

THE EXCISE TAX ON HIGH-COST HEALTH PLANS: POTENTIAL ADJUSTMENTS BY POLICYMAKERS, EMPLOYERS, AND EMPLOYEES

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DETAILS ON SIMULATION METHODS

Imputing Information on Health Savings Accounts, Health Reimbursement Arrangements, and Flexible Spending Accounts

Employment-related health benefits that are potentially subject to the excise tax include total health insurance premiums, employer contributions to Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs), and employee contributions to flexible spending accounts (FSAs). In order to simulate the total value of benefits, we require data on total premiums as well as contributions to HSAs, HRAs, and FSAs. As noted in the paper, the Medical Expenditure Panel Survey–Insurance Component (MEPS-IC) provides information on the total annual premiums for health plans offered by an establishment for single, employee-plus-one, and family coverage. It also has plan-level information on whether establishments contribute to HSAs and HRAs. However, the MEPS-IC does not collect information on the amount of the tax-preferred contributions. We, therefore, use the MEPS-IC information on whether establishments contribute to these plans combined with Kaiser Family Foundation/Health Research & Educational Trust estimates of average HSA and HRA contributions to single and family plans (Kaiser, 2015) to impute plan-level contributions for these two types of accounts. Similarly, the MEPS-IC obtains information on the availability of FSAs at the establishment level, but the MEPS-IC does not collect information on the extent to

which employees enroll in FSAs nor does it collect information on their contributions. We, therefore, follow a similar methodology to our imputation of HSA and HRA amounts and impute FSA values for eligible workers using firm-size-specific estimates on employees' take-up rates from the Mercer National Survey of Employer-Sponsored Health Plans in 2013 (Mercer, 2013) combined with estimates of average contributions for FSAs calculated from the 2014 MEPS–Household Component (MEPS-HC) for single and non-single coverage. To do this, we create separate plan-level records for eligible workers that take up FSAs (with adjusted plan-level weight = take-up rate \times weight) and those who do not take up FSAs (with adjusted plan-level weight = $[1 - \text{take-up rate}] \times \text{weight}$). Note that while we impute information on tax-preferred accounts, we find that they only comprise about 5 percent of the value of total benefits, while premiums, which are directly reported by MEPS-IC establishments, account for the remaining 95 percent.

When workers are eligible for more than one type of account, we assign them coverage under only one type, using the following hierarchy: HSAs, HRAs, and FSAs. Although it is legal to contribute to more than one type of tax-preferred account, certain limitations apply. For example, HSAs, which are used in conjunction with high-deductible health plans, do not allow additional forms of insurance or tax-preferred accounts to be used to finance the deductible. Only HSA-qualified HRAs and FSAs that cover vision, dental, and/or preventive care are allowed. An employer and employee can have both an HRA and an FSA at the same time, but the same expense cannot be reimbursed from both accounts. Unless otherwise specified in plan documents, the HRA must be used prior to the FSA.

The Health Care Adjustment Percentage

Internal Revenue Service regulations (IRS Title 26 §4980I, 2011) specify a Health Care Adjustment Percentage (HCAP) that increases thresholds if premiums grow by more than 55 percent from 2010 to 2018. Due to relatively low rates of real and assumed premium growth from 2010 to 2018, the HCAP had no effect on our tax thresholds (even in our high premium growth rate scenarios). We note, however, that the regulations stipulate that premium growth will be determined by the per employee cost of the Federal Employee Health Benefit Program's (FEHBP) Blue Cross/Blue Shield Plan (BCBS) standard plan in 2010 and 2018 *holding benefits constant* at their 2010 levels. In our simulation, we simply determine whether our assumed rates of annual premium growth result in cumulative growth, from 2010 to 2018, in excess of 55 percent. This approach implicitly assumes no change in average benefits from 2010 to 2018. Therefore, we will have overestimated premium growth if benefits had become more generous over time and underestimated growth if benefits had become less generous (which could have occurred if employers adjusted benefits in anticipation of the implementation of the excise tax).

