IRS Issues Second Notice to Assist in Developing Cadillac Tax Regulations

2018 Update: Please be aware that implementation of the Patient Protection and Affordable Care Act's excise tax on high cost employer-sponsored health coverage, also known as the "Cadillac tax," is delayed. The Cadillac tax was originally set to take effect in 2018, but it was delayed by two years under the Consolidated Appropriations Act of 2016, making the tax due in 2020. Then on January 22, 2018, Public Law 115-120 extended the effective date of the Cadillac tax to 2022. The thresholds noted below are indexed and will likely be different on the delayed effective date in 2022.

IRS Notices

The Internal Revenue Service (IRS) issued its second notice regarding the Cadillac tax's implementation. Plans that provide coverage that exceeds a threshold will owe the tax. The threshold generally will be $10,200 (indexed) for single benefits and $27,500 (indexed) for benefits provided to an employee, retiree, or member of a bargaining unit, and dependents. The tax is 40 percent of the value of coverage provided over that threshold level.

On February 23, 2015, the IRS released Notice 2015-16 to provide information on the types of benefits that will count toward the tax.

On July 30, 2015, the IRS released Notice 2015-52 to address: (1) the definitions of applicable coverage; (2) the determination of the cost of applicable coverage; and (3) the application of the dollar limit on the cost of applicable coverage to determine any excess benefit subject to the excise tax. Public comments for Notice 2015-52 were due by October 1, 2015.

The IRS has not issued any proposed regulations.

Who is liable for the tax?

The Cadillac tax is found in IRS Section 4980I and imposes an excise tax that must be paid by the coverage provider. The definition of coverage provider is:

- the health insurance issuer, in the case of applicable coverage under a group health plan that provides health insurance coverage,

- the employer, in the case of applicable coverage under an arrangement in which the employer makes contributions described in Section 106(b) or (d) (health savings accounts [HSAs] and Archer medical savings accounts [Archer MSAs]), and
- the person that administers the plan benefits, in the case of any other applicable coverage.

Currently, IRS statutes clarify (but do not provide a definition) that the "person that administers the plan benefits" includes the plan sponsor if the plan sponsor administers benefits under the plan, and the definition of plan sponsor follows the definition found in ERISA regulations. Logically, this means that a plan sponsor in a self-funded plan may be, but is not always, the person that administers the benefits under the plan. The term "person that administers plan benefits" is not defined or found in the ACA, ERISA, or the Public Health Service Act. The IRS and Department of the Treasury are considering two ways to determine who is the person that administers plan benefits (acknowledging that the term "person" will likely be an entity rather than an individual):

- Under the first suggested approach, the person that administers the plan benefits would be the person responsible for performing the day-to-day functions that constitute the administration of plan benefits. These duties include receiving and processing claims for benefits, or responding to inquiries. Under this approach, the person that administers plan benefits would likely be a third-party administrator (TPA) for a self-funded plan, unless the employer performs these functions.
- Under the second suggested approach, the person that administers the plan benefits would be the person with the ultimate authority or responsibility under the plan or arrangement, without regard for whether the person routinely exercises the authority. The agencies anticipate that this person would be identified based on plan documents and would not be the person that performs day-to-day administrative functions.

Controlled Groups – Employer Aggregation

Employers treated as a single employer under previous rules regarding controlled groups and affiliated service groups will be treated as a single employer for purposes of the Cadillac tax.

Cost of Coverage

The IRS has defined the taxable period as a calendar year, or a shorter period as determined by the Secretary of the Treasury. The Secretary may have different taxable periods for employers of different sizes.

To calculate the amount of the tax owed, an employer must determine the extent to which the cost of applicable coverage provided to an employee during any month of the taxable period exceeds the limit. The employer must notify the IRS and provider of the amount, and then the coverage provider must pay the amount. Employers will be required to make the determination shortly after the end of the taxable year to allow payment in a timely manner. The cost of applicable coverage will be determined using rules similar to those used in determining the applicable Consolidated Omnibus Budget Reconciliation Act (COBRA) premium.

