Statement before the House Ways and Means Committee

Reforming the Tax Treatment of Health Insurance

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The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Mr. Chairman, Ranking Member Levin, and members of the Committee, thank you for the opportunity to participate in today's hearing on the tax treatment of health care. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. The views I offer today are mine alone.

My testimony makes the following points:

- The current tax exclusion provides a strong incentive for employers to offer health insurance to their employees, but it is inefficient and unfair.
- The Cadillac tax discourages employers from offering high-cost health plans, but it does not correct problems with the tax exclusion.
- Congress should not simply repeal the Cadillac tax without offering a real reform plan.
- Capping the exclusion is a sensible compromise that would be both simpler and fairer than the current system, and could be accomplished without disrupting the way most people purchase health insurance.
- Comprehensive reform of the tax treatment of health insurance would address the tax exclusion, the Cadillac tax, and the subsidies offered on the exchanges through the Affordable Care Act (ACA). We should not ignore middle-class persons buying on the individual insurance market, who cannot access either exchange subsidies or subsidies through the employer market.

The Tax Exclusion is Inefficient and Unfair

The largest subsidy in the tax code is the exclusion from federal income and payroll taxes of premiums for employment-based insurance.[1] Nearly all premiums paid by employees or their employers are paid out of "pre-tax dollars," which represents a savings of about 30 percent for the typical worker. In 2015, the average premium for family coverage offered through employers was just over $17,500.[2] The exclusion saved the typical worker buying that insurance about $5,250.

According to the Congressional Budget Office (CBO), the tax exclusion will cost more than $250 billion in fiscal year 2016.[3] Over the next decade, federal tax subsidies associated with employment-based coverage will exceed $3.6 trillion. In effect, the exclusion is the third largest health program after Medicare and Medicaid.

The tax exclusion provides a strong incentive for employers to offer health insurance. Moreover, the substantial taxpayer-financed discount encourages both sick and relatively healthy people to enroll, which stabilizes the insurance risk pool. This year, 155 million people, or about 57 percent of the population under age 65, will be covered by employment-based health insurance.[4]

However, the exclusion is an inefficient and unfair way to promote the purchase of health insurance. It encourages workers to buy generous insurance that offers lower cost-sharing but higher tax-free premiums. Such coverage makes consumers less price-sensitive and promotes the use of medical services, some of which may provide little value. According to the Institutes of

Medicine, 30 cents of every dollar spent on health care in this country is wasted.[5] The exclusion's perverse financial incentives contributes to this problem.

The exclusion distorts how workers are paid. Many workers do not realize that their employer's contribution to the health insurance premium comes at the cost of lower cash wages. This has contributed to a shift from (taxable) cash wages to (nontaxable) health benefits. Between 1999 and 2015, the average employer contribution for family coverage nearly tripled while wage rates increased by only about half.[6] It is likely that many workers, given the choice, would prefer somewhat lower health benefits for somewhat higher cash wages.

The exclusion is regressive. Higher-income workers benefit the most from the exclusion, both in terms of dollar amounts and the percentage of premium that is subsidized.[7] Higher-income workers are more likely to be in jobs that offer health coverage, and they are in a higher tax bracket so the exclusion is worth more to them. According to a Joint Committee on Taxation analysis for 2007, the average savings for tax filers with incomes less than $30,000 was about $1,650 compared to about $4,580 for those with incomes over $200,000.[8] The Urban Institute-Brookings Institution Tax Policy Center finds that families earning $10,000 to $20,000 receive a subsidy of about $1,500, but spend more than one-quarter of their income on health insurance.[9] In contrast, families with income over $200,000 get a subsidy worth more than $4,500 and spend less than 4 percent of their income on insurance.

