Avoiding a Head-on Collision With the Cadillac Tax

by David McSweeney, David Ermer and Barbara P. Niehus
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Although multiemployer health plans are very likely to be hit by a 40%, non-deductible excise tax in 2018, trustees may be able to minimize the damage by starting now to control their plan’s costs. They need to understand how other features of health care reform can increase costs leading up to the excise tax.

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A daunting new cost is heading down the road toward multiemployer health plans—the Cadillac tax. This aspect of health care reform legislation passed in March is still a ways in the distance, but the authors believe few health plans will escape the impact of the tax if they don’t take precautionary measures.

Other components of the Patient Protection and Affordable Care Act (PPACA) take effect earlier and will have a bearing on the tax. The more plans understand about those components, the better prepared they will be. They can take steps, starting now, to avoid a full frontal collision with the tax.

What Is the Cadillac Tax?

Beginning in January 2018, the non-deductible 40% excise tax will be levied on both insured and self-funded employers that fail to comply with these health plan premium thresholds:

- $10,200 for individual coverage
- $27,500 for family coverage.

Fortunately for multiemployer plans, there is no separate threshold for individuals—the $27,500 threshold applies to the average of individual and family premiums.

The tax is imposed on the balance above the threshold determined on a monthly basis during the taxable period.

The following three types of adjustments apply to the family threshold:

1. **Employee classification adjustments.**

   The dollar limit increases for retirees aged 55 and over who are ineligible for Medicare and for employers when the majority of employees are in a “high-risk” profession (e.g., police, firefighters, paramedics, etc.). Those increases are $1,650 for singles and $3,450 for families.

2. **One-time adjustment.** The thresholds are subject to a one-time, catch-up adjustment in 2018 based on the premium growth of the Blue Cross Blue Shield Federal Employee Plan’s Standard Option.

3. **Annual adjustments.** Beginning in 2018, an employer-specific adjust-

ment will be made for age/gender composition (versus the national average). In 2019, the family thresholds will be adjusted by Consumer Price Index for All Urban Consumers (CPI-U) plus one and annually thereafter by the CPI-U.

There is no adjustment for geographical variations. For example, plans in New York City will be treated the same as those in West Virginia.

Also, the tax expressly applies to government plans.

**How Premium Should Be Calculated**

The premium calculation will include employer and employee contributions made on a pretax or after-tax basis for:

- Medical coverage
- Health care flexible spending account (FSA) (capped at $2,500, plus CPI-U beginning in 2013)
- Employer contributions to a health savings account (HSA)
- Health reimbursement arrangement (HRA)
- Worksite clinics.

The calculation excludes insured, standalone dental and vision coverage and, of course, the Cadillac tax itself.

Multiemployer plans will be responsible for making the calculations. Self-funded plans will calculate premium essentially the same way COBRA continuation coverage calculations are made, based on accepted actuarial methodology. Insured plans will use actual premium.

Rate determination is to be performed annually. The tax calculation should be performed monthly at the employee level.

Costs in the table are based on U.S. average costs for single and family health care in 2008, with a projection to 2018 when the Cadillac tax goes into effect.

The table shows that even plans of average cost will find it challenging to avoid the Cadillac tax in 2018.

Plan sponsors should ask themselves what their average health care spend per employee is today. Remember, every pre-

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dollar limits on essential health benefits (EHBs) that will become effective for plan years beginning on or after September 23, 2011. Restrictions on aggregate annual dollar limits on EHBs will become effective at the same time. The elimination of aggregate annual dollar limits on EHBs will become effective for plan years beginning on or after January 1, 2014.

Elimination of restrictions on preexisting conditions will apply to persons under age 19, beginning with plan years commencing on or after September 23, 2010 and all age groups beginning with plan years commencing on or after January 1, 2014.

Elimination of the maximum 90-day waiting period will become effective in 2014.

Employer-sponsored plans are not obligated to offer the EHB package but to the extent that those plans offer EHBs, those benefits cannot have aggregate dollar limits. The implementing regulations issued on June 28, 2010 define EHBs by cross-reference to PPACA Section 1302(b) and applicable regulations, which have not yet been issued. For plan years beginning before issuance of those regulations, the regulators will take into account good faith efforts to comply with a consistently applied, reasonable interpretation of the term EHBs.

Additional reform provisions will become effective through 2014 and may make avoiding the Cadillac tax extremely difficult.

