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# Benefits of the Tax-Preferred Status of Employer-Sponsored Health Insurance

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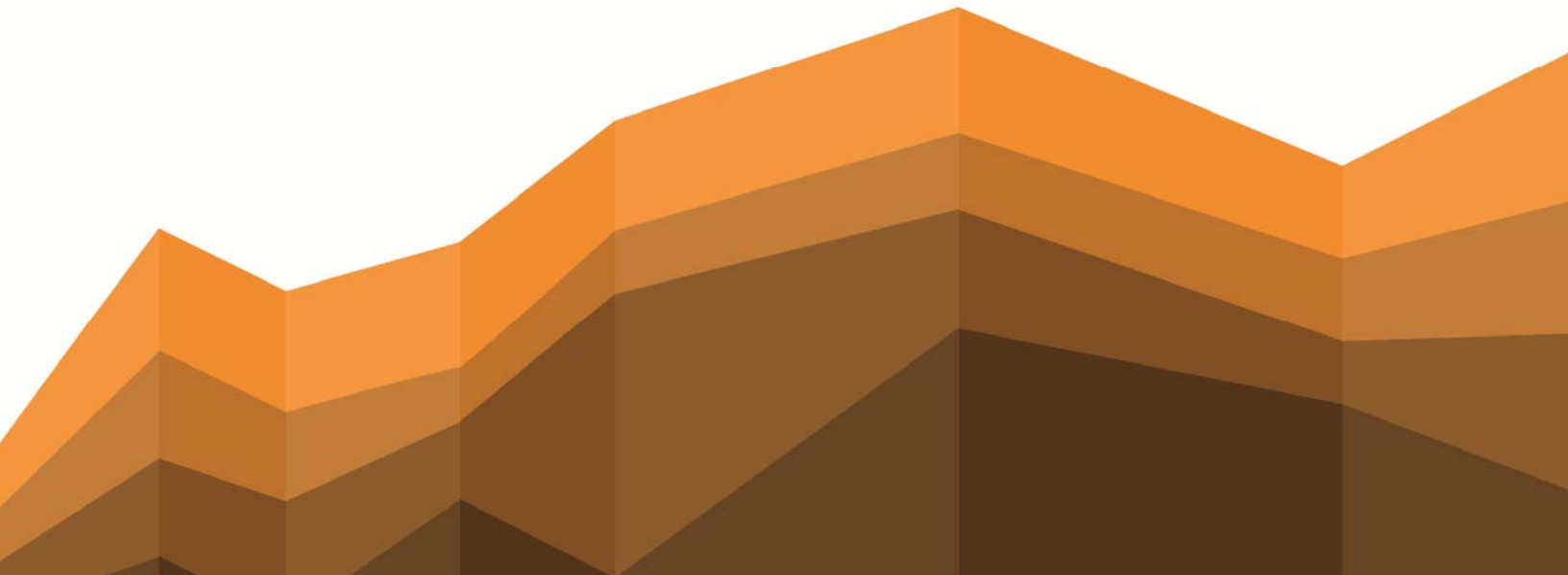

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## Introduction

More than 177 million Americans receive health care benefits through employers,[1] and the broad scope of these benefits makes for one of the few working aspects of our health care system. Yet modifying the tax treatment of employer-provided health benefits has long been a goal of some policymakers and health economists on both sides of the political aisle. The large dollar amount associated with the tax exclusion makes it a particularly tempting revenue target for those seeking to expand coverage to the uninsured under the Affordable Care Act and for those seeking to repeal and replace the law. It is important, however, to look at the downsides: Limiting the tax exclusion would likely serve as a middle-class tax hike, drive up health insurance costs for millions of American employees, and eliminate the strong incentives currently in place that constantly pressure large purchasers of health to demand more efficient, affordable, and effective care from the marketplace.

At the same time, employer-sponsored care also creates a number of economic advantages for employees. Employer-provided health care benefits facilitate risk-pooling that reduces price fluctuations, creates certain economies of scale and administrative efficiencies, simplifies purchasing insurance for employees,[2] and protects employees from the current uncertainties surrounding the ACA exchanges. Most importantly, the current tax treatment of health care benefits provides strong incentives to employers who purchase health care for their employees to focus on the overall health of their employees and to use their leverage to improve the quality and cost of the health care system.

Furthermore, changes to the tax treatment of health care benefits may discourage employers from offering coverage to their employees. Should that happen, tens of millions of Americans would need to find health insurance elsewhere, increasing the financial pressure on other parts of our health care system, especially government-financed programs. With federal and state governments already facing significant fiscal pressures, diminished employer participation would significantly add to the pressures on our health care system. In short, limiting or eliminating the current tax exclusion of employer-provided health care benefits could cost our system far more than any benefits it may provide.

