

Compendium of Reports on the Senate Health Benefits Tax

As of January 8, 2010

This compendium excerpts 19 reports and articles from government and private-sector organizations that have analyzed the effects of the excise tax on higher-cost health plans contained in legislation proposed by the U.S. Senate. The findings from these documents are summarized as follows:

1. The excise tax will affect large numbers of health plans that reach deep into the middle class.
2. High-cost plans typically are not due to “excessive” benefits. They are largely due to demographic factors in the workforce – age, gender, chronic conditions, and type of industry – and local pricing and practice patterns.
3. The excise tax will not let many workers keep the good health plan they have now. To avoid the tax, affected health plans will significantly reduce benefits and increase cost-sharing (deductibles and co-pays) in order to get premiums below the thresholds at which the tax applies. These cuts will be dramatically larger in the second decade as the difference between health plan inflation and the rate at which the thresholds increase grows exponentially.
4. The excise tax will destabilize the employer-based system resulting in plan terminations, higher costs to workers, and a shift to lower-cost high deductible health plans with limited benefits.
5. There is no evidence that the excise tax “bends the cost curve” – reducing the underlying rate of growth and inflation in the health care system. There will be some modest reduction in health care costs to employer plans and to overall health expenditures – not because the excise tax bends the cost curve but largely because it reduces the amount of health care for which people are covered.
6. The excise tax will not bend the cost curve because it does not address the fundamental cost-drivers in our health care delivery system so that care becomes less expensive and is delivered more cost effectively.
7. Higher cost sharing will lead to lower utilization and foregoing needed care, which will result in worse health outcomes and increased health disparities.
8. Lower utilization has done little to reduce costs in the United States. We are already near the bottom in hospital and physician usage, but our health costs are 50 percent more than the next highest spending country.
9. The excise tax is a large tax increase on middle class Americans, and it is a regressive tax increase, especially when compared with the surcharge on wealthy individuals proposed in the House of Representative’s legislation.
10. Most employers will not increase workers’ wages in exchange for cutting health benefits, contrary to assumptions made by the Congressional Budget Office (CBO).

Joint Committee on Taxation¹

http://files.cwa-union.org/healthcarevoices/091217_CWAExciseTaxReport.pdf

The Joint Committee on Taxation prepared an analysis of the distributional effects of the excise tax contained in Senate Majority Leader Reid's legislation, which the Communications Workers of America analyzed in a report.² JCT data shows that the excise tax would:

- Affect 27 percent of single plans and 22 percent of family plans in 2019.
- Affect nearly 25 million households in 2019, including one-fifth of middle-class households making between \$50,000 and \$75,000.
- Cost affected households an additional \$7,500 in taxes on average between 2013 and 2019, or more than \$1,000 a year.
- In 2019, cost affected taxpayers who are millionaires an extra \$2,600 in taxes and those making between \$50,000 to \$75,000 an extra \$1,100 in taxes, but the wealthy taxpayers' income will be at least 13 to 20 times greater.
- Be a tax increase equal to 0.1 percent of income for those households affected that make more than \$1 million a year and be a tax increase equal to 1.4 percent for those households affected that make \$50,000 to \$75,000.³

Centers for Medicare and Medicaid Services, Chief Actuary Richard S. Foster, December 10, 2009⁴

<http://www.tnr.com/sites/default/files/CMSActuarySenate.pdf>

- "In reaction to the tax, many employers would reduce the scope of their health benefits. The resulting reductions in covered services and/or increases in employee cost-sharing requirements would induce workers to use fewer services."⁵
- "We estimate that, in aggregate, affected employers would reduce their benefit packages in such a way as to eliminate about three-quarters of the current excess benefit value [the amount above the thresholds that the excise tax is assessed]. The resulting higher cost-sharing requirements for employees would have an initial, significant impact on overall level of health expenditures."⁶

¹ Joint Committee on Taxation letter to Rep. Joe Courtney (D-Conn.) from Thomas A. Barthold, Chief of Staff, Dec. 8, 2009. CWA prepared a report based on this data. The JCT letter and report are available at http://files.cwa-union.org/healthcarevoices/091217_CWAExciseTaxReport.pdf

² Communications Workers of America, "Senate Health Plan Excise Tax = A Big Middle Class Tax Increase," Dec. 17, 2009.

