



## ACA Excise Tax on High-Cost Health Plans – 2018\*

\*delayed until 2020

### Background

The Affordable Care Act (ACA) imposes a tax on “high-cost” employer-sponsored health coverage. Although portrayed as applicable to a small minority of “overly generous” health plans, in reality, many large employers expect to trigger this tax sooner rather than later. Consequently, employers are seeking plan design changes to shift costs to employees in order to avoid the tax.

The excise tax is 40 percent of the cost of “applicable coverage” that is above specified dollar-based thresholds. The statute includes various adjustments to these thresholds, however, details are still to be determined. Although implementing regulations are not expected soon, the Department of Treasury and the Internal Revenue Service (IRS) have issued preliminary guidance related to the tax.

In December 2015, legislation passed containing three provisions impacting this tax:

- Delayed effective date by two years, from 2018 to 2020
- Made the tax deductible by businesses; and
- Called for a study to determine how best to calculate the age and gender adjustment that can result in an increase in the base thresholds.

### Thresholds and Possible Adjustments

The initial tax thresholds for 2018 are established in law: \$10,200 for self-only coverage and \$27,500 for all other coverage tiers. Taft-Hartley multi-employer plans may use the higher threshold (other than single) for all levels of coverage. The incremental cost of coverage above those amounts is subject to the 40 percent tax. For a simple example, for single coverage that costs \$11,100 in 2018, the excise tax would be \$360:

$$\begin{aligned} \text{Total coverage cost} - \text{Threshold limit} &= \text{excess cost subject to tax} \\ \$11,100 - \$10,200 &= \$900; \quad \$900 \times 40\% = \$360 \end{aligned}$$

The thresholds above are not absolute. The thresholds may be adjusted upwards, but not down, in accordance with the following:

- *Health cost adjustment percentage:* The thresholds could be adjusted upward if the cost of the Federal Employees Health Benefits Plan BC/BS standard option plan increases at a faster rate than predicted between 2010 and 2018, but as of now that is unlikely.

- *Age and gender adjustment*: An adjustment is available if the age and gender characteristics of the employer's workforce are different from those of the national workforce. Specifics are not available yet, but this could provide some relief for plans covering AFSCME members given that they tend to have a higher percentage of older and female workers than that of the workforce in general.
- *Qualified retirees and high-risk professions*: Thresholds for pre-Medicare retirees are increased by \$1,650 to \$11,850 for self-only coverage and by \$3,450 to \$30,950 for other coverage tiers. The same increases are applied if the *majority* of a plan's participants are engaged in a high-risk profession or are employed to repair or install electrical or telecommunications lines. While not fully defined yet, high-risk professions include: law enforcement officers, firefighters, out-of-hospital medical care providers such as EMTs, paramedics and first responders, longshore workers, and workers in the construction, mining, agriculture (not including food processing), forestry and fishing industries.
- *Inflation*: The base thresholds – and the adjustment amounts available for retirees and high-risk professions – are indexed. In 2019, the limits will be increased by the cost of living plus one percent (CPI + 1%). In later years, the thresholds will be adjusted by CPI. Historically, health care costs have increased at rates well above that of general inflation, so more and more plans are likely to run up against the thresholds.

Importantly, even though it is a key factor driving costs, there is no geographic adjustment for plans covering workers in high-cost regions.

### **What plans are subject to the tax and what's included in “applicable coverage?”**

Generally, all group health plans offered to an employee or retiree are subject to the tax. This includes both private and public-sector plans, whether they are self-insured or fully-insured. So, in addition to major medical and prescription drug coverage, this includes: wellness programs (if a group health plan), on-site medical clinics, health flexible spending accounts (FSA), health savings accounts (HSA) and health reimbursement arrangements (HRA). However, advocates have urged the IRS to exclude HSAs from the cost of coverage because they are generally not treated as group health plans and therefore would not be considered “applicable employer-sponsored coverage” for the purposes of this tax.

Significantly, the health plan costs subject to the tax include both employee and employer contributions and premiums. This means that employers cannot get around the tax by shifting a greater percentage of the premium on to employees.

#### **Exceptions...**

With the exception of on-site medical clinics (unless they only provide very limited medical care), the tax does not apply to “excepted benefits.” These include: accident or

disability income coverage, liability or supplemental liability coverage, workers' compensation, automobile medical payment insurance, credit-only insurance, long-term care coverage and separately offered dental and vision plans. Keep in mind, dental and vision coverage that is integrated with the health plan will be counted toward the cost of coverage, so if possible, consider carving this coverage out into stand alone plans to avoid the cost of the coverage being included in the tax calculation.

