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The Future of the Cadillac Tax

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CHAPTER 8

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Synopsis

§ 8.01 INTRODUCTION

The Affordable Care Act[1] includes a 40 percent excise tax on high-cost employer-sponsored health care coverage.[2] Often referred to as the "Cadillac tax,"[3] this excise tax is one of the most controversial elements of the Affordable Care Act.

Currently scheduled to go into effect in 2020,[4] the Cadillac tax poses serious challenges and uncertainty for employers. On the one hand, recent estimates suggest that the Cadillac tax may hit as many as 20 percent of employers with health care plans in 2020.[5] On the other hand, there is a serious question as to whether the tax will be repealed before its effective date; it is politically unpopular and faces bipartisan opposition.[6]

This Article assesses the Cadillac tax and its future. It begins by describing the Cadillac tax.[7] It then discusses the justifications for the Cadillac tax and its likely impact on employer-sponsored health care plans.[8] It then considers the criticisms of the tax and proposed alternatives.[9] Finally, it concludes with a discussion of the likely future Cadillac tax.[10]

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[1] Patient Protection and Affordable Care Act, Pub L 111-148, 124 Stat 119 (2010), *as amended by* Health Care and Education Reconciliation Act of 2010, Pub L 111-152, 124 Stat 1029.

[2] IRC § 4980I.

[3] For a discussion of the reason why it is referred to as the Cadillac tax, see § 8.05[1], *infra*.

[4] *See* Consolidated Appropriations Act, 2016, Pub L 114-113, Div P § 101(a), 129 Stat 2242, 3037 (2015).

[5] *See* § 8.04[1], *infra*.

[6] *See* § 8.07, *infra*.

[7] *See* § 8.02, *infra*.

[8] *See* §§ 8.03 & 8.04, *infra*.

[9] *See* §§ 8.05 & 8.06, *infra*.

[10] *See* § 8.07, *infra*.

§ 8.02 OVERVIEW OF THE CADILLAC TAX

[1] In General

Currently scheduled to go into effect in 2020,[11] the so-called Cadillac tax imposes a 40 percent excise tax on any "excess benefit" provided to an employee.[12] An excess benefit is defined as the excess, if any, of the aggregate cost of the applicable coverage of the employee over the applicable dollar limit for the employee.[13] For purposes of the Cadillac tax, the term employee includes "a former employee, surviving spouse, or other primary insured individual."[14]

Generally, a health care plan qualifies as "applicable employer-sponsored coverage" if the value of coverage is excludable from the employee's income under section 106 of the Internal Revenue Code.[15] The cost of coverage is generally to be determined under rules that are similar to the rules that apply for purposes of COBRA continuation coverage.[16]

There are generally two different applicable dollar amounts for purposes of determining the Cadillac tax: (a) a limit for self-only coverage, and (b) a limit for other than self-only coverage.[17] Several adjustments to these dollar amounts are permitted.[18]

The excise tax is imposed on the "coverage provider."[19] Who is the coverage provider depends on the type of applicable coverage.[20] For example, the excise tax is imposed on the "health insurance issuer" if the applicable coverage is provided under an insured plan,[21] and the excise tax is imposed on the employer if the applicable coverage consists of contributions to an HSA.[22]

[2] Definition of Applicable Coverage

Generally, "applicable coverage" is defined as employer-sponsored health care

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[11] *See* Consolidated Appropriations Act, 2016, Pub L 114-113, Div P §§ 101(a), 129 Stat 2242, 3037 (2015) (extending effective date).

[12] IRC § 4980I.

[13] IRC § 4980I(b).

[14] IRC § 4980I(d)(3).

[15] IRC § 4980I(d)(1)(A).

[16] IRC § 4980I(d)(2)(A).

[17] IRC § 4980I(b)(3)(C)(i).

[18] IRC § 4980I(b)(3)(C)(ii)–(v).

[19] IRC § 4980I(c)(1).

[20] IRC § 4980I(c)(2).

[21] IRC § 4980I(c)(2)(A).

[22] IRC § 4980I(c)(2)(B).

coverage if the value of coverage is excludable from the employee's income under section 106 of the Internal Revenue Code.[23] Because the term group health plan is defined by reference to IRC § 5000(b), applicable coverage includes not only coverage under a traditional insured plan but also coverage under a self-insured plan.[24] In addition, applicable coverage includes contributions to fund health flexible spending accounts (FSAs),[25] health savings accounts (HSAs),[26] and health reimbursement accounts (HRAs).[27] Applicable coverage also includes an employee's contributions to fund health insurance premiums[28] as well as a self-employed individual's health insurance coverage if a deduction for the cost of coverage is allowed.[29]

A few types of coverage are explicitly excluded from the definition of applicable coverage.[30] For example, applicable coverage does not include long-term care coverage[31] and stand-alone dental and vision coverage.[32]

[3] Determining Cost of Applicable Coverage

The cost of applicable coverage is generally to be determined under rules that are similar to the rules that apply for purposes of determining the applicable premium for COBRA continuation coverage.[33] Under COBRA, the "applicable premium" is typically

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[23] IRC § 4980I(d)(1)(A).

[24] *See* IRC § 4980((f)(4) (defining group health plan by reference to IRC § 5000(b)(1) which defines group health plan to include a self-insured plan).

[25] IRC § 4980I(d)(2)(B).

[26] IRC § 4980I(d)(2)(B).

[27] IRS Notice 2015-16, at 7 (stating that future guidance is expected to provide that HRAs qualify as applicable coverage).

[28] IRC § 4980I(d)(1)(C).

[29] IRC § 4980I(d)(1)(D). For a complete list of the types of coverage included as applicable coverage, see IRS Notice 2015-16, at 6–7; Annie L. Mach, *Excise Tax on High-Cost Employer-Sponsored Health Coverage: In Brief*, Congressional Research Service Report R44147, at 3 Table 1 (March 24, 2016).

[30] IRC § 4980I(d)(1)(B).

[31] IRC § 4980I(d)(1)(B)(i).

[32] IRC § 4980I(d)(1)(B)(ii). For a complete list of the types of coverage that are specifically excluded, see IRS Notice 2015-16, at 7–10; Mach, *supra* note 29, at 3–4 Table 2.

[33] IRC § 4980I(d)(2)(A).

COBRA requires an employer that sponsors a group health plan to give the plan's "qualified beneficiaries" the opportunity to elect "continuation coverage" under the plan when the beneficiaries might otherwise lose coverage upon the occurrence of certain "qualifying events." ERISA § 601. A plan sponsor may charge the beneficiary up to 102 percent of the applicable premium for the first 18 months of continuation coverage and up to 150 percent thereafter. ERISA § 602(3). For an overview of COBRA, see Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 Nebraska L. Rev. 885, 899–900 (2011); Lawrence A. Frolik and Kathryn L. Moore, Law of Employee Pension and Welfare Benefits 98–99 (3d ed. 2012).

the cost to the plan of providing continuation coverage regardless of who usually pays for the insurance benefit.[34]

[a] Similarly Situated Individuals

IRC § 4980B(f)(4) provides that the COBRA applicable premium is generally based on the average cost of providing coverage for those covered under the plan who are similarly situated rather than the cost of providing coverage based on the characteristics of each individual. The COBRA regulations treat as similarly situated covered employees, spouses of covered employee, or dependent children of covered employees receiving coverage under the plan who are receiving that coverage for a reason other than COBRA and who are most similarly situated to the situation of the qualified beneficiary immediately before the qualifying event.[35]

According to Notice 2015-16, Treasury and the IRS anticipate applying a similar standard to the Cadillac tax. Under the anticipated approach, employees would be determined by beginning with all employees covered by an employer's particular benefit package, then using mandatory disaggregation rules to subdivide the group, and then permitting further subdivision under permissive disaggregation rules.[36]

The proposed approach would begin by aggregating all employees covered by an employer's particular benefit package. Benefit packages would be distinguished based upon differences in health plan coverage, and employees would be grouped by the benefit packages in which they are enrolled rather than by the benefit packages in which they are offered. For example, if employees were offered an HMO option and a PPO option, employees electing the HMO option would be grouped separately from employees electing the PPO option.[37]

Mandatory disaggregation rules would then disaggregate employees based on whether the employee is enrolled in self-only or other than self-only coverage. With respect to employees enrolled in other than self-only coverage, Treasury and the IRS are considering an approach under which employers would not be required to determine the cost of other than self-only coverage based on the number of individuals covered. Instead, employers could treat all employees with other than self-only coverage similarly situated regardless of the number of individuals covered.[38]

Treasury and the IRS are considering providing for permissive disaggregation rules

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[34] ERISA § 604. For a discussion of the issues and potential guidance with respect to HRAs, see Notice 2015-16, at 18–20.

