Watson Wyatt Worldwide

The Problem with Taxing Cadillac Health Plans

December 9, 2009
Roland McDevitt, Ph.D.
Director of Health Care Research

watsonwyatt.com

Summary

In the current health care debate, a “Cadillac plan” is one that pays a high percentage of health care costs. The theory is that such plans lack the necessary financial incentive for consumers to purchase care wisely: i.e., “luxury” coverage is the main driver of high health care utilization and high costs. These costs are passed along to the plan, and result in higher premiums. To address what they perceive as luxury coverage, the Senate leadership bill would impose a 40 percent excise tax on any premiums that exceed $8,500 for single coverage and $23,000 for family coverage in 2013.

The premise that high costs occur only in Cadillac plans is wrong. The new tax would also apply to plans whose members have greater health care risks and needs, and also those who live in high cost geographic areas. Employers seeking to avoid the tax would likely keep premiums under the tax thresholds by cutting back the portion of medical expense paid by the plan. Out-of-pocket costs would rise for those in high risk groups and in high cost areas.

Key findings include…

- A group with a typical PPO but higher-than-average risk could start paying the tax in 2014, even in a city like St. Louis which has average health care costs.
- An employer with a higher-risk group in a high cost area such as the Bronx could pay nearly $10,000 in excise tax for a family of four in 2019.
- The plan sponsor would pay additional taxes if it offers a flexible spending account, a vision plan or a dental plan.
- This level of taxation would create a powerful incentive to reduce plan benefits and increase the out-of-pocket costs of members.

The impact of the new tax would fall disproportionately on Americans who already face higher out-of-pocket costs. These include people who live in high-cost areas, women (whose costs are higher than men), older Americans (whose health care costs increase with age) and people suffering from chronic diseases.

“The impact of the new tax would fall disproportionately on Americans who already face higher out-of-pocket costs.”

Background

Health plans with high premiums are often described as "Cadillac plans," a term that suggests luxurious coverage. Many people believe that high premiums are the result of generous benefits, with little incentive for members to consider the underlying cost of care. Higher costs are passed on to the plan and premiums rise. One way to foster greater cost sensitivity on the part of consumers is to limit the tax preference afforded to health care benefits. A tax on high premium plans, it is argued, could make health care costs more transparent, and motivate both plan members and plan sponsors to control health care spending.

The Senate leadership bill released November 18, 2009, would impose a 40% excise tax on that portion of employer plans valued at more than $8,500 for single coverage and $23,000 for family coverage in 2013.[1] The 40 percent tax is based on the aggregate value of the plan, including medical plan premiums; reimbursements through flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs); and employer contributions to health savings accounts. Premiums for dental and vision care would also count against the aggregate limits.

Group Risk Factors

If the intention of the Senate bill is to tax only plans with rich benefits it will fall short of its goal. Recent research suggests that the actuarial value of a plan (the percentage of all charges paid by the plan) explains as little as 6.1% of the variation in group premiums.[2] Two other plan characteristics that clearly drive the spending of a plan are the characteristics of the covered population and the local markets where health care services are delivered.

Exhibit 1 presents Watson Wyatt estimates of 2009 medical expense for men and women in five-year age groupings. Clearly the age and gender composition of a covered group is a major determinant of plan expense, as women in their child-bearing years spend far more than men in the same cohort, and costs escalate after age 40 for both men and women. The expected costs for men ages 60-64 are over six times the expected costs for the youngest men. Among adults in their late 20s, women average more than two and a half times the spending of men.

---

[1] The Senate bill provides for a three year transition period with higher tax thresholds in 17 states. It also provides higher limits for plans offered to employees in certain high risk occupations.

