Replacing the Cadillac Tax: Options and Considerations

Yevgeniy Feyman and Charles Blahous

MERCATUS CENTER
George Mason University

3434 Washington Blvd., 4th Floor, Arlington, Virginia 22201
www.mercatus.org

Yevgeniy Feyman and Charles Blahous. "Replacing the Cadillac Tax: Options and Considerations." Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2017.

ABSTRACT

The Affordable Care Act (ACA) instituted, for the first time in over half a century, a tax on the value of employer-sponsored health insurance, known as the Cadillac tax. This step represented a significant shift in policy that has the potential to affect more than 150 million Americans covered by such insurance. While there are strong justifications for either repealing or reforming the Cadillac tax, policymakers should be apprised of the potential benefits and pitfalls of each approach. In this paper, we review the history of employer-sponsored health insurance and offer three options for replacing the Cadillac tax without returning to the undesirable pre-ACA status quo.

JEL codes: N4, I1, H0

Keywords: Cadillac tax, Obamacare, ESI, employer-sponsored health insurance, uninsured, American health care

The Mercatus Center gratefully acknowledges the financial support of the John Templeton Foundation for research on healthcare policy in the United States.

This paper can be accessed at https://www.mercatus.org/publications/replacing-cadillac-tax

The American healthcare system is undergoing a series of transformations. One of the most significant was the passage of the Affordable Care Act (ACA) in 2010. While expanding insurance coverage was the most frequently advocated aspect of the law, another important element is the 40 percent excise tax on expensive health insurance plans. This so-called Cadillac tax is not well understood and has drawn much ire. But public opposition notwithstanding, the Cadillac tax is one of the more justifiable, if poorly designed, provisions of the ACA, as it attempts to undo a long-standing tax distortion that has encouraged wasteful healthcare spending.

Despite its policy justification, the Cadillac tax—originally set to take effect in 2013 but almost immediately postponed until 2018—was postponed again until 2020 as part of a large budget deal in December 2015.[1] Recent proposals to replace the ACA would push the Cadillac tax even further into the future without qualitatively changing the well-intentioned but poorly designed provision. Other proposals have sought to repeal the tax altogether and return to the pre-ACA status quo. As this paper will make clear, this is also undesirable. Instead of tinkering at the margins by shifting the timing of the Cadillac tax, an eminently better policy would be a wholesale replacement of the tax with an alternative policy that weakens existing tax distortions while minimizing disruptions to businesses and patients.

This paper first offers a brief history of tax incentives, and the resulting distortions, in the American employer-sponsored health insurance system that the Cadillac tax seeks to modify. It then provides an overview of past attempts to reform this system and outlines how implementation of the Cadillac tax has moved forward. Finally, the paper provides a framework for considering the costs and benefits of reforming the Cadillac tax and offers concrete policy options for implementing this reform.

1. Consolidated Appropriations Act, 2016, Pub. L. No. 114-113 (2015).

THE ESI TAX EXCLUSION: AMERICA'S ORIGINAL HEALTHCARE SIN

Understanding why the Cadillac tax was—despite its inelegance—a necessary policy proposition first requires understanding why the US health insurance system looks the way it does, and in particular, why employer-sponsored health insurance (ESI) plays such a major role.

"The primary reason that most insured Americans receive coverage through their employers is simple: the tax code incentivizes exactly such a situation."

Employer-Sponsored Health Insurance: A Short History

Before the ACA was enacted, the majority of nonelderly Americans with health insurance received coverage through their employers.[2] While this share declined significantly to just around 56 percent after the Great Recession,[3] most Americans nevertheless depend on employers for coverage, even in the post-ACA world. The primary reason that most insured Americans receive coverage through their employers is simple: the tax code incentivizes exactly such a situation.

This tax incentive has a complicated history dating back to World War II–era price controls established by the 1942 Stabilization Act.[4] The law required the "stabilization" of "prices, wages, and salaries, affecting the cost of living" to their levels as of September 15, 1942.[5] Importantly, the law excluded insurance and pension benefits from price controls. A 1943 ruling by the War Labor Board further clarified that fringe benefits like health insurance were excluded from these price controls.[6] The idea behind this exclusion was simple. Even in a time of war, employers compete for

2. Michelle Long et al., "Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999–2014," Henry J. Kaiser Family Foundation, March 21, 2016.
3. Ibid.
4. Stabilization Act of 1942, Pub. L. No. 77-729 (1942).
5. Ibid.
6. Thomas C. Buchmueller and Alan C. Monheit, "Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform," *Inquiry* 46, no. 2 (2009): 187–202.

workers by offering what they believe to be an appropriate compensation package. Economists have long recognized that compensation isn't simply the wages an employee is paid hourly, weekly, or otherwise. It also includes various fringe benefits such as paid time off, pension contributions, and health insurance. The provision of the Stabilization Act and the later War Labor Board ruling recognized this and sought to give employers some relief by allowing them to vary fringe benefits in order to attract employees. This exception represented an early salvo aimed at drawing a distinction between wage income and "other" income.

Another ruling letter in 1943, this time from the IRS, also clarified that employer contributions to group health insurance premiums for its employees would be considered nontaxable income.[7] With the exception of the Stabilization Act, none of these changes were made by legislation. Rather, as part of a wholesale overhaul in 1954, a new section was added to the Internal Revenue Code.[8] The new section clarified that the gross income of an employee would not include employer-provided health insurance coverage. A separate provision of the code also extends this exclusion to payroll taxes.[9] A 1978 law added to this exclusion the so-called cafeteria plans, which, include flexible spending accounts (FSAs).[10] Lastly, the Medicare Modernization Act of 2003[11] created the modern-day health savings accounts (HSAs) that permit a similarly tax-advantaged savings vehicle for out-of-pocket healthcare expenses associated with a high-deductible health plan.

The ESI Tax Exclusion: A Distortive and Harmful Subsidy

The Internal Revenue Code overhaul in 1954 marked the beginning of the modern-day ESI system. Employers had already been offering health insurance for some time, there being other benefits to pooling risk at the employer level. But after the changes in 1954, it became eminently clear (since legislation is much easier to plan around than agency rules or executive orders) that the federal government would incentivize this method of providing insurance.