[35] Treas Reg § 54.4980B-3, Q&A-3.

[36] Notice 2015-16, at 13.

[37] *Id.*

[38] *Id.* at 13–14.

that would permit, but not require, employers to further subdivide groups of employees based on (1) a broad standard (such as limiting permissive disaggregation to bona fide employment-related criteria, such as nature of compensation, while prohibiting criteria related to health), or (2) a more specific standard. More specific standards could include disaggregation based on status as current versus former employee and/or bona fide geographic distinctions.[39]

[b] Self-Insured Methods

IRC § 4980B(f)(4)(B) establishes two methods for self-insured plans to determine the applicable COBRA premium: (1) the actuarial basis method, and (2) the past cost method. A plan must use the actuarial basis method unless the plan administrator elects to use the past cost method and the plan is eligible to use the past cost method.

Treasury and the IRS are concerned about the potential of abuse if a plan frequently switches between the two different methods. Accordingly, Treasury and the IRS are considering adopting rules for purposes of both COBRA and the Cadillac tax that would generally require a plan to use the same valuation method for at least five years.[40]

With respect to the actuarial basis method, Treasury and the IRS are considering whether to adopt a broad standard under which the cost of applicable coverage for a group of similarly situated individuals for purposes of the Cadillac tax would be equal to a reasonable estimate of the cost of providing coverage under the plan for individuals in that group using reasonable actuarial principles and practices. Under this standard, a cost estimate would be based on the actual cost the plan is expected to incur rather than the minimum or maximum exposure the plan could have for that period.[41]

With respect to the past cost method, IRC § 4980B(f)(4)(B)(ii) directs a plan electing to use the past cost method to determine the COBRA applicable premium based on the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding 12-month determination period with adjustments under IRC § 4980B(f)(4)(B)(ii)(II). For purposes of both COBRA and the Cadillac tax, Treasury and the IRS are considering issuing guidance that would permit plans to use as the 12-month determination period any 12-month period ending not more than 13 months before the beginning of the current determination period.[42] The measurement

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[39] *Id.* at 14.

[40] *Id.* at 16.

[41] *Id.*

[42] *Id.* at 17. For example, a plan could use the determination period ending one year before the current determination period or it could use a measurement period beginning 18 months before and ending six months before the beginning of the current determination period. *Id.*

period would have to be applied consistently in the absence of bona fide business reasons for changing the period.[43]

Treasury and the IRS anticipate proposing regulations that would describe the costs that must be taken into account in computing costs under the past cost method. Those costs could include (1) claims, (2) premiums for stop-loss or reinsurance policies, (3) administrative expenses, and (4) reasonable overhead expenses. The costs could include either claims incurred during the measurement period, regardless of whether paid or unpaid, or claims submitted during the measurement period, regardless of when incurred.[44]

[4] Applicable Dollar Limits

The excise tax is assessed on the aggregate cost of "applicable employer-sponsored coverage" to the extent that it exceeds an applicable dollar limit.

There are two different basic dollar limits—one for employees with self-only coverage and one for employees with coverage other than for self-only.[45] Three additional adjustments to the limits are permitted: (1) an age and gender adjustment; (2) an adjustment for qualified retirees; and (3) an adjustment for high risk professions.[46]

[a] Basic Dollar Limits

The per-employee basic threshold dollar limits for 2018 (when the excise tax was originally scheduled to go into effect) were set to be $10,200 per employee for self-only coverage and $27,500 per employee for employees with other than self-only coverage,[47] as adjusted by a health cost adjustment percentage.[48] For taxable years after 2018, the baseline limits are adjusted for increases in the cost of living.[49]

The Congressional Research Service estimates that, due to increases in the cost of

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[43] *Id.*

[44] *Id.*

[45] IRC § 4980I(b)(3)(C).

[46] IRC § 4980I(b)(3)(C)(iii)–(iv).

[47] IRC § 4980I(b)(3)(C).

[48] IRC § 4980I(b)(3)(C)(ii). The health cost adjustment percentage is a one-time upward adjustment that increases the dollar limits to the extent that the 2018 per-employee cost under the Blue Cross/Blue Shield standard option under the Federal Employees Health Benefits Plan exceeds the 2010 cost by more than 55 percent. *Id.* At this point it appears unlikely that there will be an adjustment under this provision. *See* Mach, *supra* note 29, at 5 n.20 (noting that premium growth between 2010 and 2015 was about 20 percent for both single and family coverage options and that premium growth for 2016 through 2018 would have to be significantly higher than in recent years for growth over the entire period to exceed 55 percent).

[49] IRC § 4980(b)(3)(C)(v). Specifically, they are adjusted by the Consumer Price Index for all Urban Consumers (CPI-U) plus 1 percent. Mach, *supra* note 29, at 5.

living, the limits in 2020 will be about $10,800 for self-only coverage and $29,100 for coverage other than self-only.[50]

[b] Age and Gender Adjustment

Although the Affordable Care imposes restrictions on rating based on age and gender in the individual and small group market,[51] the actual cost of health care coverage generally differs based on age and gender.[52] On average, younger individuals have lower health care costs than older individuals, and younger men have lower health care costs than younger women. Thus, an upward adjustment in the dollar limits is permitted if the age and gender characteristics of all employees of an employer are significantly different from the age and gender characteristics of the national workforce.[53] Specifically, the dollar limit will be increased by the amount by which the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan if priced for the age and gender characteristics of all employees of an individual's employer (employer premium cost) exceeds the premium cost for providing this coverage if priced for the age and gender characteristics of the national workforce (national premium cost).[54]

[c] Qualified Retiree Adjustment

A second adjustment is permitted for qualified retirees. Specifically, an additional amount is added to the dollar limits for an individual who is a "qualified retiree."[55] A "qualified retiree" is defined as any individual who (A) is receiving coverage by reason of being a retiree, (B) has attained age 55, and (C) is not entitled to benefits or eligible to enroll in Medicare.[56] Under this adjustment, the dollar limit for self-only coverage is increased by $1,650, and the dollar limit for coverage other than self-only is increased by $3,450.[57]

[d] High-Risk Profession Adjustment

Finally, a third adjustment is provided for high risk professions. Specifically, an additional amount is added to the threshold dollar limits for an individual "who

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[50] Mach, *supra* note 29, at 5.

[51] *See* 42 USC § 300gg(a).

[52] Notice 2015-52, at 13.

[53] IRC § 4980I(b)(3)(C)(iii).

[54] IRC § 4980I(b)(3)(C)(iii)(II). In Notice 2015-52, Treasury and the IRS proposed methods they are considering to establish the age and gender distribution of the national workforce and that of a particular employer. Notice 2015-52, at 13–15.

[55] IRC § 4980I(b)(3)(C)(iv).

[56] IRC § 4980I(f)(2).

[57] IRC § 4980I(b)(3)(C)(iv).

participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install "electrical or telecommunication lines."[58] High-risk professions are defined as (1) law enforcement officers, (2) employees in fire protection activities, (3) individuals who provide out-of-hospital emergency medical care, (4) individuals whose primary work is longshore work, and (5) individuals engaged in the construction, mining, agriculture, forestry, and fishing industries.[59] It also includes certain retirees from high-risk professions. Like the adjustment for qualified retirees, under the adjustment for high risk professions, the dollar limit for self-only coverage is increased by $1,650, and the dollar limit for coverage other than self-only is increased by $3,450.[60]

[5] Coverage Provider

The excise tax is imposed on the entity providing the applicable coverage, that is, the "coverage provider."[61] Who is the coverage provider depends on the type of applicable coverage.[62]

For applicable coverage provided under an insured group plan, the coverage provider is the health insurance issuer.[63] For coverage under an HSA or Archer MSA, the coverage provider is the employer.[64] For all other applicable coverage, the coverage provider is the person that administers the plan benefits.[65]

The statute does not define the term "person that administers the plan benefits." It does, however, provide that the "person that administers the plan benefits" includes the plan sponsor if the plan sponsor administers benefits under the plan.[66] According to Treasury and the IRS, this provision indicates that in some, but not all, instances, the plan sponsor of a self-funded plan may be the person that administers the benefits.[67]

Because the term "person that administers the plan benefits" is not defined, Treasury and the IRS announced that they are considering two alternative approaches to determining the identity of the person that administers the plan benefits. Under the first approach, the person that administers the plan benefits would be the person that is

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[58] IRC § 4980I(b)(3)(C)(iv).

[59] IRC § 4980I(f)(2).

