2018: The Excise Tax on High-Cost Plans

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Create Incentives to Control Health Coverage Costs while Raising Revenue for ACA

Clarifications Needed: Notice and Request for Information

- This presentation is intended to cover key elements of the "Excise Tax" but is subject to regulatory change and/or changes in Statute or Statutory interpretation between today and final implementation
- On February 23, 2015, the Treasury Department and Internal Revenue Service published Notice 2015-16 seeking comments on various issues related to Excise Tax on or before May 15, 2015
- On July 30, 2015, the Treasury Department and Internal Revenue Service released Notice 2015-52 seeking additional comments on issues related to Excise Tax on or before October 1, 2015
- Treasury/IRS will analyze comments and then release proposed regulations in 2016 (with final regulations effective January 1, 2018)
  - Employers taking a "wait and see" approach are running low on time

Question: Will political environment allow Cadillac Tax to survive in its current state beyond 2020? If so, will the 60% Minimum Value test drive employers out of the benefits delivery business somewhere down the road?

Excise Tax on High Cost Plans

Effective in 2018

- 40% tax on excess over threshold
- Based on total cost of coverage; employer plus employee premium share

Cost threshold for tax (indexed after 2018)

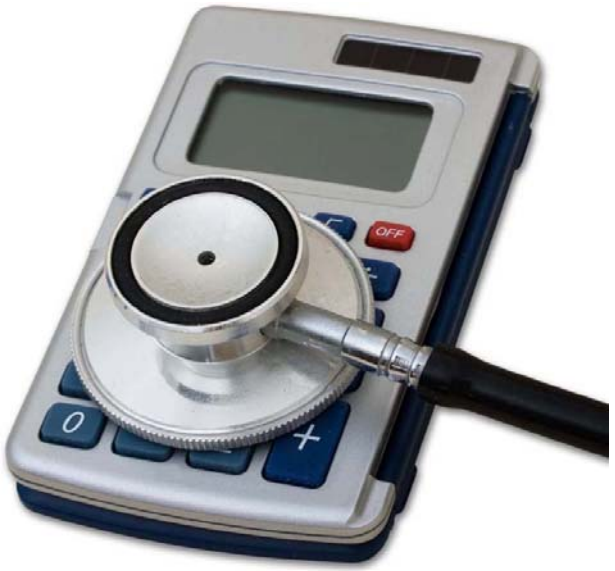
- $10,200 self-only, $27,500 other-than-self-only
- Increased by $1,650/ $3,450:
  - For retired individuals age 55 or older and not eligible for Medicare
  - If majority of employees covered by the plan are:
    - » Engaged in a high-risk profession (list in statute), or
    - » Employed to repair/install electrical or telecommunications lines
- Multiemployer plans use other-than-self-only

Coverage Subject to the Excise Tax

- Group health plans (excludable from income under IRC Sec. 106)
  - Corporate plans
  - Multiemployer plans
  - Governmental plans for civilian employees
  - Retiree coverage
- Executive physical programs (Treasury/IRS likely to include)
- Coverage for a specific disease or illness and hospital indemnity or other fixed indemnity insurance, *unless the coverage is paid for with after-tax dollars*

What is included as a Group Health Plan?

