Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

Special Series: Health Reform Issues

December 10, 2009

SENATE SHOULD REJECT PROPOSED "CAP ON EXCESS MEDICAL INFLATION," RETAIN ITS EXCISE TAX ON HIGH-COST INSURANCE PLANS

By Paul N. Van de Water

The Senate may consider an amendment to its pending health care bill that would replace its excise tax on high-cost health insurance plans – a key proposal to slow the growth in health care costs – with a "cap on excess medical inflation." Such a policy change would be ill-advised — the proposed medical inflation cap would be poorly targeted, inequitable, and difficult to understand. It also would be unpredictable and virtually impossible to administer.

Currently, the federal government provides Americans with more than $250 billion each year in health care subsidies by excluding the value of employer-sponsored health care from an individual's taxable income. These subsidies are the largest for high-income individuals who are enrolled in the most expensive health plans. The health reform bill before the Senate would limit these subsidies by imposing an excise tax on high-cost health insurance plans whose value exceeds specified thresholds.[1]

A proposed amendment by Senator Thomas R. Carper (D-DE) would delete the excise tax and replace it with a "cap on excess medical inflation." As explained below, that proposal is seriously flawed, and it is a distinctly inferior way to limit tax subsidies for health insurance and, in turn, restrain the long-term growth in health care costs.

Description of Proposal

The proposal would impose an excise tax on health insurance plans equal to 40 percent of the amount by which their annual "medical inflation" exceeds a specified target rate. For 2013 through 2019, the target would equal the annual rate of growth of the gross domestic product (GDP) for the previous year, plus a specified amount.[2] Using the latest projections of the Congressional Budget

[1] Chuck Marr, Paul Van de Water, Edwin Park, and Kris Cox, *Senate Health Reform Bill is Fiscally Responsible*, Center on Budget and Policy Priorities, November 19, 2009.

[2] The additional amount would equal 1.1 percentage points in 2013, 0.8 percentage points in 2014, and 0.5 percentage points in 2015 through 2019.

Office, the target growth rate for premiums would equal 6.5 percent in 2013 and 6.0 percent in 2014 and then fall to 4.5 percent by 2019. In 2020 and thereafter, the target would equal the annual rate of growth of premiums for the least expensive one third of health plans. The least expensive 10 percent of plans would be exempt from the tax.

The rate of "medical inflation" for each plan would *not* simply equal the rate of growth of the plan's premiums; it would exclude changes in costs stemming from increases or decreases in a plan's benefits and services, increases or decreases in cost-sharing requirements, changes in the average age of covered workers and dependents, and changes in the health status of enrollees. Each plan's medical inflation rate would be determined each year by a qualified actuary, based on rules set by the Secretary of Health and Human Services.

Problems with the Proposal

The proposed "medical inflation cap" raises a host of concerns.

- *Poorly targeted*: The proposal would leave a very expensive health insurance plan untouched, as long as the plan's "medical inflation" rate fell below the target. For example, a health plan costing $40,000 per enrollee could increase about *three times as much in dollar value* each year as an average $13,000 plan and still remain tax-free. With a 6-percent target increase, the $40,000 plan could spend $2,400 more in a year without facing the excise tax, whereas the average plan would face a tax if its cost grew by more than $780.

- *Inequitable*: The proposal would provide no incentive for health insurance plans to take many reasonable steps to limit their costs, and it would allow plans to increase costs by adding benefits. Plans would not be able to avoid the tax by introducing certain important tools to increase efficiency, such as well-structured cost-sharing, value-based insurance design, and incentives for healthy behavior (unless such changes were offset by increases in the benefit package that hold the actuarial value of a plan constant), since these changes *would not count* when calculating the "medical inflation rate." Similarly, plans could not avoid the tax by eliminating low-value benefits. In contrast, plans could add benefits with impunity and not incur the tax.

  The proposal could penalize plans in low-cost areas or those that have already taken significant steps to hold down costs. These efficient, low-cost plans (including plans in areas of the country that have an economical style of medical practice) would be taxed if their growth rate was above the percentage target. Plans with a low *level* of costs can not always keep their cost *increases* low, and many low-cost areas of the country have above-average rates of increase.

- *Difficult to understand*: The notion of a "medical inflation rate" that adjusts for changes in the actuarial value of a plan and the age-and-family composition of the plan's beneficiary pool is something that only actuaries and policy analysts will understand. In fact, this may be the only tax liability that would require an actuary to compute. To the extent that people find it difficult to understand, it would be less effective in motivating desired changes in behavior. It could also appear arbitrary and unfair.

- *Not predictable:* A good tax should be reasonably predictable. This one would be *unpredictable*. Insurers and employers cannot confidently predict how much their efforts to coordinate care, expand wellness activities, or change payment arrangements will slow the "medical inflation rate" and thereby hold down their tax liability under this proposal.

- *A*n *administrative nightmare*: The cost of insurance is affected by the scope of covered benefits, the negotiated rates paid to providers, the nature and extent of cost-sharing by beneficiaries, the risk profile of the insured group, the size of the group, the insurer's mark-up, and other factors. The proposal requires disentangling these factors to compute the "medical inflation rate," but it would be virtually impossible to do so with any accuracy. It would be especially difficult when a firm shifted from one insurer to another, or from a preferred provider organization (PPO) to a health maintenance organization (HMO), since the data required to perform the computation would probably not be available for the old and new plans on a comparable basis.

- *Easy to game:* Firms would seek to hire actuaries who would offer opinions favorable to the firm, just like U.S.-based multinational corporations today hire accounting firms to help them shift profits overseas. Without a large actuarial staff, the Internal Revenue Service could not verify or contest employers' tax liability under this provision, probably leading to extensive evasion of the tax. The proposal would also create an incentive for insurers to increase premiums in the year before the tax goes into effect in order to provide a cushion against future increases.