[60] IRC § 4980I(b)(3)(C)(iv).

[61] IRC § 4980I(c)(1).

[62] IRC § 4980I(c)(2).

[63] IRC § 4980I(c)(2)(A).

[64] IRC § 4980I(c)(2)(B).

[65] IRC § 4980I(c)(2)(C).

[66] IRC § 4980I(f)(6).

[67] Notice 2015-52, at 3–4.

responsible for the day-to-day administration of the plan, such as receiving and processing benefit claims. They anticipate that in most instances, this person would be a third party plan administrator. Under the second approach, the person that administers the plan would be the person that has the ultimate authority or responsibility with respect to plan administration, regardless of whether that person routinely exercises authority or responsibility. They anticipate that this person would be identifiable based on the terms of the plan documents and would often not be the person that performs the day-to-day administrative functions under the plan.[68]

An employee's applicable coverage may be provided by more than one coverage provider. For example, an employee may have coverage through a traditional insured plan as well as an FSA. If there are multiple coverage providers, each coverage provider is responsible for paying its applicable share of the excise tax.[69] A coverage provider's applicable share is based on the cost of the coverage provider's applicable coverage in relation to the aggregate cost of all of the employee's applicable coverage.[70]

Generally, the employer is responsible for calculating the aggregate amount of applicable coverage that exceeds the applicable threshold and determining each coverage provider's applicable share of the excise tax.[71] The employer must notify the Secretary of Treasury and each coverage provider of the amount of the excise tax.[72]

[6] Deductibility

Initially, the excise tax was not deductible.[73] The law, however, was amended in 2015 to make the excise tax deductible.[74] Making the tax deductible softens its impact. It effectively changes the tax rate from 40 percent to 26 percent for businesses subject to the corporate income tax.[75] The rate remains 40 percent for tax-exempt entities subject to the Cadillac tax.

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[68] *Id.* at 4–5.

[69] IRC § 4980I(c)(1).

[70] IRC § 4980I(c)(3).

[71] IRC § 4980I(c)(4)(A)(i). In the case of a multiemployer plan, the plan sponsor must make the calculation. IRC § 4980(c)(4)(B).

[72] IRC § 4980I(c)(4)(A)(ii).

[73] *See* Patient Protection and Affordable Care Act, Pub L 111-148 § 9001(a), 124 Stat 119, 853 (2010) (adding IRC § 4980I(f)(10) which provided "[f]or denial of a deduction for the tax imposed by this section, see section 275(a)(6)").

[74] *See* Consolidated Appropriations Act, 2016, Pub L 114-113, Div P § 102, 129 Stat 2242, 3037 (2015) (amending IRC § 4980I(f)(1) to provide that IRC "[§] 275(a) shall not apply to the tax imposed by section (a)").

[75] The corporate tax is currently generally imposed at the rate of 35 percent. *See* IRC § 11(b)(1)(D). Thus, the effective rate of the Cadillac tax is the Cadillac tax rate (40%) decreased by amount of income

[7] Example

To illustrate the operation of the Cadillac tax, assume that the limits, adjusted for increases in the cost of living as projected by the Congressional Research Service, are $10,800 for self-only coverage and $29,100 for other than self-only coverage. Assume that Employer offers (1) three insured health plans with annual premiums ranging from $8,000 to $13,000 for self-only coverage, (2) a health flexible spending account to which employees may contribute up to $2,500, and (3) a stand-alone dental plan with annual premiums of $1,000 for self-only coverage.

If Employee A, a single employee, selects self-only coverage from the highest cost health plan, contributes $2,500 to a health flexible spending account, and dental coverage under the stand-alone dental plan, the cost of her coverage will be $15,500 for purposes of the Cadillac tax. The entire $13,000 premium on the health plan will be included, regardless of whether the employer, the employee, or both paid for the premiums as will the entire $2,500 contribution to the health flexible spending account ($13,000 + $2,500 = $15,500). The $1,000 premium for the stand-alone dental plan will be disregarded.

Because the $15,500 total cost of coverage exceeds the $10,800 threshold by $4,700 ($15,500 – $10,800 = $4,700), A's health care coverage will be subject to an excise tax of $1,800 ($4,700 × 40% = $1,880.) The excise is imposed on the coverage provider, which is the health insurance issuer in the case of the insured health plan, and the person that administers the plan in the case of the health flexible spending account. The health insurance issuer's share is $1,577 ($1,800 × $13,000/$15,500) while the FSA administrator's share is $303 ($1,800 × $2,500/$15,500).

§ 8.03 JUSTIFICATIONS FOR THE CADILLAC TAX

Two principle justifications are offered for the Cadillac tax.[76] First, it is designed to

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tax not paid as a result of deducting the Cadillac tax (35% x 40%) or 26%. Put another way, the following formula applies: .40x – x(.35 x .40) = .26x.

To illustrate, suppose that an employee receives an excess benefit of $100. A Cadillac tax of $40 ($100 x .40) will be imposed on the excess benefit. The coverage provider's income tax, however, will be reduced by $40 x .35 or $14 because the coverage provider can deduct the Cadillac tax and thus will not have to pay income tax on the $40 Cadillac tax. Accordingly, the effective tax on the excess benefit is $40–$14 or $26 (which is equivalent to 26% of the $100 excess benefit).

[76] *See, e.g.,* Stephen Blakely, *The Excise Tax on High-Cost Health Plans*, 37 Employee Benefit Research Institute Notes 1, 2 (No. 2 March 2016); Sean Lowry, *The Excise Tax on High-Cost Employer-Sponsored Health Coverage: Background and Economic Analysis*, Congressional Research Service Report R44160 1, 1 (Aug. 20, 2015). An infamous youtube video of MIT economics professor Jonathan Gruber, who provided advice in the crafting of the Affordable Care Act, provides insights into the structure and purposes of the Cadillac tax. *See https://www.youtube.com/watch?v=ytys-hbsFrA*.

raise revenues. Second, it is intended to reduce health care spending by taxing a portion of the cost of comprehensive benefits.[77]

[1] Raising Revenues

When the Affordable Care Act was signed into law, its coverage provisions were estimated to cost more than $900 billion from 2010 to 2019.[78] Those costs were to be financed by a number of fees and taxes imposed on both individuals and business, including the Cadillac tax.[79]

How much the Cadillac tax is likely to raise in revenues is subject to considerable uncertainty and debate. At the time the Affordable Care was enacted, the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) estimated that the Cadillac tax would raise about $30 billion in revenue in its first two years of operation—2018 through 2019.[80]

Revenue estimates have been significantly reduced since then. In April 2014, the CBO and JCT estimated that the Cadillac tax would raise $5 billion in fiscal year 2018, then the first year it was scheduled to go into effect, and would raise $120 billion in revenue over the first seven years of its implementation.[81] By March 2015, the CBO and JCT further reduced their estimates of the revenue-raising potential of the Cadillac tax. Specifically, they estimated that the tax would raise $87 billion over its first eight years of implementation (then scheduled to be from 2018 to 2025).[82]

The reduction in revenue estimates is largely due to the fact that inflation and the rate of increases in health insurance premiums has slowed.[83] Thus, fewer employers

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[77] Sometimes a third justification, closely related to the second, is offered. Specifically, it is sometimes argued that the tax will reduce extravagant health care spending and thus promote fairness. For an illustration of the operation of the Cadillac tax, see Amy B. Monahan, *Why Tax High-Cost Employer Health Plans*, 65 Tax L Rev 749, 753 (2012); Julie Piotrowski, *Excise Tax on 'Cadillac' Plans. To slow growing costs and finance expanded coverage, the ACA imposes an excise tax on high-cost health plans to take effect in 2018,* Health Affairs Policy Brief 1, 3 (Sept. 12, 2013).

[78] *See* Piotrowski, *supra* note 77, at 2.

[79] *Id.*

[80] *Id.*

[81] Lowry, *supra* note 76, at 7.

[82] *Id.* at 7. The increased revenue is expected to come from both the excise tax and increases in taxable income that will arise as employers reduce the amount of health coverage they offer employees to avoid the excise tax, with most (75 percent) of the revenue arising from increases in taxable income. *See* CBO, *Updated Estimates of the Net Budgetary Effects of the Coverage Provisions of the Affordable Care Act* 13 (April 2014).

[83] Michelle Long *et al.*, *Recent Trends in Employer-Sponsored Health Insurance Premiums*, 315 J Am Med Assn 18 (No. 1 Jan. 5, 2016).

are expected to be subject to the tax.[84]

[2] Reducing Health Care Spending

Section 106(a) of the Internal Revenue Code generally excludes from an employee's income employer contributions to fund health care benefits.[85] In addition, if an employer establishes a cafeteria plan under IRC § 125,[86] the employee may also pay its required contributions for coverage with pre-tax income, that is, income that is not subject to income tax.

