Brief. Retrieved Oct. 1, 2015, from http://files.kff.org/attachment/issue-brief-how-many-employers-could-be-affected-by-the-cadillac-plan-tax.

16 Lowry, ibid., p. 11, Figure 1.

17 Lowry, ibid., p. 8.

18 Table XI.C.1 (2013). Retrieved Oct. 1, 2015, from http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_11/2013/txic1.htm.

19 Kaiser Family Foundation (Sept. 22, 2015). 2015 Employer Health Benefits Survey. Retrieved Oct. 1, 2015, from http://kff.org/report-section/ehbs-2015-section-fourteen-employer-opinions-and-health-plan-practices/.

20 Kaiser Family Foundation (2013). Percent of Private Sector Establishments That Offer Health Insurance to Employees, by Firm Size. State Health Facts. Retrieved Oct. 1, 2015, from http://kff.org/other/state-indicator/firms-offering-coverage-by-size/.

21 Kaiser Family Foundation (2013). Distribution of the Nonelderly With Employer Coverage by Federal Poverty Level (FPL). State Health Facts. Retrieved Oct. 1, 2015, from http://kff.org/other/state-indicator/distribution-by-fpl-3/.

22 Please see *http://www.irs.gov/Affordable-Care-Act/Employers/Employer-Shared-Responsibility-Provisions for more information.*

23 Lowry, idid., p. 4.

24 Please see http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans/ for more information.

25 2015 Poverty Guidelines. Retrieved October 1, 2015, from http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf.

Paul R. Houchens, FSA, MAAA, is a principal and consulting actuary for Milliman. He can be contacted at paul.houchens@milliman.com.