The Affordable Care Act's excise tax on high-cost plans- Cadillac Tax

The Affordable Care Act creates an excise tax on plans considered "high cost." The cost of health coverage that exceeds a dollar-based threshold will be subject to a 40 percent tax, so the impact of the tax could be significant.

The tax begins in the year 2018. Although that's still years away, it's not too soon to start preparing for it. We know that some employers are already raising the issue related to members' health plans.

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The Affordable Care Act creates an excise tax on employer-sponsored health coverage that is deemed to be "high cost." The tax, which begins in the year 2018, is 40 percent of the amount that's above the taxable thresholds—what's referred to in the law as the "excess benefit." We don't yet have regulations for the excise tax, so all we know for sure about how the tax will function is what's in the law itself.

Even though the excise tax doesn't begin until 2018, some members are already bumping into it. That's because some employers or other plan sponsors are saying that benefits must be cut now in anticipation of the tax. You should approach discussions about the excise tax and what to do about it carefully. The tax is potentially significant, and you should take it very seriously, but you have to make sure you and your employer fully understand the tax before considering if or how to respond to it. Without regulations, important practical detail is missing, and even the detail we have in the law is frequently misunderstood--to the detriment of our members--by employers.

Here's the basic idea behind the excise tax: The ACA establishes two taxable thresholds, one for self-only coverage and one for family or any other type of coverage. The base threshold for self-only coverage in 2018 is $10,200. For all other coverage, the base threshold is $27,500.

For example, for family coverage that costs $28,250 in the year 2018, the excise tax would be $300. That comes from:

$28,250 - $27,500 = $750

$750 x .40 = $300

Keep in mind two things as you read on: The tax is determined and applied on an employee-by-employee basis, and the thresholds, which cannot be decreased, are not set in stone. In fact, the thresholds could very well be higher for plans for NEA members, given the way the law calls for adjusting thresholds based on employees' age and sex (that's the tax's "age and gender adjustment").

If thresholds are adjusted to be higher, the impact of the tax will be postponed or lessened. To understand the reason, look at the example above. If the threshold in that example is adjusted from $27,500 to $29,000, the cost of coverage—$28,250—would still be under the threshold, so there'd be no tax.

1. Which plans does the excise tax apply to?

The excise tax applies to employer-sponsored coverage offered to an employee. Dental and vision plans are included if integrated with a medical plan, but not if they are stand-alone plans. Coverage in this context also refers to health flexible spending arrangements (health FSAs), health reimbursement arrangements (HRAs), health savings accounts (HSAs), and Archer medical savings accounts, although how the cost of health coverage is calculated varies. The tax applies to private- and public-sector plans (but not to plans for military personnel), whether they are self-insured or fully insured. It also applies to plans made available through health insurance exchanges. There are no exceptions for collectively bargained plans, although there is a special rule for multiemployer plans, as described in section 5, below.

2. What counts toward the cost coverage for excise tax purposes?

We still don't have regulations on the excise tax, but the law's language on the cost of coverage can be found in section 4980I(d)(2) of Internal Revenue Code.

When determining what counts toward the cost of health coverage for excise tax purposes, lawmakers were fairly broad. Given that we don't yet have regulations, we can't know for sure how cost-related details will shake out. In general, though, the cost of employer-sponsored coverage for purposes of the excise tax is "coverage under any group health plan made available to the employee by an employer" if the coverage is excludable from the employee's gross income under section 106 of the Internal Revenue Code.

So, the cost of coverage includes:

- Premiums for group health insurance;
- Employee salary-reduction contributions to a health flexible spending arrangement (health FSA) and any reimbursements made from contributions from an employer that are in addition to employee salary-reduction amounts;
- Employer contributions to a health reimbursement arrangement (HRA). Note that although section 106 of the Code doesn't specifically refer to health reimbursement arrangements (HRAs), the IRS has said that HRAs are excludable under section 106(a) of the Code); and
- Employer and pre-tax employee contributions to a health savings account (HSA) or Archer medical savings account (although the law refers only to "employer contributions" in this context, under the tax code, employee salary-reduction contributions are, technically, considered employer contributions). An employee's

after-tax contributions would not count toward the cost of coverage. If you'd like to see formal IRS language that refers to this, see the highlighted section of this IRS publication.

To the extent that there is a premium for a health plan associated with an account, such as a high-deductible health plan (HDHP) linked with an HSA, the premium amount for the HDHP and the contributions to the HSA both count as part of the cost of coverage.

