Commonwealth Benefits Group
2 Barlo Circle
Suite C
Dillsburg, Pennsylvania 17019
(717) 432-1010
http://www.commonwealthbenefitsgroup.com

HEALTHCARE REFORM UPDATE 2015-1 UPDATED

Highlights of the Excise Tax on High-Cost Plans (the "Cadillac Tax")

The excise tax on high cost plans (also referred to as the Cadillac tax and the 4980I tax) is scheduled to take effect in 2018. To date, regulations have not been issued, so many of the details about how the tax will operate are unclear. (The regulatory agencies are responsible for interpreting the law, adding needed details, and reconciling any parts of the law that may be inconsistent.) Based upon how the law itself is written, this is what is known and expected.

Q1: How much is the tax?

A1: The tax is 40% of the cost of health coverage that exceeds a threshold.

Q2: What is the threshold?

A2: For 2018 the base threshold is $10,200 per year ($850 per month) for self-only coverage and $27,500 per year ($2,291.67 per month) for all other levels of coverage. Plans that cover "qualified retirees" or which primarily cover those in a "high-risk profession" are allowed an additional $1,650 per year for single coverage in 2018 and $3,450 per year for all other levels of coverage.

"High-risk profession" means law enforcement officers, firefighters, emergency medical technicians, paramedics, first-responders, longshoremen; individuals in the construction, mining, agriculture (but not food-processing), forestry, and fishing industries; those who install or repair electrical or telecommunications lines, and employees who retired from a high-risk profession if the employee was in a high-risk profession for at least 20 years.

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It appears that the additional allowance will apply to each qualified retiree (but not to any active employees) in the plan. The additional allowance for high-risk professions will be available only if the plan primarily covers those in a high-risk profession; in that case, the additional allowance will be available to all plan participants.

Q3: Are there cost of living increases in the thresholds?

A3: Yes. Starting in 2019, the base thresholds and the adjustments for qualified retirees and those in high-risk professions will be increased by the Consumer Price Index for all Urban Consumers (CPI-U) - not medical inflation. In addition, if health inflation is higher than expected between now and 2018 (based on the cost of standard BlueCross/Blue Shield coverage under the federal employees' health plan), the 2018 base amounts will be increased.

Q4: Are there adjustments for high cost areas of the country or for employers with a higher risk workforce?

A4: There are no adjustments based on the part of the country in which the employer or employees are located.

There will be an adjustment allowed for age and gender for plans that are higher than the national average. Details on how that will work are not yet available.

Multiemployer plans may use the family threshold with all employees, even if the employee actually has single coverage.

Q5: What types of plans are subject to the tax?

A5: The tax applies to "applicable employer-sponsored coverage," which includes both insured and self-funded plans. The tax applies to grandfathered plans. It applies to all types of employers -- private, government, church, and not-for profit. Retiree plans -- even retiree-only plans -- are subject to the tax. Multiemployer plans are subject to the tax. The tax applies to coverage provided to active employees, self-employed individuals covered by the group health plan, former employees (presumably including COBRA participants) and surviving spouses.

Q6: What types of benefits are covered by the tax?

A6: The tax is based on the cost of:

- Major medical coverage (both employer and employee contributions)
- On-site clinics (employer and any employee contributions)
- Health flexible spending accounts (all employee contributions plus any reimbursement in excess of the employee's salary reduction contribution)
- Health savings accounts (employer contributions and probably any employee contributions made pre-tax through a Section 125 plan)
- Health reimbursement arrangements
- Dental and vision benefits that are provided in connection with major medical (i.e., that are bundled)

Q7: What types of benefits are excluded from the tax?

A7: These benefits do not count toward the tax:

- Stand-alone dental and vision (stand-alone means these benefits are provided under a separate policy or contract from medical; it is unclear whether a self-funded dental or vision plan would ever be

considered stand-alone)
- Life insurance
- Short- and long-term disability and accident insurance
- Long-term care
- Hospital indemnity, specified illness, Medicare supplement and other similar "excepted benefits," but only if paid 100% by the employee and with after-tax dollars
- Workers' compensation

Q8: How will the cost of coverage be calculated?

A8: In most cases, both employer and employee contributions will be considered. The total cost will be calculated in a manner similar to the way COBRA premiums are calculated.

If coverage is offered both to retired employees under age 65 (but at least age 55) and to retirees over age 65, the employer may -- but is not required to -- use the same cost of coverage for all retirees.

Q9: What if the employee changes between self-only and family coverage during the year?

A9: The cost will be determined monthly, based on coverage in effect on the first day of the month.

Q10: What if dependents are offered different coverage than the employee?

A10: If dependents receive different coverage than the employee or retiree, the employee's allowed cost will be based on the single coverage amount (i.e., $10,200 for 2018).

Q11: Is the tax deductible?

A11: No, the tax is not deductible.

Q12: When does the tax begin?

A12: The tax will be calculated monthly, based on coverage offered on the first day of the month. It begins with the 2018 calendar year. It is not yet clear when the tax actually will be due. The law gives the Secretary of the Treasury the authority to have shorter taxable periods based on employer size, which raises the possibility that large employers may be required to make excise tax payments more frequently than smaller employers.

Q13: Who calculates the tax?

A13: The employer is responsible for totaling the costs and then advising each coverage provider of its proportionate share of the cost. The employer also must provide the cost information and proportionate share information to the Department of the Treasury (details are not yet available on how this will work).

Example: Acme offers insured medical coverage through Carrier A. It also offers a self-administered health reimbursement arrangement (HRA) that provides benefits even after employment terminates. The annual cost of single medical coverage is $11,000 and the annual contribution to the HRA is $1,200. For each single employee, the excess benefit is $2,000 ($12,200 minus the $10,200 allowance for single coverage). The excise tax is $800 (40% of $2,000). Carrier A will owe 90.16% of the $800 ($11,000 is 90.16% of $12,200). Acme will owe 9.84% of the $800 tax.

In the case of multiemployer plans, the plan sponsor is the entity

responsible for calculating each coverage provider's portion of the taxable excess benefit, and for reporting that amount to the providers and the Department of the Treasury.

Q14: Who must pay the tax?

A14. The "coverage provider" is responsible for paying the tax. The coverage provider is:

- The insurer or health maintenance organization (HMO) for insured coverage
- The employer for health savings account (HSA) contributions
- The "person that administers the benefits" for all other types of coverage. If the plan sponsor administers the benefits, the plan sponsor is responsible for payment.

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