AMERICAN BENEFITS COUNCIL

TAXING EMPLOYER-SPONSORED HEALTH BENEFITS: *MYTHS AND REALITIES*

February 2017

Employer-sponsored health insurance (ESI) is the bedrock of our private market-based health coverage system. Private-sector employer-sponsored plans currently cover more than 177 million Americans, more than four out of five with non-government health insurance.[1] By providing coverage through the workplace, these plans bring together large groups of individuals for reasons unrelated to age, income or health status. Because health costs vary due to a number of factors, this risk pooling is essential to make health insurance affordable. Employer groups represent the only truly viable alternative to legal mandates on one end of the spectrum or publicly-managed systems with price controls on the other. Excluding ESI from payroll and income taxes is the catalyst that brings in workers who otherwise may not purchase health insurance. This makes employer-sponsored risk pools feasible and stable.

The tax-favored status of employer-provided coverage (in conjunction with uniform federal standards governing these plans) affords flexibility in design and benefit levels to accommodate not only widely varying individual preferences and regional variations in costs, but also other differences beyond the control of either employers or their workers. These factors include coverage of: (1) older or disabled employees, (2) women, who (due to child-bearing as well as greater longevity) are actuarially more expensive, and (3) families that have the misfortune of experiencing chronic expensive-to-treat health conditions or catastrophic health events. Employer-sponsored plans are able to:

- manage the adverse selection that has stymied efforts to create stable markets for individual insurance,
- remain at the forefront of innovative financing and consumer-driven design,
- deliver benefits at lower administrative cost, and
- integrate health coverage with wellness programs to provide for effective holistic delivery of benefits at lower costs.

What is the employee tax exclusion? *Employers deduct, as a business expense, the amount they spend on health benefits for their employees. Additionally, the amount an employer provides to an employee for health benefits, as well as the contribution the employee makes, is excluded from the employee's wages for purposes of both payroll and income taxes. This is the "employee tax exclusion." Health benefits have been structured this way since World War II. Some policymakers have proposed limiting or "capping" the value of health insurance that can be excluded from taxation.*

Some have challenged this system, suggesting that capping the current employee tax exclusion would create revenue to finance a replacement plan for the Affordable Care Act, tax reform, deficit reduction or other initiatives while helping to control the rate of increase in health care costs. These proposals to cap the employee tax exclusion are often coupled with the provision of some type of tax credit. Although tax credits might potentially offset some of the proportionally greater burden on middle-income workers

[1]Jessica C. Barnett and Marina S. Vornovitsky, U.S. Census Bureau, Health Insurance Coverage in the United States: 2015, September 2016

that would result from limiting the current employee tax exclusion, they are typically designed to be available only to individuals not enrolled in, or even offered, ESI.

The portion of the population covered by ESI dwarfs the portion that obtains coverage in the individual market, by nearly ten to one. Presumably most Americans would prefer to keep the employer-sponsored coverage they like, especially given the extraordinary instability of the individual insurance market. Regardless of whether there would be a shift from ESI to individually-purchased coverage, the implications of a cap on the employee tax exclusion for the 177 million Americans who currently enjoy ESI is the focus of this analysis.

The tax-favored status of employer-provided coverage affords flexibility in design and benefit levels to accommodate not only individual preferences and regional variations in costs, but also other differences beyond the control of either employers or their workers.

Proposals to limit the tax exclusion for ESI are predicated on a number of myths and misperceptions. In actuality, taxing employer-provided benefits would severely disrupt ESI, erode coverage and undermine recent progress in managing costs. As noted below, it also could unintentionally result in *higher* health care spending, rather than reducing such expenditures. A backdoor version of a cap on the tax exclusion was enacted under the Affordable Care Act (ACA) in the form of a 40% excise tax on expensive health plans – the "Cadillac Tax." For good reason this has proven to be among the more controversial aspects of the law, eliciting opposition across the spectrum of stakeholders, including employers, consumer and patient advocacy groups and labor unions. The many studies of this ACA provision – which analysts point out is essentially identical to a cap on the exclusion – provide valuable insights into the consequences of imposing a tax cap.

Capping the employee tax exclusion risks unraveling the underlying fabric of the health coverage system, imposing disproportionate risks and burdens on middle-income working Americans while achieving very little in return.

A clear-eyed look at the myths and realities of capping the employee tax exclusion exposes the enormous risks and negative consequences in relation to the uncertain and potentially very limited benefits. Stated simply, capping the employee tax exclusion risks unraveling the underlying fabric of the health coverage system, imposing disproportionate risks and burdens on middle-income working Americans while achieving very little in return.