Curtailment of Traditional Plan Design Tools
These include:
- Elimination of aggregate lifetime dollar limits on essential health benefits (EHBs) that will become effective for plan years beginning on or after September 23, 2011. Restrictions on aggregate annual dollar limits on EHBs will become effective at the same time. The elimination of aggregate annual dollar limits on EHBs will become effective for plan years beginning on or after January 1, 2014.
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Increase in the Dependent Eligibility Age
In 2011 alone, some 1,250,000 young

<table>
<thead>
<tr>
<th>Classification</th>
<th>2008 Actual Cost</th>
<th>2018 Projected Cost</th>
<th>FSA Addition ($2,500)</th>
<th>Cadillac Tax Threshold (Before Adjustments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$4,386</td>
<td>$9,040</td>
<td>$11,540</td>
<td>$10,200</td>
</tr>
<tr>
<td>Family</td>
<td>$12,298</td>
<td>$25,350</td>
<td>$27,850</td>
<td>$27,500</td>
</tr>
<tr>
<td>Composite**</td>
<td>$7,551</td>
<td>$15,564</td>
<td>$18,064</td>
<td>$27,500</td>
</tr>
</tbody>
</table>

* Assumes 7.5% annual cost increase trend and does not factor in any of the cost escalators created by health care reform.

** Multiemployer plans receive special treatment, allowing them to compare the average cost (composite over both single and family units) to the family threshold. This calculation assumes 60% of subscribers are single and shows that multiemployer plans have a better chance of falling below the threshold, at least for some period of time.
adults are expected to take advantage of the increase in the dependent eligibility age to 26. These “children” can be a son, daughter, adopted child, stepchild or eligible foster child of a health plan member.\textsuperscript{24}

**Mental Health Parity (Passed Pre-PPACA)**

The Mental Health Parity and Addiction Equity Act of 2008 takes on greater meaning as a result of health care reform. Although the act still does not require an employer to offer mental health benefits, it does require complete parity with medical benefits, if the employer chooses to offer mental health benefits. This means that mental health benefits are subject to all of the new provisions of reform, including:

- The elimination of restrictions on lifetime and annual limits
- The removal of restrictions on pre-existing conditions
- The increase in the dependent eligibility age.

Offering mental health benefits may have become a lot more expensive.

**Numerous New Reporting, Recordkeeping Requirements**

W-2 reporting of the cost of employer-sponsored health care will be required for taxable years beginning after December 31, 2010.\textsuperscript{25}

The Centers for Medicare and Medicaid Services is authorized to do surveys and require data from plans, and the amount of required reporting will increase over time.\textsuperscript{26}

Uniform operating rules that require certifying compliance with the Health Insurance Portability and Accountability Act begin in 2013.\textsuperscript{27}

Additionally, electronic funds transfers between plans and providers will be required.\textsuperscript{28}

To the extent that administrative fees increase to cover these costs, they will add to the total plan costs measured for the Cadillac tax.

**Increased Cost Shifting From Medicare**

Health care reform calls for $455 billion in Medicare cuts and the establishment of an Independent Payment Advisory Board that, beginning in 2014, is to submit legislative proposals to reduce the per capita growth rate in Medicare spending beyond established targets.\textsuperscript{29} Lower reimbursements to health care providers and facilities have historically caused costs to be shifted by providers and health care facilities to commercial plans.\textsuperscript{30}

**Increased Cost Shifting From Medicaid**

Beginning immediately, a projected 16 million additional low-income Americans will join the more than 60 million who currently receive Medicaid in one form or another. The pace of the increase in Medicaid enrollees will quicken in 2014, when Medicaid becomes available to all non-Medicare-eligible individuals under the age of 65 with incomes up to 133% of the federal poverty line—$14,400 in 2010.\textsuperscript{31}

Cost shifting due to decreasing Medicaid reimbursements to providers is likely to increase dramatically because of the expansion of the Medicaid population.

For self-funded plans, all of this will translate to higher costs because of cost increases and cost shifting.

**Health Insurance Provider’s Fee**

For insured plans, premiums will definitely rise because of the factors already noted, as well as a health insurance provider’s fee. This multi-billion-dollar fee will be imposed on all net written premiums for all health insurance companies, beginning in 2014, as follows:

- 2014—$8 billion
- 2015 and 2016—$11.3 billion
- 2017—$13.9 billion
- 2018—$14.3 billion.

Thereafter, the fee will be calculated using the fee from the preceding year, increased by the rate of premium growth.

All fully insured plans, including multiemployer plans, will be treated the same. Insurance companies will pass these fees on as increases in premium. The good news: Self-funded employer and multiemployer plans are exempt from this tax.\textsuperscript{32}

There’s another factor—already at play in the marketplace—that will further drive up administrative expenses and result in additional erroneous claims expense. The International Statistical Classification of Diseases (ICD-10) is being updated, expanding the number of diagnosis and procedure codes used by health care providers and facilities from 24,000 to 155,000. Providers and health plans must comply with ICD-10 by October 2013—just about the time some of the biggest of the health reform Catch-22s take effect.\textsuperscript{33}

**Cost shifting due to decreasing Medicaid reimbursements to providers is likely to increase dramatically because of the expansion of the Medicaid population.**

### Ways to Lessen the Impact of the Cadillac Tax

Although many plans will have to begin paying the Cadillac tax in 2018—with more to follow, since the Cadillac thresholds increase by the CPI-U after 2019—here are seven ways plans may avoid a head-on collision with the tax and minimize the damage.