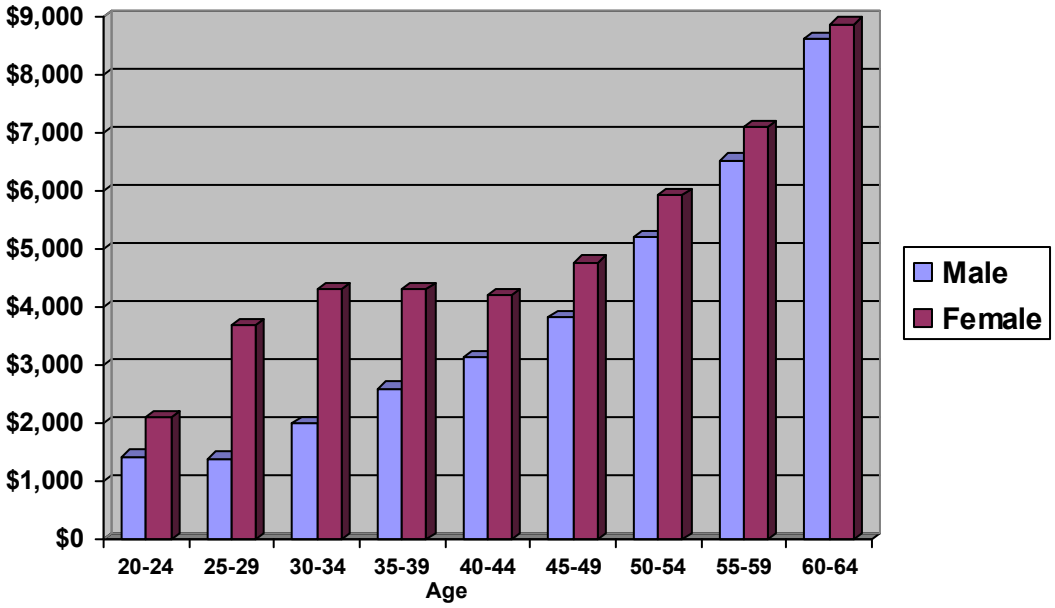
[2] Jon Gabel, Jeremy Pickreign, Roland McDevitt, and Thomas Briggs, "Taxing Cadillac Health Plans May Produce Chevy Results," Health Affairs, doi: 10.1377/hlthaff.2008.0430 (Published online December 3, 2009): http://content.healthaffairs.org/cgi/content/abstract/hlthaff.2008.0430

"…women in their child-bearing years spend far more than men in the same cohort, and costs escalate after age 40 for both men and women."

Exhibit 1 | Estimated Medical Expense for Men and Women by Five-Year Age Groupings, 2009

Source: Watson Wyatt Worldwide medical claims database of over 5 million people with coverage from large employers.

Note: Medical expense estimates in this exhibit are allowed charges submitted to large employer plans. They include both the portion paid by the plan and the portion paid out-of-pocket.



Other risk factors not captured in Exhibit 1 also influence health care spending. Chronic conditions such as diabetes and obesity have a major affect on spending. Ken Thorpe of Emory University analyzed area cost variation in the Medicare program and identified chronic conditions as an important cost factor. In addition to high cost urban areas, he found that rural areas with a high incidence of obesity also experienced high costs. These and other chronic conditions contribute greatly to the overall use of health care.[3]

[3] Ken Thorpe, "Cost Variations - What Are They From?" Partnership to Fight Chronic Disease, accessed Dec. 6, 2009 at: http://fightchronicdisease.org/media/blog/?p=167

