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GOP Doctors Caucus

"Implications of the Excise Tax on High-Cost Health Plans in the Patient Protection and Affordable Care Act (H.R. 3590)"

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Testimony by

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Mr. Chairman and members of the caucus, thank you for the opportunity to appear before you today. My name is Paul Fronstin. I am director of the Health Research and Education Program at the Employee Benefit Research Institute (EBRI). I am pleased to appear before you today to testify on health coverage and taxation for America's workers. Established in 1978, EBRI is committed exclusively to data dissemination, policy research, and education on financial security and employee benefits. Consistent with our mission, EBRI does not lobby or advocate specific policy recommendations; the mission is to provide objective and reliable research and information. All of our research is available on the Internet at www.ebri.org All views expressed are my own, and should not be attributed to EBRI.

Changing the tax treatment of employment-based health coverage has been a policy goal of many Democrats and Republicans as far back as the 98th Congress, when Ronald Reagan was president (Fronstin, 2009). Proposals have generally taken the form of either capping the income tax exclusion or creating a tax credit both for persons with and without employment-based health coverage and those in the nongroup (individual) market.

A tax cap was proposed by the Reagan administration in S. 640, and tax credit bills have been introduced over the years by Democrats and Republicans, and in some cases, bills were co-sponsored by both. Cunningham (2002) describes what has become the "joint custody" of tax credits among Democrats and Republicans. Former Sen. Lloyd Bentsen (D-TX) was a principal architect of health insurance tax credits enacted during the first Bush administration in 1991. In 1999, then-House Majority Leader Dick Armey (R-TX) and ranking Ways and Means Democrat Pete Stark (D-CA) jointly endorsed tax credits on the opinion page of the *Washington Post,* but their proposal went nowhere (Armey and Stark, 1999). Also in 1999, Stuart Butler of the conservative Heritage Foundation and David Kendall of the (Democratic) Progressive Policy Institute made a joint proposal, as did Reps. Jim McCrery (R-LA) and Jim McDermott (D-WA) in 2000 (Butler and Kendall, 1999, and Miller, 2002).

The second President Bush twice proposed tax credits as an alternative to the current tax treatment of health benefits, but during the 2007 State of the Union address he proposed a "standard deduction for health insurance" which would act more like a tax cap than a tax credit. During the 2008 presidential election, Sen. John McCain proposed a tax credit for health insurance. Sen. Max Baucus (D-MT) released his vision for health reform in Nov. 2008, and in the last section of the paper states that "Congress should explore ways to restructure the current tax incentives to encourage more efficient spending on health and to target our tax dollars more effectively and fairly."[1] Baucus ruled out conversion of the current tax treatment of employment-based health benefits to a tax deduction or tax credit as an approach that would go too far, as it would "disrupt" employment-based benefits, but he does suggest more targeted reforms, such as a tax cap.

The recently passed Senate bill, the Patient Protection and Affordable Care Act (H.R. 3590), would impose an excise tax on high-cost health coverage. Coverage with an aggregate value above $8,500 for individual coverage and $23,000 for family coverage would be subject to the excise tax. The CBO estimates that the excise tax will generate $149 billion during 2010–2019.[2] As of this writing, the White House and congressional leaders appear to have reached an agreement to increase these thresholds to $8,900 for individual coverage and $24,000 for family coverage, and to have changed other aspects of what was passed by the Senate. More detail on the excise tax is below.

From both a budgetary and political perspective, the tax preference associated with employment-based health benefits is an almost inescapable target. Tax expenditure estimates—

government revenue foregone due to its tax treatment—are large and vary depending upon the source. During FY 2009, the U.S. Joint Tax Committee (2008) estimates that $147 billion was not collected in tax revenue due to the tax treatment of health benefits and health care. It also predicts that $799 billion would not be collected over 2008–2012. In contrast, the Office of Management and Budget estimates that health benefits will account for $174 billion in foregone tax revenue during FY 2009 and $835 billion over 2008–2012. According to the Congressional Budget Office (2008), income tax revenue would increase $108.1 billion during 2009–2013 if the tax exclusion were limited, and $205.7 billion if it were replaced with a refundable tax credit.

This testimony examines implications related to the excise tax in H.R. 3590. It first summarizes the current tax treatment of health coverage. It then presents detailed information on the excise tax provision in H.R. 3590. Implications are then presented.