MYTH NO. 1

Capping the employee tax exclusion would provide revenue for other initiatives.

The Congressional Budget Office (CBO) December 2016 review of "Options for Reducing the Deficit" (Health – Option 18) estimates that repealing the 40% "Cadillac Tax" and capping the tax exclusion at the 50th percentile of current premiums, and raising this cap by the overall rate of inflation, would increase revenues by $429 billion from 2017 to 2026.[2] Naturally, if the cap were set higher, the revenue gain would be lower.

Health—Option 18

Reduce Tax Preferences for Employment-Based Health Insurance

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total 2017–2021	Total 2017–2026
Replace the Excise Tax With a Limit on the Income and Payroll Tax Exclusions for Employment-Based Health Insurance Set at the 50th Percentile of Premiums												
Change in Mandatory Outlays	0	0	0	4	6	6	7	7	8	9	10	47
Change in Revenues[a]	0	0	0	24	49	61	70	80	90	101	73	476
Decrease in the Deficit	0	0	0	-20	-44	-55	-63	-73	-82	-92	-64	-429
Replace the Excise Tax With a Limit on the Income and Payroll Tax Exclusions for Employment-Based Health Insurance Set at the 75th Percentile of Premiums												
Change in Mandatory Outlays	0	0	0	2	2	2	3	3	4	3	4	19
Change in Revenues[a]	0	0	0	8	18	23	28	33	38	44	27	193
Decrease in the Deficit	0	0	0	-7	-16	-21	-25	-30	-35	-41	-23	-174
Replace the Excise Tax With a Limit on Only the Income Tax Exclusion for Employment-Based Health Insurance												
Change in Mandatory Outlays	0	0	0	3	3	4	4	4	5	5	6	29
Change in Revenues[a]	0	0	0	14	30	37	42	47	54	60	44	283
Decrease in the Deficit	0	0	0	-12	-26	-33	-38	-43	-48	-55	-38	-254

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would take effect in January 2020.

a. Estimates include the effects on Social Security payroll tax receipts, which are classified as off-budget.

Congressional Budget Office, Options for Reducing the Deficit: 2016- 2027, Page 269,December 2016

REALITY:

At whatever level a cap would be set, long-term revenue increases available for other spending would only be about half the projected amount.

[2] Congressional Budget Office, Options for Reducing the Deficit: 2016- 2027, December 2016

About two-fifths of projected additional revenue would be from payroll taxes for Social Security and Medicare. While additional payroll tax receipts provide revenue within the ten-year scoring window, these receipts are allocated to the Social Security and Medicare Trust Funds and come with offsetting increases in future benefits. A 2014 study by the Urban Institute and Tax Policy Center found that the present value of future increases in benefits from entitlement programs would offset fully 57% of the value of increased revenues that would result from imposing payroll taxes on ESI. Moreover, the cost of future Social Security benefits would be equivalent to 72% of the Social Security (OASDI) revenues.[3] This means that revenue raised from the tax would not be available for other spending within the budget window without offsetting increases in future deficits.

While additional payroll tax receipts provide revenue within the ten-year budget scoring window, the receipts are allocated to federal trust funds and come with offsetting increases in future benefits.

MYTH NO. 2

Generous benefits are the main contributor to the high cost of health plans.

In addition to the desire to find revenue to finance other tax reductions or additional spending, the main argument in favor of imposing a cap on the tax exclusion is that it would lead to a reduction in overly generous, so-called "Cadillac" plans and thereby "bend the cost curve" of health care.

REALITY:

Studies of the factors contributing to differences in the cost of health insurance premiums find that very little is explained by the generosity of the benefits in employer-sponsored plans.

A study published in *Health Affairs* in 2010 found that less than 4% of differences in premiums were explained by variations in the share of expenses covered by the plan and only about 6% were explained by differences in the benefit design.[4] Most of the variation was attributed to differences in the industry of the sponsor (which may also capture differences in average age and regional variations in health care costs).