## Tax-Preferred Treatment of Employer-Provided Health Benefits Has Been Longstanding Policy and Integral Part of the U.S. Health Care System

For over 60 years, employer-provided health benefits have been excluded, without limit, from income and payroll taxes.[3] Over time, this benefit emerged as a basic building block of our health care system. If you are employed, the expectation is you will be offered health benefits by your employer. Making a substantial change to the tax treatment of employer-provided health benefits would cause a significant disruption to this longstanding system. It would not only raise questions about the health coverage of the 177 million people in the employer-based system, but it would also call into question the financing of the public system as well, as many of those

millions would likely seek some kind of publicly assisted health coverage, which would put additional pressure on an already strapped system.

Under present policy, employer-provided health benefits are excluded, without limit, from income and payroll taxes. The exclusion applies with respect to health benefits provided to current employees, retirees, and surviving family members of a deceased employee. On average, the tax exclusion effectively reduces the cost of purchasing health insurance by about 32 percent, compared to purchasing it with after-tax dollars.[4] According to the Joint Committee on Taxation, the exclusion of employer contributions for health care, health insurance premiums, and long-term care insurance premiums amounts to $323 billion in 2016.[5]

Under the current U.S. health care system, employment-based health care benefits cover almost 56 percent of all Americans, while government funded programs cover 37 percent.[6] Another 16 percent directly purchase their coverage both in and out of the ACA exchanges,[7] with many of those covered by policies receiving ACA premium and cost-sharing subsidies.[8] Although this system is not perfect, providing subsidies or tax credits for purchasing individual coverage should not come at the expense of those who are covered by employer-provided health care benefits.

## There Are Significant Efforts Underway to Change This Longstanding Policy

Despite the importance of the current tax treatment of health care to our current system, there are significant efforts underway to try to change that policy. Legislators, health economists, and think-tank analysts on both sides of the aisle seek to limit the tax exclusion on employer-sponsored health care. These proposals range from various forms of a cap or limitation on the tax exclusion, to completely eliminating the tax preference for employer-provided health care benefits. For example, in 2015, the Republican Study Committee proposed replacing the tax exclusion of employment-based health coverage with a standard deduction of $7,500 for individuals and $20,500 for families,[9] and Rep. Tom Price (R-GA) has proposed legislation to cap the tax exclusion of employer-provided health benefits at $8,000 for individual coverage and $20,000 for family coverage in order to provide a refundable age-adjusted tax credit to individuals without employer-provided benefits, Medicaid, or Medicare.[10]

In 2013, a bipartisan group of policymakers proposed placing a limit on the income-tax exclusion for employer health benefits at a dollar amount equivalent to the 80$^{th}$ percentile of single and family premiums (age- and gender-adjusted), indexed to per-capita economic growth.[11] The left-leaning Center for Budget and Policy Priorities has repeatedly supported limiting the tax exclusion along with other liberal health policy experts at the Brookings Institution and the Urban Institute.[12] More recently, a group of ten conservative health policy experts called for a limit on the tax exclusion for employees to "approximately the 75th percentile of employer plan costs, indexed to general inflation in subsequent years."[13]

On June 22, 2016, House Speaker Paul Ryan (R-WI) released a plan to reform America's health care system that would make significant changes to the tax treatment of

employer-provided health care benefits.[14] The plan seeks to start a conversation about bringing more parity to the tax treatment of the group and individual health markets by calling for:

- Capping the tax exclusion "at a level that would ensure job-based coverage continues unchanged for the vast majority of health insurance plans;"
- Adjusting the cap for geographic differences in health care costs; and
- Omitting from the cap employee contributions to health savings accounts.[15]

Notably, the plan "[s]trongly supports employer-based care and recognizes the certainty and stability job-based health insurance offers."[16] However, it does not explain how the tax cap would be indexed for inflation, which is often a key sticking point.[17] The plan also proposes policies that protect wellness programs and self-insurance, and to expand HSA utilization by allowing catch-up contributions and increasing accessibility for underserved populations, which would strengthen employer-provided health care benefits.

In offering these proposals, the policymakers and analysts behind them argue that the tax preference for employer-sponsored care is too expensive, that reducing it would increase wages for employees, that it disproportionately favors the wealthy, and that it encourages excess spending on health care. They also claim that most employee plans will not be affected, and that limiting the tax exclusion is fundamentally different than the current ACA excise tax on high-value employer-provided benefits (a.k.a. the Cadillac Tax). These arguments often undervalue the negative impact limiting the tax preference will have on employees. More importantly, they frequently overlook the ways in which employer-sponsored care is effective at getting people covered, something that recent experience has shown is difficult to do.

## Why the Tax Treatment of Employer-Provided Health Benefits Should Not Be Reduced or Eliminated

### Employer-Provided Health Care Benefits Are Not Overly Generous

Proponents of limiting the tax exclusion contend that the unlimited exclusion encourages employees to buy generous coverage that offers lower cost-sharing but higher tax-free premiums. According to them, by increasing plan generosity, the tax exclusion encourages excess spending on health care, in that such coverage makes consumers less price-sensitive and promotes the use of medical services, some of which may provide little value.

