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.

WHAT’S THE ISSUE?
As health coverage expands to tens of millions of Americans—through Medicaid expansion in states and the new state health insurance exchanges that will soon begin selling individual health coverage—some Americans with employer-sponsored health coverage are seeing their benefits decrease.

One of the most significant, and controversial, provisions of the Affordable Care Act is the new excise tax on high-cost health plans proposed to both slow the rate of growth of health costs and finance the expansion of health coverage. The provision is often called the “Cadillac” tax because it targets so-called Cadillac health plans that provide workers the most generous level of health benefits. These high-end health plans’ premiums are paid for mostly by employers. They also have low, if any, deductibles and little cost sharing for employees.

Proponents of the new excise tax argue that these benefit-rich plans insulate workers from the high cost of care and encourage the overuse of care—such as unnecessary tests and hospital visits—that raise US health costs overall. However, the plans may be more costly and therefore subject to the new excise tax for reasons other than their generous benefits, including plan participants’ health status or advanced age.

A 40 percent excise tax will be assessed, beginning in 2018, on the cost of coverage for health plans that exceed a certain annual limit ($10,200 for individual coverage and $27,500 for self and spouse or family coverage). Health insurance issuers and sponsors of self-funded group health plans must pay the tax of 40 percent of any dollar amount beyond the caps that is considered “excess” health spending.

Although the excise tax does not take effect for another four years, many employers are already scaling back their health benefit offerings or increasing workers’ deductibles and copays to avoid paying the tax. Proponents argue that employers need a renewed focus on cost control, and that when consumers must pay a share of the costs, they will be less likely to overuse care.

For consumers, especially those in poor health or with chronic illnesses who rely on Cadillac plans to cover high annual medical expenses, the tax means that they’ll have to pay much more for their health care. Critics of the tax say it unfairly “hollows out” and “slashes” health benefits.
It’s not yet clear how widely the excise tax will be felt by both employers and consumers. This brief explains the tax, its current and projected effects, and what’s next in the debate as the tax moves toward full implementation in 2018.

**WHAT’S THE BACKGROUND?**

Most of the national attention around the Affordable Care Act has focused on the individual mandate, upheld by the Supreme Court in June 2012, requiring people to have “minimum essential” health insurance coverage.

With 50 million uninsured Americans in 2010, the Affordable Care Act aimed to insure nearly everyone. By significantly expanding the risk pool to include both those least likely to become seriously ill and those already or likely to become sick, the law was expected to reduce uncompensated care, lowering costs across the board and dramatically reducing the national deficit.

The Obama administration pledged that health reform would save more than $200 billion over 10 years and more than $1 trillion in the second decade. Additionally, the law is expected to lower health care costs by expanding prevention and rewarding doctors, hospitals, and other providers that deliver high-quality health care.

The excise tax on high-cost health plans was among the many fees and taxes proposed as offsets to help slow the rate of growth of health costs, particularly premium growth, and finance the nationwide expansion of health coverage. When the Affordable Care Act was signed into law in March 2010, its coverage provisions were estimated to cost more than $900 billion over the next decade, from 2010 to 2019, and were to be paid for by fees and taxes on both individuals and businesses. At the time the health reform bill passed, the excise tax on high-cost plans was estimated to raise roughly $32 billion in revenue over the next decade, or by 2019.

The term *Cadillac plan* dates back to the 1970s and resurfaced during the health reform debates of the 1990s, before finally gaining new focus as part of the Obama administration’s recent efforts to cut health costs. Named for the signature American luxury car, Cadillac or “gold-plated” health plans have the highest premiums and typically offer the most generous or “richest” level of benefits. (Some health analysts have called them “bloated” offerings.)

These plans may also have less restriction 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. Critics of the plans focus on the low, if any, copays and deductibles, which tend to shield workers from the true cost of care, ultimately driving up medical costs for everyone else.

However, Cadillac plans’ high cost is not always or fully explained by their unusually generous level of health benefits. Other major reasons for their high costs include the health status, age, and gender of the workforce covered by the plan as well as enrollees’ work industry or the geography (higher medical costs in some regions versus others) represented. To account for variation in plan costs that may result from these differences, the excise tax thresholds were adjusted in the health reform law, although the details of the adjustments have yet to be announced.

Therefore, high-cost plans that are more expensive, for example, because they cover a large number of older workers; women; or people in high-risk jobs, such as law enforcement, firefighting, construction, or mining, will have higher thresholds and be protected from any disproportionate impact of the excise tax.