Current Tax Treatment of Health Insurance

The tax treatment of health benefits has been formed in the tax code through a series of laws and rulings that date back to the 1920s. Historians often suggest that the tax-preferred status of employment-based health benefits led to the rise in its prevalence and comprehensiveness. Claims have been made that employment-based health benefits grew out of Internal Revenue Service (IRS) rulings during the 1940s rendering employer contributions for health insurance tax-exempt for workers and tax deductible for employers (Gabel, 1999), and that the tax-exempt status of health benefits has encouraged employers to offer coverage and to provide more comprehensive coverage than they otherwise would have (Shiels and Haught, 2004). However, it was not until the Revenue Act of 1954 that the Internal Revenue Code made it clear, after a number of conflicting IRS rulings prompted Congress to demand a blanket exception, that employer spending on employee health benefits was not counted as employee income (Hacker, 2002).

Currently, employers can deduct from taxable corporate income the cost of providing health benefits as a business expense. This means that whatever an employer spends on health insurance or health benefits on behalf of workers is considered a business expense—just as wages and salaries are a business expense. In other words, employers get the same deduction in calculating taxable corporate income when they chose to provide compensation in the form of health benefits as they do for wages and salaries, and they should therefore be indifferent from an income tax point of view between providing health benefits or cash wages.

Employers do, however, get a break on payroll taxes when compensation is provided in the form of health benefits *instead* of wages and salaries. They do not pay the 6.2 percent payroll tax for Social Security for workers whose incomes are below the Social Security wage base, which was set at $106,800 in 2009.[3] They also do not pay the 1.45 percent payroll tax for Medicare for all levels of wages. Employer savings related to the Social Security and Medicare payroll tax savings accounted for about $73 billion in 2006 (Selden and Gray, 2006).

With respect to workers (including the self-employed), the amount that employers contribute toward health benefits is generally excluded, without limit, from taxable income. In addition, workers whose employers sponsor flexible spending accounts (FSAs) are able to pay for out-of-pocket health care expenses with pretax dollars, meaning they are not taxed on the amount of money that is put into the FSA. Employers can also make available a premium conversion arrangement, which allows workers to pay their share of the premium for employment-based health benefits with pretax dollars.

Individuals are able to deduct from taxable income contributions made to a health savings account (HSA), if they have health insurance with an annual deductible of at least $1,200 for individual coverage or $2,400 for family coverage. In order to make tax-free contributions to an HSA, the health plan must also impose a $5,950 maximum out-of-pocket limit for individual coverage, and an $11,900 limit for family coverage. There are other restrictions as well. Regardless of who contributes to the account, annual contributions are tax free for the individual who owns the account, up to a limit of $3,050 for individual coverage and $6,150 for family coverage. Those ages 55 and older can make "catch-up" contributions to an HSA as well. In 2010, a $1,000 catch-up contribution was allowed. Unused balances in an HSA grow tax free, and distributions from an HSA are tax free when used for qualified medical expenses and certain premiums.

For individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income (AGI), and only the amount that exceeds 7.5 percent of AGI is deductible. This deduction is allowed only when an individual itemizes deductions on his or her tax return. This deduction is not widely used, because the standard deduction is larger than the sum of itemized health deductions for most taxpayers, and most do not have deductible medical expenses that exceed 7.5 percent of AGI. In 2001, about one-third of all individual income tax returns had itemized deductions, but only 17 percent of these claimed a medical expense deduction, accounting for about 6 percent of all tax returns (Lyke, 2005). There is one exception to the 7.5 percent AGI rule, however: Contributions to an HSA are fully deductible from taxable income and are not subject to the 7.5 percent AGI threshold.

Excise Tax Provisions in H.R. 3590

The Patient Protection and Affordable Care Act (H.R. 3590), passed in the Senate on Dec. 24, 2009, would impose an excise tax on high-cost health coverage. Coverage with an aggregate value above $8,500 for individual coverage and $23,000 for family coverage would be subject to the excise tax. The aggregate value of a plan would not only include the cost of medical coverage (premiums paid to insurers or the value of self-insured health benefits) but would also include premiums for ancillary benefits, such as dental, vision coverage, and other supplementary coverage, reimbursements from flexible spending accounts and health reimbursement arrangements, and employer contributions to health savings accounts. The difference between the aggregate value and the thresholds above would be taxed at 40 percent. The excise tax thresholds would be indexed to CPI-U plus 1 percentage point and would take effect on Jan. 1, 2013.

There would be a number of exemptions to the excise tax. The threshold amounts would be $1,350 higher for individual coverage and $3,000 higher for family coverage for retirees age 55 and older and not yet eligible for Medicare, for workers engaged in certain high-risk occupations, and for workers employed to repair or install electrical or telecommunications lines. Similarly, the threshold amount is initially 20 percent higher in the 17 states with the highest health care costs, but this provision would be phased out by 2015.

