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REFORM UPDATE

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IRS ISSUES GUIDANCE ON CADILLAC TAX

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The Cadillac tax is scheduled to take effect in 2018. It will apply to employers or insurance carriers that sponsor plans which exceed the statutory cost thresholds:

- Individual coverage: $10,200
- Family coverage: $27,500

If a plan's cost for applicable coverage goes beyond the thresholds, then a 40 percent excise tax will be assessed on the excess amounts.

IRS Notice 2015-16 is the first guidance issued regarding the Cadillac tax. It addresses the following topics:

- Defines applicable coverage to be included when calculating cost
- Discusses how to calculate the cost of coverage
- Addresses the process for determining thresholds

The IRS is seeking feedback from stakeholders, which should be submitted by May 15, 2015. They will review stakeholder comments before issuing proposed regulations on the Cadillac tax.

COVERAGE THAT IS INCLUDED FOR THE TAX

When determining if the Cadillac tax threshold has been surpassed, comprehensive medical coverage is not the only element that must be included in the total cost. All of the following employer-sponsored benefits are considered applicable coverage that should be included in the calculation:

- Health coverage including medical and prescription drug costs
- Contributions to medical flexible spending accounts (FSAs)
- Contributions to health savings accounts (HSAs), if certain conditions are met
- Contributions to Archer medical savings accounts (MSAs), if certain conditions are met

- Onsite clinics, if certain conditions are met
- Coverage for specified disease or illness, if certain conditions are met
- Hospital indemnity or other fixed indemnity coverage, if certain conditions are met
- Federal, state and local government-sponsored plans for employees
- Retiree health coverage
- Multi-employer plans
- Possibly health reimbursement arrangements (HRAs)
- Executive physical plans

Applicable coverage is defined as "with respect to any employee, coverage under any group health plan made available by an employer which is excludible from the employee's gross income under Section 106 or would be excludible if it were employer-provided coverage (within the meaning of Section 106)." Employee and employer contributions to medical FSAs are included because they are both excludible from income.

The Notice provides additional detail on some of the conditional situations above:

- Employer contributions to HSAs and Archer MSAs are considered applicable coverage. In addition, employee pre-tax contributions made through a Section 125 plan to either of these accounts are considered applicable coverage. However, if an employee makes after-tax contributions to either of these accounts, the contributions are not applicable coverage. These after-tax contributions are deductible under Section 223.
- Coverage through an on-site medical clinic is generally considered applicable coverage. The IRS anticipates that the proposed regulations will exclude on-site medical clinics that offer only *de minimis* medical care to employees. The COBRA regulations note that an on-site medical clinic does not constitute a group health plan if:

    1. Health care consists primarily of first aid that is provided during working hours, or for the treatment of a condition, illness or injury that occurs during working hours
    2. Health care is available only to current employees
    3. Employees are not charged for use of the facility

    The IRS is seeking comment on the treatment of on-site clinics that meet the above criteria but also provide the following services:

    1. Immunizations
    2. Allergy injections
    3. Provision of aspirin and other non-prescription pain relievers
    4. Treatment of injuries caused by accidents at work (beyond first aid)
- Coverage for specified disease or illness and hospital indemnity coverage is considered applicable coverage, if the payment for coverage is excluded from gross income, or a deduction under Section 162 is allowed.

The Notice also listed specific coverage that is not considered applicable coverage, including:

- Coverage for accident-only, disability income insurance, or any combination thereof
- Supplemental liability insurance
- Liability insurance, including general liability insurance and automobile liability insurance
- Worker's compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance
- Other insurance coverage, as specified in regulations under which benefits for medical care are secondary or incidental to other insurance benefits
- Long term care coverage
- Coverage under a separate policy, certificate or contract of insurance, which provides benefits primarily for the treatment of the mouth or the eye (future guidance may exempt all limited-scope dental and vision that qualify as excepted benefits, for both insured and self-insured groups)
- Coverage for a specified disease or illness, and hospital indemnity or other fixed indemnity insurance if payment is **not** excluded from gross income
- Federal, state or local government-sponsored coverage for members of the military

Stakeholders have asked for more clarification, because this section refers to limited-scope dental and vision benefits provided under a separate policy, certificate, or contract of insurance. This implies that the exclusion will be limited to insured plans. The IRS may propose an approach under which self-funded limited-scope dental and vision plans that qualify as excepted benefits would not be considered applicable coverage.

Employee assistance programs (EAPs) are discussed in the Notice. The IRS is proposing to exclude EAPs that are considered excepted benefits from the definition of applicable coverage.