1. **Do the math.** Whether a plan is self-funded or fully insured, plan sponsors should begin now to develop an acute understanding of the cost of delivering health care to the individuals and families in the plan. They should seek advice from an actuary with a solid understanding of the plan, the workforce and the plan sponsor’s objectives.

2. **Continuously monitor paid claims.** Plan sponsors can’t do the math if they don’t have the numbers. With so many cost escalators—and so many new opportunities for errors and fraud—entering the health care system, plans should consider the new paradigm for reviewing paid claims: continuous monitoring. Such monitoring not only provides...
1. Calculate claims trends. Continued improvements in healthcare should lead to lower overall claims costs. It may be time to reexamine assumptions made about claims growth. Ongoing monitoring will help plan to experience lower-than-average trends and avoid unnecessary increases in premiums.

2. Reassess your pharmacy benefit program. Employers are paying more for prescription drugs than ever before. pharmacy benefit managers (PBMs) are critical to plan sponsors because they reduce costs, improve patient access to care, and help plan sponsors implement and maintain benefit programs. A PBM can accomplish two things: experience a lower-than-average trend and delay the impact of the Cadillac tax, possibly by years.

3. Continue efforts to manage costs. The information that a plan sponsor has collected will support ongoing efforts to manage costs. Many of the rules are changing. Some of the cost-management tools used in the past may no longer be available. And new ones will be developed. The plan’s administrator/insurer and other vendors should be continuously challenged to make sure the plan is getting the best value for its money.

4. Consider self-funding. A fully insured multiemployer plan may want to consider self-funding. The plan assumes more risk, but may have more control. The plan will also avoid the health insurance provider’s fee that will be charged to insurance companies, which will most certainly pass it along in higher premiums.

5. Rethink the plan’s contribution structure. It may be time to consider less traditional contribution structures. Charging differently for young adults (under 26) as compared to other children is prohibited. Examples of possible structures are separate contribution amounts for the employee, spouse, children (up to two children) and each additional child (applied to each child beginning with the third), or separate contribution amounts for the employee, his or her spouse, and each child.

6. Make sure dental/vision plans are standalone. As written, PPACA allows only these coverages to be excluded from the tax—if they are insured. The authors believe this is a drafting error that does not reflect intent. If the rules don’t exclude self-funded dental/vision, consider insuring these benefits.

In any event, make sure that these plans are considered standalone.

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Update plan documents and contribution schedules if necessary.

7. Manage retiree plans appropriately.

The Cadillac tax also applies to retired plan members. Plan sponsors may want to communicate with retirees to reserve the right to pass along the tax to avoid any immediate impact on other postemployment benefits liabilities under FAS 106 and GASB 43 and 45. The Cadillac tax calculations allow a plan to calculate premiums separately for active employees and retirees. This may prove to be advantageous, since higher thresholds apply to retirees.

Rules also allow for combining costs for Medicare-eligible retirees with retirees under the age of 65. Some modifications to plan documents may be required to take full advantage of this provision.

Plans that are taking advantage of the retiree drug subsidy may want to rethink their approach to Part D for 2018.

Endnotes

1. 26 U.S.C. Sec. 4980I (added by Section 9001 of the Affordable Care Act).
2. Id. Sec. 4980I(b)(3)(B)(ii).
3. Id. Sec. 4980I(b)(2).
4. Id. Sec. 4980I(b)(3)(C)(iv), (f)(2), (3).
5. Id. Sec. 4980I(b)(3)(C)(i).
6. Id. Sec. 4980I(b)(3)(C)(ii), (v).
7. Id. Sec. 4980I(d)(1)(E).
13. PPACA Sec. 1251 as implemented by federal regulations published at 75 Fed. Reg. 34,538 (June 17, 2010).
14. 29 C.F.R. Sec. 2590.715-1251(f).
15. 29 C.F.R. Sec. 2590.715-1251(g).
16. Id.
17. 75 Fed. Reg. 34,540.
18. PPACA Section 1001 (adding Section 2711 to the Public Health Service Act), 1251; 29 CFR 2590.715-2711 published at 75 Fed. Reg. 37,188 (June 28, 2010).
19. Id.
20. PPACA Sections 1001 (adding Section 2704 to the Public Health Service Act), 1251; 29 CFR 2590.715-2704.
21. PPACA Sections 1001 (adding Section 2708 to the Public Health Service Act), 1253.
24. PPACA Section 1001 (adding Section 2714 to the Public Health Service Act, implemented by regulations published at 75 Fed. Reg. 27,122 May 13, 2010).
25. PPACA Sec. 9002.
26. PPACA Secs. 1302(b)(2), 3101, 4303.
27. PPACA Sec. 1104(b)(4)(C).
28. PPACA Sec. 1104(c).
32. PPACA Section 9010.

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