SmarterHealthCareCoalition

Background and Discussion Points on the "Cadillac Tax"

Background:

Background on the ACA provision: The ACA includes a 40% excise tax on high-cost employer-sponsored health plans, often called the "Cadillac tax."[1] The amount of the tax is based on the "aggregate cost" of the employer-sponsored coverage. To the extent the aggregate cost of coverage exceeds a threshold amount – starting in 2018 at $10,200 for individual coverage and $27,500 for spouse/family coverage, with some adjustments to account for age, gender, and industry differences in premium – there is a tax equal to 40 percent of the "excess benefit." The tax is expected to take effect in 2018.

Current status of the regulatory process: In February of 2015, the IRS released a Notice[2] to initiate the process of developing regulations and guidance on the Cadillac tax. The Notice identified potential approaches to a number of issues and invited comments on these approaches. IRS anticipates issuing another notice seeking further comments, followed by proposed and then final regulations implementing this tax.

Goals of the tax, and potential unintended consequences:

The goals of the Cadillac tax should be seen in the context broader payment and delivery system reforms, which are increasingly focused not only on costs, but on how wisely we choose to spend our health care dollars and understanding the value that services provide. Similarly, a long recognized objective of reform has been to reduce unexplained variations in health care spending – that is, variation in spending that is not explained such as by differences in health outcomes or quality. Innovations in coverage design and payment methods that encourage access to evidence-based high value services are increasingly seen as a means for helping achieve these goals.

In theory, the Cadillac tax operates to address a potential concern (fueled by the fact that wages are subject to federal income tax while employer-provided health benefits are not) that group health plan designs offering generous benefits and little to no cost-sharing may do little to engage consumers in their health decisions and could encourage overutilization of low-value services that place a high cost on the health system overall. Viewed this way, the Cadillac tax aims to discourage overutilization of low-value care.

From a policy perspective, however, if this is the goal, a more structured and focused approach may be more effective and lower the risk of unintended consequences. In particular, one concern that has been voiced regarding the Cadillac tax is that its focus on the aggregate cost of coverage (even accounting for certain adjustments), may not account for the various factors and nuances in plan design that influence whether a plan contributes to these overarching goals.

Accounting for other factors that might influence the cost of coverage

A recent analysis by Milliman[3] reinforces these points. According to the analysis, a number of factors besides the richness of benefits could affect whether a given plan would be subject to the tax. These

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[1] Section 4980I of the Internal Revenue Code.

[2] Treasury Notice 2015-16, http://www.irs.gov/pub/irs-drop/n-15-16.pdf

[3] See summary at http://www.nea.org/assets/docs/Actuarial_Study_on_Excise_Tax--In_Brief--March_13_2015.pdf

include geographic location, industry, and the age and gender of plan members. Because of this, a plan that provides only moderate benefits may meet the threshold in some circumstances. Conversely, in some areas and industries, it is unlikely that the threshold could be exceeded no matter how rich the benefit plan is. Thus, in many cases, whether the tax is imposed could be based, not on the richness of the benefits or whether the coverage encourages overutilization of low-value care, but on the age, gender, geography, or industry of the specific plan and its participants. Others have expressed similar concerns.[4]

The Cadillac Tax specifically provides for the threshold amount for which the aggregate cost of the coverage is measured to be adjusted based on the age and gender of enrollees in a given plan, as well as the general industry classification. This could partially mitigate concerns in these areas. However, the report shows that in some circumstances, these adjustments may not be sufficient to take into account the effects of age, gender, and industry on the cost of coverage. In addition, the report points out other factors – particularly geography – play a key role in health care costs. If these factors are not appropriately adjusted for, plans could be "taxed" – based not on the richness of the benefits but rather based on their location, industry, or the age and gender of their workforce.

Policy Potential: Mechanisms to account for nuanced considerations in plan design that encourage high-value care

In addition to not addressing a range of factors likely to impact premium levels, a tax based solely on premium might not take into account more nuanced considerations in plan design, such as the clinical value of the services that are covered. For example, many plans, through their benefit structure, aim to encourage enrollees to focus on high-value care and discourage overutilization of low-value services. Such plans strive to incorporate the concept of clinical nuance, which recognizes that: (1) medical services differ in the benefit provided; and (2) the clinical benefit derived from a specific service depends on the characteristics of the patient receiving it, who provides it, and where the service is delivered.[5] Such plan designs may contribute to the goal of smarter and higher value care, but would not necessarily be encouraged – and might even be discouraged – if the tax does not take into account such design considerations when determining what is an "excess benefit."

Going forward, one policy consideration is whether the costs attributable to certain value-based insurance design or with a program that sought to tie and align value-based insurance design with performance-based or alternative to fee-for-service payment mechanisms might be excluded from the aggregate cost of coverage when determining whether a plan is subject to the tax, or otherwise included as part of an adjustment under the Cadillac tax. Such an approach would encourage the development of these types of programs and more directly help to achieve many of the goals that have been ascribed to the Cadillac tax as a means of improving health system performance.[6]

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[4] Early in the debate over health reform, the American Academy of Actuaries and the Society of Actuaries estimated that the Cadillac tax would likely primarily impact "plans that are high cost because of factors such as a less healthy population or higher-cost geographic areas, rather than plans with the most generous benefits." See "Technical Report: Fedseral Health Care Reform: Excise Tax on High-cost Employer Plans," January 2010, available at https://www.soa.org/Files/Research/research-fed-health-excise-tax.pdf.

[5] See the University of Michigan Center for Value-Based Insurance Design, "The 'Cadillac' Redesign: A Role for Clinical Nuance & V-BID," October, 2013, available at http://vbidcenter.org/wp-content/uploads/2014/10/V-BIDCenterBriefOctober.pdf.

[6] The policy goals underlying value-based insurance design and payment reform are reflected legislatively in the Affordable Care Act, such as through the preventive services at zero cost-sharing provision, and recent SGR legislation encouraging both performance-based and alternative payment models. Pub. L. 114-10, https://www.congress.gov/114/bills/hr2/BILLS-114hr2enr.pdf. Value-based insurance design also has support in Medicare Advantage. See a request for information released by CMS in 2014, available at http://innovation.cms.gov/files/x/hpi-rfi.pdf. Bipartisan bicameral legislation was introduced in Congress last year encouraging a demonstration exploring Value-Based Insurance Design within Medicare Advantage. http://vbidcenter.org/wp-content/uploads/2014/11/VBID-Bill-Better-Care-Lower-Costs-2014.pdf.