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'Cadillac tax' could drive up some health care costs

By Kathryn Bakich

Beginning in 2018, the Affordable Care Act imposes a 40 percent excise tax, often called the "Cadillac Tax," on high-cost health plans above certain thresholds. The base thresholds for 2018 are $10,200 for self-only coverage and $27,500 for all other coverage tiers, with higher thresholds available for certain participants. Plan sponsors should take steps now to understand when their plan may hit the excise tax thresholds and how to minimize the tax's impact.

What types of plans and benefits are subject to the tax?

In general, all group health plans are subject to the tax, including plans established and maintained by local governments or their instrumentalities. Both fully insured and self-insured plans are subject to the tax, as are retiree health plans. The value of account-based plans, such as Health Reimbursement Arrangement (HRA) and Health Flexible Spending Arrangements (health FSA) will be included in the plan's value. For Health Savings Accounts (HSA), the employer contributions appear to be included in the calculation. Dental and vision coverage that is provided under a separate insurance policy is not counted.

What entity is responsible for paying the excise tax?

The responsibility for paying the excise tax rests with the plan's coverage provider.

For insured coverage, the coverage provider is the insurer or HMO.

For self-insured coverage, the coverage provider is the "person that administers the plan benefits," in other words the administrative service provider or, if self-administered, the plan sponsor.

How the Total Cost of Coverage is Calculated

The total cost of coverage under the plan is generally determined under rules similar to calculating COBRA premiums. If there are different administrators, the law requires the employer to combine the cost of different benefits, calculate the amount of the excess benefit, and determine the pro rata share of the excess attributable to each type of benefit. The employer notifies each administrator of its applicable share of the excess benefit and notifies the Treasury Department as well. Penalties are assessed on employers who do not perform these calculations.

Will the Thresholds be Adjusted in the Future?

As noted above, the two thresholds for 2018 are set in the law: $10,200 for self-only coverage and $27,500 for all other coverage tiers. There is no variation for high-cost regions of the country.

The thresholds can be increased in several ways:

• Medical Inflation: An increase is triggered if medical inflation in the Federal Employees Health Benefits Plan exceeds expectations.

• Age and Gender: This would apply if the age and gender mix of the plan participants differs from certain national norms.

• High-Risk Professions: The threshold amounts are increased if the majority of participants are engaged in a high-risk profession or are employed to repair or install electrical or telecommunications lines.

The list of employees in high-risk professions includes law enforcement officers, fire protection activities, out-of-hospital emergency medical care (including emergency medical technicians, paramedics and first responders). This includes people who retired from a high-risk profession if they were engaged in a high-risk profession for at least 20 years.

• Qualified Retirees: The threshold amounts are increased for a person who is receiving coverage as a retiree, age 55 or older, and not entitled to benefits or eligible for enrollment under Medicare.

For the last two adjustments noted above, the self-only threshold is increased by $1,650 and the threshold for all other coverage tiers is increased by $3,450. Starting in 2019, the thresholds and the adjustment amounts will increase based on general inflation (i.e., the Consumer Price Index for All Urban Consumers), not medical inflation, which is historically higher than general inflation. In general, this means that plans will pay higher taxes, and could even pay the tax sooner than if the thresholds increased with medical inflation. With medical trends running at about three times the rate of general inflation, the gap between actual plan costs and the general-inflation-adjusted thresholds will keep getting bigger, triggering even higher taxes over time than if the thresholds increased at a more realistic rate.

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How does the tax affect retiree health valuations?

Plans that offer retiree health benefits must project the cost of the benefit to determine when a cost threshold is met, triggering the excise tax. Plans must recognize the excise tax in their retiree health valuations if the amount is deemed significant.

How can plan sponsors shield the plan from the tax?

Plan sponsors should take action now to evaluate when and under what circumstances their plans could be expected to reach the excise tax thresholds. Plan sponsors should determine in which year the plan is likely to exceed the thresholds and by how much. A plan sponsor that expects to exceed the thresholds in 2018 or a few years beyond 2018 may want to begin considering plan design changes that would slowly bring down the total cost of the coverage.

Possible options include:

• selecting cost-effective provider networks, which might include narrow networks

• stepping up efforts to promote wellness and prevention to improve the health status and future claim-cost risk of the workforce

• self-funding to avoid certain taxes, fees and risk charges

• resetting eligibility rules, and

• migrating from fee-for-service provider reimbursement.

Conclusion

The course of action that will make the most sense will vary considerably from plan to plan. Given the extended time frames necessary to make plan and program changes, plan sponsors should begin charting the course now so that necessary changes can be rolled out gradually and communicated clearly to employees.

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