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IRS Releases First Guidance on ACA's So-Called "Cadillac Tax"

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Last week, the IRS released Notice 2015-16, available here, in an effort to begin developing regulatory guidance for the Affordable Care Act's excise tax on high-cost health coverage (the "Excise Tax"), which will become effective beginning as early as 2018. The Excise Tax, which is commonly referred to as the "Cadillac Tax," imposes a 40% nondeductible excise tax on the aggregate cost of "applicable employer-sponsored coverage" (including employer-sponsored group health plan and multiemployer plan coverage) in excess of certain statutory limits. Although the Notice does not provide any definitive answers to the many questions raised, it is still welcome news in that it identifies a number of issues that could be addressed in forthcoming guidance and, in some cases, indicates the direction in which the IRS is headed. This can help many employers and plan sponsors as they now consider steps to mitigate possible exposure to the Excise Tax. This is especially true for employers contributing to multiemployer health plans who bargain benefit levels, as they may have only one more opportunity at the bargaining table to adjust benefits before the Excise Tax applies.

The Notice offers a number of initial ideas and proposed approaches on how various Excise Tax issues may be resolved. The Notice also requests comments from practitioners on specific parts of the Excise Tax, as well as related issues under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Notably, the Notice does not provide further guidance on which party will be liable for the Excise Tax in the case of self-funded coverage – i.e., whether that is the plan sponsor, the third-party administrator, or the plan administrator listed on the plan's Form 5500. In addition, the Notice does not indicate whether there are any circumstances under which the Excise Tax may be paid from plan assets.

The Notice focuses on three major issues affecting administration of the Excise Tax, namely: what types of coverage constitute "applicable employer-sponsored coverage" potentially subject to the Excise Tax; how the "cost" of applicable coverage is determined; and how the annual dollar limits are applied.

What Constitutes Applicable Coverage Subject to Excise Tax

- The Notice confirms that "applicable employer-sponsored coverage" otherwise subject to the Excise Tax is determined without regard to whether the employer or the employee pays for the coverage, whether the coverage is paid for on a pre- or post-tax basis, or whether the coverage is insured or self-insured.
- The Notice acknowledges an issue regarding self-insured dental and vision coverage that was a particular concern for many employers. Under the statute, only *insured* dental and vision benefits are specifically excluded from the Excise Tax. As has been widely anticipated, the Notice indicates that the IRS is considering adopting an approach under which both *insured and self-insured* dental and vision benefits are excluded from the Excise Tax, provided that the benefits are offered under stand-alone plans that otherwise satisfy the revised rules on excepted benefits; a position that would be in accord with the recently issued excepted benefit regulations.
- The Notice confirms that applicable coverage includes, but is not limited to, health FSAs, HSAs and Archer MSAs, coverage for on-site medical clinics, and multiemployer plans. Some related Excise Tax issues being considered by the IRS include the following:
    - *HSAs and MSAs*. The IRS anticipates that future proposed regulations will provide that employer contributions to HSAs and Archer MSAs, including salary reduction contributions, will be included in applicable coverage, and after-tax contributions will be excluded.
    - *On-site medical clinics*. The IRS is considering excluding from applicable coverage on-site medical clinics that offer only *de minimis* medical care (e.g., first aid) to employees. The IRS requested comments on this approach, particularly with respect to on-site medical clinics that provide certain services beyond (or in lieu of) *de minimis* care, such as immunizations, injections of antigens, provision of nonprescription pain relievers, and treatment of work injuries (beyond first aid). This is an important issue for employers, especially those who have historically offered robust on-site medical clinics for their employees.

The Cost of Applicable Coverage

A central provision of the Excise Tax provides that the cost of applicable coverage is determined under rules *similar* to the rules that apply for purposes of determining the applicable premiums under COBRA. As a result, the Excise Tax rules and the rules under COBRA for determining the cost of applicable coverage are now somewhat linked. The Notice addresses the COBRA rules that are likely to inform the IRS as it proposes rules applicable to the Excise Tax, while at the same time indicating possible changes to the rules under COBRA.

- Under COBRA, the applicable premium is based on the cost of coverage for similarly situated non-COBRA beneficiaries. The Notice indicates that the IRS will adopt a similar standard for purposes of the Excise Tax, and invites comments on an approach under which a group of similarly situated employees would be determined by starting with all employees covered by a particular benefit package, then subdividing that group based on mandatory disaggregation rules (based on whether an employee is enrolled in self-only coverage or other-than-self-only coverage), and then allowing further subdivision based on *permissive* disaggregation rules (based on the number of individuals covered in addition to the employee, and, potentially, other distinctions traditionally made in the group insurance market).
- Regarding *permissive* disaggregation, the IRS is considering whether disaggregation should be permitted based on (a) a broad standard (such as a bona fide employment-related distinction like job category or nature of compensation, or (b) a more specific standard (such as a list of specific categories for which disaggregation is allowed). If a more specific standard is preferable, the IRS invited comments on which specific criteria should be permitted.

