March 11, 2015

CAB 15-2

Milliman

CLIENT ACTION Bulletin
Employee Benefits

IRS Notice Seeks Comments on ACA "Cadillac Tax" Issues

SUMMARY **In its first step to develop guidance on the excise tax that in 2018 will apply to high-cost employer-sponsored healthcare coverage under the Affordable Care Act (ACA), the IRS issued *Notice 2015-16,* which provides background information, definitions, and potential approaches the agency may incorporate into future rulemaking. The IRS notice invites comments by May 15, 2015, on three key areas relating to "applicable coverage": the definition, cost determination, and the application of the annual dollar limit to the cost. A future separate IRS notice will discuss and seek comments on the procedures for calculating and assessing the excise tax (under tax code section 4980I and which commonly is referred to as the "Cadillac tax").**

DISCUSSION

The 40% Excise Tax under the ACA

The ACA imposes a 40% excise tax on group health insurers, employers, and plan administrators if the aggregate cost of applicable employer-sponsored coverage exceeds a specified annual dollar threshold. In 2018, the amounts are $10,200 per employee for single coverage and $27,500 per employee for other-than-self-only coverage, to be adjusted for 2018 based on a federal employees' health plan benchmark's cost, and potentially increased by an age and gender adjustment. Multiemployer plan coverage is treated as other-than-self-only coverage. The thresholds also are higher – $11,850/$30,950 – for coverage of pre-Medicare eligible retirees aged 55 or older and employees in "high risk" professions or employed to repair or install electrical or telecommunication lines. The amounts will be indexed for inflation in later taxable years. The employer is responsible for calculating the tax and notifying the liable entity; the tax is not deductible.

Definition of Applicable Coverage

Applicable coverage under the tax code generally means coverage under an employer-provided group health plan that is excluded from the employee's gross income (as is the typical employer-sponsored group medical plan) or that would be if it were employer-provided coverage, and regardless of whether the employer or the employee pays for it or whether it is excludable from the employee's gross income or the employee pays for the coverage with after-tax dollars.

The tax code specifies applicable coverage to include:

- health flexible spending accounts (FSAs);
- health savings accounts (HSAs) and Archer medical savings accounts (MSAs);
- federal, state, and local governmental plans for civilian employees;
- on-site medical clinics that provide more than de minimis medical care;
- retiree health plans;
- multiemployer health plans; and
- coverage for specified diseases or illnesses if payments for coverage are excluded from income or a deduction is allowed.

The tax code's applicable coverage definition excludes insurance for stand-alone dental or vision care, accidents, disability income, workers' compensation, long-term care, and automobile medical payments, as well as liability and fixed-indemnity insurance. Coverage for specified diseases or illnesses is excluded if payment for coverage is included in gross income or a deduction is not allowed. In addition, the tax code implies that governmental plans maintained primarily for the military or their families are not applicable coverage.

The IRS *Notice 205-16* indicates that future guidance is expected to consider as applicable coverage health reimbursement arrangements (HRAs) and executive physical programs. The notice also indicates the IRS's views – and seeks comments – on the following:

- *HSAs/Archer MSAs* – Employer contributions (including salary reduction amounts) to HSAs would be considered applicable coverage, while employee after-tax contributions to HSAs and Archer MSAs would be excluded from applicable coverage.
- *Limited-Scope Dental and Vision Benefits* – Self-insured coverage that qualifies as an excepted benefit would be excluded from applicable coverage, as fully insured benefits currently are.
- *Employee Assistance Plans (EAPs)* – The IRS is considering excluding EAPs from applicable coverage if the plan qualifies under recently issued regulations as an excepted benefit.
- *On-Site Medical Clinics* – Although clinics that satisfy current regulations (under COBRA) and provide de minimis benefits are not considered applicable coverage, the IRS is interested in how to treat clinics that provide services such as: immunizations; allergy shots; nonprescription pain medication; and treatment for injuries (beyond first aid) caused by workplace accidents. The agency also requests comments on whether it should consider the nature and scope of the benefits or a dollar limit on the cost of a clinic's medical services. For clinics that are applicable coverage, the IRS is interested in how to determine the cost of coverage provided.

Determining the Cost of Applicable Coverage

The tax code generally requires that the value of applicable coverage be determined under rules similar to those used for COBRA continuation coverage. For self-insured plans, there are two options: the "actuarial basis" method and the "past cost" method. The methods take into account the average cost of providing coverage for "similarly situated" individuals. COBRA premiums are determined in advance for a 12-month period.

The new IRS notice acknowledges that guidance on several issues related to calculating COBRA premiums has not been issued. The notice focuses and seeks comments on approaches to determine similarly situated individuals, first grouping employees by a particular benefits package (e.g., health maintenance organization or preferred provider organization) and then subdividing each group by aggregating or disaggregating them (by self-only or not self-only). Plan sponsors would be permitted to further group plan participants (permissive aggregation for not self-only coverage and permissive disaggregation for bona fide employment-related criteria or other to-be-specified category).

Notice 2015-16 states that future guidance will treat HRAs as applicable coverage and indicates options to calculate the cost. One method would consider amounts made newly available to a participant each year; but because this method could overvalue HRAs, an alternative method bases costs on the total amount spent each year divided by the number of participants.

Applicable Dollar Limit

The notice invites comments on the application and adjustments to the annual dollar limits. In particular, the IRS seeks to clarify how the limits apply when an employee simultaneously has self-only coverage (such as comprehensive major medical) and other-than-self-only coverage (such as an HRA that covers the employee and his/her family). In this case, the applicable dollar limit generally would depend on whether an employee's primary (major medical) coverage is self-only or non-self-only, as reflected by the majority of the coverage's cost. Where the different coverage amounts are equal, the IRS contemplates applying the non-self-only dollar limit. Alternatively, the IRS could apply a composite dollar limit determined by prorating the dollar limits for each employee according to the proportions of the cost of the self-only coverage and the cost of the other-than-self-only coverage.

The notice also seeks comments on applying the dollar limits for retirees, employees in "high risk" professions (e.g., law enforcement, fire protection), and employers with age and gender demographics that differ from the national workforce.

ACTION Group health plan sponsors and administrators should review *Notice 2015-16* for its implications and consider submitting comments to the IRS by May 15, 2015. The notice asks for input on the IRS's planned approaches and related questions, many of which are not covered in this *Client Action Bulletin.*

For additional information about the notice or for an assessment of how the IRS's guidance and alternatives could affect your group health plan, please contact your Milliman consultant.