Although the employee is not taxed on the value of these contributions, the employer may generally deduct its share of contributions as an ordinary business expense.[87] In addition, both employer and employee contributions to fund health care benefits are exempt from Social Security taxes[88] and federal unemployment taxes.[89]

The Joint Committee on Taxation has identified the income tax exclusion for employer contributions for health care, health insurance premiums, and long-term care insurance premiums[90] as the largest tax expenditure[91] for the fiscal year 2014, with an estimated loss of $143 billion in tax revenue in 2014 alone.[92]

This tax preference has been subject to a great deal of criticism. Critics contend that it is inequitable because (1) individuals who do not have employment-based health insurance do not benefit from the tax exclusion,[93] and (2) the tax exclusion is more

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[84] Piotrowski, *supra* note 77, at 4.

[85] For a history of the favorable tax treatment accorded health insurance, see Moore, *supra* note 33, at 889-91; Lowry, *supra* note 76, at 4.

[86] Cafeteria plans permit employers to offer employees the choice between cash and a variety of nontaxable benefits without requiring employees to be subject to tax on the nontaxable benefits under the constructive receipt doctrine. For an overview of cafeteria plans, see Kathryn L. Moore, Understanding Employee Benefits Law 123–28 (2015).

[87] IRC § 162; Treas Reg § 1.162.10(a).

[88] IRC §§ 3121(a)(2).

[89] IRC § 3306(b)(2).

[90] The exclusion for employer-provided coverage under accident and health plans and the exclusion for benefits employees receive under employer-provided accident and health plans are viewed as a single tax expenditure. Staff of Joint Comm. on Taxation, Estimates of Federal Tax Expenditures for Fiscal Years 2014–2018, JCS-97-14, at 3 n.8.

[91] Tax expenditures are defined as "revenue losses attributable to provisions of the Federal tax laws which allow a special exclusion, exemption, or deduction from gross income or which provide a special credit, a preferential rate of tax, or a deferral of tax liability. *Id.* at 2.

[92] *Id.* at 38. The tax expenditure for fiscal years 2014-2018 is estimated to be $785.1 billion. *Id.* Table I, at 19.

[93] To illustrate:

valuable for higher-income workers than it is for lower-income workers.[94] Moreover, critics contend that the tax exclusion creates an incentive to purchase too much health insurance which distorts the health services market, causes inefficient allocations of scarce resources, and inflates health care costs.[95]

This third, "overinsurance," argument originated with Martin Feldstein in the

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> [A]ssume that Taxpayer A and Taxpayer B desire the same insurance coverage, an individual policy that costs $3,750. Taxpayer A is offered her desired coverage through her employer, while Taxpayer B is not. Both taxpayers are in the 25% marginal rate bracket. Taxpayer A needs to earn only $3,750 in wages to purchase such coverage. Taxpayer B, however, must earn $5,000 in wages to have sufficient after-tax funds available for his purchase. If we take into account payroll taxes of 7.65% and an assumed state income tax rate of 5%, the amount of wages necessary to pay for a $3,750 policy rises to $5,162. Under these assumptions, Taxpayer A receives an effective subsidy of $1,412 to purchase her health insurance coverage, solely because her employer makes such coverage available to her, and regardless of whether her employer makes any contribution toward such coverage.

Amy B. Monahan, *The Complex Relationship between Taxes and Health Insurance*, in Beyond Economic Efficiency in United States Tax Law 137, 140 (David A. Brennen *et al*., eds. 2013).

[94] To illustrate:

Assume that Employer offers its two employees, Candece and Dirk, identical health insurance coverage. Candece and Dirk both pay $1,000 toward the cost of coverage while their Employer contributes $5,000 toward the cost of coverage. Candece is in the 33% marginal rate bracket while Dirk is in the 25% marginal rate bracket. Because Candece is in a higher marginal rate bracket, the tax exclusion is more valuable to Candece than to Dirk. Specifically, Candece receives a subsidy of $1,980 ($5,000 x .33 = $1,980) (that is, she avoids paying $1,980 in tax) while Dirk only receives a subsidy of $1,250 ($5,000 x .25 = $1,250).

According to 2009 Joint Committee on Taxation estimates, households with annual earnings between $200,000 and $499,999 receive on average tax benefits of $4,728 while households with annual earnings between $10,000 and $29,999 receive on average tax benefits of $1,952 due to the exclusion. *See* Joint Committee on Taxation, Background material for Senate Committee on Finance roundtable on health care financing, presented before the Senate Committee on Finance 5 (JCX-27-09 May 8, 2009).

Focusing on the subsidy as a percentage of family income, Steffie Woolhandler and David Himmelstein argue that the tax subsidy is most helpful for families with income between $38,550 and $100,000. Steffie Woolhandler and David U. Himmelstein, *The "Cadillac Tax" on Health Benefits in the United States Will Hit the Middle Class the Hardest: Refuting the Myth That Health Benefit Tax Subsidies are Regressive,* Intl J of Health Services 3 (2016).

[95] See Stan Dorn, Urban Institute, *Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible* 1 (2009); Paul Fronstin, *Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employer and Workers*, Employee Benefits Research Institute Issue Brief No. 325, at 5 (Jan. 2009); Bob Lyke, *The Tax Exclusion for Employer-Provided Health Insurance: Policy Issues Regarding the Repeal Debate*, Congressional Research Service Report RL 34767 12-14 (2008); John D. Banja, *The Improbable Future of Employment-Based Insurance*, Hasting Center Rep. 17 (May–Jun 2000); William S. Custer *et al*., *Why We Should Keep the Employment-Based Health Insurance System,* 18 Health Affairs 115, 119 (1999).

1970s.[96] In essence, the argument goes, because employees pay taxes on wages, but not on compensation provided in the form of health care benefits, employers have an incentive to skew compensation toward tax-free health care benefits and away from taxable wages.[97]

To illustrate, suppose that an employee has a marginal tax rate of 33 percent. At the margin, because wages are taxed and employer contributions to fund health care are not, employers may offer the employee either $1 in health insurance or $0.67 in after-tax wages. In order to take advantage of this tax differential, a rational employer would "overinsure" and offer a plan with generous benefits and limited cost-sharing[98] rather than additional wages.[99]

This overinsurance, in turn, exacerbates the moral hazard that already arises from having insurance in the first.[100] Moral hazard refers to the tendency of an individual to behave differently depending on whether or not the individual has insurance.[101] Specifically, in the case of health insurance, an individual is more likely to use health care services if the services are paid for with insurance than if the individual directly pays for the cost of the services.[102]

Proponents of the Cadillac tax contend that by taxing "excess benefits," the Cadillac tax will encourage employers to stop offering excess benefits and instead offer employees less generous plans.[103] With less generous plans, employees will be forced to pay a larger percentage of their medical expenses, and this demand-side incentive

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[96] *See* Jon Gabel, *et al*., *Taxing Cadillac Health Plans May Produce Chevy Results*, 29 Health Affairs 174, 174 (No. 1 Jan. 2010), *citing* Martin S. Feldstein, *The welfare loss of excess health insurance*, 81 J Political Econ 251 (No. 2 1973).

[97] *See* Jason Furman, *Next Steps for Health Care Reform*, The Hamilton Project 17 (Oct. 7, 2015), *citing* Martin S. Feldstein, *The welfare loss of excess health insurance*, 81 J Political Econ 251 (No. 2 1973), and Martin Feldstein, *The Rising Price of Physicians' Services*, 52 Review of Economics and Statistics 121 (No. 2 1970).

[98] As Amy Monahan has noted, the tax preference also encourages plans with limited cost-sharing because premiums can be paid with tax-free dollars while other medical expenses must generally be paid for with after-tax dollars. Although flexible spending accounts permit employees to pay for some out-of-pocket expenses with tax-free dollars, contributions to flexible spending accounts are limited and subject to the "use it or lose it" rule. Monahan, *supra* note 77, at 760. For a more detailed discussion of flexible spending accounts, see Moore, *supra* note 86, at 124–27.

[99] *See* Gabel, *et al*., *supra* note 96, at 174.

[100] Monahan, *supra* note 77, at 759.

[101] Douglas Farnsworth, *Moral Hazard in Health Insurance: Are Consumer-Directed Plans the Answer?*, 15 Annals of Health Law 251, 253 (2006).

[102] *Id.* at 254; Monahan, *supra* note 70, at 759.