Premiums are generally to be determined the same way as they are for purposes of the Consolidated Omnibus Budget Reconciliation Act (COBRA), with the exception any portion of the premium that is due to a pass-through of excise taxes is not taken into account when determining how much of the premium counts toward the taxable thresholds. Without regulations on the premium pass-through, we don't know yet how it will function in practice, but the law suggests it will work like this:

Total premium for fully insured family coverage in 2019: $30,550 Amount of premium due to excise tax payments for 2018: $200 Total premium for 2019 excise tax purposes: $30,350

For purposes of determining the excise tax in 2019, $30,350 would be compared to the threshold, not $30,550.

Dental and vision plan costs will count as part of the cost of coverage to the extent that they are integrated into the health plan. Stand-alone dental and vision plans will not count toward the cost of coverage for excise tax purposes. Long-term-care coverage is also not included. When they wrote the excise tax provisions of the ACA, lawmakers did not take into account how much employees pay toward premiums. That is, an employee could pay 100 percent of the premium, or none of the premium at all, and the excise tax provisions of the law will apply exactly the same way.

3. Who is responsible for paying the excise tax?

The ACA's excise tax on high-cost plans is to be paid by what the law refers to as "coverage providers." In essence, that means that the entity that administers the plan pays the tax. For a fully insured plan, that would be the insurance company. For a self-insured plan, it would be the third-party administrator. An employer, too, will be considered the coverage provider if it makes contributions to an HSA or Archer medical savings account. That does not mean that whoever pays the tax can't or won't pass it on to health care consumers. It does mean, though, that you shouldn't accept that employees will necessarily pay the excise tax.

If there's an excess benefit, then every coverage provider will owe some part of the excise tax. The amount owed by a coverage provider will be determined by the proportion of that provider's benefit cost to the total cost of coverage. In the example above, the total cost of coverage was $28,250, and the total excise tax was $300. If a fully insured health plan has premiums of $26,000 and the rest of the cost of coverage is attributable to an employer's

HRA contribution of $2,250, the insurance company will owe $276 in tax, and the employer will owe $24. That comes from:

Insurance company

$26,000 ÷ $28,250 = .92

.92 x $300 = $276

Employer

$2,250 ÷ $28,250 = .08

.08 x $300 = $24

As you can see from this example, this means that a health insurance plan that is under the threshold could end up owing the lion's share of the excise tax just because another part of the employer's overall health coverage puts the total cost of health coverage over the threshold.

4. What are the excise tax thresholds, and how will they change?

Excise Tax on High-Cost Plans
Base Taxable Thresholds
(Assuming 1.5% Consumer Price Index in 2017 and no health cost adjustment or age/gender adjustment)

	2018		2019	
	Active	Retiree	Active	Retiree
Self-only coverage	$10,200	$11,850	$10,455	$12,146
Coverage other than self-only (family, individual + 1, etc.)	$27,500	$30,950	$28,188	$31,724

The thresholds established by the law are not set in stone. That is one very important reason that making decisions now based on simplistic excise tax cost projections could lead to over-reactions that result in benefit cuts for members. In fact, there are five ways that the thresholds could vary, although they'll never go below the base amounts or drop from one year to the next:

1) The thresholds are indexed. In 2019, the thresholds will increase by the cost of living plus one percentage point. In subsequent years, they will increase by the cost of living. For this purpose, the cost-of-living adjustment will be based on the consumer price index from two years before the taxable year (for example, the CPI for 2017 will be used to determine the threshold increase for 2019).

2) For retirees, thresholds are increased by $1,650 for self-only coverage and $3,450 for other coverage. These amounts would be added to the thresholds for the year and then indexed as indicated above.

3) The base thresholds of $10,200 and $27,500 will be higher in the year 2018 to the extent that health insurance premiums in 2018 increased more than expected from 2010. The degree to which premiums have increased more than expected will be measured based on the per-employee cost of coverage under the Blue Cross/Blue Shield standard benefit plan option under the Federal Employees Health Benefits Program (FEHB Program). In essence, if that plan's premiums increases more than 55 percent during that time period, the base thresholds will be increased by the number of percentage points above 55 percent that the plan increases. This is called "health cost adjustment percentage."

The health cost adjustment percentage is only for the year 2018, so there will be no adjustment in 2019 or beyond. Although we can begin to track how the plan's costs are changing after 2010 (the plan cost went up a total of 11.41 percent from 2010 to 2013), the way the law is written, the year-to-year change is not enough to get a sense of what the adjustment might be. That's because the plan design of the Blue Cross/Blue Shield standard benefit plan under the FEHB Program can change from year to year, and the ACA says that to calculate the cost of the plan in 2018, it will have to be adjusted to reflect, for threshold-determination purposes, the benefits that were in place in 2010.