Proponents of the excise tax also argue that it is necessary because high-cost health plans contribute to a longstanding “unequal tax benefit” problem that has existed for decades: When the government froze wages during World War II, new laws allowed employers to offer health benefits tax free in lieu of wages. This created an incentive for employers to make health insurance a part of the compensation package they offer employees. Since health benefits were not taxed, some employers began offering generous or comprehensive health benefits to compete for better employees.

This tax-free, alternative form of compensation disproportionately benefitted people with higher incomes because they had higher income tax rates and therefore enjoyed the biggest tax break. Those without employer-based coverage comparatively did not benefit.
“Cadillac plans’ high cost is not always or fully explained by their unusually generous level of health benefits.”

Currently nearly half of Americans get health insurance through their employers, with the tax exclusion for this benefit continuing to encourage businesses to offer coverage. By excluding the full value of employer-sponsored health insurance from individuals’ taxable income, the federal government currently provides Americans with more than $250 billion each year in tax subsidies.

Because so many people and companies gain from the exclusion, any attempt to eliminate it has encountered major political opposition. The new excise tax was seen as a more viable alternative and one that accomplished some of the same goals as capping the tax exclusion.

The original Senate proposal would have hit 19 percent of all large employer plans and was projected to raise $149 billion over 10 years. Although many would like to see less reliance on the nation’s employer-based system of health coverage, the excise tax was seen as one way to address the problem of history. And after forceful lobbying from unions that were considerably hostile to the tax, the final compromise was a 40 percent tax on the value of an employer-paid plan that exceeded the agreed-upon thresholds.

The effective date was also delayed from 2013 to 2018. By redirecting the large tax subsidies from those with the most expensive coverage to those without health insurance (through the expansion of access to Medicaid and the Affordable Care Act’s new exchanges), tax equity is improved, or enhanced. Proponents of the tax remind its critics that tax expenditures for employer-sponsored insurance will total almost $3 trillion over the 2013–19 period, and the excise tax will recoup less than 5 percent of that subsidy.

**WHAT’S IN THE LAW?**

As the law now stands, beginning in 2018, both fully insured and self-funded employer health plans will be assessed the nonrefundable 40 percent excise tax on the dollar amount of any employee premiums that exceed annual limits of $10,200 for individual coverage and $27,500 for family coverage, excluding stand-alone dental and vision plans.

Additionally, the excise tax applies to the overall aggregate cost—the premium for the insured; the COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) rate for the self-insured, which doesn’t have premiums; and contributions to flexible spending accounts, health savings accounts, and health reimbursement accounts.

The excise tax applies to the insurer in cases where the plan is insured and to the employer where the plan is self-insured. In fully insured employee-sponsored coverage, the employer pays a fixed premium to the issuer or insurer for coverage of selected benefits, and the insurer, not the employer, bears financial risk for the employees’ health costs beyond the amount of the premium and other employee cost sharing (deductibles or copays, or both). In the case of self-funded coverage, an employer serves as the health plan administrator and also functions as the insurer, assuming the risk of employees’ health care costs.

For example, in either scenario, if the plan’s total value exceeds the annual limit by $1,500, the issuer or employer would pay a 40 percent excise tax of $600. Total value is calculated by including both employer and employee premium contributions and any funds put into flexible spending and health savings accounts. According to the law, adjustments to the thresholds can be made for plans with a disproportionate share of women and older workers.

Adjustments to the thresholds for plans that have pre-Medicare retirees or have the majority of workers employed in high-risk jobs also increase by $1,650 for the individual plan and by $3,450 for the family plan (to $11,850 and $30,950, respectively). The limits are also linked to inflation and would increase as the US inflation rate rises. Specifically, in 2018 and 2019 they’re indexed to the Consumer Price Index (CPI) plus 1 percentage point. In 2020 and beyond they’re linked to CPI alone, which grows more slowly than medical spending. As mentioned previously, the excise tax is expected to raise $32 billion over the 10-year period of 2010–19.

**WHAT’S THE DEBATE?**

The excise or Cadillac tax was designed to address three major goals: help finance health reform, especially the Affordable Care Act’s coverage provisions; reduce overall health care costs; and address the unequal tax benefit of excluding from taxes the value of health insurance, which encourages businesses to continue to provide generous employer-based coverage.