³ Ibid, p. 1.

⁴ CMS, Office of the Actuary, Richard S. Foster Chief Actuary, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act of 2009,' as Proposed by the Senate Majority Leader on November 18, 2009," Dec. 10, 2009. p. 15.

⁵ Ibid, p. 11.

⁶ Ibid, p. 15

- “[B]ecause plan benefit values would generally increase faster than the threshold amounts for defining high-cost plans (which are indexed by the CPI plus 1 percent), over time additional plans would become subject to the excise tax, prompting those employers to scale back coverage.”⁷
- “These further adjustments would contribute to a *small* reduction in the growth of health care expenditures for affected employees through at least 2019. In 2019, these impacts would reduce total NHE [National Health Expenditures] by an estimated 0.3 percent.”⁸ [emphasis added]

Congressional Budget Office, Letters to Sen. Evan Bayh and Senate Majority Leader Harry Reid, November 9 and December 19, 2009.⁹

- “[To avoid the tax] the majority of the affected workers would enroll in one of those plans with lower premiums. Plans could achieve lower premiums through some combination of greater cost sharing (which would lower premiums directly and also lower them indirectly by leading to less use of medial services), more stringent benefit management, or coverage of fewer services.”¹⁰
- “On balance, the average premium among the affected workers would be about 9 percent to 12 percent less than under current law. Those figures incorporate the other effects on premiums for employment-based plans that were summarized above...”¹¹ [This figure is an indication of the extent to which plans would have to reduce coverage to bring their premiums below the tax threshold. It does not represent a reduction in the price of insurance for a given amount of coverage, but rather a reduction in the amount of coverage.]
- “The excise tax on high-premium insurance plans ... would generate about \$35 billion in additional revenues in 2019 and [expects that] receipts would grow by roughly 10 percent to 15 percent per year in the following decade.”¹²

⁷ Ibid, p. 11.

⁸ Ibid, p. 15.

⁹ CBO letter to Sen. Evan Bayh, “An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act,” Nov. 30, 2009

<http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf>

CBO letter to Senate Majority Leader Harry Reid, estimating the direct spending and revenue effects of the Patient Protection and Affordable Care Act “manager’s amendment,” Dec. 19, 2009.

http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers.pdf

¹⁰ CBO letter to Sen. Bayh, p. 25.

¹¹ Ibid, p. 8.

¹² CBO letter to Senate Majority Leader Harry Reid, p. 16.

Commonwealth Fund: “Starting on the Path to a High Performance Health System: Analysis of Health System Reform Provisions of House of Representatives and Senate Health Reform Bills,” December 2009¹³

http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2009/Nov/Starting%20on%20the%20Path/Dec%20Update/1350_Davis_starting_on_path_system_reform_cong_bills_v2.pdf

- The Commonwealth Fund surveyed health care opinion leaders to rank 11 system reform provisions in the House and Senate health care bills. Putting a “tax on premiums in excess of [a] threshold” (i.e., the excise tax) was ranked last. Among those ranked significantly higher were establish insurance exchanges, institute provider payment innovations, negotiate pharmaceutical prices, and create an independent Medicare Advisory Board.¹⁴
- “[T]here is little empirical evidence that a tax on high-premium plans would target those plans that provide excessive benefits, and thus little evidence the tax would have a significant effect on health care spending.”¹⁵
- “Evidence suggests that such a policy could disproportionately affect workers in small firms, older workers, and wage earners in industries with high expected claims costs.”¹⁶

Communications Workers of America, “Federal Workers Most Popular Health Plan Will Be Hit Hard by Senate Excise Tax,” December 8, 2009

http://files.cwa-union.org/healthcarevoices/fehbp_report.pdf

- The report examines how the Federal Employees Health Benefits Program’s (FEHBP) most popular health care plan – the Blue Cross/Blue Shield Standard plan – will be affected by a 40% excise tax. Forty-eight percent of all federal employees are enrolled in this plan; including retirees and dependents, the plan covers nearly 3.8 million Americans.¹⁷
- “The BC/BS Standard plan is touted as the type of plan that will not be taxed under the Senate bill. That’s because it is not considered a “Cadillac” plan — the supposed target of this tax. It is more like a Chevy — it provides basic coverage, but participants bear significant costs. For example, federal employees pay about 30 percent of the premium and there is a relatively high out-of-pocket maximum of \$7,000 in the family plan.”¹⁸

¹³ Authors are Karen Davis, Stuart Guterman, Sara R. Collins, Kristof Stremikis, Sheila Rustgi, and Rachel Nuzum.