[103] Furman, *supra* note 97, at 17.

will result in a lower demand for health services which will reduce national health care expenditures.[104]

A Congressional Research Service Report estimates that the Cadillac tax could reduce national health expenditures by as much as $7–11 billion in 2018 (its first effective year at the time of the report) and by as much as $41–60 billion in 2024.[105]

§ 8.04 LIKELY EFFECT OF THE CADILLAC TAX ON EMPLOYER-SPONSORED HEALTH CARE PLANS

Assuming it goes into effect as scheduled in 2020, the Cadillac tax is likely to hit some employers that year. Just how many is subject to debate. What is clear is that many employers are likely to amend their plans to avoid paying the tax.

[1] How Many Employers Might be Subject to the Cadillac Tax?

In August 2015, the Kaiser Family Foundation issued a brief estimating the share of employers offering health benefits that could expect to reach the Cadillac tax thresholds in 2018, 2023, and 2028 if plan premiums were to grow at a range of reasonable rates.[106] The brief did not attempt to assess the share of employer plans that would actually be subject to the tax because the authors recognized that many employers are likely to amend their plans to avoid the tax.[107] The brief offered two different sets of general estimates. One looked solely at the costs for plan premiums plus employer contributions to HSAs and HRAs. The second took into account contributions to FSAs as well. Not surprisingly, the estimates were much higher when FSA contributions were taken into account.

Looking solely at costs for plan premiums plus employer contributions to HSAs and HRAs, about 16 percent of employers offering health benefits were estimated to have at least one plan exceed the Cadillac tax threshold for self-only coverage in 2018, with the percentage increasing to 22 percent in 2023 and to 36 percent in 2028.[108] Adding FSA contributions increased the estimates to 26 percent of employers in 2018 and rising to 30 percent in 2023, and 42 percent in 2028.[109]

In August 2015, the Congressional Research Service released a set of estimates on

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[104] Monahan, *supra* note 77, at 753, *citing* Jonathan Gruber, *The Cost Implications of Health Care Reform*, 362 New Eng J Med 2050, 2051 (2010).

[105] Jane G. Gravelle, *The Excise Tax on High-Cost Employer-Sponsored Health Insurance: Estimated Economic and Market Effects*, Congressional Research Service Report R44159 5–6 (Aug. 20, 2015).

[106] Gary Claxton & Larry Levitt, *How Many Employers Could be Affected by the Cadillac Plan Tax?*, The Henry J. Kaiser Family Foundation Issue Brief (Aug. 2015).

[107] *Id.* at 3.

[108] *Id.* at 4.

[109] *Id.* at 4–5.

the share of plans with premiums that could exceed the Cadillac tax threshold.[110] Like the Kaiser Family Foundation, the Congressional Research Service did not consider any plan changes employers might make to avoid the tax.[111] Unlike the Kaiser Family Foundation, the Congressional Research Service only considered insurance premiums and did not take into account other types of coverage, such as contributions to HSAs and FSAs, in reaching its estimates.[112]

Looking only at premiums, the Congressional Research Report estimated that on a national level,[113] about 10 percent of plans providing single coverage could be subject to the tax in 2018 while about 6 percent of plans with other than single coverage could be subject to the tax that year.[114] Assuming low premium growth rate, the report estimated that the share of plans with single coverage that could be subject to the tax would increase to 24.7 percent in 2028, and to 19 percent in 2028 for plans with other than single coverage.[115]

According to estimates by the Department of Treasury Office of Tax Analysis, seven percent of individuals enrolled in employer-sponsored plans will be in plans subject to the tax in 2020, assuming employers make no adjustments to avoid the tax.[116] Recognizing that the tax does not apply to all premiums in plans subject to the tax but instead only applies to the premiums that exceed the threshold, the Office of Tax Analysis estimates that only about one percent of plan costs are expected to be affected in 2020, and the proportion is projected increase to four percent by 2026.[117]

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[110] Lowry, *supra* note 76, at 8–14.

[111] *Id.* at 8.

[112] *Id.* at 9.

[113] The Report provides maps with estimates for each individual state. *Id.* at 11 & 12 Figures 1 & 2.

[114] *Id.* at 10.

[115] Lowry, *supra* note 76, at 12–14.

[116] Jason Furman and Matthew Fiedler, *The Cadillac Tax—A Crucial Tool for Delivery-System Reform,* New England J Medicine 1008, 1008 (March 17, 2016). For additional studies and surveys, see Lowry, *supra* note 76, at 23–24; Edward D. Kaplan, *Prepare to Avoid or Delay the Affordable Care Act Excise Tax*, HR News Magazine 6, 7 (Jan. 2016) (reporting that according to Segal Consulting estimates, 31 percent of plans would be subject to the tax in 2018, 46 percent in 2022, and 70 percent in 2027); Ascende, *Not Your Father's Cadillac: The Impact of the Cadillac Tax on the Energy Industry* 2 (Dec. 2015) (estimating that health plans sponsored by as many as 44 percent of companies in the energy industry could be subject to the Cadillac tax in 2018 with the number increasing to 89 percent in 2022); Tevi D. Troy and D. Mark Wilson, *ACA Excise Tax: Cutting Family Budgets, Not Health Care Budgets*, American Health Policy Institute 2 (2015), available at http://americanhealthpolicy.org/ (reporting that over 30 percent of large employers said they would have at least one plan impacted by the Cadillac tax in 2018 and almost half of employers that did not have any plans hitting the threshold in 2018 expected to have a plan impacted by 2023).

[117] Furman and Fielder, *supra* note 116, at 1008.

Although analysts disagree about the precise number of health care plans that are likely to be subject to the Cadillac tax and when, analysts uniformly agree that an increasing number of employer-sponsored health care plans will be subject to the tax over time. The reason why more plans will be subject to the tax over time is because the adjustments to the thresholds are tied to increases in the consumer price index, and medical costs have historically increased at a much faster rate than the consumer price index. For example, while medical care prices increased at the relatively low rate of 2.4 percent in 2014, they still rose significantly faster than the 1.6 percent rate at which all other prices rose.[118] The American Health Policy Institute projects that the cost of today's "average plan" will reach the excise tax threshold by 2031.[119]

[2] How are Employers Likely to Respond to the Cadillac Tax?

Although the Cadillac tax is not scheduled to go into effect for several years, employers have long been concerned about the tax. Indeed, according to a 2010 survey by the International Foundation of Employee Benefit Plans, close to half of respondents were focusing on redesigning their health plans to avoid the excise tax at that time.[120] More recently, in December 2015, Richard Stover, principal and consulting actuary in Xerox HR Services' Knowledge Resource Center, said that employers "are generally doing and looking at everything they can do to avoid the tax."[121]

Consultants have recommended, and employers are considering and in some cases have implemented, a variety of approaches to avoid the Cadillac tax.[122]

Some approaches are designed specifically to reduce overall health care expenditures. Those approaches include adopting wellness programs and shifting toward consumer-driven health care plans.[123] Others shift the cost of health care to employees

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[118] Troy and Wilson, *supra* note 116, at 2–3.

[119] *Id.* at 3.

[120] Intl Foundation of Emp Benefit Plans, *Health Care Reform: What Employers are Considering* 33 (2010).

[121] Blakely, *supra* note 76, at 7.

[122] For a discussion of the range of options employers may consider, see Kaplan, *supra* note 116, at 7–9. *See also* Piotrowski, *supra* note 77, at 4–5 (discussing employers' strategies to address Cadillac tax).