**HELPING FINANCE HEALTH REFORM:** The Congressional Budget Office (CBO), in esti-
Excise Tax on ‘Cadillac’ Plans

$80 billion

According to its most recent report, the Congressional Budget Office now predicts the Cadillac tax will raise $80 billion between 2013 and 2023.

The reason for the decrease, CBO says, is that inflation and health insurance premium growth has slowed. As a result, fewer employers will have to pay the excise tax. Although many health analysts view a slowdown in the rate of health cost growth as a positive development, the loss of excise tax revenue to fund health reform causes some notable funding challenges.

However, another widely cited research paper by Johns Hopkins health analysts argued differently—finding that inflation of health insurance premiums would cause an increasing number of health plans to be hit with the tax. The reason is that, as previously mentioned, the CPI—which the excise tax thresholds are indexed to—doesn’t keep pace with medical spending. If the limit grows more slowly than health insurance premiums, more and more health insurance spending—and more people—will become subject to the tax each year.

As noted by Paul Van de Water at the Center on Budget and Policy Priorities, “This would raise growing amounts of revenue over time and exert increasing pressure to slow the growth of premiums and health care costs.” According to the Hopkins researchers, about 16 percent of all plans could be affected by the excise tax when it takes effect in 2018. And some 75 percent of plans would be affected a decade later because of inflation of the annual premium limits. If the Affordable Care Act was implemented as written, this scenario would raise $931 billion in revenue over the 10-year budget window from 2020 to 2029.

Employers’ Strategies to Reduce Health Costs and Effects on Employees: In addition to slower growing premiums, analysts predict less revenue from the excise tax because employers are finding ways to avoid the tax. A 2011 Mercer survey of 2,844 public and private US employers found that 61 percent of those companies surveyed said they would trigger the excise tax unless they took steps to reconfigure their benefits offerings.

More recently, Steve Wojcik, vice president of the National Business Group on Health (a group representing large employers), said in a Bloomberg News report, “I don’t think there’s any employer that’s going to pay the tax.” In the same report, Jonathan Gruber, an economist at the Massachusetts Institute of Technology, added, “I would be surprised if [the Internal Revenue Service] even collect[s].”

Although the excise tax will not take effect for more than four years, many employers are indeed scaling back coverage to avoid the tax. Others are considering passing the cost on to employees in the form of both higher premiums and more cost sharing, requiring higher deductibles and copays to keep the health plan costs as they are. This is consistent with CBO scoring of the tax that noted some employers would avoid it by increasing costs to consumers and reducing benefits, while others would pay the tax and pass it along to workers as high premiums. Other employers are passing the excise tax cost to employees by ending employer contributions to tax-free flexible spending and health savings accounts.

Critics of these cost-shifting approaches contend that the trend will fuel a major and troubling increase in personal debt for consumers, many of whom will simply be unable to absorb the rising costs of both higher copays and higher deductibles. Critics also point out that higher cost sharing could lead some employees to forgo needed care. Many employers say they have no choice but to put the onus on workers to control their own costs within an expensive system.

Critics of the Cadillac tax say this reality is especially unfair for people with chronic or costly medical conditions, such as cystic fibrosis or cancer, who have large medical bills and rely on their generous coverage to cover their care. Although employers are looking for ways to reduce costs, they will also be adding costs to plans such as covering, as mandated by the Affordable Care Act, preventive, maternity, and emergency care.

A 2013 survey by the International Foundation of Employee Benefit Plans found that 17 percent of employers have already begun changing their employee benefits plans to circumvent the tax, up from 11 percent in 2011 (Exhibit 1). Companies’ strategies are diverse, with most businesses taking the sim-
plest approach of attempting to cut the “richness” from their plans and thus the cost of their benefit packages to below the excise-tax threshold. However, critics of this approach argue that it will lead to lower-quality care by reducing employees’ access to certain types of previously available health services.

To compensate, some employers are responding with innovative cost-reduction strategies. For example, some employers are expanding their disease-management programs to more effectively target and reduce employees’ chronic conditions. Others are experimenting with more unusual strategies. For example, according to reports, Wal-Mart is considering paying health-related travel costs to send its employees to hospitals and other providers with better track records for quality care and health outcomes.