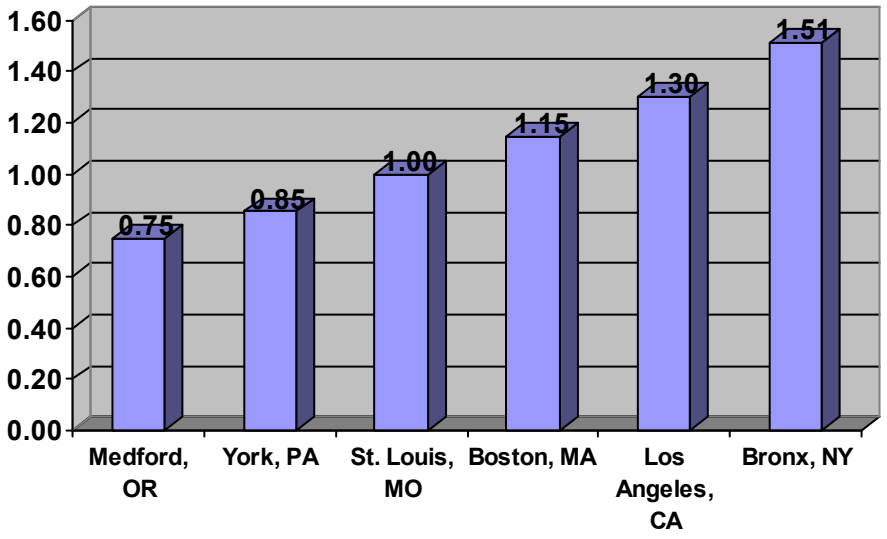
Area Cost Variation

A recent New Yorker article by Atul Gawande described two Texas towns that seem similar with respect to their populations, health conditions and levels of income. Per-member costs in one town are among the highest for Medicare, while costs in the other town are about half this level.[4] Gawande goes on to describe the differences in how providers are organized in the two communities, and how this drives their practice patterns and the level of health care utilization in the two communities. These local cost variations are independent of plan design and exist even within a single state.

The Gawande article drew on the pioneering work of Elliot Fisher and colleagues at Dartmouth who have analyzed Medicare data to demonstrate the importance of provider practice patterns.[5] Exhibit 2 presents Medicare data from the Dartmouth Atlas showing the relative levels of Medicare spending per enrollee in six hospital referral regions during 2006.

Exhibit 2 | Relative Medicare Spending per Medicare Enrollee for Part A and Part B Services in Six Hospital Referral Regions, 2006

Source: Watson Wyatt calculations from per-enrollee spending data downloaded from The Dartmouth Atlas of Health Care at: http://dartmouthatlas.org/ on November 17, 2009.



[4] Atul Gawande, "The Cost Conundrum: What a Texas town can teach us about health care," The New Norker, June 1, 2009.

[5] Jason M. Sutherland, Ph.D., Elliott S. Fisher, M.D., M.P.H., and Jonathan S. Skinner, Ph.D., "Getting Past Denial — The High Cost of Health Care in the United States," New England Journal of Medicine, September 9, 2009. See: http://healthcarereform.nejm.org/?author=9

Spending in St. Louis was very close to the national average of $8,304, while spending in Medford was 25 percent lower and spending in the Bronx was 51 percent higher. These variations existed despite a standard Medicare benefit design in every state.

Although the Senate leadership bill acknowledges the importance of cost differences at the state level by providing higher tax thresholds in 17 high cost states for the 2013-2015 period, those higher limits are fully phased out by 2016. Of equal importance, those higher limits are at the state level. The research provided by Fisher and colleagues indicates that the area cost variation is far greater at the local level than at the state level.

Combining Cost Factors for Age and Area

Exhibit 3 illustrates the cost disparities that can result from combining the cost factors of different age groups with the area cost variation reported by the Dartmouth team. Multiplying the area factors by the age-related risk factors, the combined cost variation ranges from a low of .56 for a low-risk group in Medford to a high of 1.89 for a high-risk group in the Bronx.[6]

Exhibit 3 | Combining Age-Related Cost Factors and Area Factors

Source: Age-related risk factors derived from Exhibit 1 and area factors taken from Exhibit 2. Calculations by Watson Wyatt Worldwide.

		Age-Related Risk Factors		
	Area Factors	Low	Medium	High
		0.75	1.00	1.25
Medford, OR	0.75	0.56	0.75	0.94
York, PA	0.85	0.64	0.85	1.06
St. Louis, MO	1.00	0.75	1.00	1.25
Boston, MA	1.15	0.86	1.15	1.44
Los Angeles, CA	1.30	0.98	1.30	1.63
Bronx, NY	1.51	1.13	1.51	1.89

[6] These factors are illustrative. The Dartmouth table shows more extreme values than what we report for these six hospital referral areas. Similarly, group risk characteristics might vary even more that what is illustrated here.

Impact of an Excise Tax

We use the cost factors from Exhibit 3 to adjust the average national PPO premium reported in the 2009 Kaiser Family Foundation Survey. This illustrates what the premiums might be for a standard PPO with average cost-sharing provisions, but for groups with differing ages and locations. We then trend forward estimates of premiums for single coverage and for a family of four through 2019, assuming a 7 percent medical cost trend. This allows us to estimate the excise tax for each group in each location.