Yet, employers for the past three decades have been focused intensively on trying to rein in the cost of their health care budgets. Health care accounts for between 5 and 10 percent of their compensation costs depending on industry, and nearly 2 to 5 percent of their total costs.[18] Employers have been at the forefront of advancing innovative health benefit and plan design strategies to increase consumerism, implementing chronic disease management and population health efforts to improve wellness and reduce unnecessary health care costs, and increasingly offering a variety of user-friendly comparison tools that are intended to help employees and their dependents select in-network providers, procedures, and tests based on cost and quality-of-care

data. Moreover, employers began taking these steps prior to any change in the tax treatment of the health benefits they offer, and will continue to do so in order to control costs in a responsible manner.

Prior to the ACA, from 2006 to 2010, the percentage of employers offering a consumer directed heath plan (CDHP or HDHP with some type of savings account) tripled from 4 percent to 13 percent, and has more than doubled since 2010 to 29 percent in 2016.[19] Moreover, more than 51 percent of large employers (200 or more employees) currently offer an HDHP option,[20] and 84 percent of very large employers (1,000 or more employees) offer an HDHP option.[21] In addition, 35 percent of very large employers only offer a CDHP to their employees.[22] These are all examples of how employers are seeking incentives to encourage smarter health care spending choices rather than inflating health care budgets.

Over the past ten years, employers have also adjusted their health plans to encourage consumerism and reduce excess spending on health care by giving employees more "skin in the game." Since 2006, the percentage of covered employees with a general annual deductible for individual coverage has increased from 55 percent to 83 percent in 2016, and the average deductible amount has nearly tripled from $584 in 2006, to $1,478 in 2016.[23] As a result, the amount of "skin in the game" that full-time employees have has doubled from 1.7 percent of the median weekly earnings in 2006, to 3.4 percent in 2016.[24] However, it is important to note that under the ACA employers have no control over how generous their health benefits are when it comes to preventive health services. By law, employers are required to pay 100 percent of the cost of an ever growing list of preventive health services with no out-of-pocket cost to the employee.

In addition to the general annual deductible, most employees are enrolled in health plans that require other types of cost sharing (such as a copayment, coinsurance, or a per diem charge) for an in-network physician office visit, or when admitted to a hospital or having outpatient surgery. Since 2006, the percentage of covered employees in a plan that requires coinsurance for hospital admissions has increased from 51 percent to 64 percent in 2015.[25] Further, nearly all employees are enrolled in a health plan that requires cost sharing for an in-network primary care office visit,[26] and the amount of cost sharing has increased over time.

Similarly, employers also have been at the forefront of advancing efforts to improve wellness to reduce unnecessary health care costs. Since 2006, the percentage of large employers with 200 or more employees that offer smoking cessation programs has more than doubled from 33 percent to 74 percent in 2016, while the percentage of large employers that offer weight loss programs has jumped from 28 percent to 68 percent in 2016.

Any future health care reform must take into account the vital role employers play in facilitating market-driven innovation and creativity that has, and is, restraining health care costs. Employers are acutely aware that health care costs need to be reined in, but limiting the tax exclusion of employee health benefits puts that responsibility on the backs of working Americans. Providing tax credits for purchasing individual coverage, or any other health reform, should not come at the expense of those who receive health care through their employer.

## Limiting the Tax Exclusion May Not Increase Wages, But Will Increase Out-of-Pocket Expenses

One of the principal arguments for limiting the tax exclusion is that it artificially depresses wages. The evidence, however, regarding whether the tax preferred treatments of health care holds down wages is, at best, inconclusive. Moreover, even though take-home pay may increase, some portion, and perhaps all, of the pay increase could be consumed by higher out-of-pocket health care costs, particularly those with chronic health conditions.

Economic research is mixed on the question of whether health care benefits impact wages. According to Darren Lubotsky and Craig A. Olson, economic research "has failed to find clear evidence that health insurance costs are borne by employees, which calls into question the long-standing views most economists hold about the incidence of rising health insurance costs."[27] Despite the size of the literature on the trade-off between wages and health insurance premiums, "a consensus on the size of the trade-off does not exist."[28] Further, recent research that has identified a trade-off typically shows that it is smaller than dollar-for-dollar.[29] In other words: a dollar increase in health benefits does not appear to reduce wages by a full dollar; some of the cost is born by employers.

Perhaps more importantly, no economic study has yet found that reducing health care benefit costs will increase wages.[30] Economists assume that when employers reduce health benefits, they will in turn increase wages such that total compensation is unchanged. However, when productivity growth is weak or failing, as it has been for the past five years, and unit labor costs are increasing faster than productivity, it may take a long time for lower health care benefits to translate into higher wages.