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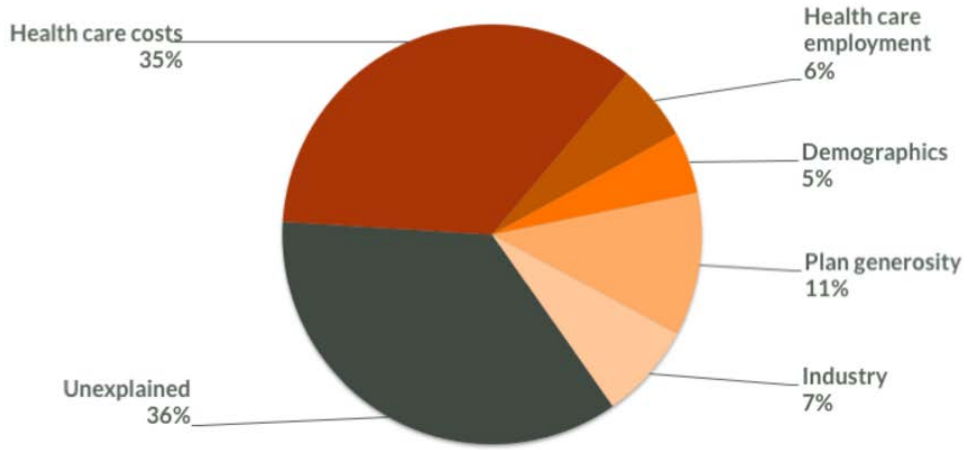
[3] Karen E. Smith and Eric Toder, Center for Retirement Research at Boston College, Adding Employer Contributions to Health Insurance to Social Security's Earnings and Tax Base, CRR WP 2014-3, April 2014

[4] Jon Gabel, Jeremy Pickreign, Roland Mc Devitt and Thomas Briggs, Taxing Cadillac Health Plans May Produce Chevy Results, Health Affairs 29:1, January 2010

A Congressional Research Service (CRS) analysis of the impact of the "Cadillac Tax" found that even at low cost-growth assumptions, three times as many plans would be affected by the tax in high-cost states as in lower-cost states, indicating the extent of regional differences in health costs.[5] A 2015 Commonwealth Fund study concluded that only 11% of variations among states in premium costs is a result of "plan generosity," with more than one-third explained by state-to-state differences in health care costs.[6]

Exhibit 1

Share of State Variation in 2014 Employer Premiums Explained by Various Factors



Notes: We conducted this analysis by regressing median premiums from the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) on state measures of health care costs, plan characteristics, workforce composition, and demographics from a variety of sources. Full details on the approach can be found in our separate technical appendix. "Demographics" include age, sex, and health status of workers. "Plan generosity" reflects HMO status and deductibles. "Health care employment" measures state variation in health care employment that is not explained by the demographic composition of state residents. "Industry" includes the percent of workers in mining and hospitality; these industries have the highest and lowest health insurance premiums, respectively. "Health care costs" are measured using a Medicare price index that captures state-level variation in medical prices after netting out variation due to practice patterns, patient and provider choice of care setting, and patients' willingness and ability to use care. The "Unexplained" component reflects variations that we were unable to explain with available data.

Sarah Nowak and Christine Eibner, The Commonwealth Fund, Rethinking the Affordable Care Act's "Cadillac Tax": A More Equitable Way to Encourage "Chevy" Consumption, December 2015

Capping the tax exclusion would therefore unfairly impose greater costs on workers who live in high-cost areas or who happen to work for employers with an older or less healthy workforce. These are often the old-line industrial firms that have struggled to preserve jobs and maintain benefits. Thus, capping the employee tax exclusion would further disadvantage the same workers who have faced the greatest challenges in

[5] Congressional Research Service, The Excise Tax on High-Cost Employer-Sponsored Health Coverage: Background and Economic Analysis, August 2015

[6] Sarah Nowak and Christine Eibner, The Commonwealth Fund, Rethinking the Affordable Care Act's "Cadillac Tax": A More Equitable Way to Encourage "Chevy" Consumption, December 2015

maintaining income and job security in an increasingly competitive globalized economy.

Compounding the problem is that the employees potentially most price-sensitive to benefit cost increases are younger and healthier workers – precisely the groups that need to be brought into risk pools to maintain affordability and stability. A tax exclusion cap would likely drive more of these workers away from participation in employer plans, especially since a central objective of ACA repeal efforts is to eliminate the current mandate on individuals to obtain health coverage.

Capping the employee tax exclusion would unfairly disadvantage the same workers who have faced the greatest challenges in maintaining income and job security in an increasingly competitive globalized economy.

MYTH NO. 3

Capping the tax exclusion will reduce health care costs.

Proponents of capping the employee tax exclusion argue, largely on the basis of economic theory, that an unlimited tax exclusion for employer-sponsored health benefits is a major contributor to the high level and rates of increase in national health expenditures.