[123] *See* National Business Group on Health, *U.S. Employers Changing Health Benefit Plans to Control Rising Costs, Comply with ACA, National Business Group on Health Survey Finds* (Aug. 13, 2014), available at https://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=234 (according to a 2014 survey of about 400 large U.S. employers, 73% are adding or expanding tools to encourage employees to be better health care consumers; 57% are implementing or expanding consumer-driven health plans and 53 percent will either add or expand wellness programs); Aon Media Center, *New Aon Hewitt Survey Shows Majority of Companies Taking Immediate Steps to Minimize Exposure to Excise Tax* (Oct. 16, 2014), available at http://aon.mediaroom.com/2014-10-16-New-Aon-Hewitt-Survey-Shows-

and thus reduce the cost of health care plans. Those approaches include imposing higher deductibles, co-payments, and out-of-pocket maximums, and reducing spousal subsidies.[124]

According to the Kaiser 2015 Employer Health Benefits Survey, 53 percent of large firms (defined as employers with 200 or more employees) that offer health benefits have conducted an analysis to determine if their health plans will exceed the Cadillac tax thresholds.[125] Of the large firms that have made changes in anticipation of the Cadillac tax, 64 percent have increased cost sharing, 34 percent have moved benefit options to account-based plans such as HRAs or HSAs,[126] 18 percent have increased incentives to use less costly providers, and 10 percent have reduced the scope of covered health services.[127]

Employers' desire to restructure their health benefits to avoid the tax is hardly surprising. Indeed, one of the justifications for the tax is premised on the belief that the tax will encourage employers to offer less generous benefits.[128] Moreover, the other justification for the tax, increased revenues, also contemplates that employers will reduce health benefits. Specifically, proponents of the tax expect that the reduction in benefits will be offset by an increase in taxable wages. Indeed, the offsetting increase in taxable wages is expected to account for 75 percent of the projected revenues from the tax.[129]

§ 8.05 CRITICISMS OF THE CADILLAC TAX

Analysts have raised two significant criticisms to the Cadillac tax. First, they contend

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Majority-of-Companies-Taking-Immediate-Steps-to-Minimize-Exposure-to-Excise-Tax (reporting that 31 percent of employers that have determined impact of Cadillac tax are increasing the use of wellness options in their plans). For a discussion of Booz Allen Hamilton's multi-faceted approach to addressing the Cadillac tax which included launching a wellness campaign and adopting a wholesale redesign of their health benefits to include consumer-driven health plans and HSAs, see Blakely, *supra* note 76, at 6–7.

[124] Aon Media Center, *supra* note 123 (reporting that 33 percent of employers that have determined impact of Cadillac tax are reducing the richness of their plan designs by imposing higher out-of-pocket costs and 14 percent are significantly reducing spousal eligibility or subsidies through mandates or surcharges).

[125] Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits, 2015 Annual Survey Exhibit 14.16.

[126] *Cf.* Sherry A. Glied and Adam Striar, *Looking Under the Hood of the Cadillac Tax*, Commonwealth Fund Pub. 1880 (June 2016) (speculating that employers are initially likely to respond to the Cadillac tax by limiting contributions to FSAs and HSAs).

[127] Kaiser Family Foundation and Health Research 7 Educational Trust, *supra* note 125, at Exhibit 14.15.

[128] *See* § 8.03[2], *infra*.

[129] CBO, *Updated Estimates of the Net Budgetary Effects of the Coverage Provisions of the Affordable Care Act* 13 (April 2014).

that the tax is flawed because cost is not a proxy for luxury. Second, they contend that it could have an adverse impact on vulnerable workers.

[1] Cost is Not a Proxy for Luxury (or Sometimes a Cadillac is Just a Chevy)

The term "Cadillac" in the so-called Cadillac tax refers to the American automobile that has long been synonymous with luxury.[130] The tax is imposed on "Cadillac" health care plans which have the highest premiums[131] and thus are assumed to offer the most generous benefits.[132]

Some critics of the tax are sympathetic to the desire of targeting "luxurious" health care benefits.[133] They contend, however, that cost is not a proxy for luxury and the tax is too "blunt" an instrument.[134]

Jon Gabel, Jeremy Pickreign, Roland McDevitt, and Thomas Briggs analyzed data from the 2007 Kaiser Family Foundation/Health Research and Educational Trust Employer Benefits Survey and found that only a small part of the variation in premium costs is related to the actuarial value of benefits or even plan design. Specifically, they found that less than four percent of the variation in premiums was attributable to actuarial value, and taking plan type into account only increased that figure to six percent.[135] They found that industry and geographic variations were more highly correlated with cost than actuarial value or plan design.[136] Thus, in their view, cost should not be equated with luxury. Simply targeting cost "could exacerbate rather than

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[130] *See* Eleanor Hagan, *Sometimes that Cadillac is a Lemon: Why the High-Cost Health Insurance Excise Tax Needs a Tune-Up Before Implementation*, 66 Tax Law. 251 n.26 (2012) (noting that "[i]ts metaphor in the health care industry began in the 1970s and was popularized during the debate on universal health care in the 1990s.").

[131] For a discussion of how premiums are calculated, see Robert H. Dobson and Stuart D. Rachlin, *What does the ACA excise tax on high-cost plans actually tax?*, Milliman Client Report 8–9 (Dec. 9, 2014).

[132] Piotrowski, *supra* note 77, at 2 (stating that [t]hese plans may also have less restrictions on or wider provider networks and wide menus of covered health services to choose from, including even the most expensive services such as in vitro fertilization, which can run tens of thousands of dollars").

[133] *See e.g.,* Joseph White, *Reform The "Cadillac Tax" to Target Rich Benefits, Not High Costs*, Health Affairs Blog (March 16, 2016), *available at* http://healthaffairs.org/blog/2016/03/16/reform-the-cadillac-tax-to-target-rich-benefits-not-high-costs/.

[134] Sarah Nowak and Christine Eibner, *Rethinking the Affordable Care Act's "Cadillac Tax": A More Equitable Way to Encourage "Chevy" Consumption*, Commonwealth Fund Publication 1852, at 1 (Dec. 2015).

[135] Gabel, *supra* note 96, at 180.

[136] *Id.*

ameliorate current inequities."[137]

Sarah Nowak and Christine Eibner analyzed median premiums from the Medical Expenditure Panel Survey-Insurance Companies on state measures of health care costs, plan characteristics, workforce composition, and demographics from a variety of sources. They found that "plan generosity" only accounted for 11 percent of the variation in premiums. For these purposes, plan generosity was defined to include deductibles and plan design, that is, whether the plan was an HMO. They found that most of the factors that accounted for the differences in premiums was outside the control of employers and their workers. Specifically, demographics, the share of individuals working in the health care sector, industry, and regional differences in health care costs accounted for 53 percent of the differences in premiums. Thirty-six percent of the variation was unexplained.[138]

Nowak and Eibner found that workers in some states, such as Alaska, Connecticut, and New Hampshire, are likely to be affected by the Cadillac tax much sooner than workers in other states, such as Arizona, Idaho, and Michigan. They are concerned that the Cadillac tax could have an adverse impact on low-income workers in those states if they are faced with absorbing the tax or moving to a plan that requires very high cost-sharing.[139]

The Cadillac tax's current structure recognizes that cost is not always a proxy for luxury.[140] Specifically, it recognizes that premiums may be affected by such factors as age, gender, and profession. Accordingly, it permits adjustments to the thresholds for age and gender, qualified retirees, and high risk professions.[141]

A study by Milliman found that the age and gender adjustment appropriately addresses the variations in premiums caused by age and gender differences.[142] In

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[137] *Id.* at 180. *See also* Monahan, *supra* note 77, at 762 (discussing Gabel study and asserting that "[t]here is reason to believe that there is significant noise in the premium level, and that it is not directly correlated with plan generosity").

[138] Nowak and Eibner, *supra* note 134.

[139] *Id.* at 4. They recognize that technically the Cadillac tax is imposed on the coverage provider and not on the insured individuals. They note, however, that the costs could be passed onto workers in the form of higher premium contributions or lower wages. *Id.* at 7 n.10.

[140] Piotrowski, *supra* note 77, at 2 (noting that Cadillac plan costs are not always or fully explained by the generosity in the level of their benefits; adjustments in the thresholds are permitted to account for the variation in plan costs that may arise from differences in the age and gender of the workforce as well as type of work).

[141] IRC § 4980I(b)(3)(C)(iii)–(iv).

[142] Dobson and Rachlin, *supra* note 130, at 12 & 21. Legislation enacted in December 2015 extending the effective date of the Cadillac tax until 2020 includes a provision requiring the U.S. comptroller general to work with the National Association of Insurance Commissioners to conduct a study on whether the

addition, the study found that the adjustment for high risk profession partially mitigates for differences in premiums due to industry.[143] Yet, like the other studies discussed above, the study found that only a small percentage (about six percent) of variations in premiums is due to benefit level.[144] They found that the most significant factor is geographical area with almost 70 percent of the variation in premiums due to differences in geographical area.[145] Thus, like the other studies, the Milliman study confirms that cost is not an appropriate proxy for benefit level, and not all high-cost plans are overly generous.