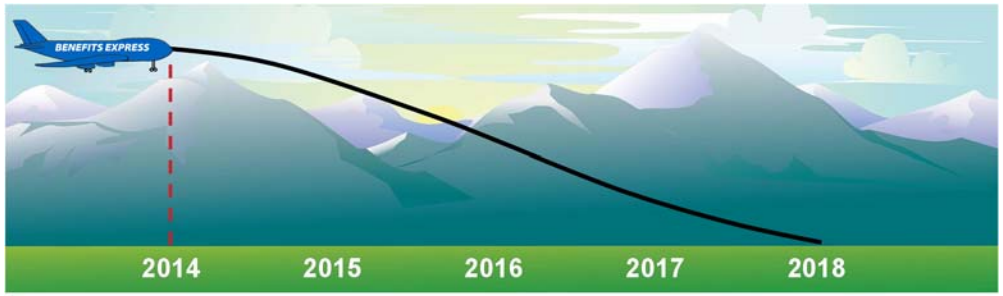
- Starting with tax year in 2018, both insured & self-funded plans are subject to a 40% excise tax on the total cost* for health coverage in excess of the statutory/regulatory threshold
  - ***the total cost for health coverage includes ALL these items:**
    - **both the employer & employee contributions for coverage** (but not a person's copays, coinsurance, deductibles)
    - **employee & employer contributions to a Health FSA, or Health Savings Account**
    - **Employer contributions to a HRA**
    - **cost of dental, vision and EAP if not specifically excluded**
    - **onsite medical clinics**
    - **wellness programs**



Who Pays?

- Insurer for insured plan
- Plan Administrator for self-insured group health plan, Health FSA or an HRA
- For self-insured plans, comments are being requested for ways to define the “person that administers the plan benefits”
- In practice, we expect Insurers and Plan Administrators will ultimately be reimbursed by the plan sponsor

What's Your Excise Tax Avoidance Plan Glide Path vs. Sheer Drop



- Actives, Non-Medicare Retirees <55, Medicare Retirees
  - Initial estimate for 2018
    - $10,200 Single Coverage
    - $27,500 Family Coverage
  - Initial estimate will change for health cost and age/gender adjustments
  - Future years adjusted for CPI which is lower than healthcare trend, resulting in significant pressure to reduce benefits annually once the threshold is reached
- Retirees ≥55 and Actives, and Retirees with 20 years of service for High-Risk Employers
  - Initial estimate for 2018
    - $11,850
    - $30,950
  - Same adjustment factors as above

HINT: 1) Ask your actuary to model your health benefits costs in the future, or 2) Start tracking the value of health benefits annually & develop a response strategy when projection cost hits 80% of the threshold for a 2-3 year implementation strategy, <80% for a longer glide path

The Cadillac Tax will likely drive plan design trends…

Ideas	Rationale
Make dental, vision and EAP into limited scope plans	Limited scope plans not factored into Cadillac tax calculation
Consider reducing value of plan by converting it to a HDHP with HSA	Most effective in Total Replacement situations
Reducing coverage for subjective benefits (e.g. Chiro, PT/OT/Speech) between the required preventive and necessary catastrophic services	Must still meet 60% Minimum Value Test
Eliminate spousal coverage (or coverage for working spouses)	Less likely to hit family threshold, or reduce # of households exceeding threshold
Self Fund Health plans	Eliminates ACA Health Insurer Fees, insurer margins and potentially reduces administrative fees
Restrict In-Network Benefits to ACO Partners	ACO Partners can be incented to reduce cost per member per month
Eliminate or reduce coverage for Non-network services to 40% or less with high or unlimited Out-of-Pocket Limits, or restrict reimbursement for Non-network services to 150% of Medicare	Generally ensures the plan sponsor's out-of-network treatment costs are less than in-network costs
Convert copays to coinsurance and increase OOP Limits	Helps manage healthcare trend by automatically adjusting patient cost share
Restrict or eliminate employee FSA contributions	Plan sponsor does not want to be taxed on voluntary employee contributions
Reduce cost-sharing for evidence based medical treatment compliance	Provide incentive to participants to take better care of their compliance-sensitive health conditions so as to reduce cost to the plan
Mandatory Generic Program (eliminate Brand drugs with generics)	Reduces prescription drug costs
Add price transparency tools or adopt reference based pricing for elective services	Create tools and incentives for patients to shop for cost effective elective care
Carefully consider cost effective onsite clinics, or telemedicine	Works if Non-Clinic services have only relatively modest patient cost sharing, telemedicine is particularly effective for rural populations