REALITY:

Overall health care expenditures are not particularly sensitive to cost, especially among higher-income groups.

In its evaluation of the fiscal and economic effects of health legislation, the Congressional Budget Office (CBO) uses an assumption that a 10% increase in the cost of health care is associated with a 2% decrease in overall expenditures.[7] This represents a very low "elasticity of demand" or price sensitivity, consistent with the intuitive understanding that individuals treat health care as a "life or death" matter rather than a price-driven commodity. To the extent there are behavior and utilization changes, they have a negative impact on lower and middle income populations while health care spending by the affluent remains largely unaffected.

Using CBO's assumption, the CRS estimated in January 2017 that total national health care expenditures paid by private insurance would be reduced by a total of between $47.6 and $69.2 billion in 2025 as a result of imposing a tax cap on the cost of health coverage through the Cadillac Tax.[8] Moreover, the aforementioned December

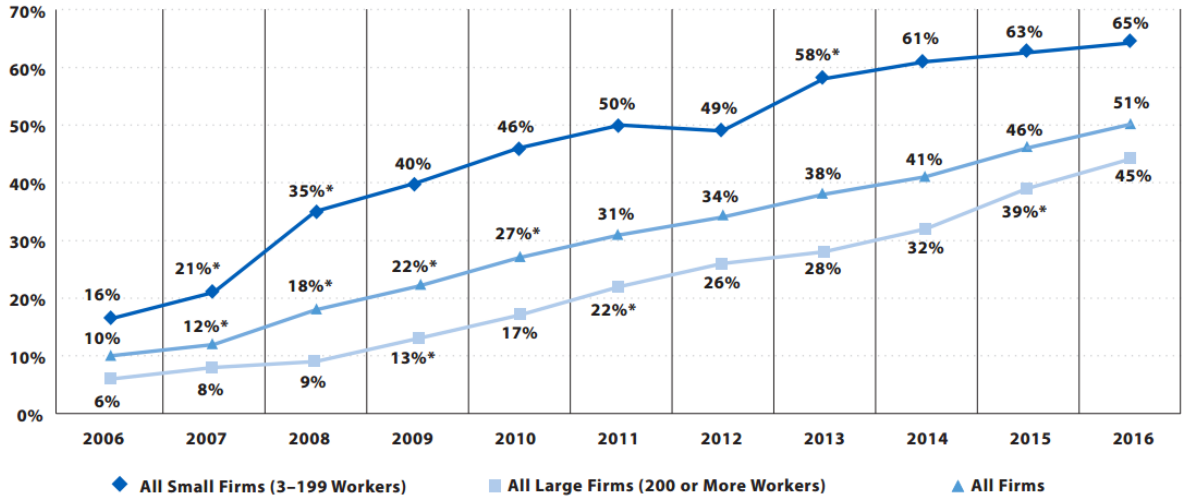
[7] Congressional Budget Office, Private Health Insurance Premiums and Federal Policy, February 2016
[8] Congressional Research Service, The Excise Tax on High-Cost Employer Sponsored Health Insurance: Estimated Economic and Market Effects, January 2017

2016 CBO analysis indicates that repealing the Cadillac Tax and imposing a tax cap at the 75th percentile of current premiums, (somewhat lower but similar to the "Cadillac Tax" thresholds) would generate revenue of $38 billion in 2025.[9] These projections indicate that the overall reductions in health care expenditures would be on the same order of magnitude as the additional taxes that would be paid, largely converting health care benefits to new tax revenues collected from working Americans.

Most troubling is that if employers are able to make changes to keep the cost of their plans below the threshold that triggers the tax, middle- and lower-income individuals will be harmed the most, because they are much more sensitive to high deductibles and, consequently, more likely to forgo essential and preventive care.

EXHIBIT F

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2016



* Estimate is statistically different from estimate for the previous year shown (p < .05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2016.