Experts from across the ideological spectrum have long recognized the structural flaws of the tax exclusion as it is currently configured. The exclusion can be restructured to promote better health insurance choices that lead to more efficient, higher value care. Such reforms can make the subsidy fairer without eliminating the financial incentive employers have to offer health coverage to their employees. Moreover, a well-designed policy can free up a portion of the $250 billion that the exclusion currently costs to help subsidize coverage for the 27 million left uninsured by the ACA.[10]

The Cadillac Tax is No Solution

One of the most controversial provisions of the Affordable Care Act (ACA) is the "Cadillac tax"—a 40 percent excise tax on employment-based health insurance that exceeds specified cost thresholds. The tax does not correct the problems inherent in the tax exclusion, which was left untouched. Instead, it creates financial pressure on employers and insurers to reduce the cost of their health plans below levels that would trigger the tax.

The ACA specified that the Cadillac tax would not be implemented until 2018—4 years after the rest of the legislation would go into effect. That delay may have been intended to give unions and employers a chance to adjust to the tax by paring back their health benefits, but it also served to shift to the next Administration some of the political controversy surrounding this highly unpopular tax. Implementation was further delayed until 2020 in the budget deal signed by the President in December.

As enacted, the 40 percent excise tax would be levied on insurers, employers, and other sponsors of employment-based insurance whose coverage costs more than $10,200 for a single

person or more than $27,500 for couples and families, beginning in 2018. (An inflationary adjustment would be applied to the thresholds in subsequent years.[11]) For example, a family plan costing $30,000 would pay the tax on the amount exceeding the threshold. The plan sponsor would be charged 40 percent of $2,500, or $1,000 for each family plan purchased.

Using political sleight of hand to de-emphasize who faces its consequences, the ACA imposed the tax on insurers and other plan sponsors. Nonetheless, workers will bear the financial burden in two ways. Plans that exceed the thresholds will pay the tax, but that cost will be passed through to workers in higher premiums. Plans that cut back their benefits by increasing cost-sharing requirements and narrowing provider networks may avoid the tax, but the value of the health coverage is reduced. That means higher costs for many patients.

Although the Cadillac tax will not be implemented for several years, it is already working.[12] According to a 2014 survey conducted by Aon Hewitt, firms planned to reduce the generosity of their health plans, implement narrow provider networks, reduce spousal coverage, and other steps to cut costs subject to the tax.[13]

Even taken on its own terms, the Cadillac tax has serious defects. They include:

- Workers are not in charge of their own health insurance under the Cadillac tax. Key decisions on which health plans are offered to workers are left in the hands of employers. Families who would have been willing to pay the tax if they could retain their current health plan may not have that opportunity.
- The Cadillac tax undercuts the use of health savings accounts (HSAs), which promote prudent purchasing of health care services. All contributions to HSAs count towards the threshold limits set by the law. These accounts are an increasingly popular way of financing health care costs, particularly in conjunction with high-deductible health plans.[14] Mercer's Tracy Watts points out that "eliminating pre-tax contributions will be one of the easiest ways to reduce cost for the excise tax calculation while still preserving the basic health care benefits package."[15]
- Low-wage workers are disadvantaged by the Cadillac tax. Although most employers are likely to focus on trimming health benefits to avoid the tax, some firms may reduce hiring and limit wage increases to cover the extra cost resulting from the tax. This will mostly impact low-wage workers, who have fewer financial resources to fall back on than higher-paid workers.
- Workers living in high-cost areas such as New York City or San Francisco are disadvantaged by the Cadillac tax. The use of fixed-dollar limits fails to account for regional variations in health care costs.
- The Cadillac tax will eventually impact everyone with employer coverage. The cost thresholds are indexed to general inflation. Because health care costs generally rise much faster than that, eventually all employer health plans will exceed what the ACA considers acceptable levels of health care coverage.

The President's 2017 budget, released February 9, includes a proposal to tie the tax thresholds to health care costs in each state based on the average premium for "gold" coverage

on the health insurance exchange.[16] According to the White House, this would prevent the tax from "creating unintended burdens" in high-cost states.[17] However, the effect of such a change would be to weaken the incentive to reduce costs, particularly where costs are highest.