Notably, the IRS confirmed that the Excise Tax rules do not require that the cost of coverage be determined separately based on the number of individuals who are receiving coverage in addition to the employee. Therefore, the IRS is considering an approach whereby employers would be permitted to use just one cost of coverage for other-than-self-only coverage (even if the actual cost of such coverage varies depending on how many individuals other than the employee are covered). The approach being considered by the IRS appears to suggest that it would be permissible to have only two costs of coverage for purposes of the Excise Tax (self- and other-than-self-only), even if under COBRA the costs of the same coverage were broken down further into how many individuals other than the employee were covered (e.g., employee plus one, employee plus two, family, etc.).

- The COBRA regulations provide two methods for self-insured plans to use when developing the COBRA-applicable premium – the actuarial basis method and the past cost method. Concerned about the possibility of abuse in a plan that switches between these methods frequently, the IRS is considering, for purposes of the COBRA regulations and the Excise Tax, rules that would generally require a plan to use its chosen valuation method for at least five years. The IRS invites comments on whether these approaches should be adopted for the Excise Tax.

The Notice also addresses a number of other issues concerning the cost of applicable coverage:

- The Notice clarifies that the applicable cost of applicable coverage refers to coverage in which an employee is *enrolled*, and not coverage that is merely *offered* to the employee.
- The Notice confirms that any coverage under a multiemployer plan is treated as other-than-self-only coverage for purposes of the Excise Tax.
- The Notice confirms that the cost of applicable coverage for health FSAs equals the sum of salary reduction contributions and also any reimbursements under the arrangement in excess of the salary reduction contributions, such as employer flex credits.

The IRS also indicated that a Health Reimbursement Arrangement (HRA) constitutes applicable coverage. The IRS is considering various methods of determining the cost of coverage for HRAs, including: (i) basing it on the amounts made newly available to a participant each year; (ii) adding together all claims and administrative expenses attributable to HRAs for a particular period and dividing that sum by the number of employees covered for that period; and (iii) using the actuarial basis method. Comments also were requested on issues relating to whether the cost of applicable coverage should not include (i) an HRA that can be used only to fund the employee contribution toward coverage, and/or (ii) an HRA that can be used to cover a range of benefits, some of which would not be applicable coverage.

- The IRS also invited comments on whether alternative methods for calculating the cost of applicable coverage would be consistent with the statute. This is response to certain stakeholder suggestions that the cost of applicable coverage be determined by reference to similar coverage elsewhere (e.g., on the Health Insurance Marketplace).

The Applicable Dollar Limit

There are two applicable dollar limits – self-only coverage (estimated at $10,200 in 2018) and other-than-self-only coverage (estimated at $27,500 in 2018). In Notice 2015-16, the IRS addresses certain related issues:

- Acknowledging the potential for an employee simultaneously to have different types of coverage to which different dollar limits apply, the IRS is considering determining the applicable dollar limit based on whether an employee's primary coverage/major medical coverage (i.e., the type of coverage that accounts for the majority of the aggregate cost of applicable coverage) is self-only or other-than-self-only coverage. Alternatively, a composite dollar limit could be determined by prorating the dollar limits for each employee according to the ratio of the cost of the self-only coverage and the cost of the other-than-self-only coverage. The IRS invited comments on these approaches.

Under the statute, an additional amount is added to the dollar limits for an individual "who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunication lines" (including a retired employee who satisfied these requirements for at least 20 years). The IRS requested comments on how to determine whether the majority of employees covered by the plan are so engaged, what the term "plan" means for this purpose, how to make the 20-year determination, and whether further guidance on the definition of a "high-risk profession" is needed.

- Under the statute, the applicable dollar limits may be increased by an age and gender adjustment if the age and gender characteristics of a particular employer are less favorable than the national workforce. The IRS invited comments on whether it would be desirable or possible to develop safe harbors to assist employers in adjusting the dollar limits for their particular workforce.

Although the Notice does not provide a great deal of concrete guidance, it does offer a considerable degree of insight into the IRS's thinking with respect to a number of issues concerning the Excise Tax, and also presents a significant opportunity for practitioners to provide comments to the IRS for consideration. Public comments on these issues are due by May 15, 2015.

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