HOW TO CALCULATE THE COST OF COVERAGE

The excise tax will be assessed on a monthly basis. If the aggregate cost of applicable coverage exceeds the applicable dollar limit for the month, then the excise tax will apply. The cost of coverage should be determined in the same way that the COBRA premium is calculated. The Notice provides more details on the calculation rules that apply to the specific arrangements.

COBRA's applicable premium is generally based on the average cost of providing coverage for similarly situated individuals enrolled in the plan, instead of the cost to provide coverage based on the characteristics of each individual.

The COBRA premium must be calculated for a 12-month determination period, with rates calculated before the determination period begins. Employers must operate in good faith compliance with a reasonable interpretation of the COBRA rules when determining the rates.

For insured plans, the COBRA premiums are based on the insured rates. For self-funded plans, the COBRA rules provide two options for calculating the premiums:

1. **Actuarial basis method** – the applicable COBRA premium is equal to a reasonable estimate of the cost of providing coverage for similarly situated beneficiaries that:
    a. Is determined on an actuarial basis
    b. Takes into account such factors that the Secretary of the Treasury may prescribe in the regulations. Neither Treasury nor the IRS has ever issued regulations.
2. **Past-cost method** – the COBRA applicable premium is equal to:
    a. The cost to the plan for similarly situated beneficiaries for the same period occurring in the preceding determination period, adjusted by percentage increases or decreases of the implicit price deflator of the gross national product.
    b. A plan can elect not to use the past-cost method when there is a significant change in coverage between the preceding and current determination periods.

A self-funded plan must use the actuarial basis method, unless the plan is eligible to use the past-cost method and elects to use it.

The IRS is considering proposing a rule to require employers to use their chosen method of premium calculation for a period of at least five years. This will be done to limit potential abuse related to switching between the two options. In addition, the IRS is considering prohibiting the use of the past-cost method when significant benefit changes have been made for the new plan year.

The Notice includes a number of additional thoughts on both the actuarial basis and past-cost methods:

- For the actuarial basis method, the IRS is considering whether to propose a broad standard. The standard would state that the applicable cost of coverage for a group of similarly situated individuals would be equal to a reasonable estimate of the cost of providing coverage during the determination period, using reasonable actuarial principles and practices. Under this arrangement, the applicable cost would be based on projected cost, not the minimum or maximum exposure. The IRS has requested comments about the following specific issues:
    – Should the proposed regulations require some accreditation of the individuals making actuarial estimates?
    – Should the proposed regulations specify a list of factors that must be satisfied when making an actuarial determination of applicable cost?
    – Should the same rules apply for determining COBRA premiums?
- Under the past-cost method, the IRS is considering requiring the use of a 12-month measurement period, ending no more than 13 months before the beginning of the current determination period, for setting COBRA rates. The measurement period would need to be applied consistently, and could only be changed for a bona fide business reason. The IRS is asking for comments on whether this approach should also be used for Cadillac tax purposes.

- The IRS anticipates that the proposed regulations will specify what costs must be included under the past-cost method:
  - Claims, which could include claims incurred during the measurement period (whether paid or unpaid) or claims submitted during the measurement period (regardless of the date incurred). The IRS is asking for comments on which approach is preferable.
  - Premiums for stop loss or reinsurance fees
  - Administrative fees
  - Reasonable overhead expenses – the IRS is asking whether additional guidance is needed regarding overhead expenses.
- The IRS indicated that the proposed regulations will not take into account reserves and claims that are reimbursed by stop loss or reinsurance carrier.

Further discussion regarding the determination of applicable premiums was provided:

- Cost must be determined for self-only coverage and other than self-only coverage.
- Coverage provided under a multiemployer plan is treated as other than self-only coverage.
- Cost of coverage for medical FSAs should include both employee contributions and any potential employer contributions to the account.
- In determining the HSA cost, the actual employer contributions and pre-tax employee contributions are includible in the applicable cost.
- The IRS has requested comments on how to determine the cost of coverage provided by an on-site clinic that would be considered applicable coverage.
- If the cost is determined on a basis other than monthly, the costs can be allocated to months during the taxable period. If the cost is annualized, the monthly cost is considered to be 1/12th of the total cost.

The cost for applicable coverage is determined by the plan in which the employee is enrolled, not the coverage for which the employee is eligible.

Additional details were addressed in terms of setting COBRA rates and applicable cost for the Cadillac tax.

Similarly Situated Individuals

COBRA premiums should be determined based on similarly situated non-COBRA beneficiaries. COBRA defines similarly situated non-COBRA beneficiaries as covered employees, spouses and dependent children covered by the group health plan. These individuals must be receiving coverage for a reason other than COBRA. They must also be the most similarly situated to the circumstances of the qualified beneficiary immediately preceding the qualifying event.