This minor tinkering is certain to satisfy no one and will soon disappear from view. Pressure will continue to be applied by unions, employers, insurers, and patient groups to repeal the Cadillac tax, and there is bipartisan support in Congress for repeal.

Simple repeal costs money and ignores the tax exclusion's structural problems. CBO estimates that the Cadillac tax increases federal revenue by $59 billion over the next decade.[18] If future Congresses follow past practice with the Medicare Sustainable Growth Rate, they might delay implementation indefinitely, but that would require annual budget offsets that grow over time. Moreover, this would leave a threat hanging over employment-based health insurance that could not be tolerated for long. Reasonable reform would repeal the Cadillac tax and modify the tax exclusion to produce both budget savings and better incentives for the health sector.

Options for Reform

Thanks in large part to the tax exclusion, most Americans purchase health insurance at the workplace. The substantial subsidy makes employment-based insurance far less expensive than coverage bought in the individual market. Moreover, employers offer health coverage as an important tool in recruiting and retaining their best workers, and employees appreciate the administrative simplicity of having their premiums automatically deducted from their paychecks. However, we can find better ways to subsidize health coverage for workers.

There are two major strategies for reforming the tax treatment of employment-based health insurance: replacing the tax exclusion with a refundable tax credit or retaining the tax exclusion but capping the maximum amount that may be excluded. Under either approach, the Cadillac tax would be repealed.

Tax credits would break the financial link that motivates employers to offer health insurance and employees to buy it. Money wages could be expected to increase with the loss of the health benefit in firms dropping their own health plans. Although employment-based coverage would remain an attractive part of the compensation package in some companies, many workers would shift to coverage on the individual market.

The credit would be advanceable, and could be a fixed dollar amount or could vary according to the regional cost of health care or other factors that could affect the cost of the insurance, including the type of coverage (with higher credits for family coverage than for individual coverage). The credit would be indexed for inflation.

Tax credits could also be tied to the individual's income, similar to the exchange tax credits. However, experience thus far with the exchanges demonstrates the complexity of this approach.

Unlike the tax exclusion, whose value to the employee increases with the cost of the health plan, a credit would have a set dollar value for a given worker. That provides a strong incentive to choose lower-cost coverage.

Alternatively, the tax credit could be set as a fixed percentage of the cost of the plan that a person chooses.[19] In essence, this provides the same "discount" for health-insurance-premium costs for anyone purchasing coverage — whether as individuals or through group-purchasing arrangements. Although the subsidy would not be a fixed amount, this approach would also encourage the purchase of lower cost plans.

Tax credits have long been advanced by economists as the best alternative to the exclusion. Employers would no longer feel obligated to deal with the complexities of health insurance, although some would continue to offer coverage. Employees would no longer be restricted to the limited options typically available now but would have more plan choices on the open market. However, other insurance market reforms would be necessary to resolve existing problems in order to achieve these objectives. Such reforms are unlikely in the current political climate.

Capping the amount of the tax exclusion is a less dramatic reform that represents a sensible compromise that would be both simpler and fairer than the current system. Under this proposal, workers would pay income and payroll taxes on employer contributions above the cap. This is a progressive policy: lower-wage workers have a lower marginal income tax rate, and would pay a lower dollar amount of tax.

Limiting rather than eliminating the tax exclusion would not erode employer-sponsored insurance. Employers would continue to have a financial incentive to offer coverage to their employees. The limit would encourage employers to seek lower-cost plan options, but would not drive employers to offer only low-cost plans.[20]

A cap on the exclusion also has the advantage that it would work within the existing administrative systems used by employers today. Employees would continue to have their premiums deducted from their pay. If the cap is a fixed percentage of the premium for every employee in a firm, the employer would easily and accurately account for the portion of the premium not subject to taxation in preparing their employees' paychecks. A more complex design would complicate administration of the exclusion, but could yield a fairer system.