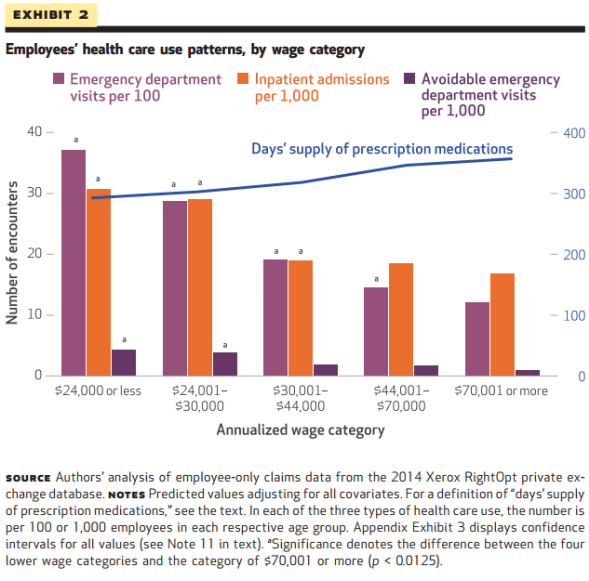
Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2016 Annual Survey, September 2016

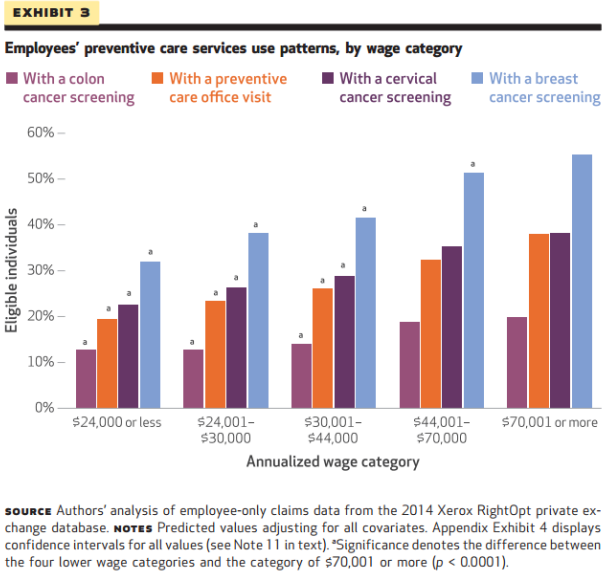
When faced with a cap, rather than impose new taxes on their workers, employers will likely respond by redesigning their plans to remain below the threshold. This is most readily done by raising the level of deductibles and co-pays. A recent Kaiser Family Foundation survey of employer plans indicates that, despite lower levels of premium growth in recent years, this is already happening in response to the now-delayed implementation of the "Cadillac Tax," with 65% of workers in small firms and

[9] Congressional Budget Office, Options for Reducing the Deficit: 2016- 2027, December 2016

45% in larger firms now enrolled in plans with deductibles of more than $1,000.[10] This represents a 63% increase in deductibles for single coverage since 2011.

New research indicates that higher deductibles not only result in differential use of preventive services by lower income groups but that, over the long run, they also may *increase* overall health care spending. A 2016 study by the Employee Benefit Research Institute (EBRI) found that among plans with an annual deductible of more than $1,300 for a single enrollee or $2,600 for family coverage (the current minimums for a plan to include a Health Savings Account (HSA)), there was a greater decrease in the use of preventive services (including office visits and vaccines) that was directly related to income levels. The study further found that the decline in other outpatient visits (not involving preventive services) was twice as great for those with incomes of less than $50,000 per year compared with those with incomes above $100,000.[11]





Bruce W. Sherman, Teresa B. Gibson, Wendy D. Lynch and Carol Addy,
Health Care Use and Spending Patterns Vary by Wage Level in Employer Sponsored Plans,
Health Affairs 36:2, Pages 254-255, February 2017

A February 2017 study published in *Health Affairs* found indications of a lower use of preventive services related to income and greater use of more expensive services, such as hospital emergency rooms. This indicates that a tax cap could not only harm lower income groups but ultimately lead to *less efficient* and *more expensive* patterns of use of health care services. The study found that, when controlling for demographics and other factors, workers in the lowest wage group had *half* the usage of preventive

[10] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2016 Annual Survey, September 2016

[11] Paul Fronstin and M. Christopher Roebuck, Employee Benefit Research Institute, The Impact of an HSA-Eligible Health Plan on Health Care Services Use and Spending by Worker Income, EBRI Issue Brief No. 425, August 2016

services but *three times* the rate of emergency room visits, *twice* the rate of hospital admissions and *more than three times* the rate for what were deemed avoidable hospital admissions.[12] This indicates why a tax cap is a blunt instrument with unforeseen consequences to vulnerable populations and is not likely to achieve broader cost containment.

MYTH NO. 4

The financial impact of the tax increase from capping the employee tax exclusion will fall mostly on people with high incomes.

Proponents of the "Cadillac Tax" and a cap on the employee tax exclusion assert that most of the additional taxes will fall on individuals in the top 40% of the income distribution.