## Who calculates and pays the tax?

Employers are responsible for calculating the amount (if any) of tax liability and notifying each "coverage provider" what portion they are responsible for paying. The insurer is responsible for paying the tax for insured plans and for self-insured plans, the plan administrator or employer must pay the tax. There are no provisions prohibiting or limiting the ability of an employer or insurer from passing the tax through to employees.

## Possible Excise Tax Strategies

Because the 40 percent tax rate is high, considerable attention is being paid to avoiding the tax. Strategies for managing the tax will begin with estimates of 2018 health care costs and possible excise tax amount due. After confirming the cost of coverage amount, the reasonableness of the inflation rate used to estimate 2018 (and later) costs and the dollar thresholds used in the calculation, an appropriate strategy for managing the estimated tax should be developed. Most strategies come at a cost to plan participants in terms of restricting provider choice or shifting costs. For example, our union has opposed the implementation of high deductible health plans as inappropriate cost-shifting to plan participants that may also result in adverse selection. Some possible strategies targeted at reducing the cost of coverage include:

- Utilizing a value-based insurance design (VBID) or wellness program targeted at treatable chronic conditions to encourage use of high-value health care services. More information can be found on the University of Michigan's [Center for Value-Based Insurance Design](#) and in Families USA Issue Brief: [Principles for Consumer-Friendly Value-Based Insurance Design](#).
- Introducing narrow or tiered networks which provide premium savings by restricting network participation to the most efficient/effective providers and/or by varying the deductibles, copays and coinsurance for providers in different tiers of the network. Providers and facilities selected for the network should be based on *both* quality and cost. Two good sources of information are the report [High-Value Healthcare Provider Networks](#) by Milliman and Academy Health's Research Insights [Health Plan Features: Implications of Narrow Networks and the Trade-Off between Price and Choice](#).

- As mentioned earlier, if not already done, carve out dental and vision coverage into stand alone plans.
- Incorporate a reference-based pricing strategy for non-emergency, “shoppable” health care services. In this approach, a plan sponsor sets an upper limit on the amount the plan will pay for a specific service (e.g. knee/hip replacement, MRI) and plan participants are required to pay the difference in cost if they select a more costly provider. More information can be found in this Employee Benefit Research Institute Issue Brief: [Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits](#) and this Center for Studying Health System Change Research Brief: [The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer](#).
- Transitioning toward plans that pay providers/facilities based on outcomes instead of fee-for-service such as through Patient Centered Medical Homes (PCMH) and Accountable Care Organizations (ACO). Research is still being done (mainly in the Medicare/Medicaid population) to determine how much (if any) measurable savings can be realized using this approach. This approach has potential but the programs and networks are not fully developed. A variety of helpful ACO related blog entries can be found on the Health Affairs website including [here](#) and [here](#) and a paper highlighting research showing positive outcomes for PCMHs can be found [here](#).
- Implementing a high-deductible health plan (HDHP) with a corresponding shift of some compensation into wages or other desired areas. The calculations of the amount of money collected through the excise tax provision assumed a compensation shift to increased wages. Whether or not this happens will depend in large part on the strength and engagement of members and the bargaining team in negotiations.

### **Sample Contract Language**

(adjust timeframe to suit circumstances):

#### Section Z. Excise Tax on High Cost Health Plans

A. In the event any of the health benefit plans offered in accordance with this Agreement may be subject to the excise tax on high cost health plans, the Employer shall provide the Union with notice within seven (7) days of the Employer becoming aware that the plan may be subject to the tax based on prospective costs exceeding the applicable dollar limit established pursuant to 26 USC §4980I. The notice will include the prospective costs of the plan(s) and be accompanied by statements from the health insurer, carrier and/or plan actuary certifying that costs for the ensuing plan year shall exceed the applicable limit. The Employer shall promptly provide the union with information relevant and necessary to verifying prospective plan costs subject to any restrictions under law.

- B. Within seven (7) days of the notice described in subsection A above, the Employer shall provide the union with plan design change options (increases in co-insurance, co-payments, deductibles, narrower networks, higher out of pocket limits, etc) accompanied by the cost reduction to the plan associated with each change. The Employer shall obtain estimated plan cost reductions for other plan design options proposed by the Union. The Union shall select the plan changes to reduce prospective plan costs below the applicable dollar limits.
- C. All cost savings resulting from plan design changes shall be used to offset required health care benefit contributions from employees. Upon application of the plan design cost savings, the resulting percentage of total plan cost paid by the employee at each dependent tier shall be the revised employee percentage premium share as established in Section (X) of this Article.