View From Groom: Looking Ahead To the ACA’s ‘Cadillac Tax’ on High-Cost Health Coverage

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Employers that sponsor health coverage for their employees are beginning to turn their attention to Section 4980I of the Internal Revenue Code (‘Code’), as added by Section 9001(a) of the Patient Protection and Affordable Care Act (‘ACA’). Informally known as the “Cadillac Tax,” starting in 2018, Section 4980I will impose a 40% excise tax on employers, health insurers, and/or plan administrators if the aggregate value of employer-sponsored coverage for an employee, former employee, surviving spouse, or other primary insured individual exceeds a threshold limit. It appears that the intent of Section 4980I is twofold. First, it will increase federal tax revenues in two different ways. Obviously, to the extent that high-cost employer-sponsored coverage triggers the excise tax, it will result in additional tax revenue. But even if employers react by reducing expenditures on health benefits to avoid the tax, it is anticipated they will shift those expenditures to other forms of employee compensation (e.g. wages and salaries). That shift from compensation that is generally subject to a broad tax exemption (employer-sponsored health care) to compensation that is generally taxable will also result in higher tax revenue.²

Second, some analysts believe that overly “rich” health benefit plans encourage over-consumption of health care, which ultimately raises the cost of health care globally. Section 4980I may encourage employers and employees to adopt strategies that will impact market forces and reduce the cost of health care more generally.

Given the potentially dramatic financial effect of the Section 4980I excise tax, some employers have determined that radical modifications to benefits may be required to avoid liability. Employers are developing strategies for limiting its negative impact, including plotting out a “glide path”, whereby the value of employer-sponsored coverage will be reduced gradually between 2014 and 2018 to bring the cost of coverage under the Section 4980I thresholds (and employees will not see their benefits dramatically reduced between 2017 and 2018).

Complicating the development of any long-term strategy, however, is the paucity of guidance related to Code Section 4980I. As of the current time, the Department of Treasury and Internal Revenue Service have not released any regulations, notices, bulletins, or FAQs relating to this provision. Therefore, our understanding of Code Section 4980I is based only on the statutory language and limited legislative history. As a result, there are many open questions regarding how Section 4980I will apply in practice.

This article will provide an overview of Section 4980I, and then will explore some of the open questions regarding its application, which hopefully will be ad-

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dressed in subsequent formal guidance from the relevant agencies.

**Calculating the 4980I Tax**

Code Section 4980I provides for an excise tax on 40% of the aggregate value of applicable employer-sponsored coverage for an “employee” (which, as explained in more detail below, includes a former employee, surviving spouse, or other primary insured individual) that exceeds a specified annual limitation. Specifically, the Cadillac Tax is triggered for a calendar year if there is an “excess benefit” with respect to applicable employer-sponsored coverage, as defined below, of an employer at any time during the calendar year.

The “excess benefit” is defined as the amount by which the “aggregate cost” of an employee’s applicable employer-sponsored coverage for a month exceeds 1/12 of the “annual limitation” for the calendar year which includes that month.

**Aggregate Cost**

Section 4980I(d)(2) provides that “aggregate cost” is determined using rules similar to the rules under Code section 4980B(f)(4). Those are the rules that apply for determining the “applicable premium”, or the cost of coverage, for COBRA purposes. Code section 4980B(f)(4) provides that the term “applicable premium” means “the cost to the plan for... the coverage for similarly situated beneficiaries....” Therefore, in determining the “aggregate cost” of applicable employer-sponsored coverage for purposes of Section 4980I, it appears that the principles for determining the cost of COBRA coverage will apply.

**Annual Limitation**

The determination of the “annual limitation” will be complex, and take into account a number of factors. For 2018, the “annual limitation” is (i) $10,200 for self-only coverage and (ii) $27,500 for coverage other than self-only coverage, multiplied by a “health cost adjustment percentage.” The “health cost adjustment percentage” equals 100% plus the excess (if any) of (1) the percentage by which the per employee cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan (“FEHBP”) for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010, over (2) 55%.

However, additional adjustments apply in addition to the “health cost adjustment percentage.” For 2018, an age and gender adjustment will apply that is equal to the excess (if any) of (i) the premium cost of the Blue Cross/Blue Shield standard benefit option under the FEHBP for the type of coverage provided to an individual in 2018 if priced for the age and gender characteristics of all employees of the individual’s employer, over (ii) the premium cost for the provision of such coverage under such option in 2018 if priced for the age and gender characteristics of the national workforce.

For 2019 and later years, the annual limitation will be adjusted not only for age and gender, but also for inflation. For 2019, the threshold dollar amounts will be increased based on a cost-of-living adjustment tied to the CPI-U, plus one percentage point, rounded to the nearest $50. In 2020 and later years, the threshold amounts will be adjusted based simply on the CPI-U, rounded to the nearest $50.

There are additional adjustments that apply to individuals who are either (i) “qualified retirees” or (ii) participants 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 and telecommunications lines. With respect to such individuals, the dollar thresholds are increased by $1,650 for self-only coverage, and $3,450 for coverage other than self-only coverage.

**Coverage That May Be Subject to the Tax**

Section 4980I applies to “applicable employer-sponsored coverage,” which is defined under Section 4980I(d) as “with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under Code section 106, or would be so excludable if it were employer-provided coverage (within the meaning of Code section 106).” Therefore, the 4980I excise tax takes into account both insured and self-insured plans, as well as governmental plans and the health insurance coverage of a self-employed individual. Health flexible spending arrangements (“FSAs”), Archer Medical Savings Accounts (“MSAs”), and health reimbursement arrangements (“HRAs”) also appear to be “applicable employer-sponsored coverage” under this definition.

