CHEIRON HEALTH ALERT

"Cadillac Tax" Notice Requests Comments

March 13, 2015

On February 23, 2015, the Department of the Treasury (Treasury) and the Internal Revenue Service (IRS) released Notice 2015-16 to start the process of developing regulations to implement the excise tax on high cost employer-sponsored health coverage (popularly known as the "Cadillac Tax"). The tax applies to taxable years beginning after December 31, 2017.

Prior to this notice, no guidance had been released. The Treasury and IRS intend to issue another notice describing and inviting comments on potential approaches to a number of issues not addressed in Notice 2015-16, including timing of a return and payment of the tax. After comments from both notices, the Treasury and IRS anticipate issuing proposed regulations.

Notice 2015-16 describes an overall computation method starting from the methods used to determine COBRA rates. The Notice primarily addresses (1) definition of applicable coverage subject to the Cadillac tax, (2) computation of the cost of applicable coverage, and (3) application of the annual statutory limit.

Notice 2015-16 explicitly states that the notice "does not provide guidance under § 4980I upon which taxpayers may rely." (See Section VIII; Notice 2015-16)

Action Needed Now: Plan sponsors need to consider whether they want to submit comments. Comments are due **May 15, 2015**.

Where to Send Comments

Send written submissions to CC:PA:LPD:PR (Notice 2015-16), Room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Notice 2015-16), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC 20044.

Submission may be sent electronically, via the following e-mail address: Notice.comments@irscounsel.treas.gov. Please include "Notice 2015-16" in the subject line of any electronic communication.

All material submitted will be available for public inspection and copying.

Background/Overview

Section 4980I of the Internal Revenue Code was added by the Affordable Care Act (ACA), and applies a 40% excise tax if the ***cost*** of "applicable employer-sponsored coverage," referred to as "applicable coverage," exceeds a statutory dollar limit. The tax applies to the excess portion of the cost of applicable coverage above the limit. The ***annual dollar limit, which will be revised annually,*** for self-only coverage is $10,200 and for "other-than-self" coverage, $27,500, for calendar year 2018. Adjustments are allowed to the dollar limits in certain circumstances, including: retirees ages 55 through age 64 not on Medicare, high-risk professions, and

demographics differing from the national average. In addition, all coverage under a multiemployer plan is treated as other-than-self-only coverage.

Seemingly Clarified Issues

Table 1 below highlights some areas that the Notice appears to clarify, assuming that the language in the Notice is not changed in the proposed or final regulations.

Table 1

Issued Addressed	Conclusion	Pages
Whom to Include	Taxes are based on cost of applicable coverage for "**former employees, surviving spouses, and other primary insured individuals**." All three groups are referred to as employees. This definition would include employees, COBRA participants, retirees, and dependents. Employees include enrolled individuals only and exclude those offered coverage but not enrolled.	2 &12
What Coverage to Include	The Notice clarifies what coverage to include. Details are shown in Table 2.	6 & 7
Monthly Calculation	The Notice suggests a monthly computation of costs applicable coverage versus dollar limits with self only or other-than-self-only determined at the beginning of the month.	3
Dependent Coverage	Minimum Essential Coverage must be provided to dependents at the same level as to the employee for the employee to be considered enrolled in other-than-self-only coverage for single employers.	3
Retiree Groups	Costs for retired employees who are under and over age 65 may be combined together for purposes of evaluating whether the Cadillac Tax applies. This appears to permit non-Medicare and Medicare retiree program costs to be blended together, when comparing a retiree "applicable" coverage costs to the limit.	11
Multiemployer Plans	This notice states "…any coverage under a multiemployer plan … is treated as other-than-self-only coverage."	3

Table 2 below shows a more complete list of coverages to include/exclude as addressed in the Notice:

Table 2: What Coverage to Include/Exclude, i.e., Applicable Coverage	
Coverage to Include	**Coverage to Exclude**
a. Health Flexible Spending Accounts (FSA) b. Archer Medical Savings Accounts (MSA) c. Health Savings Accounts (HSA) except for voluntary HSA contribution not made through a payroll deduction d. Government plans for civilian employees e. On-site medical clinics (comments suggested clinics providing *de minimis* care could be excluded) f. Retiree coverage g. Multiemployer plans h. Coverage described in section 9832(c)(3), i.e., specific diseases or illnesses, hospital indemnity, other fixed indemnity excluded from gross income or deduction allowed under section 162(l) i. Health Reimbursement Accounts (HRA) (questions remain on measurement) j. Executive physicals	a. Accident or disability income insurance or any combination b. Supplement to liability insurance c. Liability insurance including general and automobile d. Workers' compensation or similar insurance e. Automobile medical payment insurance f. Credit insurance g. Other health insurance coverage for which benefits for Medicare care are secondary h. Long-term care i. Excepted benefits, both insured and self-insured (Comments requested) j. Coverage described in section 9832(c)(3), i.e., specific diseases or illnesses, hospital indemnity, other fixed indemnity if included in gross income and no deduction allowed under section 162(l)

Specifically Requested Comments

In the context of the broad overview of a computation method, the IRS and Treasury identified at least 35 areas where they invite comments.