¹⁴ Ibid, p. vi, Exhibit ES-1.

¹⁵ Ibid, p. 27.

¹⁶ Ibid.

¹⁷ P. 1.

¹⁸ Ibid.

- The Blue Cross/Blue Shield Standard plans have increased about 9 percent a year over the last decade. At that rate of inflation in the future, the effect of the excise tax on the BC/BS Standard plans with average dental and vision benefits is projected as follows:
 - The plan serving singles will get hit by the excise tax in the first year – 2013. The family plan will start getting hit in the third year.
 - Over the first 10 years, the single plan will face an excise tax of more than \$16,000 per worker, or an average of \$1,600 a year. The family plan will face an excise tax of more than \$20,000 per worker, or an average of \$2,000 a year.
 - By 2022, the family plan could face an excise tax of \$5,500 per worker and the tax on a single plan could be \$3,500 per worker.¹⁹

Economic Policy Institute, “The House Health Care Bill is Right on the Money, Taxing High Incomes is Better than Taxing High Premiums,” Dec. 11, 2009²⁰

http://epi.3cdn.net/d4461bae3920d3a28a_7jm6b9314.pdf

- “The excise tax will hit many workers with ordinary health plans, not exclusively high-value plans.”
- “The excise tax shifts health costs and risks onto workers and their families, especially hitting hard those with high medical needs.”
- “Consumers may respond to their increase in out-of-pocket burden by cutting back on medically indicated as well as cost-effective medical care.”
- “Even if workers receive cash wages in exchange for the cut in their benefits, their total compensation will still go down, and much of their wages may be eaten up by increased health costs.”
- “Any cost containment from the excise tax is likely to be completely swamped by other determinants of health care costs.”
- “The existing academic literature as well as indirect evidence provided by overall income tax changes in recent decades indicate that any cost-containment from the excise tax will be completely swamped by other determinants of health care costs.”²¹

¹⁹ Ibid.

²⁰ EPI Issue Brief #267; authors are Josh Bivens, EPI economist, and Elise Gould, Director of Health Policy Research, EPI

²¹ Ibid, pp. 1-2.

Economic Policy Institute, "Employer Health Costs Do Not Drive Wage Trends," Jan. 6, 2010²²

http://epi.3cdn.net/f121df10fab53d2b16_3nm6bhd7e.pdf

- "One claim for the Senate excise tax has recently surfaced: that health care cost increases have been a major driving force in constraining wage growth and that wages will grow more strongly by curtailing employer health costs via the excise tax. This claim boldly asserts that health care costs are large enough (and the tradeoff with wages is large enough) to drive major changes in overall wages."
- "Proponents of this theory point for evidence to the latter half of the 1990s, a five-year period when wages were growing rapidly while growth in employer health care spending was relatively constrained. They contrast the period from 1995 to 2000 with the periods from 1989 to 1995 and 2000 to 2006, when wages stagnated while health care costs grew much more rapidly."
- "[T]his 'health care theory of wage determination' is wrong, and other factors explain these overall wage trends. The simple explanation is that productivity accelerated in the mid-1990s, and the low unemployment (and hikes in the minimum wage) facilitated faster wage growth. That this wage growth disappeared entirely in the 2002-07 recovery is not due to faster health care cost increases but to weak employment growth and employers' ability to achieve increased profitability rather than pass on productivity gains to workers. This reveals a fundamental flaw in our economy: productivity gains are not passed on to higher living standards for workers."
- "There is something fundamentally broken about our economy when workers gain nothing from productivity growth, and this should give pause to those who assume that when employers lower their health care expenses they will automatically pass these savings onto workers in the form of higher wages. This is an especially problematic assumption given the very high unemployment expected to prevail over the next five years, an environment where workers will have little leverage."²³