From a tactical point of view

Obviously, we don't know what the health cost adjustment percentage will be in the year 2018, so we don't know what the actual thresholds will be. That fact is important to keep in mind when it comes time to talk about the possible impact of the excise tax and what to do about it. And if employer proposals contain cost projections but don't address the health cost adjustment percentage, don't underestimate the significance of undermining those proposals by pointing out that the thresholds they're using could be too low and that, as a result, the impact of the projected impact of the excise tax may be over-stated. In any case, an employer that makes projections without even considering (or knowing about) the adjustment is acting without full knowledge of the law.

4) For any individual plan, the thresholds for any year can be increased to the extent that employees in the plan are older or more female than the national workforce. This is called the "age and gender adjustment." The amount of the adjustment will be determined by pricing the Blue Cross/Blue Shield standard benefit plan option under the Federal Employees Health Benefits Plan based on the age and gender characteristics of the employees of the employer. Then, the plan will be priced based on the age and gender characteristics of the national workforce. The thresholds will be increased by the dollar-based difference between the two. The thresholds will not be decreased if the plan priced for the general population is higher than the plan priced for an individual plan.

From a tactical point of view

The law establishes the age and gender adjustment based on an employer's employees, not based on all plan participants. That seems to suggest that a plan for school employees who are predominantly women would stand a good chance of having higher thresholds, even if the male spouses of those women also participate in the plan. We don't yet know how regulators will define "national workforce," so for now, we are assuming that it means employed and unemployed civilian employees 16 years old or older. That's a reasonable definition based on the way the U.S. Bureau of Labor Statistics compiles data on workers. So, you might consider bringing to the bargaining table demographic information on your members and, if you have it, demographic information on all employees working for the employer. Looking at data from the U.S. Bureau of Labor Statistics for 2012, we found that the national workforce is 46.88 percent female. That's probably a lot lower than the workforce of many school employers. That could help increase thresholds for employees participating in the plan. We also found that 43.55 percent of the national workforce is 45 years old or older. If your employer's employees tend to be more experienced than the national workforce, that could also help you boost thresholds for the plan.

The bottom line is this: Don't let general excise tax projections set the stage for discussions about changing benefits. If you can make an argument that thresholds for your particular plan are likely to be higher than those used by employers for tax-related projections, you can reasonably argue that the projected impact of the tax is over-stated. You don't have to know what the adjusted thresholds will be to point out that projections may be wrong.

5) Multiemployer plans will apply the threshold for coverage other than self-only coverage to all types of coverage. In this context, multiemployer plans are those that meet the definition of Internal Revenue Code section 414(f). The definition can be a bit tricky, so, if you think you might have a multiemployer plan, it would be wise to check with legal counsel.

5. Preparing for the excise tax in bargaining and non-bargaining contexts

If you have a collective bargaining agreement that covers health benefits, addressing issues related to the excise tax on high-cost plans will, in some ways, be different from dealing with the tax without a CBA. With a CBA, the excise tax could influence how long you think your contract should be, what types of reopener language you may want to include, and how to address possible language related to employees' responsibilities related to the tax.

Even though CBAs create excise tax-related issues that don't exist in non-bargaining contexts, there's still a lot you can do to deal with the excise tax if you don't bargaining collectively. A labor-management health benefits committee might deal with excise tax issues, and your ability to correct employer and plan sponsor errors related to the excise tax, and to make constructive suggestions about how to deal with it, could make a big difference for your members.

6.Projections of when and how hard the excise tax will hit

If you're told when the tax will hit and how much the tax is likely to be, make sure you obtain basic information about how those projections were done—before you start discussing details, making decisions, or accepting solutions related to the excise tax. Simplistic assumptions are easy to make, but they can easily overstate the impact of the excise tax. Back-of-the-envelope projections about the excise tax can hurt members, but calling your employer on the inadequacy of such projections can potentially give you more power in health care discussions, undermine employers looking for any excuse to cut health care benefits, and push back excise tax-related decisions until a more appropriate time in the future.

To clarify how projections were made, figure out the answers to these questions:

- What were the plan-by-plan beginning costs included in the projections, and what year did the projection begin? For example, you may learn that the projection started with 2012 data and that the ABCD PPO premium for self-only coverage in 2012 was $5,123, and that for family coverage it was $14,678.
- At what rate of inflation was that premium data projected forward, and why was that rate chosen? Be careful that projections were not based on unrealistically high assumed rates of health care inflation, because that would exaggerate the impact of the excise tax and potentially lead to stronger demands for health care cuts. For example, you may learn that a projection was made based on an inflation of 9 percent premium growth per year, and you may be told that the rate was chosen because that's what it was from 2011 to 2012. Or you may learn that the national average was used. Reflect on what other, lower rates may be more reasonable—perhaps the plan's actual rate over three or five years.
- What thresholds were used to establish how much the excise tax would be in 2018 and afterward? For example, it's likely that you'll be told dismissively that the ACA sets the thresholds, and those are what was used—$10,200 for self-only coverage in 2018 and $27,500 for other coverage. It's true that the law says that, but the ACA also creates the possibility of higher thresholds for everyone in 2018, and higher thresholds in 2018 and thereafter depending on the age and sex of the employees participating in the plan (based on the "age and gender adjustment"). You can find some tactical considerations related to the age and gender adjustment in our excise tax briefing here. And there are CPI-related increases in thresholds and bumps for retirees. Depending on how much time you have, and how forthcoming your employer is, you may want to wait to see what response you get to this question before you ask any of these follow-up questions, because it could help you to show that your employer's projections were made based on an incomplete modeling of the law. Follow-up questions: What assumed age and gender adjustment was used? What were the employee-specific and national workforce-related data used for the age and gender adjustment? What assumed health cost adjustment percentage was used? What assumptions were used related to the costs of relevant Federal Employees Health Benefits Program (FEHB Program)? What assumed CPI was used? And, if there were retirees in the plan, what retiree threshold adjustments were made?

Discussing what to do about the excise tax

Assuming you have excise tax projections that make sense, the next logical issue to discuss is what, if anything, to do about the excise tax. The first thing to keep in mind is that we can't yet know what the actual excise tax will be, because we don't know what the thresholds will be in 2018 or thereafter, and we don't know how much health plan costs will actually increase. With that in mind:

1. Understand what contributes to the cost of employer-sponsored health coverage as defined for excise tax purposes. Knowing what does and doesn't count toward excise tax-related costs will help you focus on the right issues. For example, premiums for health coverage are likely to be the largest contributors to the costs that count toward the excise tax, but for excise tax-related purposes, it doesn't matter who pays for the premiums. So, shifting responsibility for paying premiums from the employer to the employee won't help address the excise tax.
2. Watch out for excuses for cutting health care costs. At this point, the excise tax's impact is speculative and years away, so fine-tuning a health plan now—for example, by increasing deductibles to cut premiums—may ultimately do nothing to really address the excise tax, while it could save the employer money now. That doesn't mean that you should now be looking for major ways to cut premiums and other excise tax-related costs. Instead, consider taking it slowly until you have a clearer picture of what's coming down the pike.
3. Figure out how to calibrate your long-term goal with short-term decision making. Make sure you know what your employer is trying to do, and figure out what you want to do before you talk about the excise tax. Are you trying to ensure all at once that the excise tax never hits? Are you trying to establish a series of incremental plan changes so that the pain of avoiding the excise tax is gradually felt? Are you trying to push back the date when the excise tax is likely to hit? Are you trying to undermine the employer's projections so that excise tax discussions are off the table?
4. Don't let the conversation turn to how employees can pay more or get less before first talking about how insurance companies can be saving money.
5. There are many ways that a plan can change to help keep the cost of coverage down, but some ways hurt members more than others. Thinking them through in advance is important, so you know what you're willing to do and what you're not willing to do, and so that you're clear about which options will be so painful for members that you need to reject them completely. It's also important so that, if you need to make changes, you don't accept painful choices when less painful ones are available. With that in mind, these are not recommendations; instead, they are some of the options you may see put forward:
6. Creating stand-alone dental and vision plans, because only dental and vision plans integrated with a medical plan count toward the cost of coverage.
7. Separating retirees from a plan with active employees, if actives subsidize directly or indirectly the cost of coverage for retirees.

8. Eliminating some of what the plan covers (within the limits allowed by federal and state law).
9. Shifting to plans with much higher deductibles and other out-of-pocket costs.
10. Eliminating employer-sponsored coverage and letting employees—with or without employer financial support—obtain coverage through the individual health insurance market.
11. Keep in mind that lawmakers were fairly broad in determining what counts toward the cost of coverage for excise tax purposes, so trying to use health reimbursement arrangements or health flexible spending arrangements to minimize the impact of the tax will not work.

Recapturing money that used to go toward the cost of health coverage

For many members, health benefits have been—and remain—a crucial component of compensation. Cutting those benefits may not be desirable or easy, but if your goal is to ensure that any changes to the health plan result in increased salaries, or that the designation of funds that used to go toward health benefits are dedicated toward something else, you need to consider what you'll need to make that happen.

If you make changes to employer-sponsored health coverage to address future excise tax issues, don't forget to think through how to recapture employer savings. For example, if employees currently pay a portion of the premium for a lower-deductible plan and you agree to move to a plan with a higher deductible, the employer could be paying a higher percentage of the premium and still not be paying as much in dollar terms as was paid before. So, shoot to have the employer pick up a higher percentage of the premium or to add that money to employees' pay.