Definition of Applicable Coverage

Commentary: The types of plans to which the tax could apply. Applicable Coverage seems to be the most settled area. Comments are requested in three areas.

1) **On-site medical clinics** are expected to be excluded only if they cover de minimis care. How should the exclusion for on-site medical clinics be determined where services in addition to first aid are provided, e.g., based upon the nature and scope of benefits or as a specific dollar amount? (page 9)
2) Why Treasury and IRS should not exclude the cost of self-insured limited scope **dental and vision** benefits that are considered excepted benefits? (page 10)
3) Why Treasury and IRS should not exclude the cost of **employee assistance programs** that are considered excepted benefits? (page 10)

Determination of Cost of Applicable Coverage

Com*mentary: The Notice frames out a methodology that first identifies a group of "similarly situated employees," who are covered by a particular benefit package. Then, the Notice describes the potential computation method to include steps of:*

- **"Aggregation by benefit package"** – combining costs for those in similar plans to establish a group to compute costs.
- **"Mandatory disaggregation"** – requiring costs be separated; costs for employees with self-only coverage are to be separate from those with other-than-self-only coverage.
- **"Permissive aggregation within Other-Than-Self-Only Coverage"** – combining costs for those with different types of other-than-self-only coverage is allowed (but not required) for those with 1, 2, 3, etc. dependents.
- **"Permissive disaggregation"** – costs may (but are not required to) be separated, such as for a geographic region.

The Notice goes on to explain that self-insured plans need to compute the applicable COBRA premiums using either an actuarial basis method or a Past Cost Method. Neither method has been previously defined in the regulations. The Notice requests comments on 27 areas related to the methodology for calculating the Cost of Applicable Coverage.

4) How should **similarly situated employees** be determined? The approach under consideration would start with groupings by benefit package, mandatorily disaggregating employees with self only and other than self-only coverage, and allow some permissive aggregation and disaggregation. (page 13)
5) Should **permissive disaggregation** be permitted on a broad standard (such as limiting it to bona fide employment-related criteria, i.e., job categories, collective bargaining status, etc.), or a more specific standard (such as only current and former employees, or geographic distinctions, or the number of employees covered by other than self-only coverage)? (page 14)
6) To what extent should **benefit packages be considered the same package?** And, if there can be some differences, what differences should be allowed? (page 14)
7) If the more **specific disaggregation approach** is preferable, what criteria should be used? (page 14)
8) What additional guidance would be beneficial with respect to the treatment of retired **employees under age 65 and retirees age 65 or over**, as similarly situated beneficiaries? (page 14)
9) Should Treasury and IRS attempt to harmonize the COBRA applicable premium rules to the rules for determining the cost of applicable coverage? (page 15)
10) What differences between the determination of the **COBRA applicable premium** and the cost of applicable coverage are appropriate? (page 15)
11) To prevent abuse, should a plan be only **allowed to change methodology** between the Actuarial Basis Method and the Past Cost Method only once every five years? (page 16)
12) If there is a significant difference in covered benefits or change in population, should plans be **required to use the Actuarial Cost Basis** for the two years following the change? (page 16)
13) Should the Treasury and IRS propose a broad **standard for** determining the Cost of Applicable Coverage using the **Actuarial Cost Basis** for similarly situated individuals that use reasonable actuarial principles and practices (under which an estimate of the actual cost the plan is expected to incur would be determined)? (page 16)
14) If actuarial cost estimates are used, is it preferable to **specify a list of factors** that need to be satisfied to make the actuarial determination, and should a similar standard apply for COBRA premium purposes? (page 16)
15) Should there be some required **accreditation for individuals** making actuarial estimates? (page 16)
16) Should Treasury and IRS adopt a **standard** under the **Past Cost Method** for COBRA purposes that would allow the 12-month measurement period to be any 12-month period ending not more than 13 months before the beginning of the plan year? (page 17)
17) Should Treasury and IRS adopt a similar standard under the Past Cost Method for the cost of applicable coverage, i.e., that would allow the **12-month measurement period** to be any 12-month period ending not more than 13 months before the beginning of the plan year? If so, what administrative issues need to be addressed? (page 17)