Although proponents of a cap on the tax exclusion for employer-provided health benefits say that employees' take-home pay will increase, some portion, and perhaps all, of the increase in take-home pay could be consumed by higher out-of-pocket health care costs shifted to employees, particularly those with chronic health conditions. For example, if an employer increases the deductible in its health plan by $1,000 and reduces an employee's premium by $500 to avoid the tax cap, the employee's pre-tax pay will increase by $500, but their take-home pay will only increase by $340 after taxes,[31] while their out-of-pocket costs are now up to $1,000 higher for the same health care services. For those employees with chronic health conditions, their higher out-of-pocket medical costs could easily consume all of their higher take-home pay and more.[32]

## Limiting the Tax Exclusion Will Be A Large Tax Increase On Middle-Class Employees

Proponents for limiting the tax exclusion also argue the exclusion is an unfair way to promote the purchase of health insurance because it is regressive as it disproportionately favors the wealthy. However, when testifying before Congress in 2009, economist Jonathan Gruber, one of the architects of the ACA, noted that capping or eliminating the tax exclusion on employer health care benefits would be a "middle-class tax increase."[33] Although such a proposal would apply across all incomes, "it would still be a sizeable increase in taxation for

middle income families, with 10% of the revenues coming from families below $50,000 in income, and 28% from families with $50,000 to $100,000 of income."[34]

A number of studies estimating what impact capping the tax exclusion on employer-provided health benefits would have on employees show exactly what Gruber described it would be in 2009. For example:

- In 2013, the Urban Institute estimated that capping the tax exclusion at the 75th percentile of the value of employer plans beginning in 2014 would increase taxes on employees by $102 billion from 2014 to 2023.[35] *The study found that by 2023, 21.5 percent of the middle-class (middle-quintile) would be paying $914 per year in higher taxes.*
- More recently, the National Institute for Health Care Reform estimated that capping the tax-exclusion at a level that would raise about the same amount of tax revenue as the Cadillac Tax *would reduce a middle-class family's take-home pay after accounting for their lower health benefits by $1,030 per year.*[36]
- A 2015 Urban Institute study in 2015 estimated that capping the tax-exclusion at $10,746 for single coverage and $28,930 for family coverage in 2020 *would increase taxes on 16.0 percent of middle-class (middle-quintile) employees by an average $710.*[37]
- Most recently, the non-partisan Center for Health and Economy estimated the impact of the House Republican health reform plan that found capping the tax exclusion at the 90th percentile of the value of employer plans beginning in 2018,[38] *costing 11.4 million employees an average $636 in higher payroll and income taxes per year from 2018 to 2026.*[39]

Policymakers may argue that capping the tax exclusion on employer-provided health benefits is about "[b]ringing more parity to the group and individual health markets,"[40] as did House Republicans in their "A Better Way" proposal, but practically speaking, it is really about raising revenue to pay for other parts of any health care reform plan. In addition, policymakers would be well advised to carefully consider the unintended consequences of taking such action as "[t]ax credits would break the financial link that motivates employers to offer health insurance and employees to buy it,"[41]according to Joseph Antos of the American Enterprise Institute. Delinking employers from health insurance could have a negative impact on insurance coverage rates since, according to Peter Nelson, Director of Public Policy at the Center of the American Experiment, "Employers do get people covered— they very successfully get people covered."[42]

## Limiting the Tax Exclusion Will Eventually Impact Every Employee

Proponents for limiting the tax exclusion also claim only the most generous plans would be affected and that most Americans' plans would not be taxed. However, depending on how a limit on the tax exclusion is indexed for inflation, more and more employees over time could be taxed on their health benefits because the cost of employer-sponsored health benefits typically increases much faster than other prices. For example, while medical care prices have increased 4.9 percent over the past 12 months, they are rising seven times faster than all other prices (0.7

percent).[43] If the threshold limit for the tax limitation increases over time by the Consumer Price Index and not medical inflation, the tax limitation threshold will increase more slowly than the cost of the average employer health care plan. Eventually, the cost of today's "average plan" will be subject to the tax.

By our calculation, capping the tax exclusion at 90 percent would increase costs on the average employee by $520 between the years of 2020 and 2026. Capping the exclusion using Cadillac Tax thresholds would increase costs by $710. By comparison, the current Cadillac Tax is projected to increase employee costs by $636 during this time period. Eliminating the tax exclusion altogether would impose a $5,263 tax on the average employee.

### Capping Tax Exclusion Will Increase Taxes On Employees

| Average Employee Cost Per Year | 2020 to 2026 |
|---|---|
| Current Cadillac Tax | $636 |
| Capping Tax Exclusion at 90% | $520 |
| Capping Tax Exclusion at Cadillac Tax Thresholds | $710 |
| Eliminating Tax Exclusion in 2020 | $5,263 |

## Limiting the Tax Exclusion Will Have Other Negative Impacts On Employees

In addition to increasing taxes on employees, limiting the tax-preferred treatment of employer-provided health benefits would have a number of other costs as well. The Congressional Budget Office (CBO) has analyzed what could happen if policymakers imposed a limit on the extent to which employer-provided health care benefits could be excluded from income and payroll taxation.[44] According to the CBO, this would:

- "Increase the financial burden on some people with substantial health problems;"
- "[P]robably limit some people's access to health care and cause them to forgo some care;"
- Reduce "the use of effective care" and "could be accompanied by worse health for some people;"
- [M]ight decrease employers' willingness to hire older workers or cause employers to reduce other forms of compensation for older workers, such as cash wages or contributions to pension plans;" and
- "[L]ead fewer employers to offer health insurance, thus increasing the number of uninsured workers."[45]