REALITY:

When viewed in terms of the share of income or current tax liability, the burden would fall disproportionately on the middle class.

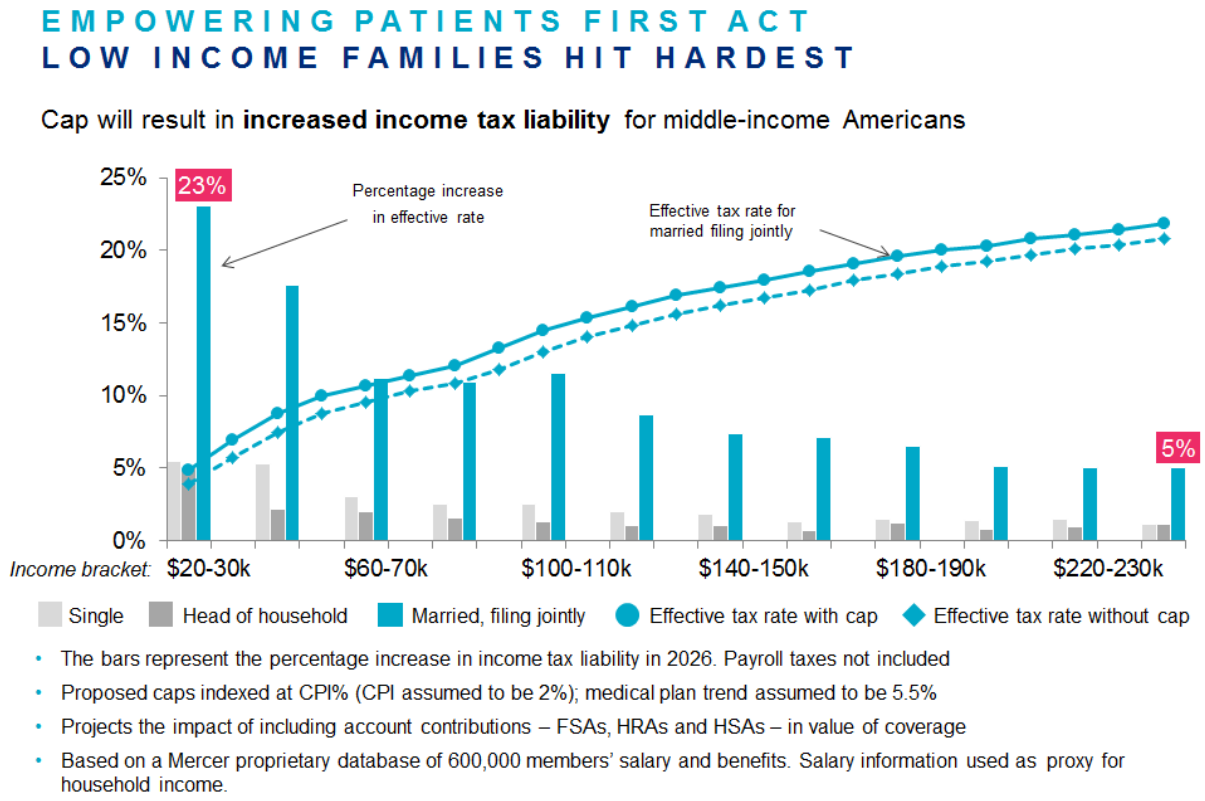
Largely due to the progressive nature of the income tax system, the top 40% of the income distribution pay more than 80% of the total value of federal taxes. This is significantly more than their likely share of additional taxes that would result from capping the employee tax exclusion, since employer-provided coverage, itself, is highly progressive, in that the same plan is offered to workers regardless of their salaries/wages. The tax increase resulting from capping the employee tax exclusion would be a smaller proportion of current taxes for the highest earners and their share of the new taxes would be *less* than their current share of the overall tax burden. The impact of a cap would, instead, fall disproportionately on middle-income groups relative to their current share of income and taxes.

Employer-provided coverage is highly* progressive*, in that the same plan is offered to workers regardless of their salaries or wages.