The resulting distortions and harms fall into several categories: effects on compensation structure, effects on demand for health insurance (at the intensive

7. D. Andrew Austin and Thomas L. Hungerford, *The Market Structure of the Health Insurance Industry* (Washington, DC: Congressional Research Service, November 17, 2009).
8. Internal Revenue Act of 1954, Pub. L. No. 83-591, § 106 (1954).
9. Austin and Hungerford, *The Market Structure of the Health Insurance Industry*.
10. Revenue Act of 1978, Pub. L. No. 95-600 (1978).
11. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173 (2003).

and extensive margins), regressive effects on income, reduced labor mobility, and the public finance cost.

Compensation structure. Following the 1954 overhaul of the tax code, a worker's net, after-tax compensation became a function of whether it was provided as wages or as health insurance. A worker at the 25 percent marginal tax bracket, for instance, takes home $0.75 for every dollar earned as wages (excluding payroll taxes), paying $0.25 in taxes. But if the same worker receives $0.80 in wages and $0.20 in health insurance, he or she pays $0.20 in taxes, and takes home $0.80 in total compensation (including health insurance).

The distortion created by this exclusion is clear. When payroll taxes are factored in, both employers and employees face an incentive to shift more compensation into health insurance instead of wages.

It is important to note a critical assumption here: the cost of health insurance for an employer is passed directly on to employees. (In turn, this assumption means that the Cadillac tax is entirely passed on to employees as reduced benefits, wages, or other compensation.) The extent to which this is true varies by the type of firm and by the years examined. This point is discussed in greater detail later.

Demand for health insurance. Perhaps the most important inefficiency resulting from the exclusion is how it affects demand for insurance.

While some have questioned the extent to which the exclusion incentivized the offer and take-up of ESI, research is relatively unambiguous that the ESI exclusion—by making ESI less expensive than wage income—led to a higher take-up of insurance and increased generosity of insurance, especially among higher-income individuals.

In 1952, for instance, 47 percent of households in one survey held group health insurance policies (in 99 percent of the cases, purchased through an employer). But in 1957, just a few years after the tax code overhaul, 66 percent of households held group health insurance policies.[12] More precisely, the literature has found that "when the tax subsidy lowered the after-tax price of insurance for the average household by 17.5 percent, the amount of coverage purchased by the average insured household increased by 9.5 percent." Similarly, a 10 percentage point increase in the marginal tax rate was estimated to increase the likelihood of a household having health insurance by about 9 percent.[13]

12. Melissa A. Thomasson, "The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance," *American Economic Review* 93, no. 4 (2003): 1373–84.
13. Ibid.

Other research has similarly found that firms are more likely to reduce the generosity of coverage (the intensive margin) in response to increases in price than to simply stop offering coverage altogether (the extensive margin).[14] This distinction is important because it suggests that, while the exclusion does incentivize take-up of ESI coverage, it may not be the primary determinant of *where* individuals purchase coverage. Instead, it likely has the largest effect in determining the *amount* of coverage that individuals purchase.

A related distortion that arises here is not only the incentive to purchase *more* healthcare coverage than is necessary, but to purchase healthcare coverage that pays for inefficient services. The generosity and structure of ESI typically insulate patients from the cost of their treatments. Among traditional ESI plans, HMOs, PPOs, and POSs[15] have average deductibles ranging from $917 to $1,737, respectively, while the average deductible for all plans is around $1,500.[16] Even with these relatively modest deductibles, workers typically face low copays for basic low-value services, and even coinsurance for more expensive services tends to be relatively small.[17]

Because of well-known information asymmetries in the market for healthcare services,[18] patients are not able to judge for themselves what services are high value or low value. In normal markets—such as the market for cellphones, cars, or smartphones—customers can access simplified information that helps them compare the costs and benefits of various goods. Health economist Scott Harrington notes that the tax exclusion "produces extensive moral hazard and excessive utilization of low-valued medical care, including less willingness to choose tighter managed care arrangements with limits on access to specialists and other high cost care."[19] In turn, this reduces the demand for so-called comparative effectiveness research that might help employers, patients, and insurers better gauge the value of health services and use this information to tailor insurers' coverage offerings and to encourage the use of more cost-effective services.

---

14. Jonathan Gruber and Michael Lettau, "How Elastic Is the Firm's Demand for Health Insurance?," *Journal of Public Economics* 88, no. 7–8 (July 2004): 1273–93.
15. Health maintenance organizations, preferred provider organizations, and points of service, respectively.
16. Gary Claxton et al., "2016 Employer Health Benefits Survey," Henry J. Kaiser Family Foundation, September 14, 2016.
17. Ibid.
18. Kenneth J. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* 53, no. 5 (1963): 941–73.
19. Scott E. Harrington, "Incentivizing Comparative Effectiveness Research" (Research Paper, Ewing Marion Kauffman Foundation, Kansas City, MO, January 1, 2011).

As a result, patients are often steered to low-value services, and they may not understand the benefits of higher-value services. The generous insurance coverage propagated by the tax exclusion means that patients will overuse these low-value services relative to high-value services. This puts upward pressure on healthcare spending while offering fewer benefits than would otherwise accrue. In turn, the ESI tax exclusion's effect of inducing more generous coverage has almost certainly led to higher spending on healthcare services, as reflected in studies such as the RAND Health Insurance Experiment.[20]

Of course, one shouldn't expect an explosion of demand for cost-effectiveness research simply as a result of less generous plan designs. Indeed, there is evidence that even in the presence of high-deductible health plans, patients do not tend to price-shop for lower-cost, higher-value services.[21] However, research does indicate that there is significant moral hazard in the Medicare supplemental insurance market,[22] which suggests that overly generous health insurance coverage does lead to the use of low-value services.