In 2013, the Senate leadership bill would levy a 40 percent tax on any individual premium higher than $8,500 and any family premium higher than $23,000, with the thresholds rising by 1 percent more than the Consumer Price Index. We assume a CPI-U of 1.9 percent and an overall threshold trend of 2.9 percent per year.

Appendix 1 presents the results for hypothetical employer groups in St. Louis and the Bronx. The Senate bill provides for higher tax thresholds in 17 high cost states during a transition period, with the tax thresholds in high cost states set at 120% of the national standard in 2013, dropping to 110% in 2014 and to 105% in 2015. Our estimates assume that New York would be designated a high cost state, and our excise tax estimates for the Bronx reflect this adjustment.

“By 2019 an employer with a higher cost group in St. Louis could be paying $805 in taxes per single contract and $2,572 per family contract.”

Under these assumptions, groups located in an average cost area like St. Louis would not pay excise taxes initially when the law is implemented in 2013. Nevertheless, a group with an age mix 25% more costly than average could expect to start paying the excise tax in 2014 even in St. Louis, and the tax grows over time. By 2019 an employer with a higher cost group in St. Louis could be paying $805 in taxes per single contract and $2,572 per family contract.

The excise tax imposes a far heavier burden on employers in high cost areas such as the Bronx. In 2013 a higher cost group in the Bronx would cost employers an additional $761 in taxes for single coverage and $2,537 for family coverage. By 2019 these taxes would rise to $3,229 for single coverage and $9,454 for family coverage. Even an employer with an age mix 25% less costly than average would be paying the excise tax if located in the Bronx. We

estimate that such an employer would be paying $350 per single contract and $1,304 per family contract in 2019.

Regardless of the geographic area, it appears that the excise tax will eventually hit all plans with average cost sharing provisions. The thresholds above which premiums are taxed are indexed at CPI-U plus 1 percent (just under 3 percent growth per year). That growth rate is far less than the long term rates of growth in medical spending over the past 50 years.

Conclusion

The term "Cadillac plan" implies luxurious benefits with little financial incentive for members to concern themselves with the cost of care. Our analysis shows that even a standard PPO plan with average cost sharing may have excess benefits under the Senate leadership bill, depending on the characteristics of plan members and where they live.

During 2007, the average single adult in a PPO plan paid $810 out-of-pocket, and the top 10 percent of spenders averaged $3,875.[7] These out-of-pocket costs will rise in the future and they will rise even faster than health care costs if employers increase member cost sharing to reduce premiums. A recent survey of employers found that 63% would cut plan costs to avoid paying the excise tax threshold, 23% would share the cost of the tax with employees and 7% would terminate the plan.[8]

As policymakers strive to extend coverage to more Americans, they must keep coverage affordable for those with employer plans. An excise tax based solely on premiums is a very blunt instrument to control spending. As demonstrated in this paper, many factors influence spending, including age, gender, chronic conditions, and local pricing and practice patterns. These factors are largely beyond the control of individual employers and their employees. Taxing groups in high cost areas and with high cost members could make health care unaffordable for many families that currently have employer coverage.

---

[7] Jon R. Gabel, Roland McDevitt, Ryan Lore, Jeremy Pickreign, Heidi Whitmore and Tina Ding, "Trends in Underinsurance and the Affordability of Employer Coverage, 2004–2007," Health Affairs, July/August 2009; 28(4): w595-w606.

[8] Mercer, "Majority of employers would reduce health benefits to avoid proposed excise tax, survey finds," accessed December 6, 2009 at http://www.kaiserhealthnews.org. Another survey by Towers Perrin found similar results: "Towers Perrin Health Care Cost Survey Shows Employer-Sponsored Medical Benefit Costs to Rise 7% to Over $10,000 for the First Time," press release on October 9, 2009. Accessed December 7 at: http://www.towersperrin.com/

"…a standard PPO plan with average cost sharing may have excess benefits under the Senate leadership bill…"

The Senate leadership bill would establish higher limits for some retirees and employees in certain high-risk professions. It would also offer temporarily higher tax thresholds in 17 states. But the Dartmouth research demonstrates that health care costs and practice patterns vary greatly among hospital referral regions – geographic areas that are much smaller than states.