18) With respect to the Past Cost Method, **what costs** (claims, stop-loss premiums, administrative expenses, reasonable overhead expenses, etc.) **should be included**? (page 17)
19) With respect to the Past Cost Method, should costs be based on **claims incurred** during the measurement period (whether paid or unpaid) **or** should costs be based on **claims submitted** during the period (regardless of when incurred)? (page 18)
20) What **data** do employers and insurers traditionally track? And, if relevant, the maximum length of time permitted to account for claims to be submitted (the run-out period)? (page 18)
21) Would additional guidance on what constitutes reasonable **overhead expenses** be beneficial (including whether a presumption should be adopted that a third party administrative fee reflects overhead expenses and whether a safe harbor should be adopted for self-administered plans that assumes a set percentage of claims)? (page 18)
22) Whether costs should not take into account **reserves** for potential future costs?
23) How should the cost of applicable coverage be determined for an **HRA** (including whether it should be determined based upon the amounts newly made available each year)?
24) Should the cost of the **HRA** be determined by ignoring all **carry-over amounts** from pre-2018 and include all possible claims and administrative expenses added to an HRA for a particular period (of each level of coverage) and dividing by the number of employees? (page 18-19)
25) Should **HRAs** permit or require employers to use the **Actuarial Cost Basis**? (page 19)
26) How often do **HRAs allow reimbursement** that can only be used to fund employee contributions for coverage? (page 19)
27) How should the **cost of an HRA** be determined if it can be used for both applicable and not Applicable Coverage? (page 19)
28) How often do **HRAs allow reimbursement** for types of coverage that are not Applicable Coverage? (page 19)
29) If only **one method** was to be allowed **for HRA** cost determination, what method is preferable? (page 19)
30) Should the COBRA rules pertaining to the **determination period** (for example, the requirement to choose a method before the 12 month period begins) be extended to determine the cost of applicable coverage? (page 20)

Applicable Dollar Limit

Commentary: The Applicable Dollar Limit can be adjusted by high-risk profession, non-Medicare retirees ages 55 to 64, and age in addition to a defined inflation rate. There remain many unanswered questions of what combination of groups is allowed and how to adjust and apply the Applicable Dollar Limits.

31) How should the **applicable dollar limit** be determined when an employee has coverage that is **self-only coverage and** coverage that is **other-than-self-only coverage** (for example, self-only major medical coverage and an HRA for the employee and family)?
    - Should the applicable dollar limit be based upon the primary coverage on both applicable and not applicable types of coverage?
    - Alternatively, should the applicable dollar limit where there are both types of coverage be based upon a ratio of the cost of each type of coverage? (page 21)
32) How does an employer determine that a retired employee is not eligible for **enrollment under the Medicare program** (which is a part of the definition of a "qualified retiree" who has an addition to the dollar limit)? (page 22)
33) How does an employer determine whether the **majority** of employees covered by a plan are engaged in a **high-risk profession**, and what does the term "plan" means in that context? (page 23)
34) How does an employer determine that an employee was engaged in a **high-risk profession for at least 20 years**? (page 23)
35) Would further guidance on the **definition of** "employees engaged in a **high-risk profession**" be beneficial? (page 23)

36) Is it desirable and possible to develop **safe harbors** that appropriately adjust the dollar limit thresholds for employee populations with age and gender characteristics that are different from those of the national workforce? (page 23)

Other Methods

37) Are there alternative methods for determining the cost of applicable coverage consistent with the statutory requirements? (page 24)

Cheiron's Additional Comments

We recommend plan sponsors provide comments on any and all items that would assist them in determining any potential tax liability and simplifying the calculation burdens. Also, even though the list of areas identified in the Notice for comment is extensive, we have identified other open issues to consider, including for example:

1) Secondary coverage - Are dependents who are covered as secondary coverage excluded from the calculation? If so, are Medicare eligible retirees excluded?
2) Retirees - Can non-Medicare retired participants be combined with other primary insured individuals? If so, can the dollar limit be increased proportionately? Are surviving spouses ages 55 through 64 to be included with the group that receives the higher dollar limit?
3) Age Adjustments - Are the age adjustments calculated for the entire plan or split by the permissive disaggregated groupings?
4) Claim Adjustments - To what extent is the plan permitted to make adjustments for claims fluctuations? (i.e., will a small self-insured plan be subject to the tax simply because it had a high claims year?) Would retrospective adjustments have to be included for minimum premium plans or retrospectively rated plans?
5) Risk Adjustment Aggregation/Disaggregation - Can a plan with multiple benefit packages risk adjust based on the morbidity, i.e., participant selection, of that benefit package? (e.g., if an employer offers two benefit packages where Package 1 attracts the unhealthy employees and Package 2 attracts the healthy employees, would Package 1 be at greater risk for being taxed?)
6) FSAs - Will the rules of HRAs apply to FSAs? Specifically, may calculations exclude amounts for FSAs paid for benefits not covered by the medical plan (such as dental & vision)? Would employers need to track FSA payments separately by those with self-only coverage vs. those with other-than-self-only coverage? Can employers aggregate employees who do not participate in the FSA with those who do?

Cheiron consultants can assist you developing comments or analyzing the impact of the proposed approaches described in the notice.

Cheiron is an actuarial consulting firm that provides actuarial and consulting advice. However, we are neither attorneys nor accountants. Therefore, we do not provide legal services or tax advice.