Regressive effects on income. The structure of the ESI exclusion is also necessarily regressive in nature, as the benefit is proportional to a taxpayer's income tax rate. The evidence here is more than theoretical—indeed, research has documented this fact empirically. One analysis from researchers at the Tax Policy Center, a joint venture of the Brookings Institution and the Urban Institute, estimated that if the ESI exclusion had been eliminated in 2007, the bottom income quintile would have seen an increase in after-tax income of 0.07 percent, while the top quintile would have seen a reduction of 1.51 percent.[23] Another analysis by health economist Bradley Herring illustrates the distributional effects of the Cadillac tax's implementation, showing that the tax benefit of various health

20. The RAND Health Insurance Experiment, conducted from 1974 to 1982, randomized individuals to different insurance designs, which ranged from no cost-sharing to a 95 percent coinsurance design. While individuals with high levels of coinsurance did reduce the use of both effective and ineffective services, there did not appear to be large health outcome differences between the groups—with a few key exceptions, including better control of hypertension, improved vision, and improved access to dental care. See Willard G. Manning et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* 77, no. 3 (1987): 251–77.
21. Zarek C. Brot-Goldberg et al., "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics" (NBER Working Paper No. 21632, National Bureau of Economic Research, Cambridge, MA, October 2015).
22. Michael Keane and Olena Stavrunova, "Adverse Selection, Moral Hazard and the Demand for Medigap Insurance," *Journal of Econometrics* 190, no. 1 (2016): 62–78.
23. Leonard E. Burman, Christopher Geissler, and Eric J. Toder, "How Big Are Total Individual Income Tax Expenditures, and Who Benefits from Them?," *American Economic Review* 98, no. 2 (2008): 79–83.

insurance designs is significantly larger for higher-income than lower-income individuals.[24]

Reduced labor mobility. Aside from the effects on compensation structure, other important labor market distortions are likely to arise from a health insurance system tied to employment. In particular, labor mobility is likely to be reduced when alternative sources of health insurance coverage are unavailable. Put more simply, when employment is the best guarantee of health insurance, decisions to change jobs, leave a job, or become self-employed become more difficult. On the other hand, the availability of retiree health insurance for former employees is likely to increase the probability of retirement. A large review of over 50 studies comes to the conclusions that "the availability of retiree health insurance raises the odds of retirement by 30–80%," and that "there is on net strong evidence for job lock."[25]

Of course, as discussed later in this paper, it is very likely that even without the exclusion, employer-sponsored health insurance may still be the dominant source of coverage. Depending on what other policies are implemented simultaneously, this would suggest that the exclusion may actually do little to limit labor mobility.

To the extent that the exclusion does incentivize job lock, it might still be reasonable to argue that policies that keep individuals employed—and those that encourage "appropriate retirement"—have social benefits. That being

"When employment is the best guarantee of health insurance, decisions to change jobs, leave a job, or become self-employed become more difficult."

24. Bradley Herring and Erin Trish, "The Distributional Effects of the Affordable Care Act's Cadillac Tax by Worker Income," *AMA Journal of Ethics* 17, no. 7 (2015): 672–79. Some analysts have argued that the ESI tax exclusion is actually a progressive tax policy, given the often inaccessible insurance market outside of group coverage and given that the benefit of the exclusion—as a share of income—is larger for lower-income individuals than for higher-income workers. See Cathy Schoen et al., "Progressive or Regressive? A Second Look at the Tax Exemption for Employer-Sponsored Health Insurance Premiums," Issue Brief, *Commonwealth Fund* 53 (2009): 1–8.

25. Jonathan Gruber and Brigitte C. Madrian, "Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature" (NBER Working Paper No. 8817, National Bureau of Economic Research, Cambridge, MA, February 2002).

said, it is unlikely that the ESI tax exclusion is the best way to encourage appropriate labor force participation, particularly because of its regressive nature as well as its interference with job mobility.

Public finance cost. One final harmful effect is the public finance cost of the tax exclusion. For every additional dollar paid as health insurance rather than standard wages, the federal government loses some revenue relative to what it would have received if that dollar had been paid as a wage. Health economist Austin Frakt's calculations suggest that the federal government alone loses over $0.30 of revenue on the marginal dollar of ESI coverage for someone at the 20 percent marginal tax rate.[26] However, because the exclusion is not part of a federal outlay category but rather a tax expenditure, its total cost is not reflected in standard presentations of the federal budget. This is unfortunate, given that the overall cost of the ESI deduction effectively makes it one of the largest government-funded insurance programs in the United States. The Tax Policy Center estimates that in 2017 the federal government will forgo some $260 billion in income and payroll tax revenue because of the ESI tax exclusion.[27] This doesn't include lost revenue to states and localities, which would likely bring the net total cost to over $300 billion.[28] While any attempt to incentivize insurance coverage would likely affect government finances, the ESI tax exclusion is a particularly expensive and suboptimal approach to doing so.

Taken together, the combination of increased moral hazard; inflation of healthcare service demand, spending and prices; labor market distortions; regressive effects on income distribution; and the lost revenue to the federal government and states provides ample evidence of the harm and lack of significant policy rationale for the ESI tax exclusion.

The same factors create a policy rationale for the Cadillac tax, which was intended to begin phasing out this tax subsidy.

---

26. Austin Frakt, "Understanding the Employer Based Insurance Tax Subsidy," *Incidental Economist*, February 3, 2010.

27. "How Does the Tax Exclusion for Employer-Sponsored Health Insurance Work?," in *Tax Policy Center Briefing Book: Key Elements of the U.S. Tax System*, accessed March 11, 2017, http://www.taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work.

28. Jonathan Gruber, "The Tax Exclusion for Employer-Sponsored Health Insurance" (NBER Working Paper No. 15766, National Bureau of Economic Research, Cambridge, MA, February 1, 2010). Though these estimates are larger than those estimated by the Tax Policy Center, they provide a relative sense of the magnitude of lost state and local revenues, which Gruber estimates at around $30 billion in 2009.