Employee Benefit Research Institute, "Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employers and Workers," January, 2009²⁴

http://www.ebri.org/pdf/briefspdf/EBRI_IB_1-2009_TaxCap1.pdf

- "If retiree health benefits were subject to the tax cap, retirees would be much more likely to incur higher taxes than active workers. Retirees are older and less healthy than the average worker... Premiums for retirees are higher than active worker premiums because they are older and use more health care services than

²² EPI Issue Brief #269; author is Lawrence Mishel, President of the Economic Policy Institute.

²³ Ibid., pp. 1-3.

²⁴ Author is Paul Fronstin, director of the Health Research and Education Program at EBRI.

- the typical younger active worker. A uniform tax cap across workers and retirees would mean that a disproportionate number of retirees would be above the tax cap simply because of their age and health status.”²⁵
- “Workers face a variety of equity issues if the tax exclusion of health coverage were capped. For instance, there are several reasons why the value of health coverage might be above the cap, completely independent of the comprehensiveness of coverage: Coverage costs are known to vary with firm size, employee health status, average age of the group of employees, and geographic region.”²⁶
 - “As a result of these factors some workers may incur higher taxes simply because of where they live, their employers’ ability to negotiate premiums, and the composition of the risk pool in which they are insured. Retirees may also be affected simply because of their age or health status.”²⁷

Health Affairs, “Taxing Cadillac Health Plans May Produce Chevy Results,” December 3, 2009²⁸

<http://content.healthaffairs.org/cgi/reprint/hlthaff.2008.0430v1>

- “It’s often assumed that high-cost health insurance plans – sometimes called “Cadillac” plans – provide rich benefits to plan subscribers. ... Only 3.7 percent of variation in the cost of family coverage can be explained by benefit design (actuarial value). Benefit design plus plan type (HMO, PPO, POS, or high deductible plans) explains 6.1 percent of this variation.”²⁹
- “Our inquiry suggests, however, that analysts should not equate high-cost plans with Cadillac plans, but that in fact other factors – industry and cost of medical inputs – are as important in predicting whether a plan is a high-cost plan. Without appropriate adjustments, a simple cap may exacerbate rather than ameliorate current inequities.”³⁰
- “Because the health status of the workforce and cost of medical inputs are beyond a firm’s control, public policy efforts to limit deductibility of employee benefits should make adjustments for these two factors. The implication is that limiting deductibility of employee benefits is not the targeted policy mechanism advocated for more than thirty years.”³¹

²⁵ Ibid, p. 13.

²⁶ Ibid, p. 16.

²⁷ Ibid.

²⁸ Jon Gabel, Jeremy Pickreign, Roland McDevitt, and Thomas Briggs, Health Affairs, Vol. 29, No. 1 (2010).

²⁹ Ibid, p. 1.

³⁰ Ibid, p. 7.

³¹ Ibid.

Health Affairs, “Market Failure and the Failure of Discourse: Facing Up to the Power of Sellers,” 2009³²

<http://content.healthaffairs.org/cgi/reprint/28/5/1305>

- “Health economists, especially those in the United States, are enamored with patient cost sharing. It’s easy to see why. If one assumes that people have good information, why not let them have some ‘skin in the game,’ letting them weigh the costs versus benefits of obtaining another service?”³³
- “We do not dispute that higher patient cost sharing reduces service usage. But lower utilization in the United States has done nothing to reduce costs. The United States spends more than 50 percent more than the second highest country, Switzerland, and nearly twice the amount of many others, but it is tied for the lowest hospital usage rates and ranks eighth of ten in use of physician services.”³⁴
- “To sum up, it is hard to argue that (1) consumer demand overall is too high in the United States and therefore needs to be moderated by rationing via the price mechanisms...”³⁵
- “U.S. health care spending is high because U.S. health care prices are high. Americans don’t use more health services than their counterparts in other industrialized nations, nor is the quality of care they receive systematically higher. They just pay more per unit, and the people and companies who provide those services earn more, in general, than their foreign counterparts do.”³⁶
- “There is much hand-wringing about spending, but little attention is paid to the main culprit: lack of market power by purchasers—something that exists in nearly all other countries.”³⁷
- “Every other industrial nation has sought to redress this imbalance through a variety of governmental or quasi-governmental regulatory mechanisms designed to improve purchasers’ market power. In the United States we have actively fled from such a posture.”³⁸

³² Bruce Vladeck and Thomas Rice, “Market Failure and the Failure of Discourse: Facing Up to the Power of Sellers,” *Health Affairs*, vol. 28, no. 5 (2009).