Even a mainstream PPO can run up against excise tax thresholds rather quickly, as illustrated by our projections. We assume a 7 percent medical trend, but a cost trend of 8 percent could produce a much greater tax burden for employers over time. Finally, our projections ignore some health care benefits that would count against the excise tax thresholds. Employees who set aside money in an FSA would be pushing their plan toward the tax thresholds. Dental and vision benefits could add another 10 percent to aggregate benefits – in some cases moving an employer's benefit package into the taxable status, even when the medical plan is a PPO with average cost sharing provisions.

This new tax could undermine the affordability of mainstream employer health benefits for those groups already facing the highest health care costs, including women, older Americans and those with those with chronic conditions. It would also fall disproportionately in those who live in areas where local costs are above the national average. If employers respond by cutting benefits, the cuts could go far beyond what most people would characterize as Cadillac plans.

"This new tax could undermine the affordability of mainstream employer health benefits for those groups already facing the highest health care costs, including women, older Americans and those with those with chronic conditions."

Appendix 1 | Projection of Premiums and Excise Taxes for Low, Medium and High-Risk Groups with a Typical PPO Plan in St. Louis, MO, and Bronx, NY

Source: PPO premiums from national averages reported in the 2009 KFF/HRET Employee Health Benefits Survey. Tax thresholds for the Bronx include higher transition amounts for 2013-2015. Calculations by Watson Wyatt Worldwide.

St. Louis	Tax threshold	Single coverage premium by risk			Excise tax by risk				Tax threshold	Family of four premium by risk			Excise tax by risk			
		Low	Medium	High	Low	Medium	High			Low	Medium	High		Low	Medium	High
2010		3,950	5,267	6,583				2010		11,009	14,679	18,349	2010			
2011		4,226	5,635	7,044				2011		11,780	15,707	19,634	2011			
2012		4,522	6,030	7,537				2012		12,605	16,806	21,008	2012			
2013	8,500	4,839	6,452	8,065	-	-	-	2013	23,000	13,487	17,983	22,479	2013			
2014	8,747	5,178	6,903	8,629	-	-	-	2014	23,667	14,431	19,242	24,052	2014	-	-	154
2015	9,000	5,540	7,387	9,233	-	-	93	2015	24,353	15,441	20,589	25,736	2015	-	-	553
2016	9,261	5,928	7,904	9,880	-	-	247	2016	25,060	16,522	22,030	27,537	2016	-	-	991
2017	9,530	6,343	8,457	10,571	-	-	417	2017	25,786	17,679	23,572	29,465	2017	-	-	1,471
2018	9,806	6,787	9,049	11,311	-	-	602	2018	26,534	18,916	25,222	31,527	2018	-	-	1,997
2019	10,090	7,262	9,682	12,103	-	-	805	2019	27,304	20,241	26,987	33,734	2019	-	-	2,572
Bronx																
2010		5,964	7,904	9,880				2010		16,624	22,166	27,707	2010			
2011		6,382	8,457	10,571				2011		17,788	23,717	29,647	2011			
2012		6,829	9,049	11,311				2012		19,033	25,378	31,722	2012			
2013	10,200	7,307	9,682	12,103	-	-	761	2013	27,600	20,366	27,154	33,943	2013	-	-	2,537
2014	9,621	7,818	10,360	12,950	-	296	1,332	2014	26,034	21,791	29,055	36,319	2014	-	1,208	4,114
2015	9,450	8,365	11,085	13,857	-	654	1,763	2015	25,571	23,316	31,089	38,861	2015	-	2,207	5,316
2016	9,261	8,951	11,861	14,827	-	1,040	2,226	2016	25,060	24,949	33,265	41,581	2016	-	3,282	6,609
2017	9,530	9,577	12,692	15,864	19	1,265	2,534	2017	25,786	26,695	35,593	44,492	2017	363	3,923	7,482
2018	9,806	10,248	13,580	16,975	177	1,510	2,868	2018	26,534	28,564	38,085	47,606	2018	812	4,620	8,429
2019	10,090	10,965	14,531	18,163	350	1,776	3,229	2019	27,304	30,563	40,751	50,939	2019	1,304	5,379	9,454

For more information on taxation of health benefit plans, call Watson Wyatt at 800.388.9868 or visit watsonwyatt.com.

Funding for the research presented in this brief was provided by the Partnership for Healthcare Reform.