FIXING THE ESI TAX EXCLUSION: PAST AND PRESENT

The Cadillac tax was not the first attempt at reforming the ESI tax exclusion. Indeed, one of the first proposals to receive presidential support came during President Reagan's administration. Under the proposed reform offered in 1983, the ESI exclusion would have been capped at a fixed monthly rate that differed for individual and family coverage. This limit would in turn be indexed to inflation so that, over time, as long as healthcare spending grew faster than general inflation, a larger share of insurance plans would be taxed under the cap. Two other proposals came about during President George W. Bush's administration, both of which would have capped the deduction in similar ways. The second Bush-era proposal would also have extended the exclusion to individuals who purchase coverage on their own, in order to address the current bias of the law in favor of ESI. None of these proposals ultimately made it into law.[29] Importantly, none of these proposals sought to address the large uninsured population, for whom capping the exclusion would likely be of little help.

Thus, the ACA, which became law in March 2010, marked the first time that legislation to counter the ESI tax exclusion was enacted. Enshrined in section 9001 of the ACA, the Cadillac tax established a 40 percent excise tax on the value of health insurance benefits above certain thresholds. The tax is imposed not on individuals directly but on the insurers and administrators that manage the various health payment vehicles that fall within the scope of the tax. However, it is expected that the vast majority of the tax's effects would be passed on to employees. Originally slated to begin in 2018, the Cadillac tax had a threshold of $10,200 for individuals and $27,500 for non-self-only coverage. These thresholds would then grow with inflation. Recent estimates that consider the tax's widespread effects (including those on healthcare savings accounts and FSAs) suggest that by 2028, between 29 percent and 54 percent of all employers would be expected to have at least one plan above the thresholds.[30]

A key element of the Cadillac tax is that, while it functions in a similar way to a cap on the ESI deduction, it lacks the progressivity of a cap. Consider that someone at the 25 percent marginal tax rate who is $1,000 over the threshold would pay an additional $400 in taxes—no different than someone would pay at the 39.6 percent marginal rate (the highest federal income tax bracket). Under a hypothetical cap on the ESI tax exclusion, workers would pay their individual

29. Henry Aaron and Leonard E. Burman, eds., *Using Taxes to Reform Health Insurance: Pitfalls and Promises* (Washington, DC: Brookings Institution Press, 2008).
30. Gary Claxton and Larry Levitt, "How Many Employers Could Be Affected by the Cadillac Plan Tax?," Henry J. Kaiser Family Foundation, August 25, 2015.

marginal rate for each dollar above the cap, making it a relatively more progressive tax change.

Under its initial specifications, the nonpartisan Congressional Budget Office (CBO) estimated that, when accounting for changes in pay structure (i.e., shifting more compensation to wages and away from health insurance benefits) the Cadillac tax would increase revenues by about $87 billion from 2018 to 2025.[31]

Since enactment, however, the Cadillac tax has undergone some modification. In addition to the delays discussed earlier, the structure of the Cadillac tax has also changed. A key element of the tax, initially, was that it could not be deducted as a cost of doing business, meaning that the full brunt of the tax would be felt by all workers and businesses equally. The 2015 agreement made the Cadillac tax deductible as a cost of doing business, which permits a business to reduce its income tax payments by deducting what it has paid through the Cadillac tax. Analysts have estimated that, for a for-profit corporation facing a 35 percent marginal tax rate, the effective rate of the Cadillac tax has been reduced to 26 percent.[32] It is noteworthy that this remains regressive for individuals below the 26 percent marginal rate, and it also leaves the federal, state, and local governments, as well as nonprofit corporations, still paying the full 40 percent excise tax since these employers typically do not incur income tax liabilities.

Levying the Cadillac tax on insurers obscures the incidence of the tax, thus making it politically easier to sell in theory, but it also makes administering the tax significantly more difficult. The political maneuvering required to sell the Cadillac tax, coupled with its regressive nature, suggests that it is far from an ideal policy solution and makes it ripe for reform.

CONSIDERATIONS FOR REPLACING THE CADILLAC TAX

Modifying the Cadillac tax is critical. If the provision is ever to be implemented, the various concerns and potentially harmful effects of the tax will need to be addressed by policymakers while still keeping a bullseye on the inefficient ESI tax exclusion. Before delving into potential options that policymakers might consider in reforming the Cadillac tax, it is worth reviewing some general considerations around reforming the ESI tax exclusion and—by extension—the Cadillac tax.

31. Congressional Budget Office, *Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline*, 2015.
32. Scott Greenberg, "The Cadillac Tax Will Now Be Deductible. Here's What That Means," Tax Foundation, January 14, 2016.

Indifference to Employer-Sponsored vs. Individually Purchased Insurance

One major concern policy analysts have routinely expressed with respect to the ESI tax exclusion is its unequal treatment of ESI and individually purchased insurance. This is a failure of broader tax policy, which should strive to avoid creating unnecessary market distortions. To the extent that any tax exclusion remains for health insurance, that exclusion should be available to all purchasers, whether it is purchased in the group market or not.

Reduction of Regressivity

Certainly, a progressive tax policy is not necessarily superior to a regressive one. So-called sin taxes, for instance, are often used to disincentivize harmful behaviors like smoking. Such taxes are expected to be regressive, but this is deemed a price worth paying to disincentivize certain behavior. Subsidizing the purchase of health insurance, however, should arguably have a progressive element to it. There is little policy reason to subsidize the purchase of insurance for higher-income workers—who are more likely to purchase insurance on their own to begin with—at a greater level than for lower-income workers. Moreover, because lower-income individuals are more likely to be sick and and their health care more costly, health insurance may have larger benefits for them than for higher-income individuals.

Extended Implementation Period

Reforming a policy that affects over 150 million Americans risks being disruptive. This is one important reason that the Cadillac tax has drawn so much ire. The authors of the Cadillac tax correctly assessed that sharp and immediate disruptions would spell political failure for the tax and accordingly designed it to have gradually increasing effects. This design helps ensure enough time for employers and administrators to understand the full scope of the legislative change and plan how they will adapt. An important element here is the gradual increase in the tax's thresholds. Setting thresholds too low and having them grow too slowly or not at all risks large disruptive effects that could result in unintended consequences. On the other hand, setting thresholds too high and indexing them to grow too quickly risks a failure to meaningfully reform the tax exclusion. Striking a balance that hits truly high-cost plans initially and gradually brings more into the fold is key.