Either way, companies will continue to need to address the unique population health challenges—identifiable by looking at claims data—affecting their workforces. An October 2012 Bloomberg BNA report noted that when self-funded plans cut the richness of their benefits, they will erode one of the primary benefits of self-funded benefit plans: “Employers will quickly lose the ability to tailor their plan to meet the unique needs of their populations. If a self-funded plan does not address specific issues within the employer’s population, the effectiveness of the benefit program will decrease and metrics of effectiveness, such as employee absenteeism and productivity, will begin to erode.”

**EXHIBIT 1**

**Employers’ Responses to the Excise Tax, 2013**

The International Foundation of Employee Benefit Plans asked 879 single-employer plans if they were taking action to avoid the 2018 excise tax.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>16.8%</td>
</tr>
<tr>
<td>No, but considering</td>
<td>40.0%</td>
</tr>
<tr>
<td>No, no plan to do so</td>
<td>13.5%</td>
</tr>
<tr>
<td>Not sure</td>
<td>9.6%</td>
</tr>
<tr>
<td>Not applicable, have no high-cost plans</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

**Employers that answered “yes,” by size**

<table>
<thead>
<tr>
<th>Size</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–50</td>
<td>4.1%</td>
</tr>
<tr>
<td>51–499</td>
<td>13.1%</td>
</tr>
<tr>
<td>500–4,999</td>
<td>18.2%</td>
</tr>
<tr>
<td>5,000–9,999</td>
<td>18.5%</td>
</tr>
<tr>
<td>10,000+</td>
<td>29.4%</td>
</tr>
</tbody>
</table>

**WHAT’S NEXT?**

Perhaps the biggest and most apparent unanswered question about the excise tax is whether it will work as intended to achieve its dual goals of both raising revenue to fund health coverage expansion nationwide and lowering health care costs.

As discussed, the recent slowdown in the rate of health cost growth—which many analysts see as a positive development—would mean a reduction in excise tax revenue to fund health reform, causing various funding challenges. Additionally, it remains to be seen whether inflation of health insurance premiums will also cause more health plans to get hit with the excise tax over time.

In addition, will health plans make the changes they need, either in the near term or closer to the excise tax effective date of 2018 and beyond, to avoid paying the tax? In turn, will less generous health plans contribute to lower health costs?

Because, from year to year, studies observe little changes in the effects of benefit plan design, it will likely take longer to determine the effects—usually more significant change is seen over three-to-five-year periods, such as trends tracked in the Employer Health Benefits Survey by the Kaiser Family Foundation and the Health Research and Educational Trust.

One aspect that both Democrats and Republicans do agree on about the excise tax is that it will make employers and employees pay much closer attention to their medical spending over the long run. On average, employer health costs are increasing 5–8 percent a year.

To control costs, it appears the tax will compel some businesses to use this opportunity to structure more managed care plans focusing on care coordination and long-term management of care. Others will shift rising costs, including the potential tax penalty, to employees. Some analysts suggest a paradigm shift is necessary to help consumers make more responsible choices about their use of care. Others point out that for those who really need the gold-plated care, there will be little alternative to paying more.

Already the Obama administration recently delayed—for one year, until 2015—the other major employer-related tax provision in the
“Although the excise tax will not take effect for more than four years, many employers are indeed scaling back coverage to avoid the tax.”

Affordable Care Act, the employer mandate requiring companies to provide insurance for their employees or face tax penalties. Some analysts question whether the excise tax could also be delayed.

A few have pondered whether the tax could also face similar appeals regarding its complexity. On this matter, the Hopkins study suggested reconfiguring the tax to fully account for additional factors. For example, as noted, some high-cost plans are at risk of being taxed as overly generous because they’re located in geographic regions with higher medical care costs.

Tying the tax to plans’ actuarial values instead of premiums would, as one analyst argued, “avoid a nightmare scenario in which political pressure forces Congress to enact annual ‘patches’ for the excise tax as it once did for the alternative minimum income tax.” Regardless of whether the tax remains tied to premiums, the Internal Revenue Service will need to provide additional guidance regarding the thresholds and the adjustments to the threshold in its regulations.

In evaluating the impact and success of the Cadillac tax in the next decade and beyond, it’s important to note that the excise tax is just one of the Affordable Care Act’s many tax provisions. The overall reduction on health costs will be achieved from the cumulative effect of all the law’s provisions, ideally implemented with integrity.

**RESOURCES**


Congressional Budget Office, “Table 1: May 2013 Estimate of the Affordable Care Act on Health Insurance Coverage,” May 2013.