### Limiting the Tax Exclusion Could Destabilize Employer Health Benefit Risk Pools

Proponents for limiting the tax exclusion rationalize the policy change is needed in order to bring more parity to the group and individual health markets, and that such a change need not disrupt employer-provided health benefits. However, limiting the tax exclusion is likely to increase the problem of "adverse selection" in employer risk pools whereby less healthy people are more likely to buy health insurance (or to buy specific types of plans) than healthier people are.[46] According to the CBO, the current tax exclusion for employer-provided health benefits reduces the problem of "adverse selection," in which less healthy people are more likely to buy health insurance (or to buy specific types of plans) than healthier people are.[47] In other words, the current tax exclusion "encourages relatively healthy workers to obtain coverage. (People with lower expected costs for health care would be less likely to obtain coverage without the subsidy; by contrast, people with higher expected costs would be more likely to purchase coverage regardless of the subsidy.)"[48] Capping or reducing the tax exclusion would therefore discourage relatively healthy workers from participating in employer-provided health benefits and increase the problem of "adverse selection" in employer risk pools – and according to the CBO: "Adverse selection can cause health insurance markets to break down or to operate inefficiently."[49] Given what we have learned about the adverse selection problem in the ACA exchanges, the fact that far too few healthy people are purchasing health care in the exchanges, policymakers should be encouraging employers to maintain their insurance risk pools, not discouraging them.

## ACA Cadillac Tax: A Cautionary Tale

We know that efforts to limit the tax exclusion for health care benefits can be extremely problematic since we have recently witnessed a failed attempt to do exactly that. As part of the ACA, Congress modified the tax treatment of employer-provided health benefits by imposing an excise tax on high-value employer-provided benefits (a.k.a. the Cadillac Tax). However, instead of directly reducing or eliminating the tax exclusion for employees, which Congress viewed as politically dangerous, it imposed the Cadillac Tax on employers.

Under the ACA, if the aggregate cost of employer-provided health benefits exceeds $10,200 for individual coverage and $27,500 for family coverage, a 40 percent excise tax is applied to the amount of the employee benefit that exceeds the tax threshold. In 2019, the threshold amounts for the excise tax are increased by the Consumer Price Index (CPI) plus one percentage point. In 2020 and thereafter, the threshold amounts are indexed by just the CPI. In doing this, the critics of the exclusion attained their goals as the Cadillac tax effectively caps or limits the tax exclusion on employer-provided health benefits.[50]

The Cadillac Tax is both flawed and deeply unpopular—so highly unpopular that Congress delayed the effective date of the tax from the end of 2018 to December 31, 2020.[51] Policymakers and health economists on both sides of the political aisle recognize the key flaws of the Cadillac tax: It fails to account for regional variations in health care prices, undercuts wellness programs and health savings accounts (HSAs), and will eventually impact everyone with employer-provided health benefits because of the way it is indexed.[52] According to two recent surveys,

over 25 percent of employers with 5,000 or more employees say their largest health care plan will be subject to the Cadillac Tax in 2020.[53] By 2022, over half of large employers' health care plans with the largest enrollment will be hit by the tax if no changes are made to the plan design.[54]

In terms of cost, CBO currently estimates the Cadillac Tax will cost employees $61 billion from 2020 to 2026, or an average $9 billion per year, and employers $18 billion, or an average $2.6 billion per year.[55] CBO estimates the higher taxes on employees will come from a combination of increased income and payroll tax revenue from the higher taxable wages employers are assumed to pay to offset the reduction in the health care benefits that is expected to occur because of the tax.[56] Although proponents of the Cadillac Tax or a different type of cap on the tax exclusion for employer-provided health benefits say that employees' take-home pay will increase, some portion, and perhaps all, of the increase in take-home pay could be consumed by higher out-of-pocket health care costs shifted to employees, particularly those with chronic health conditions.

- From 2020 to 2026, the Cadillac Tax will cost 12.9 million employees an average $636 in higher payroll and income taxes per year, *if* employers increase their taxable wages as they reduce the cost of health care benefits, as CBO assumes.[57]
- Even if taxable wages rise, many employees with health care costs will see their take-home pay decline. For example, after-tax take-home pay may increase by an average of $1,990 per year, but if an employer reduces the value of their health care benefits by $2,000 per year to avoid the Cadillac Tax, then an employee's higher out-of-pocket medical costs could easily consume all of their higher take-home pay and more.[58]

### Limiting the Tax Exclusion Will Have the Same Problems as the Cadillac Tax

Proponents for limiting the tax exclusion also claim it is a fundamental departure from the Cadillac tax. However, regardless of whether policymakers choose to tax the value of employer-provided health care benefits above some threshold amount by imposing a tax on either employers (*i.e.*, the Cadillac tax), or employees (*i.e.*, limiting the individual's tax exclusion), both policy prescriptions share the same two fatal flaws:

- Both cannot account for regional price differences, age and gender factors, and employer size without becoming so complex they would be nearly impossible to administer for multi-state employers; and
- Eventually all employees will have to pay some tax because of the way the thresholds are indexed, or likely to be indexed, to inflation.