"In all likelihood, revenues gained from an alternative policy to the Cadillac tax would be used, in turn, to subsidize—in a targeted manner—coverage through the nongroup market. The key is ensuring that such a mechanism exists when a replacement for the Cadillac tax is enacted."

Should All Tax Exclusions Be Reformed?

An important question that has not been subject to thorough investigation is whether a replacement for the Cadillac tax—which applies to *all* health benefits, including HSAs, FSAs, and health reimbursement arrangements (HRAs)—should similarly affect all health benefits, or whether some should be favored by federal policy. A first-order principle of treating all health benefits equally suggests that there is no reason to favor health savings vehicles or other pretax HRAs above cash wages. Indeed, one potential concern about exempting such accounts from taxation, while limiting the exclusion for premiums, is that employers may attempt to game the system by shifting away from premiums and into contributions to such arrangements.

Nevertheless, while treating health benefits and cash wages equally is an important first-order principle, behavioral economics suggests that individuals are more likely to save (for retirement or for catastrophic health expenses) when the savings vehicle is maximally simplified.[33] While these savings arrangements are often complicated and come with myriad rules, a properly structured vehicle does encourage households to save for out-of-pocket health expenses. Additionally, with nearly 30 percent of insured employees now enrolled in high-deductible health plans (a number that has grown substantially over the last decade),[34] reducing the burden of these plans—particularly when employers contribute to employees' savings vehicles—may be a justifiable policy.

Availability of Alternative Coverage Is a Priority

Regardless of the scope of the legislation used to reform or replace the Cadillac tax, ensuring a functional market

33. Robert Powell, "Behavioral Economist Richard Thaler on the Key to Retirement Savings," *Wall Street Journal*, November 29, 2015.
34. Claxton et al., "2016 Employer Health Benefits Survey."

for individually purchased health insurance is important. For all its flaws and distortions,[35] the ACA attempted to turn a failing nongroup health insurance market into a functioning one. Through several mechanisms, including subsidies and an individual mandate, as well as reinsurance, the ACA has tried to stabilize the nongroup market in order to offer an alternative source of coverage for individuals without ESI or public health insurance.

It is critical to ensure that individuals who lose ESI coverage as a result of policy decisions can find adequate coverage through a functioning nongroup (or public) health insurance market. In all likelihood, revenues gained from an alternative policy to the Cadillac tax would be used, in turn, to subsidize—in a targeted manner—coverage through the nongroup market. The key is ensuring that such a mechanism exists when a replacement for the Cadillac tax is enacted.

Relatively Weak Revenues Are a Good Sign

Reducing the scope of the exclusion is likely to spur employers and administrators to make changes to their health insurance offerings in order to avoid the tax. While this means less revenue being generated, it also means that the incentives are functioning effectively. Indeed, there is some evidence that employers and administrators were responding to the specter of the Cadillac tax by shifting to high-deductible health plans, narrowing benefit offerings, or switching to a defined contribution model for health insurance.[36]

Lower federal revenues from the tax imply an increase in take-home wages as employers respond to new incentives to limit offerings of ESI. If employers reduce health insurance benefits, they tend to increase cash wages in order to keep total compensation constant. Alternatively, they might increase health insurance benefits and reduce cash wages to arrive at the same result.[37] Of course, there are some limitations to this tradeoff—for instance, workers at the minimum wage won't see a reduction in wages due to increased healthcare costs. Additionally, in industries with a monopolistic labor supply (unionized industries and the public sector in particular), this relationship is likely to be broken, as employers may contractually be required to take on some share of higher healthcare cost growth.

35. Brian Blase, "Replacing the Affordable Care Act the Right Way" (Mercatus Policy Primer, Mercatus Center at George Mason University, Arlington, VA, 2016).
36. Claxton et al., "2016 Employer Health Benefits Survey."
37. Jonathan T. Kolstad and Amanda E. Kowalski, "Mandate-Based Health Reform and the Labor Market: Evidence from the Massachusetts Reform," *Journal of Health Economics* 47 (2016): 81–106; Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," *Journal of Labor Economics* 24, no. 3 (2006): 609–34.

Analysis from the past several years has estimated that the premium-wage tradeoff among public-sector employees is anywhere from zero (though take-home pay is reduced through higher premiums) to about 50 percent—substantially smaller than a one-to-one tradeoff.[38] Nevertheless, most economists agree that some tradeoff (not necessarily one-to-one) does exist between healthcare costs and wages. Generally speaking, the fewer entities paying the Cadillac tax (or paying marginal rates above some threshold), the more successful the policy.

POLICY OPTIONS FOR REPLACING THE CADILLAC TAX

Having established several principles for addressing the ESI tax exclusion and replacing the ACA's Cadillac tax, this paper now turns to policy specifics for fixing this tax. The ideas presented here are intended to maximize welfare gains while minimizing harmful disruptive effects. The extent to which these options are politically feasible is an important consideration, but it remains outside the scope of this discussion.

Eliminate the Cadillac Tax and the ESI Tax Exclusion

Arguably, the most economically efficient option in the long term would be to simply legislate away both the ESI tax exclusion and the Cadillac tax. Under this system, any health insurance benefits offered by the employer would be subject to taxation. Thus, employers would report all income paid to employees as taxable income, and employees would pay the requisite taxes at their required tax brackets.

This approach has the advantage of administrative simplicity, as it would make the tax code less complex, and it would entirely eliminate the labor market distortions created by the existing exclusion. It would also be less regressive and would eliminate the need under the current Cadillac tax for employers and plan administrators to determine what "excess value" needs to be taxed. Wages and health insurance would be treated equally, and thus, both would be taxed equally.