As with the tax credit, the cap could be adjusted to reflect the cost of health care in each region as well as the type of coverage (individual, family, etc.), and could be indexed for inflation.[21] Such adjustments could be accommodated by existing administrative systems. Other refinements, such as adjusting the cap based on the employee's income or age or occupation (to account for "high-risk" occupations), would add considerably to the complexity of operating this system. Such adjustments have been proposed in the name of greater fairness across individuals, but they could make administration by employers and oversight by the federal government unworkable.

A cap on the exclusion would reduce the subsidy afforded to high-income workers, but not eliminate the financial advantage those workers have compared with workers in lower tax brackets. This policy represents a shift toward a more equitable system that could be implemented without disrupting the way most people purchase health insurance.

We also need a full-scale reassessment of all tax subsidies for health insurance, including the premium and cost-sharing subsidies offered on the exchanges. The ACA exchanges have largely failed to attract middle-income purchasers.[22] That poor result is largely due to the uneven distribution of tax subsidies across different income groups and different insurance markets. In short, a middle-class person buying on the individual market cannot access either the exchange subsidies or the tax exclusion through the employer market. Comprehensive reform would not ignore those individuals.

Conclusion

Former White House official Ezekiel Emanuel predicts that by 2025, fewer than 20 percent of workers in the private sector will receive traditional employer-sponsored health insurance.[23] He argues that the Cadillac tax will help pave the way by discouraging companies from offering those plans.

Whatever one might think about that prediction, the debate over the Cadillac tax has focused policy attention on underlying problems caused by the tax exclusion. Congress should not make the mistake of repealing the Cadillac tax without replacing it with a more sensible policy that comprehensively addresses the way we subsidize health insurance.

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[1] A detailed discussion of the subsidies available through the tax system to employment-based health insurance is provided by Matthew Rae, Gary Claxton, Nirmita Panchal, and Larry Levitt, *Tax Subsidies for Private Health Insurance,* Kaiser Family Foundation, October 2014, http://kff.org/private-insurance/issue-brief/tax-subsidies-for-private-health-insurance/.

[2] Kaiser Family Foundation and Health Research & Educational Trust (KFF/HRET), *2015 Employer Health Benefits Survey*, September 2015, http://kff.org/health-costs/report/2015-employer-health-benefits-survey/.

[3] Congressional Budget Office (CBO), *Private Health Insurance Premiums and Federal Policy,* February 2016, https://www.cbo.gov/publication/51130.

[4] CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*, March 2016, https://www.cbo.gov/publication/51385.

[5] Nicole Cafarella Lallemand, "Reducing Waste in Health Care," Health Affairs Health Policy Brief, December 13, 2012, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=82.

[6] KFF/HRET, *2015 Employer Health Benefits Survey*, Exhibit 6.3: Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single Coverage, 1999-2015, http://kff.org/report-section/ehbs-2015-section-six-worker-and-employer-contributions-for-premiums/; and Bureau of Labor Statistics, Average Hourly Earnings of Production and Nonsupervisory Employees, Series CES0500000008, http://www.bls.gov/ces/.

[7] Christopher J. Conover, *American Health Economy Illustrated* (Washington, DC: American Enterprise Institute, 2012), Figure 4.2a: Higher-income families get a substantially higher subsidy from the employer tax exclusion compared with the subsidy for low-income families, https://www.aei.org/publication/american-health-economy-illustrated/.

[8] Joint Committee on Taxation, *Tax Expenditures for Health Care,* JCX-66-08, July 30, 2008, https://www.jct.gov/publications.html?func=startdown&id=1193.

[9] Len Burman, Surachai Khitatrakun, and Sarah Goodell, "Tax subsidies for private health insurance: Who benefits and at what cost?" Robert Wood Johnson Foundation, July 2009,

http://www.taxpolicycenter.org/sites/default/files/alfresco/publication-pdfs/1001297-Tax-subsidies-for-private-health-insurance-Who-benefits-and-at-what-cost-.PDF.