The House of Representatives Affordable Health Care for America Act (H.R. 3962), passed on Nov. 7, 2009, has no such provision to tax high-cost health plans. However, as part of a compromise in merging the House and Senate bills, the White House and congressional leaders are reported to have changed a number of aspects of the Senate-passed provision:

- The threshold for triggering the excise tax would be increased to $8,900 for individual coverage and $24,000 for family coverage.
- Separate costs for dental and vision coverage would not be included in the aggregate value of coverage starting in 2015.
- Coverage for state and local government employees and collectively bargained plans would be exempt from the excise tax until 2018.
- Gender and age adjustments would be adopted.

The tax would be imposed on insurers, rather than on the employers offering coverage. In the case of a self-insured plan, the tax would be paid by the plan administrator. When the employer self-administers the plan, the tax would be paid by the employer.

The tax would be allocated pro rata among the insurers and plan administrators. Employers would be responsible for calculating the amount subject to the tax allocable to each insurer and plan administrator and for reporting these amounts to each insurer and plan administrator. Each insurer and plan administrator would then be responsible for calculating, reporting and paying the tax to the IRS.

Using the thresholds from the reported agreed-upon White House/congressional leadership compromise, for an employee electing family coverage under a fully insured plan with a value of $25,000, the amount subject to the excise tax would be $1,000 ($25,000 less the threshold of $24,000). The employer would report $1,000 as taxable to the insurer, which would calculate and remit the tax to the IRS. The tax would amount to $400.

In the case where there are reimbursements from an FSA of $2,000 in addition to the medical example above, the aggregate value of the plan would be $27,000. The amount subject to the excise tax would be $3,000 ($27,000 less the threshold of $24,000). The employer would report $2,778 ($3,000 x $25,000/$27,000) as taxable to the medical insurer, for a tax of $1,111, which would then remit the excise tax to the IRS. If the employer uses a third-party administrator for the FSA, it would report $222 ($3,000 x $2,000/$27,000) as taxable to the FSA administrator, for a tax of $89. If, instead, the employer self-administrates the FSA, the employer would remit the $89 to the IRS.

It is important to point out that adding the FSA to the medical plan would increase the tax to the insurer even in the absence of a change in premiums paid to the insurer. In some cases, adding the FSA to the medical plan would trigger a tax on the insurer that the insurer would have otherwise not incurred in the absence of an FSA.

Why Cap the Health Exclusion?

The theory behind capping the health exclusion rests on the assumption that, because of the tax-preferred status of employment-based health benefits, workers prefer health benefits over cash wages—and because of this preference for health benefits, they are "over-insured" and therefore use more health care services than they otherwise would. The theory holds that workers over-insure because health insurance premiums are not included in taxable income, but out-of-pocket spending on health care services is usually not deductible from taxable income. As a result, workers prefer comprehensive insurance with low cost-sharing. Ultimately, it is argued that low cost-sharing, or the ability to pay out-of-pocket spending with pre-tax dollars, leads to overuse of health care services, which drives up insurance premiums and makes insurance less affordable, especially for lower-income workers. Taxing the benefit is expected to reduce the cost of coverage by reducing the comprehensiveness of high-cost coverage, which is

expected to reduce the use of health care services. Savings from lower premiums are then expected to increase worker wages, thereby increasing taxable income and generating part of the $149 billion to pay for health reform. The other part of the $149 billion would come from the excise tax on coverage that does not change to avoid the tax.

Implications of the Excise Tax

Moving Away From Comprehensive Benefits

The use of health care is different than the consumption of other goods and services. Most people are healthy and do not use a lot of health care. It is well established that roughly 20 percent of the population uses roughly 80 percent of the health care services provided in any given year. The bulk of the money goes toward treating people with chronic conditions, such as heart disease, cancer, lung disorders, mental health, hypertension, and diabetes. With the obesity rate in the U.S. at one-third (it was 15 percent in the mid-1990s), the incidence of these diseases will only increase. The unanswered question is whether a tax on high-cost plans that reduces the comprehensiveness of plan design will reduce spending on health care services among the chronically ill. For example, take the case of diabetes: The average annual cost per case reached nearly $10,000 for diagnosed diabetes in 2007 (Dall, et al., 2010). Such an average individual would incur various amounts of out-of-pocket expenses depending on the level of deductible and coinsurance. For example, an individual with a deductible of $500 and coinsurance of 10 percent would pay $1,450 out of pocket on $10,000 worth of health care, whereas an individual with a $2,000 deductible and 20 percent coinsurance would pay $3,600 out of pocket (Figure 1).