This approach addresses most, if not all, of the concerns detailed earlier. Offering no tax exclusion to either employer-purchased or individually purchased

38. Paige Qin and Michael Chernew, "Compensating Wage Differentials and the Impact of Health Insurance in the Public Sector on Wages and Hours," *Journal of Health Economics* 38 (2014): 77–87; Darren Lubotsky and Craig A. Olson, "Premium Copayments and the Trade-Off between Wages and Employer-Provided Health Insurance," *Journal of Health Economics* 44 (2015): 63–79; Jeffrey Clemens and David M. Cutler, "Who Pays for Public Employee Health Costs?," *Journal of Health Economics* 38 (2014): 65–76.

health insurance necessarily treats both forms of coverage equally, without favoring one over the other. Regressivity, as noted above, would be reduced, and efficiency would increase by virtue of no longer distorting individual choices with an unlimited subsidy. Under this proposal, in fact, regressivity would exactly mirror any regressivity or progressivity in the overall tax code. In order to minimize disruptions, such a reform could certainly be paired with an extended implementation timeline that gradually phased out the current exclusion. For instance, a 15-year implementation period could—similar to the Cadillac tax—create a starting threshold of, say, $15,000. Over the next 15 years, this threshold would decline by $1,000 each year until the 16th year, in which it would be zero.

Even without a tax preference, employer-sponsored health insurance would likely continue to play a prominent role in national healthcare provision. Employers are a natural vehicle for pooling health risk because individuals work at a company for reasons extending beyond their expected health costs. Consequently, for large employers in particular, employees represent a diverse set of potential health risks—if all are paying into the pool, the healthy employees subsidize the sick. Given that the most expensive 5 percent of the under-65 population accounts for roughly half of all healthcare spending,[39] this form of pooling might be desirable. Moreover, employees are still likely to value employer-based benefits. A 2012 survey found that even if benefits became taxable, more than half of employees would either keep their plan or switch to a lower-cost, but still employer-based, plan.[40]

Another hypothetical advantage of ESI coverage is that employers might be able to negotiate better rates for insurance because of their large risk pools. While this benefit is theoretically possible, it is unlikely to actually transpire. Health insurance is priced based on the expected value of healthcare costs for a given pool of individuals, plus some administrative costs and markup. For employer leverage to reduce the costs of insurance, administrative costs and profits would have to be significantly large. However, data from the Bureau of Economic Analysis illustrate that total profit and administrative costs for health insurance have hovered around just 1 percent of GDP over the past decade and a half.[41] Moreover, recent analysis from the Urban Institute found that "average

39. Steven B. Cohen and Namrata Uberoi, "Differentials in the Concentration in the Level of Health Expenditures across Population Subgroups in the U.S., 2010" (Statistical Brief #421, Agency for Healthcare Research and Quality, Rockville, MD, August 2013).
40. Paul Fronstin, "Views on Employment-Based Health Benefits: Findings from the 2012 Health Confidence Survey," *EBRI Notes* 33, no. 12 (2012).
41. US Bureau of Economic Analysis, "Personal Consumption Expenditures: Services: Net Health Insurance/Gross Domestic Product," Federal Reserve Bank of St. Louis, accessed March 12, 2017.

second-lowest-cost silver nongroup premium (single coverage) was 10 percent lower than the average employer-sponsored insurance premium in 2016 using the actuarial value, utilization, and age-distribution adjustments."[42]

For these and other reasons, it remains unclear how eliminating the tax exclusion would affect the availability of ESI coverage. The most extreme possible result is that employers would simply stop offering ESI coverage, but this is unlikely to happen for several reasons. A 2011 report from the Congressional Research Service (CRS) explains why:

> It is likely that employers provide health insurance for other reasons as well. One is that insurance is an attractive benefit to most workers, both for the coverage it provides and for the time it saves them in shopping for policies on their own. Given these preferences, when other employers competing for the same workers offer health insurance, it is difficult for one employer not to do so. Second, employers have an economic interest in healthy workers and, to some extent, workers' healthy families.[43]

Economic modeling of such a change tends to comport with this more nuanced view from the CRS. MIT health economist Jonathan Gruber has estimated that eliminating the ESI tax exclusion would lead to a modest reduction of individuals with ESI—on the order of about 15 million people. Some 30 percent of those individuals would, in his estimation, either purchase nongroup insurance or end up receiving coverage through a public program.[44] Of course, such theoretical estimates don't always pan out in the real world. CBO notes, for instance, in its January 2017 baseline projections of changes in insurance coverage under the ACA that the agency overestimated the number of employers that would stop offering ESI coverage in response to the Cadillac tax.[45]

Taken together, these considerations suggest that repealing the Cadillac tax and replacing it with a repeal of the ESI tax exclusion that phases in over the medium term would likely be welfare enhancing, even if a substantial share of employers stop offering coverage. Importantly, doing so would likely need to

---

42. Linda J. Blumberg, John Holahan, and Erik Wengle, "Are Nongroup Marketplace Premiums Really High? Not in Comparison with Employer Insurance," Urban Institute, September 19, 2016.
43. Congressional Research Service, *The Tax Exclusion for Employer-Provided Health Insurance: Issues for Congress*, January 4, 2011.
44. Gruber, "The Tax Exclusion for Employer-Sponsored Health Insurance."
45. "Federal Subsidies under the Affordable Care Act for Health Insurance Coverage Related to the Expansion of Medicaid and Nongroup Health Insurance: Tables from CBO's January 2017 Baseline" (Congressional Budget Office, January 2017).

be coupled with appropriately subsidized coverage in the nongroup market for lower-income individuals. Otherwise, those most likely to be uninsured ex ante are the lower-income population who will not be able to afford either ESI or nongroup coverage.

Nevertheless, important questions remain to be addressed, in particular, whether other forms of health benefits like FSAs and HSAs will remain tax advantaged, and to what extent.

Eliminate the Cadillac Tax and Cap the ESI Tax Exclusion

A more modest version of the above proposal would take a similar approach, but instead of eliminating the ESI tax exclusion outright, it would place a cap on the value of the exclusion. This would be similar to the Cadillac tax in that, up to a certain threshold, the current tax exclusion would remain. However, above the threshold—as with total repeal of the exclusion—normal marginal rates would apply. Many of the points noted earlier apply here as well: A cap is relatively less regressive than the Cadillac tax or the exclusion; it is more efficient than the exclusion because it limits the subsidy received by higher-income individuals; and it can similarly be implemented over an extended period of time.

