Prepare to Avoid or Delay the Affordable Care Act Excise Tax

By Edward A. Kaplan

Editor's Note: The same day HR News went to print, Congress passed its FY2016 omnibus budget and tax bill, delaying implementation of the ACA excise tax until 2020. All the other information presented here on the so-called "Cadillac Tax"remains accurate.

By now, most state and local governments have forecast if, when and how much they would likely have to pay in Affordable Care Act (ACA) excise tax for every employee covered under their health care plans. Many have implemented comprehensive clinical programs for prescription drugs, wellness initiatives and plan design changes in the hopes of delaying or avoiding the tax. Nevertheless, as shown below, close to half of all plan sponsors—even those with well-managed plans—are destined to exceed excise tax thresholds in just a few years unless they take additional steps now to control future plan costs.

This article looks at the origin of the excise tax—which is also known as the "Cadillac tax"—that is slated to take effect in less than three years, and also at how the tax is expected to function. Long-term effects on public employers are considered, and recommendations for what organizations could do to avoid or delay the tax's financial penalties without reducing the quality or value of their health care plans are presented.

The Economic Drivers of the ACA Excise Tax

The ACA's designers wanted to insure the uninsured, spread the risk and cost of covering the uninsured, and create a network of national insurance-purchasing markets. In addition, the economists who helped design the law wanted to slow the ever-rising cost of health care. They believed that allowing employers and employees to finance generous health care coverage on a pretax basis had resulted in overutilization of the health care system and to provide and receive excessive tax-free compensation that suppressed real wage growth while limiting disposable income that could drive economic growth. As a result, buried in the more than 2,000 pages that became ACA in 2010 is a mechanism to address the economists' tax-reform objectives: the excise tax.

What Triggers the Tax

Starting in 2018, plan sponsors that fail to keep their annual health plan costs below a tax-free threshold must pay a 40 percent tax on costs that exceed the threshold. The standard tax-free threshold for 2018 is $10,200 for single coverage and $27,500 for family coverage.

Note that plan costs generally include qualified medical and prescription drug benefits, as well as flexible spending account contributions, health reimbursement arrangements and pretax health savings account (HSA) contributions. For excise tax purposes, total value will be based on gross plan costs (i.e., total premium or covered claims expenditures and qualified administrative expenses) before employee contributions (i.e., payroll deductions for member premium sharing). Proposed guidance from the IRS would include both employer and employee pretax contributions to HSAs, although many plan sponsors think employee pretax contributions should be excluded.

Because the final regulations have yet to be released, several technical rules, assumptions and methods to determine what plan costs will apply against the tax-free threshold may change. Adjustments currently include a slightly higher tax-free threshold for employees in high-risk professions such as first responders and construction workers and for retirees who are over 55 and not eligible for Medicare. Comments to the IRS note that plan sponsors should also be allowed to adjust for regional cost differences, to exclude some health care-related expenses such as operating worksite clinics and paying preventive care claims, and to make other reasonable adjustments.

Importantly, the excise tax will be based on the plan in which each employee enrolls and not on the lowest-cost plan offered by the plan sponsor. Furthermore, the tax will be based on the total premium or premium-equivalent rate, which includes both plan sponsor and employee costs. Although plan sponsors are generally responsible for paying the tax, the insurer will pay the tax for fully insured plans (with the cost probably being passed on to the plan sponsor).

The federal government will reset the tax-free threshold each year from 2019 on, based on core Consumer Price Index (CPI) results rather than actual medical plan cost inflation. Health spending has historically risen three to five times faster than the core CPI. As a result, plans with costs below the 2018 tax-free threshold will eventually outpace the government escalators in tax-free thresholds and incur a new tax liability unless their cost trends are managed to align with core CPI rates.

What Does This Mean for Your Organization?

Enactment of the ACA excise tax will require plan sponsors to perform an annual calculation and report their health plan expenses to the IRS. This could trigger painful new federal tax liabilities. To determine how painful, Segal Consulting analyzed approximately 130 active employee plans from 60 clients representing the public sector and other types of plan sponsors using our proprietary Excise Tax Forecaster. The modeling tool uses 2014 Consolidated Omnibus Budget Reconciliation Act (COBRA) rates as a proxy for current plan costs and various assumptions about future cost factors to project 10-year scenarios for annual medical plan cost trends. Based on an assumed annual growth of 8 percent for medical and prescription drug benefits combined, and using the published starting 2018 tax-free threshold with CPI annual increases, Segal produced the results in the table that accompanies this article.

The average estimated per-employee tax for plans that hit the excise tax threshold in 2022 is projected to be $950. This means that for every thousand employees, a plan sponsor could face $950,000 in additional annual expenses in the form of taxes paid to the federal government.

Percent of Employer-Sponsored Health Plans With Excise Tax Liability

Plan Year Beginning	Percent of Plans
2018	31%
2022	46%
2027	70%

Source: Segal Consulting

It should be noted, however, that the probability of a plan sponsor's health plan exceeding the tax-free limits will be greatly influenced by the final regulations and possible changes imposed on rating methods, such as the ability to use area factors or composite rating. In some cases, plan costs do not reflect overly generous benefits, just the reality of having workers in high-cost locations like New York or Los Angeles. Or they simply reflect a population that has a higher utilization of health care due to their employment in jobs where the risk of injury and illness is high.