[2] Adverse Impact on Vulnerable Workers

Proponents of the Cadillac tax contend that the tax will result in higher wages for employees. Pointing to standard economic theory, they contend that to the extent that employers reduce their health benefits to avoid the tax, employers will pass the cost savings on to employees in the form of higher wages.[146] Indeed, the CBO and JCT estimate that the Cadillac tax will result in an estimated $50 billion annual increase in wages by 2026, and taxation on that projected increase in taxable wages accounts for 75 percent of the Cadillac tax's projected revenue.[147]

Although economic theory supports the contention that employers will pass the cost-savings on to employees in the form of higher wages, some critics of the Cadillac tax question whether this will actually happen in practice.[148] Some survey data supports this view. Specifically, according to a June 2015 employer survey by the American Health Policy Institute, 71 percent of respondents said that they probably would not provide a corresponding wage increase to offset health benefit reductions.[149] The authors reporting the survey results concede that given the current low productivity-low inflation environment, taxable wages may increase in the long run as

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Cadillac tax uses appropriate standards in determining age and gender adjustments to the tax thresholds. Consolidated Appropriations Act, 2016, Pub L 114-113, Div P § 103, 129 Stat 2242, 3037 (2015).

[143] Dobson and Rachlin, *supra* note 130, at 14. According to the study, industry accounts for about 20 percent of the variation in premiums.

[144] *Id.* at 3.

[145] *Id.* at 3.

[146] Furman, *supra* note 97, at 18. *See also* Letter to Chairman Hatch, Senator Wyden, Chairman Ryan, and Congressman Levin (Oct. 1, 2015), available at http://www.cbpp.org/sites/default/files/atoms/files/cadillac_tax_letter.pdf.

[147] Furman and Fiedler, *supra* note 116, at 1009.

[148] *Cf.* Jorge Castro, *As Employers Try to Avoid the Cadillac Tax, Treasury And The IRS Need to Act*, Health Affairs Blog (May 12, 2015), available at http://healthaffairs.org/blog/2015/05/120as-employer-try-to-avoid -the cadillac-tax-treasury-and-the-irs-need-to-act/ (describing the second possible scenario arising from the Cadillac tax as "a reduction of employee benefits without a pay increase").

[149] Troy and Wilson, *supra* note 116, at 4.

the CBO and JCT predict. They note, however, that wages are "sticky" in the short run, and any long run wage increase may be invisible to employees because not only will the wage increase be subject to tax but it may also be consumed in the form of higher out-of-pocket health care costs.[150]

Other critics contend that even if employers do pass the savings from reduced health care benefits on to employees in the form of higher wages, the higher out-of-pocket costs could discourage some individuals, particularly lower-income individuals and their families, from seeking needed health care[151] and thus exacerbate the current inequalities in health and health care.[152] Studies show that when individuals move from more generous health plans to less generous health plans, they often use less health care—both needed and unneeded.[153] Thus, according to these critics, the Cadillac tax could lead to worse health outcomes for some individuals, particularly lower-income individuals.[154]

Proponents of the Cadillac tax respond that employers are not likely to adopt higher cost-sharing to the extent that many opponents of the Cadillac tax believe. Recognizing that employers use health benefits as an important tool for recruiting and retaining workers, employers are likely to try to find the most attractive overall package for employees. Instead of increasing cost-sharing, they are likely to focus on encouraging more efficient care delivery by deploying innovative payment models, directly complementing public-sector efforts, and finding creative ways to steer patients toward

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[150] *Id.*

[151] Josh Bivens, *Tax on Expensive Health Insurance Plans Could Cut Care Along with Costs,* Wall Street Journal (Oct. 2, 2015), available at http://blogs.wsj.com/washwire/2015/10/02/excise-tax-on-expensive-health-plans-could-cut-care-along-with-costs/; Piotrowski, *supra* note 77, at 4.

[152] Woolhandler and Himmelstein, *supra* note 94, at 5.

[153] *See, e.g.,* Katherine Baicker and Dana Goldman, *Patient Cost-Sharing and Healthcare Spending Growth*, 25 J of Econ Perspectives 47 (No. 2 2011); Melinda Beewkes Butnin, *et al*., *Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans*, 17 Am J of Managed Care 222 (No. 3 2011). Kathleen N. Lohr, *et al., Use of Medical Care in the Rand Health Insurance Experiment: Diagnosis- and service-specific analyses in a randomized controlled trial*, 24 Med Care S1, S31–S38 (9 Suppl 1986); RAND Health, *The Health Insurance Experiment* 2–4 (2006) http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf. *See also* Katherine Baicker and Amitabh Chandra, *Myths and Misconceptions About U.S. Health Insurance*: *Health care reform is hindered by confusion about how health insurance works,* 27 Heath Affairs w533, w540 (Oct. 21, 2008) (noting that there is evidence that patients underuse drugs with very high value when confronted with greater cost sharing and even $5–$10 increases in copayments can result in increased hospitalizations).

[154] Monahan, *supra* note 77, at 762–63. *See also* Nowak and Eibner, *supra* note 134, at 7 n.7 (noting that "[a]n additional concern . . . is that higher cost-sharing could discourage both low-value and high-value care, ultimately leading to worse health outcomes.").

more efficient providers.[155]

As Professor Amy Monahan has noted, the Cadillac tax proponents' response is appealing from a theoretical standpoint. One would, in theory, expect employers to be effective agents for their employees and restructure their health plans to provide the maximum benefit for their employees. Unfortunately, there is no empirical evidence on the question as to how employers are likely to respond to the Cadillac tax. Moreover, there are multiple reasons, including the very complexity of structuring health care plans, why employers may not restructure their plans as precisely as one might hope.[156] Thus, there appears to be at least a realistic possibility that the Cadillac tax could lead to worse health outcomes for some workers.

The Obama Administration appears to be sensitive to this concern. The President's fiscal year 2017 budget calls on the Government Accountability Office, in consultation with the Treasury Department and other experts, to conduct a study of the potential effects of the Cadillac tax on employers with unusually sick employees.[157]

§ 8.06 ALTERNATIVES TO THE CADILLAC TAX

Critics have offered a host of alternatives to current Cadillac tax. Some of the proposals call for modest adjustments to the tax. Others call for wholesale change. This section discusses three of the proposed alternatives.[158]

[1] Modest Adjustments to the Cadillac Tax

Some commentators have recommended that the Cadillac tax be amended to expand the number of adjustments made to the tax thresholds. For example, some commentators recommend that the adjustments for regional variation in price levels be permitted as well as possibly for other factors, such as industry.[159]

The Obama Administration appears to be open to this suggestion. Indeed, the

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[155] Furman and Fiedler, *supra* note 116, at 1009. Amy Monahan describes this as a reasonable theoretical argument but notes that there is little empirical evidence to either refute or support the argument. Monahan, *supra* note 77, at 763–64.

[156] *Id.* at 763–66.

[157] Office of Mgmt. & Budget, Exec. Office of the President, Budget of the United States Government, Fiscal Year 2017, at 60.

[158] For a discussion of other alternatives, see, for example, Monahan, *supra* note 77, at 771–78; Christopher Condeluci, *Obamacare's Cadillac tax Must Be Repealed: Former Senate tax counsel Christopher Condeluci lays out a plan to replace the tax in a way that would meet both Democratic and Republican policy goals*, CFO.com (Nov. 18, 2015), *available at* http://ww2.cfo.com/tax/2015/11/obamacares-cadillac-tax-must-repealed/.

[159] Nowak and Eibner, *supra* note 134, at 6 (suggesting that safe harbor approach that would provide that the Cadillac tax would not apply if a minimum-generosity plan were not available at a premium below the Cadillac tax threshold and that minimum generosity be defined as a price equal to 60 to 70 percent of actuarial plan value). *Cf.* Gabel, *supra* note 96, at 180 (critiquing proposed Cadillac tax and contending

President's fiscal year 2017 budget specifically provides for a geographic adjustment to the Cadillac tax. Under the proposed adjustment, in any state in which the average premium for "gold" coverage on the state's individual health insurance marketplace exceeds the current law Cadillac tax threshold, the threshold would be set at the level of that average gold premium.[160]

[2] Limit Tax Preference to Deserving Benefits

According to at least one critic, modest modifications to the Cadillac tax thresholds are not enough. Joseph White, Luxenberg Family Professor Public Policy in the Department of Political Science at Case Western Reserve University, contends that the Obama Administration's proposed solution would only lead to an extremely complicated set of adjustments that would inevitably be inadequate. He contends that the fundamental problem with the Cadillac tax is that it aims at the wrong target.

