The Cadillac Tax: A Game Changer for U.S. Health Care

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While the current debates over the Affordable Care Act (ACA) revolve around the individual mandate and the exchanges, one of the most important features of the law doesn’t take effect until 2018: the so-called Cadillac tax. This tax represents a key public policy innovation that is a rare win-win: it will hold down health care costs while raising substantial tax revenues.

The ACA is fundamentally a compromise between those who would rely on our existing private insurance system and those who would implement broader public sector involvement. The compromise resulted in major financial investments and regulatory interventions in the market for individually purchased insurance, with more modest interventions in the much larger employer-sponsored insurance sector. As a result, in the near term, the ACA will have minimal impact on employer-sponsored insurance (ESI).

My estimates, as well as those of the Congressional Budget Office, suggest that the effect on employer-sponsored insurance will be relatively modest: the number of individuals with employer-sponsored insurance will decline by about 3%. This modest impact reflects fairly sizable dropping of insurance among smaller firms, offset by large influxes of individuals in large firms who were previously eligible for insurance but who now take it up because of the mandate. While this is a non-trivial effect, it is fairly small relative to the 18% decline in employer-sponsored insurance we have seen over the past 15 years. The CBO also preliminarily estimated that premiums on average will not significantly change for either small or large firms; that was also my assessment for small firms in states I have studied, as well.

In the long run, cost controls included in the ACA will have a more fundamental impact on ESI. The primary mechanism for doing so will be the Cadillac tax.

Under current U.S. tax law, workers are taxed on their compensation that comes in the form of wages, but not on their compensation in the form of health insurance. So if MIT pays me $1,000 in wages, I take home less than $600; but if MIT pays me in health insurance, I get the full $1000 in insurance. Economists call this a “tax subsidy” because it is equivalent to the government’s giving me a check for 40% of the costs of my insurance; either way insurance is 40% cheaper than wages because wages are taxed and insurance is not.

This tax subsidy to ESI has three costs. First, it is incredibly expensive: the annual cost of this tax break is about $250 billion, or about twice what it would cost to cover every uninsured American with insurance. Second, it is regressive: the richer you are, the higher your tax rate, so the bigger the tax break you are getting. Third, it is inefficient: since individuals are buying health insurance with tax-subsidized dollars, they buy too much insurance, which in turn leads to too much health care. Economists have for years pointed out that this tax break is a major driver of high and rising health care costs in the United States.
The ideal solution to this problem would be to treat health insurance like wages, addressing all three of these issues. One alternative that has frequently been proposed is a “cap” on the tax break, so that health insurance is only taxed like wages above a certain threshold. The Cadillac tax is an indirect means of accomplishing this same policy goal. Insurers will pay an excise tax at 40%, approximately equal to the top income tax rate, on policies above a certain threshold (which should amount to about the top 10% most expensive insurance plans). Insurers will quickly pass this cost on to consumers, and it will serve to counteract the existing tax break – so effectively this operates in a similar way to just ending the tax break itself.

The Cadillac tax begins in 2018 and will affect only a minority of firms. But over time the tax threshold is indexed at the overall rate of price inflation, which is typically well below health premium inflation. As a result, more and more firms will be subject to this tax. The tax will lower the rate of health care spending growth and substantially reduce employer health insurance spending. At the same time, it will raise substantial new revenues for a cash-strapped federal government. Indeed, the rising Cadillac tax revenues are a major reason why the ACA overall is greatly deficit reducing over the long run.

Usually, when discussing new sources of revenue, society faces a tradeoff: higher taxes mean more distortion to economic activity. Slowly removing the tax subsidy to employer-sponsored insurance presents a rare win-win solution that doesn’t involve this tradeoff: revenues go up and economic efficiency improves because we no longer subsidize the purchase of expensive health insurance.

The Cadillac tax is not ideal. A flat 40% tax does not precisely offset the tax subsidy to insurance for individuals who have different tax rates, so a better solution would be to simply treat health insurance like wages, including health insurance spending on the W-2 and taxing it as earnings. My recent estimates for the Bipartisan Policy Committee suggest that replacing the Cadillac tax with a policy that included in taxable income the top 20% of employer health insurance spending would raise more than $250 billion over a decade. But the Cadillac tax remains better than the alternative, a continuation of our existing open-ended insurance subsidy.

The ACA includes other provisions that should further help control the costs of employer insurance: the insurance exchanges should introduce competition into insurance markets that will bring down premiums; research on comparative effectiveness will help us assess the lowest-cost options for treating disease; and alternative reimbursement structures such as accountable care organizations (ACOs) will coordinate care across providers and lower costs as a result. It is difficult to confidently project the impact of these changes on costs, but taken together they represent the best collective thinking on how to “bend the cost curve.”

When all is said and done, the ACA will really not matter much in the near term for the majority of Americans who have ESI. In the longer term, it can benefit that majority through combatting the insatiable rise of health care costs.