An analysis by Milliman, an independent actuarial firm, found that "although the [Cadillac] tax is often referred to as a tax on overgenerous health benefits, it is likely to be a tax based on factors other than benefit richness and beyond the control of health plan members." According to Milliman, factors such as age, gender, geography, occupational industry, and plan size have much greater effects on the cost of a plan than any perceived generosity in the plan's benefit structure, with geography accounting for up to 69 percent of employer plans' premium growth.

Limiting the tax exclusion for individuals will have the same problem. For example, an employer plan of similar generosity (*i.e.*, gold level) costs 20 percent more in Milwaukee, WI, than in Dayton, OH, and 59 percent more in San Francisco, CA than in Huntington, WV. Moreover, Milliman also found that the age and gender adjustment in the ACA for the Cadillac tax "fails to compensate for the impact on premiums of age and sex in many parts of the country." Whether it is in the form of the Cadillac Tax or the other proposals seeking to limit tax-preferred treatment of employer-sponsored care, caps on the tax exclusion could also disproportionately harm women and older workers who typically have higher than average health care costs.

Further, as discussed above, depending on how a limit on the tax exclusion is indexed for inflation, over time, more and more employees could be taxed on their health benefits because the cost of employer-sponsored health benefits typically increases faster than other prices.

### Limiting the Tax Exclusion Will Be Even More Unpopular Than the Cadillac Tax

There is already significant public opposition to the Cadillac Tax, which is a tax directly on employers. There is likely to be even more opposition to limiting the tax exclusion, a direct tax on employees. More than 295 members of House and 37 members of the Senate have co-sponsored bipartisan legislation to repeal the tax (H.R. 879, H.R. 2050, S. 2045, and S. 2075), and there is broad support for repealing the excise tax among both employer organizations and unions. This includes the Business Roundtable, HR Policy Association, U.S. Chamber of Commerce, National Association of Manufactures, National Retail Federation, American Benefits Council, the ERISA Industry Committee, the Laborers' International Union of North America, UNITE HERE, the United Brotherhood of Carpenters and Joiners of America, the United Steelworkers, and the AFL-CIO.[59] Policymakers and health economists may try to go down the path of limiting the tax-preferred treatment again, but it will likely face the same problem, and the same opposition, as the Cadillac Tax.

### Employees Do Not Want Their Health Care Benefits Taxed

For more than 60 years, the majority of Americans have relied upon their employer-sponsored health coverage to provide access to high-quality, affordable health care services for themselves and their families. This is an important benefit that employees and their dependents value and they are concerned about any tax on those benefits. A number of polls show:

- The public currently opposes the Cadillac Tax by a wide margin: 75 percent oppose the limiting the tax exclusion when told the tax would "likely cause employees to pay more out of pocket for health care services due to higher deductibles and co-pays;"
- Another poll found 76 percent of Americans are concerned about the Cadillac tax, going into effect;
- A 2009 poll found 62 percent oppose taxing employees whose health insurance benefits are above a certain value; and
- A majority of voters (52 percent) say the Cadillac Tax will "harm the quality of health care."

Recent surveys also show employer-provided health benefits remain a top priority for employees. For example:

- 88 percent of employees report that employment-sponsored health benefits are "extremely" or "very important"—far more than for any other workplace benefit.
- 79 percent of employees would prefer new or additional benefits to a pay increase, and more women (82%) than men (76%) prefer benefits to a pay raise.
- And, more U.S. workers say they worry about having their benefits reduced (30%) than worry about having their wages cut (20%), being laid off (19%), having their hours cut back (17%), or their company moving their jobs overseas (8%).

There is already significant public opposition to the Cadillac Tax, which is a tax directly on employers. There is likely to be even more opposition to limiting the tax exclusion, which would be a direct tax on employees.

## Conclusion

Policymakers on both sides of the aisle have long sought budgetary "savings" by reducing the value of the tax preference for employer-sponsored care. Too often, these efforts fail to take into account the entirety of the substantial benefits derived from encouraging employer-sponsored care. Getting rid of or reducing the tax preference would not only serve as a middle class tax hike, it would also harm efforts to maintain strong risk pools and to cover the maximum number of people. As we have learned from experience with the ACA, encouraging people to get covered is a costly and challenging endeavor, and risk pools are difficult to maintain as well. Employers, however, are both good at getting people covered and maintaining manageable risk pools. Public policy should be aimed at encouraging these important goals.

# Endnotes

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

[2] Paul Fronstin and Dallas Salisbury, "Health Insurance and Taxes: Can changing the Tax Treatment of Health Insurance Fix Our Health Care System?" Employee Benefit Research Institute, September 2007.

[3] Internal Revenue Act of 1954 (P.L. 83-591), Section 106.

[4] Cogan, John F., R. Glenn Hubbard, and Daniel P. Kessler, "Evaluating Effects of Tax Preferences on Health Care Spending and Federal Revenues," Tax Policy and the Economy, 2007.

[5] Joint Committee on Taxation, Exclusion for Employer-Provided Health Benefits and Other Health-Related Provisions of the Internal Revenue Code: Present Law and Selected Estimates, April 12, 2016, Table 3.

