

No Room to Stand



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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. It also reveals that the method of determining the taxable benefit threshold may create unintended consequences – especially when coupled with other benefit-level requirements under various reform proposals, leaving little room between benefit floors and the ceiling in certain slices of the insurance market. Is there a better way to structure a ceiling for maximum benefits? One solution might entail better defining *actuarial value* and using the refined notion to address both the floor and the ceiling.

The healthcare reform proposal currently under discussion in the U.S. Senate Finance Committee¹ includes a provision that would, beginning in 2013, impose an excise tax on employer-sponsored health coverage that costs more than \$8,000 for an individual and \$21,000 for a family. The tax has been described by some as a way of capping what may appear to be excessive spending, in an effort to reduce the rate of cost increases, and also as a possible source of revenue that can help fund healthcare reform.

The most common interpretation of this proposal is that the tax would apply to Wall Street bankers with the richest group benefit plans, and it may well be that taxing particular plans whose premiums are otherwise tax-deductible makes sense. But the actuarial reality of a tax indexed to a specific dollar-amount ceiling is that it would likely affect others with less rich benefits. 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.

BREAKING THROUGH THE CEILING

Consider this example from the Milliman Medical Index (MMI): in 2009, the cost of healthcare for a typical family of four in Miami covered by an employer-sponsored PPO is \$20,282.² The cost of care for a similar family in Phoenix is less than \$15,000. While these

numbers include employee cost-sharing (copays, deductibles, and other coinsurance are reflected in the MMI totals but are not subject to the excise tax), they still show how much more susceptible certain areas of the country are to hitting a fixed-dollar excise tax threshold such as \$21,000. Given that medical costs have trended upward at a rate of between 7% and 10% over the last five years,³ one is left to wonder if the average Miami family will find its benefits exceeding the tax-triggering ceiling by the time the tax provision is imposed in 2013.

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The question of age and gender is also relevant. 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,⁴ which exceeds the excise tax threshold or ceiling.⁵ So groups that include retirees and older workers (e.g., public employers such as school districts) can be

¹ Baucus, Max. Chairman's mark (modified): America's Healthy Future Act of 2009. Retrieved Sept. 16, 2009, from <http://finance.senate.gov/sitepages/leg/LEG%202009/092209%20Modifications%20to%20the%20Chairman's%20Mark%20Final.pdf>.

² 2009 Milliman Medical Index (May 2009). Retrieved Sept. 28, 2009, from <http://www.milliman.com/expertise/healthcare/products-tools/mmi/pdfs/milliman-medical-index-2009.pdf>.

³ Ibid.

⁴ Snook, T., Dobson, R., & Harris, R. (June 2009). Understanding healthcare plan costs and complexities. Retrieved Sept. 28, 2009, from <http://www.milliman.com/perspective/healthreform/understanding-healthcare-plan-costs-rr06-15-09.php>.

⁵ One idea currently under discussion in the Senate Finance Committee is to extend the excise tax threshold by \$750 for people in the *pre-Medicare* age bracket. This amendment was apparently introduced to try to remedy some of the problems listed here. But note that, in this scenario, the enhanced threshold barely clears the cost of the average 60-year-old female's PMPM – and these are 2009 numbers.

expected to hit the threshold more readily than groups with only younger active employees, even if the groups have identical benefits.⁶

Then there is the question of profession. Certain professions have higher utilization associated with them than others; those most cited in the press include coal miners, firefighters, and others in high-risk jobs. Does this reform risk penalizing those in higher-risk professions?⁷

WHAT HAPPENS OVER TIME?

Those who do not exceed the threshold in 2013 might still see their benefits taxed in the future. Aging is the most obvious contributor to higher cost over time. But there is also the question of how the threshold is scheduled to escalate. As currently proposed, the threshold amounts are indexed to the *Consumer Price Index for Urban Consumers (CPI-U)* as determined by the Department of Labor beginning in 2014.⁸ In the last year, CPI-U actually decreased,⁹ compared to a 7.4% increase in healthcare costs reported by the MMI between 2008 and 2009.¹⁰ Furthermore, that 7.4% is the lowest increase in at least five years.¹¹ Assuming healthcare cost increases will continue to outpace the CPI, the tax threshold will catch more people each year.

The comparison has been made elsewhere,¹² and deserves mentioning here, that the *Cadillac* excise tax could behave similarly to the alternative minimum tax, dipping further into the middle class than intended. As currently drafted (and discussed above), the tax is indexed to a number that does not reflect the reality of healthcare cost increases.¹³ In fact, the Congressional Budget Office (CBO) estimates that the revenue from the tax will be \$5 billion in 2013 but increase to \$53 billion by 2019.¹⁴ This dramatic increase in the CBO's revenue estimates over a six-year period is consistent with the point made above: 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.

THE REVENUE GENERATION PROBLEM

Much of the analysis put forward so far in this paper assumes a certain preservation of the status quo in terms of benefit design. In the face of potential tax penalties, couldn't insurers find ways to design plans that do not exceed these thresholds? The limited age bands already suggested for the small employer market may help in that regard. The

costs for younger individuals would likely increase in such a scenario. Would the excise tax create even more of an incentive (or need) to try to pass costs on to younger, healthier people? And will employers and employees be tempted to drop such employee-pay-all benefits as flexible spending accounts (FSAs)¹⁵ and supplemental dental and vision, because the premiums employees pay for these benefits also count toward the tax threshold?