Regardless of these caveats, the long-term implications for the ACA excise tax as currently designed are clear. Plan sponsors must apply aggressive strategies to control plan costs. Whether they do this by increasing employee cost-sharing by imposing higher deductibles, co-insurance and co-payments or pursuing strategies such as implementing lower-cost provider networks and improving employees' health status through wellness and preventive incentives and programs, the tax will still reach a growing proportion of employer-sponsored group health plans. This could mean a slow regression to less-expansive coverage being offered by public sector employers—a race to the bottom—even for organizations that use comprehensive coverage as a means to attract and retain talent.

How Can You Control Costs and Maintain Plan Quality?

There are several steps public sector employers can take to avoid or delay incurring the excise tax while continuing to provide effective medical benefits to their employees for many years to come. To begin, plan sponsors should

1. Measure the potential tax exposure now,
2. Start generating options to lower plan costs and slow long-term cost trends, and
3. Model the impact of expected plan, network, contract and accounting changes.

There are many ways public employers can reduce current costs and annual cost growth. Moreover, lowering the annual cost growth from 8 percent to 5 percent can delay a plan sponsor's potential excise tax liability by more than 10 years. Although the best solution will differ for each plan sponsor, it is important to consider the following options:

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- Plan redesign
- Lower-cost provider networks
- Comprehensive medical management
- Reference-based pricing
- Aggressive vendor contracting
- Engaging employee communications

Each is described below.

Plan Redesign

Plan redesign may be the most effective way to lower a plan's baseline costs and its long-term cost trend while more effectively rationing employee coverage.

Establishing a high-deductible health plan (HDHP) with a personalized tax-free HSA that the public employer partially funds to cover a portion of the high deductible has merit and is being adopted by a growing number of plan sponsors. Importantly, taking this approach does not require relying solely on a full migration to a HDHP. Redesigning co-payments so employees pay less for lower-cost settings such as outpatient imaging facilities and telemedicine and for routine services such as primary care visits and generic medications for chronic conditions while paying more for higher-cost settings and services such as emergency room visits and hospital admissions will help lower costs and trends without applying across-the-board cuts.

"Public employers can significantly reduce … costs by demanding more vendor transparency and negotiating the elimination of administrative fees for supplemental services."

Deductibles for each inpatient admission, co-payments for each elective surgery and higher co-payments for emergency room visits can dramatically reduce avoidable services and visits to high-cost settings. Public employers that impose percentage co-payments for brand-name drugs instead of fixed dollar co-payments tend to have lower longer-term cost growth because the percentage co-payment does not erode in value over time. Moreover, employees become better consumers of their pharmacy benefits and choose more lower-cost generics and over-the-counter options.

Lower-Cost Provider Networks

Some public employers are looking to trade a degree of provider choice for lower prices or better discounts. Contracting with narrow-network providers that have value-based provider reimbursement provisions (e.g., shared savings, bundled payments and capitations) has reemerged as a way to transition away from a highly inflationary fee-for-service environment. This tactic should be followed in conjunction with adding and promoting telemedicine services and retail primary care clinics as covered services.

Comprehensive Medical Management

Public employers should focus on adding programs that address proven areas of waste. Greater use of prior authorization for compounded medications, pain-management treatments and sleep agents can yield substantial savings without compromising the ability of employees with real needs to get their proper therapies. Expert and independent patient advocate services have also become popular and show promise for helping patients get the right care the first time.

Last, encouraging reliance on better methods for managing patients with chronic health problems can slow disease progression and reduce the occurrence of costly complications. For example, a high-touch hospital discharge follow-up service can dramatically reduce readmission rates for many patients. Similarly, greater use of step-therapy for back surgery, weight-loss surgery, complex imaging procedures and several other elective procedures can reduce the cost of treatment substantially.

Reference-Based Pricing

Public employers can use reference-based pricing strategies to help limit excessive provider payments and costs. The strategies are proven to save 20 percent or more for targeted procedures without compromising access to quality providers.

Aggressive Vendor Contracting

Public employers can significantly reduce administrative, intermediary vendor and other add-on costs by demanding more vendor transparency and negotiating the elimination of administrative fees for supplemental services that do not provide value. Market comparisons can also be used to squeeze out excess price margins in older vendor contracts.

Self-insured Segal clients have a median administrative expense load that is approximately 6 percent to 7 percent of total medical plan costs. For some very large clients, that administrative load is less than 3 percent of total medical plan costs. A low administrative expense means more plan dollars can be spent on better employee coverage.

Engaging Employee Communications

Just as the excise tax will eventually affect a plan sponsor's plan costs, so will the behavior of employees and dependents. It is important to get all plan participants involved in their health care management. Employees—and their dependents—who make better choices will help the plan experience below-average cost growth and, thereby, avoid the excise tax as long as possible.

Conclusion

The ACA seeks to make health insurance available to everyone, provide 100 percent coverage for many preventive services, eliminate preexisting condition exclusions from insurance policies and offer other costly provisions. If a public employer's coverage is "too good," however, an excise tax will soon apply to "excess" plan costs. That will hurt both the employer and its employee.

Although some are hoping the ACA excise tax will be repealed, plan sponsors need to prepare for the possibility that it will survive. Plan sponsors that are willing to explore new options and make appropriate changes will be able to preserve attractive benefit coverage for current and future employees and avoid paying the excise tax for many years.

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