There are different ways to pursue this approach. One is to continue to treat employer-sponsored insurance differently from individually purchased coverage by offering the capped tax exclusion only for ESI. Up to the threshold, employer-sponsored insurance would be treated differently under the tax code than would individually purchased coverage. Under this approach, there would still be an incentive for employees to carry insurance coverage through their employers in lieu of cash wages up to the threshold amount.

Alternatively, a capped tax deduction could be extended to those in the individual nongroup insurance market. One important advantage of this approach is that it equalizes the playing field between ESI and nongroup insurance—the after-tax cost to an individual of the same policy purchased through an employer versus the nongroup market would be the same (holding risk constant). Simply limiting the existing ESI exclusion without extending it to the nongroup market would still advantage employer-based coverage over individually purchased insurance. In turn, equalizing the treatment of nongroup and employer-based coverage would have the effect of ameliorating the labor market distortions of current policy.

An important distinction between this approach and total repeal of the ESI tax exclusion has to do with the expected effects on the size of the insured

population. Under wholesale repeal, there is no intensive margin along which an employer or employee might be able to avoid paying an additional tax, thus holding total compensation constant. That is, without the exclusion, an employer or employee saves no money, on net, by varying the level of benefits. Dropping ESI coverage is thus a more realistic option for employers under wholesale repeal. With a cap on the deduction, by contrast, employers are more likely to keep offering coverage while reducing the value of benefits. The analysis cited earlier from Jonathan Gruber estimates that capping at the national median level of premiums would reduce ESI coverage only by about 2 million.[46] Thus, a cap on the exclusion would likely leave ESI coverage as the dominant source of coverage, but it would reduce the value of insurance purchased through such arrangements.

Various options are available for the design of a cap on the ESI tax exclusion. The Cadillac tax simply sets thresholds to start in some year and indexes them to grow each year. A cap could similarly be set at a dollar amount indexed to change annually, or it could be set to capture a certain percentile of national premiums, as under a proposal from the 2017 Project.[47] Another approach might set thresholds relative to the actuarial values of plans, such as the average, the median, or some percentile. These broad concerns are important to consider, as they would affect not only revenue generated, but also the total number of insured Americans.

Beyond this macro-level concern is a nested concern—specifically, that expensive health insurance is not *necessarily* caused by overinsurance, because different employers have different risk profiles. For instance, some employers' health benefits might be more expensive because they have an older workforce. A firm that employs coal miners would likely have significantly more expensive healthcare costs than a Silicon Valley startup. Good policy would not penalize the coal-mining firm simply for employing individuals with more expensive healthcare needs. This is somewhat crudely addressed in the Cadillac tax. The ACA provides for a higher threshold for individuals employed in "high-risk professions." Further, these thresholds are adjusted upward if the premiums for the Blue Cross Blue Shield Standard Plan for federal employees grow faster than 55 percent from 2010 to 2018.

46. Gruber, "The Tax Exclusion for Employer-Sponsored Health Insurance."
47. This proposal set the cap at the 75th percentile of premiums and proposed to grow it by 3 percent annually. See Center for Health and Economy, *2017 Project: "A Winning Alternative to Obamacare,"* September 8, 2014.

This all suggests that a cap on the exclusion, which replaces the Cadillac tax, could strive to avoid penalizing differences in healthcare costs that are *not* driven by over-insurance. One approach might be to set thresholds at the state level, perhaps tied to premiums in the individual market. Alternatively, thresholds might be adjusted for each employer's risk profile (or at least the average risk profile of an industry). While this would make the cap more targeted, it would also significantly increase the complexity of administering the cap.

Replace the Cadillac Tax and the ESI Tax Exclusion with Income-Based Subsidies

A third approach for replacing the Cadillac tax would be to eliminate both the existing tax exclusion and the Cadillac tax and replace them with an income-based subsidy for health insurance coverage—for either employer-sponsored coverage or for nongroup coverage. In some ways, this would represent an even more radical shift than simply eliminating the ESI tax exclusion. In other ways, however, it strikes a balance between the existing exclusion and a world with no exclusion.

Offering a subsidy for health insurance coverage builds on ideas in the ACA and some alternative healthcare reform proposals. Directly subsidizing the purchase of health insurance—through credits rather than just deductions—might be a more targeted approach that is more likely to maintain widespread coverage participation. Where it differs from existing law, however, is that the subsidy would be permitted to pay for employer-sponsored coverage. Indeed, most health reform proposals (including the ACA) expressly prohibit individuals eligible for affordable coverage through their employers from receiving a tax credit.

One approach to designing a hypothetical tax credit is to tie it to two measures: the cost of some health insurance plan (perhaps tied to actuarial value) and the individual's income. The value of such a credit would be tied to a

"Directly subsidizing the purchase of health insurance—through credits rather than just deductions—might be a more targeted approach that is more likely to maintain widespread coverage participation."

benchmark plan (but would not pay for overly generous coverage), and it would scale inversely with income (so that lower-income workers would receive a larger credit than higher-income workers). The credit could flow either to employees directly or to employers to be used on behalf of employees.[48]

As with the proposals discussed above, this last approach would reverse the regressivity of the tax exclusion and the Cadillac tax while making employer-sponsored health insurance more progressive. Efficiency, as above, comes from the reduced subsidy of higher-income individuals. The elimination of the exclusion—and the creation of tax credits available for either group or nongroup coverage—would also equalize the treatment of employer-purchased and individually purchased insurance coverage.

Proper crafting of such a proposal involves many critical considerations. First, offering tax credits for employer-sponsored insurance could well strengthen the relationship between specific employment and healthcare coverage, particularly if the credit flows directly to the employer. Therefore, care must be taken so that this does not interfere with labor market mobility.

Second, as with any income-based credit, ensuring that subsidy cliffs are minimized is critical, so that individuals are not unduly penalized for additional employment earnings. Third, the interaction of employment-based credits with credits offered for purchase of nongroup coverage is an important consideration. One might simply decide to allow credits for the nongroup market to also flow into the group coverage market, which would sever the link between this policy and actual employment, lessening labor market distortions. It would also increase the total number of individuals receiving the subsidy and thus aggregate costs as well.