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

[7] *Id.*

[8] See Department of Health and Human Services, "About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies," ASPE Data Point, October 4, 2016. Also see: Centers for Medicare & Medicaid Services, "March 31, 2016 Effectuated Enrollment Snapshot"

[9] American Health Reform Act, H.R. 2653, 114th Congress, available at: https://www.congress.gov/bill/114th-congress/house-bill/2653/text.

[10] Empowering Patients First Act of 2015, H.R. 2300, 114th Congress, available at: https://www.congress.gov/114/bills/hr2300/BILLS-114hr2300ih.pdf. See also, Jeffrey H. Anderson, "An Alternative to Obamacare," Hudson Institute, January 2016.

[11] Alice M. Rivlin, et.al., "A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment," Bipartisan Policy Center, April 18, 2013.

[12] Paul N. Van de Water, "The Excise Tax on High-Cost Health Plans Should Stay," Center for Budget and Policy Priorities, September 29, 2015. Also see: "Health Policy Experts' Statement about Excise Tax on High-Cost Plans," Center for Budget and Policy Priorities, October 1, 2015.

[13] Joseph Antos, et.al., "Improving Health and Health Care: An Agenda for Reform," American Enterprise Institute, December 2015.

[14] House Health Care Reform Task Force, A Better Way: Our Vision of America: Health Care, June 22, 2016.

[15] *Id.*

[16] *Id.*

[17] This is a sticking point because depending on which inflation measure is used to index a limit on the tax exclusion over time more and more employees could be taxed on their health benefits. If the threshold limit for the tax limitation increases over time by the Consumer Price Index and not medical inflation, the tax limitation threshold will increase more slowly than the cost of the average employer health care plan and eventually, the cost of today's average plan would be subject to income and payroll taxes.

[18] AHPI estimate based on Bureau of Labor Statistics and Bureau of Economic Analysis data.

[19] Kaiser Family Foundation and Health Research & Education Trust, "2016 Employer Health Benefits Survey," September 2016.

[20] Kaiser Family Foundation and Health Research & Education Trust, "2016 Employer Health Benefits Survey," September 2016.

[21] National Business Group on Health, Large Employers' 2017 Health Plan Design Survey, August 2016.

[22] National Business Group on Health, Large Employers' 2017 Health Plan Design Survey, August 2016.

[23] Kaiser Family Foundation and Health Research & Education Trust, "2016 Employer Health Benefits Survey," September 2016.

[24] AHPI estimate based on data from the Bureau of Labor Statistics, Usual Weekly Earnings of Wage and Salary Workers, 2006 and 2016; and Kaiser Family Foundation and Health Research & Education Trust, "2016 Employer Health Benefits Survey," September 2016.

[25] Kaiser Family Foundation and Health Research & Education Trust, 2006 Employer Health Benefits Survey and 2016 Employer Health Benefits Survey.

[26] Kaiser Family Foundation and Health Research & Education Trust, 2016 Employer Health Benefits Survey.

[27] Darren Lubotsky and Craig A. Olson, "Premium Copayments and the Trade-off between Wages and Employer-Provided Health Insurance," August 6, 2015, available at: http://lubotsky.people.uic.edu/uploads/2/3/1/7/23178366/lubotsky_olson_august_6_2015.pdf. See also: Jed DeVaro and Nan L. Maxwell, "The Elusive Wage-Benefits Trade-Off: The Case of Employer-Provided Health Insurance," International Journal of Industrial Organization, November 2014; and Janet Currie and Brigitte C. Madrian, "Health, Health Insurance and the Labor Market, Vol. 3, in Handbook of Labor Economics, by Orley Ashenfelter and David Card, 1999. But see: Paul B. Ginsburg, "The Future of U.S. Health Care Spending Scenarios: Implications for Employers and Working Households," Brookings Institution, April 11, 2014.

[28] Darren Lubotsky and Craig A. Olson, "Premium Copayments and the Trade-off between Wages and Employer-Provided Health Insurance," August 6, 2015. Although some research shows that growing health care costs appear to have limited wage growth and has accounted for a large share of the increase in earnings inequality, it is not clear that if health care costs had grown more slowly from 1996 to 2010 that wages would have increased. It is just as likely that other tax-preferred and taxable benefits would have increased instead of wages.

[29] Sarah Kliff, "Will cheaper health insurance really raise wages? The evidence is thin." Vox.com, November 2, 2015, available at: http://www.vox.com/2015/11/2/9634504/health-premium-wages-evidence. But see: Katherine Baicker and Amitabh Chandra. "The Labor Market Effects of Rising Health Insurance Premiums," Journal of Labor Economics, July 2006; and Jeffrey Clemens and David M. Cutler, "Who pays for public employee health costs?" Journal of Health Economics, December 2014.

[30] Sarah Kliff, "Will cheaper health insurance really raise wages? The evidence is thin." Vox.com, November 2, 2015, available at: http://www.vox.com/2015/11/2/9634504/health-premium-wages-evidence.