Exclusion of Amounts Attributable to the Excise Tax

The excise tax will be paid by the health insurance issuer for insured coverage and by the "person that administers the plan benefits" for self-funded coverage. If a person other than the employer is liable for the tax, that entity might pass all or part of the tax to the employer. Reimbursement for the excise tax

payment would be additional taxable income, so it is anticipated that the coverage provider will pass along both the excise tax amount and an amount to cover the additional income tax the coverage provider will incur. The excise tax reimbursement should be excluded from the cost of applicable coverage. Federal agencies are concerned that the methodology for excluding income tax reimbursement might not be administrable due to variability of tax rates and other factors.

The IRS is anticipating that coverage providers would be permitted to exclude the amount of any excise tax reimbursement if it is separately billed and identified as being attributed to the cost of the excise tax.

In the event that income tax reimbursement can be excluded, the agencies believe the amount of reimbursement will be calculated using the formula used to calculate "tax gross-ups."

$$\text{Income Tax Reimbursement} = \frac{\text{[amount of tax]}}{\text{(1 - [marginal tax rate])}} - \text{[amount of tax]}$$

The amount of tax is the excise tax multiplied by the initial excess benefit calculated without regard to any portion of the cost of applicable coverage that the coverage provider identifies as arising from an excise tax reimbursement. The IRS is considering two possible approaches to applying the formula:

- The first approach would use the coverage provider's actual marginal tax rate in the formula, providing greater flexibility to taxpayers, but creating IRS administrative challenges.
- The second approach would use a standard marginal tax rate based on typical tax rates applicable to different types of health insurance issuers. The rates would reflect an approximate representative marginal rate, less than the statutory maximum. While easier to administer, the approach may not permit some taxpayers to exclude the total income tax reimbursement from the cost of applicable coverage.

HSAs, Archer MSAs, FSAs, and HRAs

Applicable coverage under the Cadillac tax includes certain health savings accounts (HSAs), Archer medical savings accounts (MSAs), flexible savings accounts (FSAs), or health reimbursement arrangements (HRAs). The agencies are considering an approach under which contributions to account-based plans would be allocated on a pro-rata basis over the period to which the contribution relates (the plan year, generally) regardless of the timing of the contributions.

Cost of Coverage under FSAs with Employer Flex Credits

The cost of applicable coverage of an FSA for any plan year would be the greater of the amount of an employee's salary reduction, or the total reimbursements under the FSA. The cost of the non-elective flex credit would be the amount that is actually reimbursed in excess of the employee's salary reduction for the plan year. The IRS provides the following example:

> If an employee elects to make a salary reduction contribution to an FSA in the amount of $1,000 for a plan year, and the employer makes a non-elective flex credit in the amount of $500 available to the employee under the FSA for that plan year, but the employee only has $1,200 in medical expenses reimbursed under the FSA for that plan year, the cost of applicable coverage for the FSA for the plan year would be $1,200 (comprised of the $1,000 salary reduction plus the

additional $200 in reimbursements attributable to the non-elective flex credit provided by the employer) rather than the full $1,500 elected or available for the FSA for the plan year.

To avoid issues with double counting for amounts that are carried over from year to year, the agencies are considering a safe harbor in which the cost of applicable coverage would be the amount of the salary reduction without regard to carry-over amounts. This would be limited to cases in which non-elective flex credits are not available for use in the FSA. Other safe harbors are being considered for FSAs with non-elective flex credits.

Inclusions of Self-Insured Coverage Includible in Income

Applicable coverage includes coverage under a group health plan made available to an employee by an employer that is excludable from the employee's gross income under IRS Section 106, which excludes accident or health plans from the employee's gross income. IRS Section 105 provides for reimbursement of medical expenses of the employee or family members under an employer-provided accident or health plan, which is excluded from the employee's income. Although excess reimbursement can be excluded from the cost reported on the Form W-2, the IRS does not believe these amounts reduce the cost of applicable coverage. Prior Notice 2012-9 will be modified in the future to make excess reimbursement subject to reporting.