³³ *Ibid.* p. 1310.

³⁴ *Ibid.*

³⁵ *Ibid.*, p. 1312.

³⁶ *Ibid.*, p. 1305.

³⁷ *Ibid.*

³⁸ *Ibid.*, p. 1306.

Hewitt Associates, Testimony to the Senate Finance Committee, May 26, 2009³⁹

http://www.hewittassociates.com/ MetaBasicCMAssetCache /Assets/Legislative%20Updates/2009/Testimony_Sperling_May_26_09.pdf

- Hewitt Associates is a global human resources consulting company, providing services to major employers in more than 30 countries.
- “Hewitt believes that changes to the tax exclusion for employer-provided coverage carry the risk of destabilizing the employer-based system and undermining the support of the American public for health care reform.”⁴⁰
- “Over time, more employees would be subject to taxation if the cap were indexed at something less than the full cost of medical cost increases. Indeed, depending on the indexing method used, it is possible that over the long term, the threshold for taxation and the value of the minimum required benefits could converge. This would leave employers and employees with *no health plan options that are not, at least in part, taxable.*”⁴¹ [emphasis added]
- “[A]s employees and employers shift to less valuable coverage, employees will pay more in premiums, or employees and dependents will pay more for care, or there will be some combination of both ... [P]articularly as cost sharing is increased, they tend to lower the enrollee’s use of maintenance care and maintenance medications.”⁴²
- “By some estimates, 75 percent of the health care expense in the U.S. is related to chronic conditions. As the Committee knows, many of these conditions are preventable or controllable at much lower cost through regular care, appropriate medication and behavioral compliance. For this reason, it is important not to impose additional financial barriers to getting that care.”⁴³

Mercer, “Majority of Employers Would Reduce Health Benefits to Avoid Proposed Excise Tax,” December 3, 2009

<http://www.kaiserhealthnews.org/Stories/2009/December/02/~media/D8E9E662C4B64AB9B1C8E64984EF49B0.ashx>

- Mercer is a leading global consulting firm that “works with clients to solve their most complex benefit and human capital issues, designing and helping manage health, retirement and other benefits.” It surveyed 465 employer health plan sponsors, a roughly equal number of small, mid-sized and large employers.⁴⁴

³⁹ Hewitt Associates, “Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options,” testimony to Senate Finance Committee by Ken Sperling, Global Health Management Leader, May 26, 2009.

⁴⁰ Ibid, p. 2.

⁴¹ Ibid, p. 3

⁴² Ibid, p. 3-4.

⁴³ Ibid, p. 4.

⁴⁴ P. 5.

- “Mercer estimates that one in five employers offer health coverage that would be deemed ‘too generous’ and thus be subject to the” excise tax.⁴⁵
- “For many employers, it’s a matter of when, not if, they will hit the cap... [I]t’s important to note that not all the plans that would be subject to the tax are particularly generous. There are other factors beside plan design that drive up cost.”⁴⁶
- “Nearly two-thirds (63 percent) of employers [in the survey] say they would cut health benefits to avoid paying the excise tax. About a fourth of respondents (23 percent) say they would maintain their current plan, but pass along the cost of the tax to their employees. Just 2 percent say they would keep their plan, but absorb the new tax themselves.”⁴⁷
- “Of those employers that would reduce covered benefits, 75 percent say they would use the familiar strategy of raising deductibles and co-pays. Forty percent would add an alternative low-cost plan to their benefit offerings and 32 percent would replace their current plan with a low-cost option.”⁴⁸
- “Seven percent of the responding employers say they would terminate the high-cost plan. Notably, 9 percent of small employers – which typically offer only one medical plan choice – would terminate their plans, potentially forcing their employees into the individual market.”⁴⁹
- “However, less than a fifth of respondents (16 percent) say they would convert their cost savings [from cutting benefits in response to the excise tax] into higher pay.”⁵⁰