Such a tax credit would also introduce administrative concerns. If administered through employers, there would be issues of eligibility verification based on the individual's income level, which could require tracking outside income otherwise unknown to the employer.

These concerns all add to the difficulty of crafting a workable tax credit that replaces the current tax exclusion for ESI insurance. They should be weighed

48. Alternatively, the tax credit might not need to be indexed to either plan cost or income. Such a credit would likely be less expensive, but it could make widespread participation more difficult to maintain, particularly for low-income individuals. Regulations restricting the pricing of insurance plans would help increase participation but would likely require more spending to compensate insurers for the added risk. Of course, the credit might also be indexed to either income or the cost of health insurance—or to something else altogether, such as plans available through the Federal Employees Health Benefits Program.

against the larger disruption to ESI coverage that would arise with wholesale repeal of the exclusion.

Final Considerations

There are additional, important details (beyond the scope of this paper) to consider when thinking about the alternatives proposed in this paper.

For instance, under a capped exclusion, a firm offering multiple plans will have a different experience than a firm offering only one plan. In the former, employees may simply choose lower-cost plans. In the latter, if the firm is unable (for some reason) to offer lower-cost plan options, the predicted effect would be an overall reduction in coverage.

Yet another concern is how self-insured firms—those that pay claims costs directly and use an administrator to establish networks and benefit structures—would fare under any of these proposals. With different levels of claims costs between workers, a firm might allot the additional taxes due at the individual level, which would likely require sicker workers to pay a larger amount. Alternatively, averaging these costs across all workers might affect the risk pool, as healthy individuals may—depending on regulations—seek coverage outside of the firm.

How such details are structured would in turn affect the relative benefits of the alternative approaches to the Cadillac tax proposed here. Indeed, because the Cadillac tax treats these considerations at the firm level rather than the individual level, the relative gains from these alternatives (in terms of reducing regressivity) may be smaller.

CONCLUSION

The employer-sponsored health insurance system that provides coverage to over 150 million Americans exists, at least in part, because of an inefficient and regressive tax deduction. This policy preference has been established despite the lack of evidence that the employer-sponsored system offers clear superiority to other approaches to providing insurance; in fact, this system appears to increase healthcare costs unnecessarily. The ACA doubled down on the employer-sponsored system by requiring employers with 50 or more employees to offer health coverage. At the same time, the ACA's Cadillac tax represented an attempt to mitigate the cost and inefficiency of the tax preference for employer-sponsored insurance. Unfortunately, the Cadillac tax also stands to create its own new dis-

tortions and regressive effects, and it remains to be seen whether lawmakers are willing to implement it.

Replacing the Cadillac tax should be a key priority for policymakers. Yet returning to the status quo with an unlimited deduction for ESI coverage would make for poor policy. The options for replacing the Cadillac tax discussed in this paper would be significant improvements over both the Cadillac tax and the pre-ACA status quo. Any of these options would likely increase welfare relative to the ACA as currently enacted. Making a policy change such as one of those suggested here would set the United States forward on a path to separate health insurance from employment and to reduce distortions that currently put upward pressure on healthcare demand, spending, and prices.

ABOUT THE AUTHORS

Yevgeniy Feyman is a senior research assistant in the department of health policy and management at the Harvard T. H. Chan School of Public Health, and he is an adjunct fellow at the Manhattan Institute for Policy Research. His research has addressed a variety of issues including the cost of healthcare and entitlement reform, drug pricing reform, hospital consolidation, dynamics in the Medicare Advantage market, and the role of patients as consumers in health care. Feyman has written for various publications, including the *Health Affairs Blog*, *Politico*, *National Affairs*, *Boston Globe*'s *STAT*, the *New York Times*'s *Room for Debate*, and *National Review Online*. He has spoken on numerous radio and TV shows regarding ongoing healthcare reform efforts and is a contributor to *The Apothecary*, the Forbes healthcare blog on healthcare policy and entitlement reform. Feyman holds a BA in economics and political science from Hunter College of the City University of New York.

Charles Blahous is the J. Fish and Lillian F. Smith Chair and senior research strategist at the Mercatus Center at George Mason University. He specializes in domestic economic policy and retirement security (with an emphasis on Social Security), as well as federal fiscal policy, entitlements, and healthcare programs. Blahous's media appearances include *The Diane Rehm Show*, Fox News, and C-SPAN's *Washington Journal*. He was named to *SmartMoney*'s "Power 30" list in 2005 and has written for the *Wall Street Journal*, the *Washington Post*, *Financial Times*, *Politico*, *National Review*, *Harvard Journal on Legislation*, *National Affairs*, *Journal of Chemical Physics*, and *Baseball Research Journal*, among others. Blahous is the author of *Social Security: The Unfinished Work* and *Pension Wise: Confronting Employer Pension Underfunding and Sparing Taxpayers the Next Bailout*, as well as the influential study *The Fiscal Consequences of the Affordable Care Act*. Blahous served as a public trustee for Social Security and Medicare from 2010 through 2015. He was formerly the deputy director of President Bush's National Economic Council, special assistant to the president for economic policy, and executive director of the bipartisan President's Commission to Strengthen Social Security. He recently served on the Bipartisan Policy Center's Commission on Retirement Security and Personal Savings. Blahous received his PhD in computational quantum chemistry from the University of California at Berkeley and his BA from Princeton University.

ABOUT THE MERCATUS CENTER AT GEORGE MASON UNIVERSITY

The Mercatus Center at George Mason University is the world's premier university source for market-oriented ideas—bridging the gap between academic ideas and real-world problems.

A university-based research center, Mercatus advances knowledge about how markets work to improve people's lives by training graduate students, conducting research, and applying economics to offer solutions to society's most pressing problems.

Our mission is to generate knowledge and understanding of the institutions that affect the freedom to prosper and to find sustainable solutions that overcome the barriers preventing individuals from living free, prosperous, and peaceful lives.

Founded in 1980, the Mercatus Center is located on George Mason University's Arlington and Fairfax campuses.