Then there is the possibility that *designing away* high-cost plans could jeopardize the revenue-generating potential of this tax. The current proposal seems to view the excise tax as both a carrot (an incentive for insurers to design *cheaper* plans) and a stick (a penalty for *richer* plans) to encourage movement to less rich healthcare plans. However, the excise tax is also used as a significant source of tax revenue. Can it simultaneously serve both roles? This is a classic catch-22, similar to the tobacco taxes that are designed both to discourage smoking and to raise revenue.

HIGH FLOOR, LOW CEILING

But, again, the complications of a benefit ceiling are not so simple. The ability of insurers to *design away* plans that exceed the tax threshold might be imperiled by the simultaneous move toward minimum benefit levels in the small-group market based on certain *actuarial values* that identify bronze-, silver-, gold-, and platinum-level plans.¹⁶ An insurer looking to create a plan that does not exceed the threshold would naturally look first to cost-sharing – changing copays, coinsurance, or deductibles. But the minimum *actuarial values* being posited in the same reform proposals limit these options because they are ultimately measures of cost-sharing. How much standing room is left for a more cost-effective small-group plan¹⁷ design, given the minimums proposed for, say, gold plans?

As suggested elsewhere in other Milliman research,¹⁸ the working definition of *actuarial value* that has been proposed has a number of problems or limitations. Here, then, is another: Will this reform potentially install both a ceiling and a floor without leaving room to even stand up? The ceiling is based on fixed dollar amounts, while the floor is based on specified *actuarial values* (ratios of benefit value to total cost). It is certainly not out of the question for situations to arise where the ceiling for a given employer group could be lower than one or more of the prescribed floors.

⁶ Certain proposed reforms may narrow rating bands, thereby minimizing the cost difference between young and old.

⁷ Another idea under discussion calls for a higher ceiling for these high-risk professions. This may help somewhat, provided the individual in question is not also pre-Medicare, because the higher ceiling is predicated on the idea of *no double dipping* (i.e., a 60-year-old policeman can only raise the ceiling by \$750 dollars, not \$1,500).

⁸ Baucus, *ibid.*

⁹ U.S. Bureau of Labor Statistics (Sept. 16, 2009). Consumer price index – August 2009. Retrieved Sept. 28, 2009, from <http://www.bls.gov/news.release/cpi.nr0.htm>.

¹⁰ MMI, *ibid.*

¹¹ Another amendment suggests indexing the threshold at *CPI-U + 1%*. Once again, the spirit of the amendment is in keeping with the issues raised here, but the central issue remains.

¹² Abelson, Reed (Sept. 20, 2009). A tax on Cadillac health plans may also hit the Chevys. *New York Times*. Retrieved Sept. 28, 2009, from <http://www.nytimes.com/2009/09/21/health/policy/21insure.html?pagewanted=1&r=2&hp>.

¹³ The Finance Committee seems to be aware of this issue.

¹⁴ Elmendorf, Douglas W. (Sept. 16, 2009). Letter to Sen. Max Baucus. Retrieved Sept. 28, 2009, from http://finance.senate.gov/sitepages/leg/LEG%202009/091609%20CBO_Analysis.pdf.

¹⁵ Another amendment under discussion involves raising the threshold for FSAs.

¹⁶ Baucus, *ibid.*

¹⁷ Small group plans are also disadvantaged in another way. One ramification of basing the tax on premiums rather than claim costs is that plans with higher administrative expenses will be penalized. This may have merit in the large-group market, incentivizing greater efficiency. But in the small-group market, the economies of scale are not as pronounced, further removing room under the ceiling in the small-group market.

¹⁸ One of several problems with the "actuarial value" definition currently being used is that there is nothing actuarial about the ratio of payments to covered benefits. More details at Healthcare Town Hall (July 14, 2009). Divergence in actuarial value. Retrieved Sept. 28, 2009, from <http://www.healthcaredowntownhall.com/?p=1329>.

IS THERE A BETTER WAY?

The idea of limiting benefit richness arguably has value in attempting to contain healthcare costs overall. Depending on one's viewpoint, it may also benefit the healthcare system overall to generate tax revenue from the insurer providing a plan to the Wall Street banker who has 100% of his medical costs covered. But for the market to perform effectively, any threshold should be determined not by crude, total-dollar limits but rather by a working definition of *actuarial value* that can accurately serve to measure the levels for both a floor and a ceiling.

First, the reform discussion needs a better notion of *actuarial value*. To date, the approach and numbers suggested by Congress as benefit floors have not been broadly vetted within the actuarial profession. While various expertise has no doubt been solicited, a number of other factors remain for consideration. How does the current notion of *actuarial value* encompass the breadth and depth of the provider network? How does it weigh out-of-network benefits? How does it value mail-order drugs? Will tomorrow's minimum *actuarial values* drive today's happy healthcare consumers out of their current plans? These questions have not yet been answered.

Second, if a benefit ceiling is to be incorporated into a reform package – such as an excise tax on so-called *Cadillac plans* – then it needs to be defined in a way that is compatible with the benefit floors also being imposed. Otherwise, the standing room issue is likely to be problematic, generating undesirable and ultimately untenable consequences.

This is no easy matter, but if we are to set minimum and maximum thresholds for benefits, the conversation should turn to the best possible, most cohesive method for determining those thresholds. In the case of benefit minimum and maximum levels, a better *actuarial value* measuring stick is imperative. Otherwise, we will build a system that does not achieve the goals of reform.

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