Milliman, Inc. “No Room to Stand,” Sept. 2009⁵¹

<http://www.milliman.com/perspective/healthreform/pdfs/no-room-to-stand.pdf>

- “The idea of taxing so-called *Cadillac* plans may not sound unreasonable upon first glance. But an actuarial view quickly reveals that the high cost of these plans has as much to do with the characteristics of the covered population as it does with benefit richness.”⁵²
- “[T]he most common interpretation of this proposal is that the tax would apply to Wall Street bankers with the richest group benefit plans. ... Whether someone hits the ceiling is not so much driven by benefit richness as it is by age, gender, profession, health status, and the geography of the covered population.”⁵³

⁴⁵ Ibid, p. 1.

⁴⁶ Ibid, p. 2.

⁴⁷ Ibid

⁴⁸ Ibid

⁴⁹ Ibid

⁵⁰ Ibid, p. 3.

⁵¹ Milliman Health Reform Briefing Paper, Robert Dobson (FSA, MAAA), principal and consulting actuary.

⁵² Ibid, p. 1.

⁵³ Ibid

- “Assuming a similar employer-sponsored PPO plan, the national average per-member per-month (PMPM) cost this year for an age-30 male is \$155 per month – less than \$2,000 per year. For an age-60 female, however, the PMPM is \$717 – or \$8,604 annually, which exceeds the excise tax threshold or ceiling. So groups that include retirees and older workers (e.g., public employers such as school districts) can be expected to hit the threshold more readily than groups with only younger active employees, even if the groups have identical benefits.”⁵⁴
- “[T]he Cadillac excise tax could behave similarly to the alternative minimum tax, dipping further into the middle class than intended ... The fixed dollar indexing of the tax threshold will cause the application of the excise tax to quickly dip substantially further into the mainstream of health plans.”⁵⁵

Towers Perrin Employer Survey, “Health Care Reform 2009: Leading Employers Weigh In,” September 17, 2009

http://www.towersperrin.com/tp/getwebcachedoc?webc=USA/2009/200909/HCR_Pulse-Survey_Sept-09_Final.pdf

- Towers Perrin, a global professional services firm that helps companies improve performance and develop innovative solutions in areas including insurance and actuarial consulting, surveyed 433 human resources executives.
- 87 percent of employers say they will reduce benefits “if health care reform increases employer costs,” 38 percent will “increase prices for consumers,” and 27 percent will “reduce salaries/direct compensation.”⁵⁶
- Only 9 percent of employers say they will “increase salaries/direct compensation if health care reform reduces benefit costs to the organization.” Seventy-eight percent say they will “retain savings in the business,” and 23 percent will “pass on savings to customers.”⁵⁷

The Segal Company, “National Health Care Reform: Analysis of Proposed Senate Excise Tax,” December 11, 2009⁵⁸

<http://www.segalco.com/uploads/Segal-Excise-Tax-Study.pdf>

- **Methodology:** Surveyed 38 large fully credible multiemployer plans with at least 1,000 covered lives per plan. Plans represented various industry groups and regions throughout the country. Segal used current COBRA rates from a representative sample of Multiemployer Health Plans and assumed private

⁵⁴ Ibid

⁵⁵ Ibid, p. 2.

⁵⁶ Towers Perrin, Exhibit 10, p. 6.

⁵⁷ Ibid, Exhibit 12, p. 7.

⁵⁸ Author is Edward A. Kaplan, Senior Vice President, National Health Practice Leader

sector cost trends of 7.5 percent, based on the low end of the range of The Segal Company estimate for private plan annual cost increases.