Figure 1

Out-of-Pocket Spending by Cost Sharing and Total Use of Health Care Services

$10,000 in Health Care Use		
	Coinsurance	
Deductible	10%	20%
$500	$1,450	$2,400
1,000	1,900	2,800
2,000	2,800	3,600
$8,000 in Health Care Use		
	Coinsurance	
Deductible	10%	20%
$500	$1,250	$2,000
1,000	1,700	2,400
2,000	2,600	3,200

Source: Employee Benefit Research Institute.

A valid question to ask is whether moving to higher deductibles and coinsurance will get a person to reduce their use of health care services. The appropriate comparison is not the out-of-pocket expense difference between the lower and higher *cost sharing* amounts. Instead, the appropriate comparison is out-of-pocket spending differences between the lower and higher *health care use* amounts. As an example, if coinsurance was 10 percent, reducing the use of health care services from $10,000 to $8,000 (a 20 percent decline in total use of services) would save an individual $200, regardless of the level of deductible. Similarly, if coinsurance was 20 percent, reducing the use of health care services from $10,000 to $8,000 would save an individual $400. Hence, if an individual with diabetes using average health care services of

$10,000 were to cut back on use by 20 percent (a potentially large reduction in use for a person with a chronic condition), out-of-pocket expenses will fall by $200 at 10 percent coinsurance, and $400 at 20 percent coinsurance. An important question to ask is whether the $200 or $400 is a large enough annual savings to reduce use of services by 20 percent for a person with a chronic condition such as diabetes. If a person with diabetes does not change his or her use of health care as a result of the excise tax, health care costs will not be affected, and the long-held hope of economists that taxing high-cost plans will reduce total health spending, and increase wages, could be proven wrong.

In a number of studies, researchers have noted the *negative* effects of increased cost sharing on patients' compliance with prescribed drugs. They have found that while increased cost sharing is effective in reducing drug costs, it can also result in higher spending for other medical services, such as emergency-room visits and non-elective hospitalizations as a result of decreased medication compliance (Hsu, et al., 2006). In other words, higher cost sharing can and does reduce health-care spending, but in some cases, it reduces beneficial health-care spending on prescribed medications and preventive services. A number of employers and health plans have recognized these suboptimal behavioral effects, and have begun to explore ways to counteract them, either by excluding the cost of preventive services from plan deductibles, by adjusting copayment amounts by the value of the services, as opposed to just the costs, or by rewarding good health behaviors (Chernew et al., 2007).

Incidence of the Excise Tax

The incidence regarding who pays the tax is an important issue. Insurers and plan administrators (in the case of self-insured arrangements) would be responsible for remitting the tax to the IRS. However, there is every reason to believe that insurers will try to recoup the tax and they have a number of ways to do so.

Insurers could simply bill employers for the tax, much like consumers pay a sales tax on the consumption of most goods and services. In this case, the tax would not be combined with the premium but billed separately. There is precedence for passing along a tax in this way, such as the 9-11 security tax imposed on airlines. Consumers are getting used to seeing such taxes broken out from the cost of purchasing the product. However, the key difference between the proposed excise tax and taxes seen by consumers is that the excise tax would be collected from employers *after* they have already paid the premium.

Once the tax is billed back to the employer, the employer would have to decide if and how to pass the tax along to workers. The employer could reduce the comprehensiveness of the plan in order to lower premiums to avoid the excise tax. The employer could reduce wages or slow wage growth. The employer could cut other benefits, delay hiring a potential worker, or even lay off a worker to pay the tax. How employers deal with the tax is a very personal decision, given the circumstances of the labor force, and will vary from employer to employer. With 10 percent unemployment currently, the expectation is that workers will ultimately bear the burden of the tax through lower wages.