Simulating Age/Sex Adjustments

The purpose of the age/sex adjustment in the regulations is to increase the tax thresholds for employers that have higher than average insurance costs due to the age/sex mix of their workforce. This adjustment is described generally in IRS Title 26 §4980I (IRS, 2011) as a ratio factor used to increase the single and non-single thresholds. The denominator of the ratio is the per employee cost of single and non-single coverage in FEHBP BCBS assuming the national workforce was enrolled in the plan. The numerator is the cost assuming the employer's workforce, defined only by their age/sex mix, is enrolled in the plan.

Since this adjustment is not fully specified in the regulation, we simulate it using medical expenditure data from the 2007–2011 MEPS-HC, as follows. First, we limit the MEPS-HC data to individuals with private-sector employer-sponsored insurance for the entire calendar year. These individuals are either covered as policyholders or as dependents. Next, we construct annual private insurance payments for these individuals. For policyholders with single coverage, we assign the policyholder’s total annual private insurance payment to a variable measuring the cost of single coverage. For policyholders with non-single coverage, we calculate the sum of private insurance payments for all persons covered by the policyholder’s plan and assign that sum to a variable measuring the cost of non-single coverage. In some cases, individuals have coverage through more than one policyholder. If the individual is a dependent, we divide their total private insurance payments across the two plans. If the individual is a policyholder, we assign their entire private insurance payment to the coverage they hold. The MEPS-HC does not collect information on employee-plus-one coverage, so we categorize non-single coverage as employee-plus-one (two persons) or family (three or more persons) based on the number of persons covered by the policy.

To simulate the denominator of the ratio adjustment, we calculate the weighted averages of the private insurance payment variables, for single, employee-plus-one, and family coverage, using the MEPS-HC weights. Since the MEPS-HC is a nationally representative data set, this represents the cost for “the national workforce.” To calculate the numerator of the ratio for a range of employers, we would need to know the percent of workers who are female and who are age 50 or older. Because we are calculating these variables from the household survey and need to merge the information onto the MEPS-IC establishments, we calculate the numerator for 121 possible combinations of the percent distributions of female (e.g., 0, 10, 20, 30, 40, 50, 60, 70,

80, 90, and 100% female) and workers age 50 or older (e.g., 0, 10, 20, 30, 40, 50, 60, 70, 80, 90, and 100% older workers). To do that, we begin by raking, or iteratively adjusting, the MEPS-HC sample weights so the weighted sample has 0% female and 0% older workers. Then, we use the adjusted weights to calculate mean private insurance payments for a workforce that has no women and no older workers. We repeat this process for each combination of percent female and percent older workers. We repeat the entire process for each type of coverage (single, employee-plus-one, and family). In the MEPS-IC data, we round the reported “percent female” and “percent ages 50 and over” variables to the nearest decile and merge our age/sex indices onto the data set. Finally, we estimate regressions of the probability that plans exceed the excise tax thresholds in 2020 and iteratively adjust the age/sex factors until the coefficients on our variables for percent female and percent older workers are statistically insignificant and close to zero. This is similar to the approach in Herring and Lentz (2011), who adjust thresholds until the percentage of young workers in a firm has no effect on the probability that a plan will exceed the threshold.

REFERENCES

- Herring, B., and L. K. Lentz, 2011. “What Can We Expect from the ‘Cadillac Tax’ in 2018 and Beyond?” *Inquiry* 48, 322–337.
- Internal Revenue Service, 2011. “Title 26 §4980I,” <http://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleD-chap43-sec4980I.pdf>.
- Kaiser Family Foundation and Health Research & Educational Trust, 2015. “Employer Health Benefits, 2015: Annual Survey,” <https://www.kff.org/health-costs/report/2015-employer-health-benefits-survey/>.
- Mercer, 2013. “Mercer’s National Survey of Employer-Sponsored Health Plans, MTEBC, February, 2013,” http://benefitcommunications.com/upload/downloads/Mercer_Survey_2013.pdf.