- **Percentage of plans that exceed threshold:**
 - In 2013, the first year of the assumed effective date of the tax, approximately 13 percent of plans would exceed the cost threshold and incur an excise tax for single coverage, and 11 percent of plans would exceed the threshold for family coverage.
 - Unless the annual adjustment to the threshold is linked directly to private plan cost trend rates, the tax would reach a majority of plan sponsors overtime. For example, by 2022, more than 60 percent of all Multiemployer Health Plans are projected to have plan costs that exceed the threshold and have tax liabilities.
 - For single coverage, the average amount of excess premium subject to a tax in 2013 would be \$1,604 and would grow to \$3,383 by 2022.
 - For family coverage, the average amount of excess premium subject to a tax in 2013 would be \$3,600 and would grow to \$9,043 by 2022.
 - There would be significant regional variation, with plans in the Northeast being the hardest hit. Individual plan costs vary dramatically by region and industry (e.g., no plans in the South region had cost that exceeded the proposed tax thresholds). By 2022 the percent of plans with excise tax by region was: 89 percent Northeast, 75 percent West, 50 percent Midwest, 0 percent South).

- **Impact on plan participants:**
 - The amount of cost shifting to plan participants (composite of single and family coverage) required to avoid the tax, for those plans projected to hit the tax threshold, would be approximately 5 percent (or \$2,802) of projected annual wages (\$56,410) in 2013, rising to 10 percent (or \$6,779) by 2022.
 - Based on the proposed 40 percent excise tax, the average tax per participant for plans exceeding the threshold would be \$642 for single coverage and \$1,440 for family coverage in 2013. In 2022, these levels would be \$1,353/single and \$3,617/family.

**Watson Wyatt Worldwide, “The Problem with Taxing Cadillac Health Plans,”
December 9, 2009⁵⁹**

<http://www.ourfuture.org/files/Taxing-Cadillac-Health-Plans-WatsonWyatt-120909.pdf>

- “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 employees.”⁶⁰
- “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.”⁶¹
- “Taxing groups in high cost areas and with high cost members could make health care unaffordable for many families that currently have coverage.”⁶²
- “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.”⁶³
- “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.”⁶⁴
- “This level of taxation would create a powerful incentive to reduce plan benefits and increase the out-of-pocket costs of members.”⁶⁵
- “The impact of the 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.”⁶⁶

⁵⁹ Author is Roland McDevitt, PhD, Director of Health Care Research.

⁶⁰ Ibid, p. 8

⁶¹ Ibid

⁶² Ibid

⁶³ Ibid., p. 2

⁶⁴ Ibid

⁶⁵ Ibid

⁶⁶ Ibid

American Journal of Managed Care, “What Does the RAND Health Insurance Experiment Teach Us About the Impact of Patient Cost Sharing on Health Outcomes?” July, 2008.⁶⁷

<http://www.mahp.org/resources/otherresources/FendrickVBIHandout2.pdf>

- A landmark RAND study and other research “report that greater cost sharing is associated with reductions in use of clinically important services.”⁶⁸
- “We believe it is reasonable to expect that higher cost sharing may lead to worse health and may increase health disparities.”⁶⁹
- “Evidence suggests that in many situations cost sharing reduces the likelihood that patients will use appropriate services. This could lead to additional hospitalization, emergency department visits, and even death.”⁷⁰

Citizens for Tax Justice, “Would the Senate Democrats’ Proposed Excise Tax on ‘High-cost’ Employer-paid Health Insurance Benefits be Progressive?” December 11, 2009

<http://www.ctj.org/pdf/healthexcisetax20091211.pdf>

- “By 2019 about 58 million people would be adversely affected by the excise tax. That number would continue to rise rapidly in subsequent years.”
- “As shares of income, the proposed tax increases would be 10-20 times as high on middle-income families as on the very rich.”
- “Even if employers do replace all of the dropped health insurance benefits with taxable wages, the result will be to make the overall federal tax system less progressive than it is now.”
- “While the excise tax proposal would impose only modest burdens on the wealthy, it would noticeably lower living standards, not to mention health security, for tens of millions of Americans.”⁷¹

⁶⁷ Authors are Michael E. Chernew, PhD and Joseph P. Newhouse, Ph.D.

⁶⁸ Ibid, p. 412.

⁶⁹ Ibid, p. 413.

⁷⁰ Ibid

⁷¹ P. 1.