Age and Gender Adjustments

The excise tax threshold generally will be $10,200 (indexed) for single benefits and $27,500 (indexed) for benefits provided to an employee, retiree or member of a bargaining unit, and dependents. Adjustments for some factors will be provided, including age and gender characteristics of all employees and an employer. No downward adjustments can occur. Instead, the adjustment increases the dollar limit by an amount equal to the excess of the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan (FEHBP standard option) if priced for the age and gender characteristics of all employees of an individual's employer (the employer's premium cost), over the premium cost for providing this coverage if priced for the age and gender characteristics of the national workforce (the national premium cost). Age and gender adjustment is determined separately for self-only coverage and coverage that is not self-only.

In order to compare the employer's premium cost with the national premium cost, the IRS is considering using the Current Population Survey, Employed Persons and Employment-Population Rations by Age and Sex, Seasonally Adjusted, published annually by the Department of Labor.

The agencies are considering requiring an employer to use a snapshot date (first day of the plan year) for determining the composition of the employee population.

The IRS and Department of the Treasury anticipate formulating and publishing adjustment tables to facilitate and simplify the calculations of age and gender adjustment. The following seven determinations are being considered for the development of the tables:

1. Determination of average cost for FEHPB coverage. The average cost of applicable coverage under the FEHBP (FEHBP average cost) would be determined by aggregating all claims expenses of the FEHBP standard option and dividing the total by the number of coverage units. Each employee policyholder would be a coverage unit.

2. Determination of average cost for each age and gender group. Claims expense data would be sorted into groups, separating the population into male and female coverage units and further separating each gender population into multi-year age bands. For example, the dollar amount of claims for all male individuals between the ages of 30 to 34 would be added together. The dollar amount of claims for each group would then be divided by the number of coverage units in that age and gender group to yield the average cost for that group (group average cost). A group average cost would be calculated in this way for each of the age and gender groups.
3. Determination of group ratios. Each group average cost would be divided by the FEHBP average cost to establish the ratio (group ratio) of the group average cost to the FEHBP average cost. The group ratio would be expressed as a fraction or percentage and would be determined periodically, but less frequently than annually.
4. Determination of group premium cost. The group ratio would be multiplied by the most recent annual premium cost of the FEHBP standard option to determine the annual premium cost for each age and gender group (group premium cost). The dollar amounts representing each group premium cost would then be used to populate the adjustment tables, to be published annually.
5. Determination of national premium cost. To determine the national premium cost, each group premium cost would be multiplied by the fraction of employees in the national workforce who are in that group. The product of each of these calculations would be added together to yield the national premium cost, which would be a single dollar amount that would be published annually.
6. Determination of the employer's premium cost. Each employer would determine the fraction of its employees who are in each age and gender group. The employer would then multiply the group premium cost from the relevant adjustment table by the fraction of its employees in each group. The product of each of these calculations would be added together to yield the employer's premium cost, which would be a single dollar amount.
7. Determination of adjustment. The employer's premium cost would then be compared to the national premium cost. If the employer's premium cost exceeds the national premium cost, the excess dollar amount would be added to the dollar limit for that employer for purposes of determining the amount of any excess benefit.

There are two approaches to step one, the first relying on actual claims data from the FEHBP standard option, the second relying on national claims data reflecting plans with a design similar to that of the FEHBP option. One approach will be adopted.

Notice of Calculation

The agencies are considering both the form in which information must be provided to coverage providers and the IRS, and the time in which the information should be provided.

Payment

The IRS and Department of the Treasury are considering designing the filing of Form 720 as the appropriate method for paying the Cadillac tax. Although Form 720 is filed quarterly, the Cadillac tax would be assigned to a particular quarter, similar to payment of the ACA's Patient-Centered Outcomes Research Institute (PCORI) fee.

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