The Tax Policy Center conducted a study in 2015 of the distributional effects of the "Cadillac Tax," (prior to the enactment of the two-year delay in the effective date from 2018 to 2020). It indicated that the direct and indirect effects of the "Cadillac Tax" in its first year of implementation would impose about 25% of the additional taxes on the middle fifth of the income distribution (*i.e.* those earning on average $66,000 per year) despite this

[12] Bruce W. Sherman, Teresa B. Gibson, Wendy D. Lynch and Carol Addy, Health Care Use and Spending Patterns Vary by Wage Level in Employer Sponsored Plans, Health Affairs 36:2, February 2017

group having only 15% of all income and incurring less than 10% of overall federal tax.[13] This represents *nearly double* the proportional burden on this group. An Urban Institute study found that although the dollar cost of increased taxes resulting from either the "Cadillac Tax" or capping the employee tax exclusion at a similar level would be greater for higher income groups, the percent change in federal tax would be *twice as great* for the middle-fifth of earners affected by the cap as for the top fifth of earners.[14]



Mercer and The Alliance to Fight the 40 | Don't Tax My Health Care, Capping the Employee Tax Exclusion for Employer Health Coverage: Projection of the Long-Term Impact, Slide 10, February 2017

A recent Mercer analysis of the potential effects of a tax cap indicates that married workers earning between $20,000 and 30,000 per year would experience a 23% increase in tax liability as a result of certain proposals, compared to a less than 10% increase in taxes for those with earnings above $100,000 per year.[15] An often overlooked factor

[13] Gordon Mermin and Eric Toder, Tax Policy Center, Distributional Impact of Repealing the Excise Tax on High-Cost Health Plans, July 2015
[14] Linda J. Blumberg, John Holahan and Gordon Mermin, The ACA "Cadillac" Tax Versus a Cap on the Tax Exclusion of Employer-Based Health Benefits: Is This a Battle Worth Fighting?, The Urban Institute, October 2015
[15] Mercer and The Alliance to Fight the 40 | Don't Tax My Health Care, Capping the Employee Tax Exclusion for Employer Health Coverage: Projection of the Long-Term Impact, February 2017

influencing this result is the current exclusion of health benefits from payroll taxes. Consequently, subjecting the cost of health coverage to these taxes would disproportionately affect workers with incomes below $100,000 due to the cap on earnings subject to the Social Security payroll tax.

MYTH NO. 5

Only a few large employers that provide overly generous health benefits would be affected by the cap.

Analyses of the impact of the "Cadillac Tax," and similar proposals to cap the employee tax exclusion, estimate that relatively few, and mostly larger employer-sponsored plans, would be subject to the tax in the first year of implementation.

REALITY:

Within a few years any type of cap on the exclusion would affect the majority of employers currently providing health benefits to their workers.

How Many Employers Could be Affected by the Cadillac Plan Tax?

Table 2: Share of Employers with At Least One Plan Hitting Threshold By Firm Size

Year	HCPT Self-Only Threshold	Premium, HSA, HRA & FSA	
		Small Firms (3-199 workers)	Large Firms (200 or more workers)
2018	$10,200	25%	46%
2023	$11,800	29%	56%
2028	$13,500	41%	68%

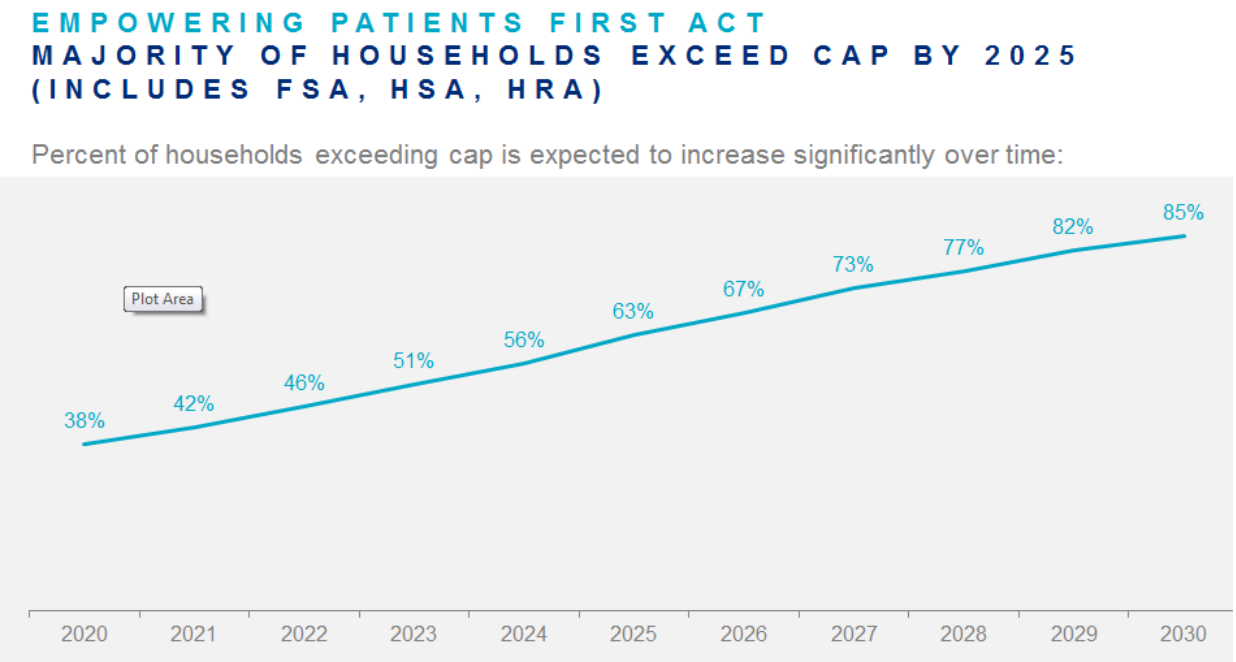
Source: Kaiser Family Foundation analysis