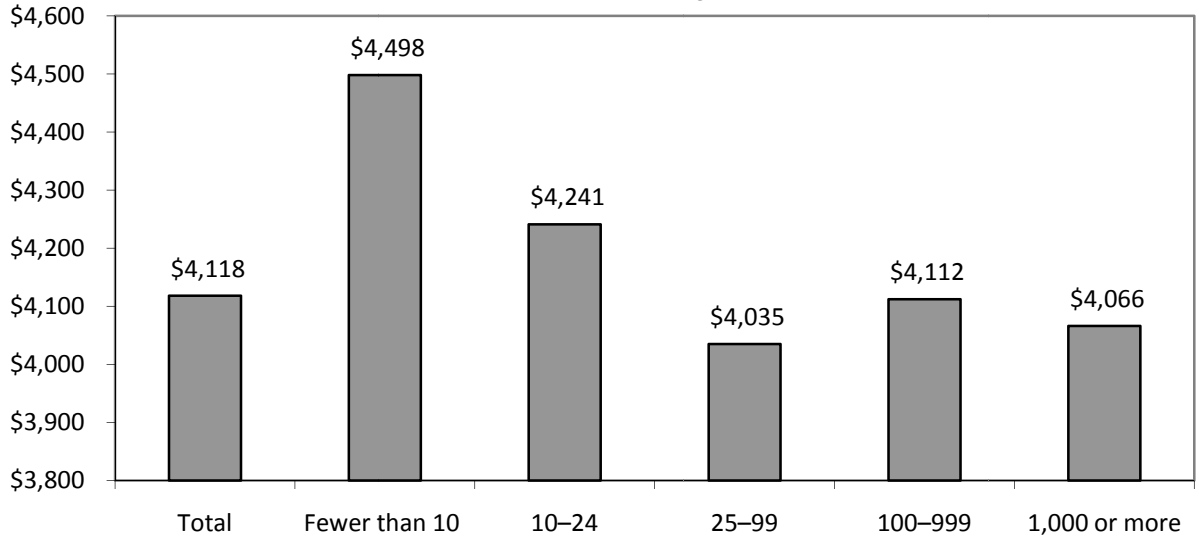
Employers could also decide to drop benefits to avoid the tax. This would enable their employees to qualify for coverage through the insurance exchange.

Fairness of the Excise Tax

The excise tax has been associated (or confused) with a tax on so-called "Cadillac" plans, meaning health plans that provide unusually comprehensive coverage. The excise tax would apply to health plans with an aggregate value above the set thresholds regardless of the determinants of the aggregate value. There are a number of reasons— completely independent of the comprehensiveness of the coverage—why health insurance premiums in a fully insured plan or the value of health coverage in a self-insured plan would be above the tax cap. The cost of health coverage is known to vary with firm size, employee health status, average age of the group of employees, and geographic region. To the degree that individuals face higher taxes as a result of these factors violates the principle of "horizontal" equity (Congressional Budget Office, 1994). [4]

Firm size—The cost of providing health coverage varies by firm size. Small employers pay more than large employers for identical health coverage. Small employers tend to provide less comprehensive coverage than large employers and even when they do they pay more on average than large employers. On average in 2006, employers with fewer than 10 employees paid $4,498 for employee-only coverage, whereas employers with 1,000 or more employees paid $4,066 (Figure 2). Smaller employers face higher costs for coverage than larger employers because they do not have the same purchasing power as larger employers, and smaller employers do not realize the same economies of scale in the purchasing of health coverage. As a result, workers employed at small firms would be more likely to pay an excise tax on health coverage than workers at larger firms, even when the actual health insurance coverage is the same. The difference in cost of coverage may be solely due to firm size and may have nothing to do with the comprehensiveness of the coverage.

Figure 2
Average Total Employee-Only Premium at Private-Sector Establishments, by Firm Size, 2006



Source: www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2006/tic1.htm

Group Composition—Premiums may be over the excise tax threshold not because of the comprehensiveness of insurance but instead because of the composition of the group an individual belongs to. Insurers can and often do charge higher premiums for the same benefits package to groups with higher-than-expected expenses than to groups with lower-than-expected expenses. This could translate into one firm paying higher taxes because their premium is above the excise tax threshold simply because the workers employed in that firm were less healthy or older than the average group. Hence, two employers in the same industry, in the same city, offering the same health coverage could pay different taxes on the benefits (with one subject to the excise tax and the other not seeing any change in taxes) simply because of the health status of the workers at the firm.

A recent study examined the determinants of variation in premiums (Gabel, et al., 2010). The study found that only about 4 percent of the variation in premiums could be attributed to differences in benefit design. Also affecting variation in premiums were industry and underlying medical costs in the region. The study was unable to account for variation in the health status of workers, which would explain far more of the variation in premiums.

Mr. Chairman and members of the caucus, I commend you for exploring these topics, and thank you for the opportunity to appear before you today.

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U.S. Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2008–2012*, 2008, www.house.gov/jct/s-2-08.pdf.

Endnotes

[1] See http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf.

[2] http://cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf

[3] Employers do not get a tax break on Social Security taxes for workers whose incomes are above the wage base, since the portion of their income that is above the wage base is not subject to the Social Security tax.

[4] The principle of horizontal equity is violated when income tax changes do not treat people of similar positions equally. See Congressional Budget Office (1994) for a more detailed treatment of how capping the tax exclusion of health benefits improves horizontal equity when measured in terms of income.