[10] CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026.*

[11] Although the implementation date was delayed by the Consolidated Appropriations Act, 2016, indexing would continue to be applied to the thresholds. See Susan M. Dash and Sarah G Raaii, "Cadillac Tax Delayed to January 1, 2020; Extension of ACA Health Plan Information Reporting Due Dates," McDermott Will & Emery, December 29, 2015, http://www.mwe.com/Cadillac-Tax-Delayed-to-January-1-2020-Extension-of-ACA-Health-Plan-Information-Reporting-Due-Dates-12-30-2015/.

[12] Rebecca Adams, "Employers Trimming Benefits Now to Avoid Cadillac Tax in 2018," CQ Healthbeat, October 7, 2013, http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2013/oct/october-7-2013/employers-trimming-benefits-now-to-avoid-cadillac-tax-in-2018.

[13] Aon Hewitt, "New Aon Hewitt Survey Shows Majority of Companies Taking Immediate Steps to Minimize Exposure to Excise Tax," October 16, 2014, http://aon.mediaroom.com/2014-10-16-New-Aon-Hewitt-Survey-Shows-Majority-of-Companies-Taking-Immediate-Steps-to-Minimize-Exposure-to-Excise-Tax.

[14] Dennis Triplett, "Cadillac tax hurting HSAs," Benefitspro, August 10, 2015, http://www.benefitspro.com/2015/08/10/cadillac-tax-hurting-hsas?slreturn=1460228851.

[15] Tracy Watts, "Cadillac Tax Deconstructed: Behind the Government's Math," Mercer/Signal, March 13, 2015, http://ushealthnews.mercer.com/article/346/cadillac-tax-deconstructed-behind-the-government-s-math.

[16] Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2017,* "Meeting Our Greatest Challenges: Opportunity for All," February 9, 2016, https://www.whitehouse.gov/sites/default/files/omb/budget/fy2017/assets/opportunity.pdf.

[17] Jason Furman and Matthew Fiedler, "The Cadillac Tax — A Crucial Tool for Delivery-System Reform," *New England Journal of Medicine*, March 17, 2016, 1008-1009, http://www.nejm.org/doi/full/10.1056/NEJMp1514970.

[18] CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables From CBO's March 2016 Baseline*, Table 5: Comparison of CBO and JCT's Current and Previous Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, https://www.cbo.gov/sites/default/files/51298-2016-03-HealthInsurance.pdf.

[19] Tom Miller, "Kill the Tax Exclusion for Health Insurance," *National* Review, http://www.nationalreview.com/article/385704/kill-tax-exclusion-health-insurance-tom-miller.

[20] A recent RAND study states that firms are likely to respond to an exclusion cap through a mix of reduced contributions and some direct additional tax payments. See Chapin White, Sarah A. Nowak, and Christine Eibner, "Can the Cadillac Tax Be Made Less Regressive by Replacing It with an Exclusion Cap?," RAND Corporation, 2015, note 4, http://www.rand.org/pubs/research_reports/RR1321.html.

[21] Paul Van de Water addressed placing a cap on the tax exclusion and the key implementation issues in a report written before enactment of the ACA. Those implementation issues are applicable to a tax credit as well as a cap on the exclusion. See Paul N. Van de Water, "Limiting the Tax Exclusion for Employer-Sponsored Insurance Can Help Pay for Health Reform," Center on Budget and Policy Priorities, June 4, 2009, http://www.cbpp.org/research/limiting-the-tax-exclusion-for-employer-sponsored-insurance-can-help-pay-for-health-reform.

[22] Caroline F. Pearson, "Exchanges Struggle to Enroll Consumers as Income Increases," Avalere, March 25, 2015, http://avalere.com/expertise/managed-care/insights/exchanges-struggle-to-enroll-consumers-as-income-increases.

[23] Robb Mandelbaum, "Why Employers Will Stop Offering Health Insurance," New York Times, March 26, 2014, http://boss.blogs.nytimes.com/2014/03/26/why-employers-will-stop-offering-health-insurance/.