White contends that policymakers need to focus on benefits rather than cost. Rather than imposing an excise tax on plans that are too costly, the law should limit the tax exclusion to benefits that are deserving of a tax exclusion. White recognizes that such an approach faces its own set of difficulties. First, it is likely to raise less revenue than the current Cadillac tax. Second, it will be hard to reach an agreement on which benefits are not deserving of a tax exclusion. Nevertheless, he contends the likely conflict that would arise from trying to identify deserving benefits is "otherwise known as representative government. Voters should be given a chance to express their views of what constitutes decent health insurance."[161]

[3] Replace Cadillac Tax and Tax Exclusion for Employer-Sponsored Health Insurance with Tax Credit for Health Care

Some commentators have recommended that the current system of tax exclusion for employer-sponsored health care be replaced with a tax credit modelled on the Affordable Care Act's marketplace tax credits. Under the proposal, tax credits could allow for adjustments based on the regional cost of health care, be scaled with income, and be capped at 70 percent of actuarial plan value. Advocates of this approach contend that it could insure more people than the Affordable Care Act at no additional cost to the government.[162] Its proponents, however, recognize that it could disrupt the employer market and cause some employers to eliminate their health care coverage.

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that analysts should not equate high cost with Cadillac plans but that other factors such as industry and cost of medical inputs should be considered).

[160] Office of Mgmt & Budget, *supra* note 157, at 60.

[161] Joseph White, *Reform The "Cadillac Tax" to Target Rich Benefits, Not High Costs*, Health Affairs Blog (March 16, 2016), available at http://healthaffairs.org/blog/2016/03/16/reform-the-cadillac-tax-to-target-rich-benefits-not-high-costs/.

[162] Nowak and Eibner, *supra* note 134, at 6.

§ 8.07 LIKELY FUTURE OF THE CADILLAC TAX

Politically fraught since its inception, the Cadillac tax's prognosis is guarded at best.[163]

Economists are nearly unanimous in supporting the tax.[164] For example, Larry Summers, Secretary of the Treasury under President Bill Clinton, and Gregory Mankiw, chairman of the Council of Economic Advisors under President George W. Bush, co-wrote an editorial for the New York Times praising the tax.[165] Perhaps more significantly, more than 100 health economists, "a virtual Who's Who of both liberals and conservatives in the field,"[166] signed a letter to the Chairs and Ranking Members of the Senate Committee on Finance and House Committee on Ways and Means urging Congress to take no action to weaken, delay, or reduce the Cadillac tax unless and until it is replaced by an alternative tax that would more effectively curtail the growth in health care costs.[167]

Few outside of economists, however, support the tax.[168] For obvious reasons, employers do not like the tax. It is designed to force them to cut back on health care benefits, their most popular employee benefit.[169] Insurers do not like the tax. Not only are health insurance issuers directly subject to the tax but the tax puts pressure on them to lower premiums. Labor unions do not like the tax. Indeed, they may be the fiercest opponents of the tax. Many of the recipients of the best health care benefits are unionized workers, and unions do not like the levy impeding their contract negotiations.[170]

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[163] *Cf.* Edward A. Zelinsky, *The Health Related Tax Provisions of PPACA and HCERA: Contingent, Complex, Incremental and Lacking Cost Controls*, 2010 NYU Rev of Employee Benefits and Exec Comp 7-1 7-25 (describing Cadillac tax's prognosis as uncertain at best).

[164] Woolhandler and Himmelstein, *supra* note 94, at 2.

[165] N. Gregory Mankiw and Lawrence H. Summers, *Uniting behind the divisive "Cadillac" tax on health plans*, New York Times (Oct. 24, 2015).

[166] Woolhandler and Himmelstein, *supra* note 94, at 2.

[167] Letter to Chairman Hatch, Senator Wyden, Chairman Ryan, and Congressman Levin, *supra* note 146.

[168] *But see* New York Times Editorial, *Keep the Tax on High-End Plans*, NY Times A18 (Aug. 12, 2015).

[169] *See* Paul Fronstin & Ruth Helman, *Views on the Value of Workplace Benefits: Findings from the 2015 Health and voluntary Workplace Benefits survey*, 36 EBRI Notes No 11, at 2 (Nov. 2015) ("reporting that [w]orkers overwhelmingly consider health insurance to be the most important workplace benefit").

[170] *See* Jonathan Cohn, *Hillary Clinton Calls For Eliminating Obamacare's "Cadillac Tax:" Economists won't be happy, but unions will be*, Huffington Post Politics (Sept. 30, 2015), available at http://www.huffingtonpost.com/entry/hillary-clinton-obamacare-cadillac-tax_us_

Many have lobbied long and hard for repeal of the tax. Indeed, Katy Spangler of the American Benefits Council (ABC), has announced that ABC's top three priorities are repealing the Cadillac tax.[171] ABC is a member of the Alliance to Fight the 40, a broad based coalition of private and public employer organizations, unions, health care companies, and others formed to promote the repeal of the Cadillac tax.[172]

In light of the widespread opposition to the Cadillac tax, it is perhaps not surprising that legislators on both sides of the aisle oppose the Cadillac. Both Republican and Democratic legislators have introduced bills to repeal the Cadillac tax.[173] Democratic Presidential candidates, Hillary Clinton[174] and Bernie Sanders,[175] endorse repeal of the Cadillac tax. Moreover, Republican candidate Donald Trump supports repeal of the Cadillac tax because he supports repealing the entire Affordable Care Act,[176] and the Cadillac tax is one of the elements of the Affordable Care Act.

A quick look at the history of the Cadillac tax illustrates its precarious nature. Initially, the Cadillac tax was scheduled to take effect in 2013.[177] A week later, its effective date was extended to 2018.[178] At the end of 2015, its effective date was extended yet again, until 2020.[179]

This is not to suggest that repeal of the tax is absolutely certain.[180] The Cadillac tax

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560b0792e4b0dd850309b2c2 (discussing opposition to tax).

[171] Blakely, *supra* note 76, at 4.

[172] *See* Alliance to Fight the 40, *http://www.fightthe40.com/about-the-alliance/*.

[173] *See* American Worker Health Care Tax Relief Act of 2015, S 2075, 114th Cong (2015) (sponsor Sen. Sherrod Brown (D. Ohio)); Middle Class Health Benefits Tax Repeal Act of 2015, S 2045, 114th Cong (2015) (sponsor Sen. Dean Heller (R-NV)); Middle Class Health Benefits Tax Repeal Act of 2015, HR 2050, 114th Cong (2015) (sponsor Rep. Joe Courtney (D-CT)); Ax the Tax on Middle Class Americans' Health Plans Act, HR 879, 114th Cong (2015) (sponsor Rep. Frank Guinta (R-NH)).

[174] *See* Laura Meckler and Stephanie Armour, *Hillary Clinton Supports Repealing "Cadillac Tax" on Health Plans: The Affordable Care Act's tax on high-priced health insurance plans is opposed by labor unions and republicans*, The Wall Street Journal (Sept. 29, 2015).

[175] Bernie Sanders sponsored a bill with Sen Sherrod Brown to eliminate the tax. American Worker Health Care Tax Relief Act of 2015, S 2075, 114th Cong (2015).

[176] *See* Dan Diamond, *Donald Trump Hates Obamacare—So I Asked Him How He'd Replace It*, Forbes (July 31, 2015), available at http://www.forbes.com/sites#/sites/dandiamond/2015/07/31/donald-trump-hates-obamacare-so-i-asked-him-how-hed-replace-it/#5c581efc5d5e.

[177] Patient Protection and Affordable Care Act, Pub L 111-148 § 9001(c), 124 Stat 119, 853 (2010).

[178] Health Care and Education Reconciliation Act of 2010, Pub L 111-152 § 1401(2)(B), 124 Stat 1029, 1059.

[179] Consolidated Appropriations Act, 2016, Pub L 114-113, Div P § 101(a), 129 Stat 2242, 3037 (2015).

[180] Castro, *supra* note 148 (contending that Congress is unlikely to repeal the tax because that would create a sizeable hole in the budget and Congress has struggled to reach compromise on legislation,

was intended to serve as a major source of revenue to cover the Affordable Care Act's ongoing costs. In addition, it was intended to reign in health care spending. Proponents of the Affordable Care Act are likely to fight long and hard for the tax unless and until an alternative source of funding and constraint on health care spending is found.[181] As Larry Levitt, senior vice president of Kaiser Family Foundation, has said, it is a bit premature to write the epitaph for the Cadillac tax.[182]

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particularly with respect to the Affordable Care Act).

[181] *See, e.g.,* Jared Bernstein, *A message to my friends and allies about why repealing the Cadillac tax is the wrong thing to do*, Washington Post (Nov. 12, 2015), available at https://www.washingtonpost.com/posteverything/wp/2015/11/12/a-message-to-my-friends-and-allies-about-why-repealing-the-cadillac-tax-is-the-wrong-thing-to-do/.

[182] Larry Levitt, *Why the Rukus over the Cadillac Plan Tax,* JAMA Forum (Oct. 14, 2015), available at http://newsatjama.jama.com/2015/10/14/why-the-ruckus-over-the-cadillac-plan-tax/.