The IRS anticipates that similar rules will apply in regard to the Cadillac tax. The IRS is considering that similarly situated employees would be determined by starting with all employees covered by a specific benefit package. The group would then be subdivided based on the mandatory disaggregation rules, with further subdivision based on the permissive disaggregation rules, as discussed in the Notice and described below.

Mandatory Disaggregation

After aggregating all employees covered by a particular benefit package, the employer would have to disaggregate those enrolled in self-only coverage and those enrolled in other than self-only coverage.

Aggregation by Benefit Package

The employer can determine cost based on benefit packages. Benefit packages would be considered different based upon differences in health plan coverage.

Permissive Aggregation with Other than Self-Only Coverage

Employers are required to look separately at self-only coverage and other than self-only coverage. However, the employer is not required to determine cost by the number of individuals covered by other than self-only coverage. Employers could consider all employees in other than self-only coverage as similarly situated.

Permissive Disaggregation

For the purposes of COBRA and the Cadillac tax, the IRS is considering permitting further disaggregation based on distinctions that have traditionally been made in the group insurance market. They are considering allowing disaggregation based on:

a. Broad criteria (such as nature of compensation, job category and collective bargaining status) – this would prohibit the use of any criterion related to employee health
b. A more specific standard (such as geographic differences, current and former employment, or by number of individuals covered in addition to an employee)

The IRS is seeking comments on all of the possible approaches discussed above. Their intent is to align the COBRA rate guidance with the Cadillac tax guidance.

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS)

The IRS wants stakeholder input on how employers should determine the cost of coverage in relation to the Cadillac tax. They are considering a number of approaches:

- Cost would be the amount of funding made newly available to employees each year. However, this may result in the HRA being overvalued, because employees do not always exhaust HRA funds each year.
- Employers could determine cost by adding together all claims and administrative costs attributed to HRAs for a particular period. This is similar to using the actuarial basis method for determining COBRA rates for a self-funded health plan.

Additional comments are requested on a number of issues related to HRAs:

- Can employers exclude, from the applicable cost, HRAs that limit eligible expenses to employer contributions for coverage? The thought is that this cost will be included in the cost of coverage. The IRS is seeking feedback on the number of employers that sponsor this type of HRA.

- Can employers exclude, from the applicable cost, HRAs that are used to cover a range of benefits, some of which would not be considered applicable coverage? The IRS is looking for feedback on how often HRAs reimburse services that would not be considered applicable coverage.

THE PROCESS FOR DETERMINING THRESHOLDS

The Cadillac tax applies when the cost for applicable coverage exceeds specific thresholds. The 2018 thresholds will be:

- Individual coverage: $10,200
- Family coverage: $27,500

These thresholds will be indexed annually.

The thresholds can also be adjusted for the following employee populations:

- Qualified retirees: A qualified retiree has attained age 55, receives coverage by virtue of being a retiree and is not covered by Medicare.
- High risk professionals: Employees in high risk professions include law enforcement officers, firefighters and emergency medical technicians. It also includes individuals who work in the longshore, construction, mining, agriculture, forestry, telecommunication installation and fishing industries.

The IRS is seeking comments on how an employer determines whether the majority of employees covered by a plan are engaged in a high risk profession. A further adjustment is permitted for qualified retirees engaged in a high risk profession for at least 20 years.

The IRS is seeking comments on a number of concerns:

- The list of applicable coverage includes options that are typically elected independently. An employee can make a self-only election for specific applicable coverage and a family election for other applicable coverage. Which threshold should apply in this situation? The IRS has proposed two potential options:
  - The employer would look at the cost for the self-only elections and the family elections. If the self-only election represents the majority of the cost, the individual coverage threshold should be used. If the family election represents the majority of the cost, however, the family threshold should be used. If the costs are evenly split, the family threshold should be used.
  - The employer could create a separate threshold that applies to the employee by adding the pro-rated thresholds associated with single coverage and family coverage.
- The rules permit the thresholds to be adjusted for age and gender of the plan's population. This is only allowed if the characteristics of the employer's workforce are different the national workforce. Comments are requested about whether this adjustment is desirable and how to approach these potential adjustments.

The IRS will need to address the issues relating to thresholds in more detail in the proposed regulations.

CONCLUDING THOUGHTS

This is the first attempt made by the IRS to discuss the Cadillac tax. They are actively seeking feedback from stakeholders on the issues addressed in this Notice. As a result, it is likely that many of these details will change.

The next step will be to issue proposed regulations based on stakeholder feedback. As with all things related to the ACA, our understanding will evolve over time.