Note: Calculations performed prior to two-year delay of "Cadillac Tax" effective date.

Gary Claxton and Larry Levitt, The Henry J. Kaiser Family Foundation, How Many Employers Could be Affected by the Cadillac Plan Tax?, Table 2, Page 5, August 2015

Most proposals to cap the employee tax exclusion set the initial thresholds for the tax at or just above current costs of most employer-sponsored plans. However, because health costs (though moderating in recent years) are still increasing faster than inflation, caps at this level will very rapidly affect the majority of employer-sponsored plans. A 2015 Kaiser Family Foundation study of the "Cadillac Tax," conducted prior to the two-year effective date delay, found that a threshold for the "Cadillac Tax" set at levels just above the costs of most ESI would affect 26% of employers in the first year of implementation and 42% by 2028. Among employers with more than 200 workers, the proportion with a plan above the thresholds was estimated to be 46% in the first year of implementation, increasing to 68% by 2028.[16]

[16] Gary Claxton and Larry Levitt, The Henry J. Kaiser Family Foundation, How Many Employers Could be Affected by the Cadillac Plan Tax?, August 2015



Mercer and The Alliance to Fight the 40 | Don't Tax My Health Care, Capping the Employee Tax Exclusion for Employer Health Coverage: Projection of the Long-Term Impact, Slide 9, February 2017

The recent Mercer analysis found that 37% of households would either have their health benefits lowered or pay more in taxes in 2020, rising to 85% of households by 2030.[17]

MYTH NO. 6

Limiting the value of the tax exclusion is the only way to control costs and create a more efficient system of health care financing.

Economic theory that is used to support curtailing the tax exclusion perceives behavior and outcomes in the provision and use of health benefits as primarily a function of the price of health insurance and the direct costs to the beneficiary, assuming that consumers respond solely to their level of "skin in the game."

[17] Mercer and The Alliance to Fight the 40 | Don't Tax My Health Care, Capping the Employee Tax Exclusion for Employer Health Coverage: Projection of the Long-Term Impact, February 2017

REALITY:

Capping the employee tax exclusion will undermine employer-sponsored coverage and the many ways that employers engage with workers to incentivize more effective use of health benefits.

Patterns of utilization and costs in health care are the result of a complex interplay of price-driven economics and numerous other factors. In recent years, employers have been at the forefront of innovation to improve health outcomes, drive greater efficiency and moderate the rate of increase in health care costs. These innovative strategies include value-based insurance design, onsite and nearsite health centers, wellness programs, telehealth, centers of excellence and direct contracting.

Employers have been at the forefront of innovation to improve health outcomes, drive greater efficiency and moderate the rate of increase in health care costs.

An accelerated shifting of costs to workers and limitations on the value of benefit packages that would result from capping the tax exclusion could alter the ability of employers to further innovate efficient and affordable plan designs. By virtue of the size of the groups they represent employers are able to apply their bargaining leverage for the benefit of the employer and workers alike. Keeping employers "in the game" is critically important as employer plans can help level the playing field in markets that are increasingly dominated by fewer health care providers.

CONCLUSION:

Policymakers should avoid, at all costs, proposals that will destabilize the employer-sponsored system that provides health coverage for the vast majority of Americans. Taxing a portion of employer-sponsored health coverage will impose a disproportionate burden on lower- and middle-income families and, unintentionally, is likely to increase rather than mitigate health care costs.