[31] $500 times (1 minus 0.32), which is the average federal tax rate, equals $340.

[32] Also see: Alliance to Fight the 40, "Dispelling the Myth that Workers Will Get A 'Raise' From the Cadillac Tax," August 2016.

[33] Jonathan Gruber, "Statement of Professor Jonathan Gruber," Senate Committee on Finance, May 12, 2009.

[34] Jonathan Gruber, "Statement of Professor Jonathan Gruber," Senate Committee on Finance, May 12, 2009.

[35] Lisa Clemans-Cope, Stephen Zuckerman, and Dean Resnick, "Limiting the Tax Exclusion of Employer-Sponsored Health Insurance Premiums: Revenue Potential and Distributional Consequences," Urban Institute and Robert Wood Johnson Foundation, May 2013. Middle-class is defined has family income between 200% and 500% of the federal poverty level.

[36] Paul B. Ginsburg, Chapin White, Christine Eibner and Sarah Nowak, "Limiting Tax Breaks for Employer-Sponsored Health Insurance: Cadillac Tax vs. Capping the Tax Exclusion," National Institute for health Care Reform, October 2015.

[37] Linda J. Blumberg, John Holahan, and Gordon Mermin, "The ACA's "Cadillac" Tax Versus a Cap on the Tax Exclusion of Employer-Based Health Benefits: Is This a Battle Worth Fighting?" Urban Institute and Robert Wood Johnson Foundation, October 2015.

[38] Center for Health and Economy, "A Better Way to Fix Health Care," August 24, 2016. There is not enough information in the H&E report to estimate an average per employee cost estimate.

[39] AHPI estimate using Census Bureau data and Kaiser Family Foundation data.

[40] House Health Care Reform Task Force, A Better Way: Our Vision of America: Health Care, June 22, 2016.

[41] Joseph R. Antos, "Reforming the Tax Treatment of Health Insurance," American Enterprise Institute, Statement before the House Ways and Means Committee, April 14, 2016.

[42] Getting beyond employer-sponsored health insurance: Some fitful starts, The American Enterprise Institute, March 31, 2016. https://www.aei.org/events/getting-beyond-employer-sponsored-health-insurance-some-fitful-starts/

[43] Bureau of Labor Statistics. U.S. average for medical care compared to all items less medical care.

[44] Congressional Budget Office, "Options for Reducing the Deficit: 2014 to 2023," November 13, 2013.

[45] *Id.*

[46] *Id.*

[47] *Id.*

[48] Congressional Budget Office, Private Health Insurance Premiums and Federal Policy," February 2016.

[49] Congressional Budget Office, "Options for Reducing the Deficit: 2014 to 2023," November 13, 2013.

[50] Sherry Glied and Adam Striar, "Looking Under the Hood of the Cadillac Tax," The Commonwealth Fund, June 2016

[51] Joseph R. Antos, "Reforming the Tax Treatment of Health Insurance," American Enterprise Institute, Statement before the House Ways and Means Committee, April 14, 2016.

[52] Joseph R. Antos, "Reforming the Tax Treatment of Health Insurance," American Enterprise Institute, Statement before the House Ways and Means Committee, April 14, 2016.

[53] Kaiser Family Foundation and Health Research & Education Trust, "2016 Employer Health Benefits Survey," September 2016, Exhibits 14.19 and 14.20. According to the survey, 88 percent of large employers (5,000 or more employees) have conducted an analysis to determine if one of their plans will be subject to the Cadillac Tax when it takes effect, and 29 percent of those large employers who have conducted an analysis believe their plan with the largest enrollment will exceed the tax threshold in 2020. Therefore, more than 25 percent of all large employers believe their plan with the largest enrollment will exceed the tax threshold in 2020 (29% times 88% equals 25.5%).

[54] National Business Group on Health, "Large Employers' 2017 Health Plan Design Survey," August 2016, Figure 36. By 2028, 90 percent of large employers' health care plans with the largest enrollment will be subject to the ACA's Cadillac Tax if no changes are made by employers to their health plan designs.

[55] Congressional Budget Office, Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026, March 2016.

[56] Congressional Budget Office, Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026, March 2016. CBO also notes that "Even if the excise tax caused employers to shift to lower-cost health insurance plans without increasing employees' wages by a corresponding amount, other taxes (such as those on corporate profits) would tend to rise. The resulting revenues would be similar to the amounts projected in CBO's extended baseline" [CBO, "The 2016 Long-Term Budget Outlook," July 12, 2016].

[57] AHPI estimate using Census Bureau data and Kaiser Family Foundation data.

[58] If an employer increases their annual deductible from $500 to $2,500 to avoid the tax and increases wages by $2,000, the employee's after-tax take-home pay will increase by $1,360 (and their taxes will increase by $640). However, if the employee's annual medical expenses are $2,000 per year because of some chronic health condition, the employee's out-of-pocket medical costs will increase by $1,500 (from $500 to $2,000), and consume more than their increase in take-home pay.

[59] These organizations have all made public statements, or have signed onto public statements, supporting repeal of the Cadillac tax.