Since the definition of “applicable employer-sponsored coverage” also takes into account coverage that “would be so excludable if it were employer-sponsored coverage,” it includes both the employer- and employee-paid portions of coverage. In other words, employers cannot evade the 4980I excise tax by eliminating their pre-tax contributions to health plans and providing coverage with post-tax compensation instead.

However, Code Section 4980I also specifically excludes certain types of coverage. Specifically excluded are:
- Coverage only for accident, or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;

3 The term “qualified retiree” is defined under Section 4980I(f)(2) as any individual who (i) is receiving coverage by reason of being a retiree, (ii) has attained age 55, and (iii) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act. The term “employees engaged in high-risk profession” is defined in Section 4980I(f)(3) as law enforcement officers, employees in fire protection activities, individuals who provide out-of-hospital emergency medical care, individuals whose primary work is longshore work, and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. It also includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of the preceding sentence for not less than 20 years during employment.
Workers’ compensation or similar insurance;
Automobile medical payment insurance;
Credit-only insurance;
Other similar insurance coverage (specified in regulations) under which benefits for medical care are secondary or incidental to other insurance benefits;
Coverage for long-term care;
Any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye;
Coverage for a specified disease or illness (as described in Code section 9832(c)(3)) if offered as an independent, noncoordinated benefit and paid for with after-tax dollars (or, in the case of a self-employed individual, coverage that is not deductible);
Hospital indemnity or other fixed indemnity insurance (as described in Code section 9832(c)(3)) if offered as an independent, noncoordinated benefit and paid for with after-tax dollars (or, in the case of a self-employed individual, coverage that is not deductible).

Liability for the Tax

Under Code Section 4980I(c)(4), the employer is responsible for calculating the total amount of the excise tax and the excess benefit. It must then notify each coverage provider (and the Secretary of Treasury) of the amount of tax and excess benefit. Liability under Section 4980I is allocated as follows:

- If the “excess benefit” is attributable to the expense of health insurance, the health insurance issuer is liable.
- If the “excess benefit” relates to the HSA or MSA contributions of the employer, the employer is liable.
- If the “excess benefit” relates to other applicable employer-sponsored coverage, the person that administers the plan benefits is liable. While the “person that administers the plan benefits” is not defined, it is most likely the plan “administrator” as defined by Section 3(16) of ERISA. If so, in most instances the “plan sponsor,” which is usually the sponsoring employer, will be liable for this portion of the tax.

Note that the 4980I tax is explicitly non-deductible, which means the actual cost to the party liable for paying the tax is greater than the 40% assessment, because of the lost deduction.

If an employer fails to correctly calculate the tax, the provider must pay the amount of the underpaid tax, and the employer or plan sponsor will have to pay a penalty equal to the underpaid amount, plus interest.

Open Questions About Section 4980I

The determination of the excise tax under Section 4980I is likely to be exceedingly complex, but further complicating matters is the uncertainty about certain questions relating to how Section 4980I will apply in practice. Some of the questions that are currently unanswered are as follows:

Who is an “employee?” “Employee” is defined in Section 4980I(d)(3) as “any former employee, surviving spouse, or other primary insured individual.” “Primary insured individual” is not defined, and it is therefore unclear how broadly this definition could apply. It does, however, appear that the Section 4980I tax will apply to active employees as well as retirees, and that it will apply to retiree-only plans. (While retiree-only plans are exempt from the ACA’s market reform provisions, the excise tax under Section 4980I provides no such exemption.)

How is the cost of coverage aggregated for employers in a controlled group? Per Section 4980I(f)(9), the controlled group rules of Section 414 of the Code apply in determining employer coverage. This means that all members of the controlled group are treated as a single employer for purposes of determining the cost of “applicable employer sponsored coverage.” Employers within a controlled group will have to determine how to calculate the cost of such aggregated coverage.

How is the cost of coverage determined, particularly for self-insured groups? The cost of applicable employer-sponsored coverage is to be determined “under rules similar” to the rules for determining COBRA premiums. However, it is not clear what those “similar” rules would entail—presumably, future regulations will shed additional light on how the calculation will be performed. Also, it has never been entirely resolved how COBRA premiums are to be calculated for self-insured plans. Absent further clarification, the cost of coverage for employees with similar coverage could vary significantly based on whether the coverage is insured or self-insured, and the geographic locations of the employer groups.

How are the various adjustments for the “annual limitation” applied? As discussed in more detail above, a variety of adjustments apply in determining the threshold amounts that will trigger the Section 4980I tax. Specifically, there is the “health cost adjustment percentage,” as well as age, gender, cost-of-living, “qualified retiree,” and “high risk profession” adjustments that may apply. But it is not entirely clear how these adjustments work in conjunction with each other. The ordering of the adjustments may be critical in determining the thresholds.

A report issued by the Joint Committee on Taxation in 2010 does contain one relevant example:

Example. If the growth in the cost of health care during the period between 2010 and 2018, calculated by reference to the growth in the per employee cost of standard FEHBP coverage during that period (holding benefits under the standard FEHBP plan constant during the period) is 57%, the threshold amounts for 2018 would be $10,200 for individual coverage and $27,500 for family coverage, multiplied by 102% (100% plus the excess of 57% over 55%), or $10,404 for individual coverage and $28,050 for family coverage. The new threshold amounts (as indexed) would then be increased for any employee by the age and gender adjusted excess premium amount, if any. For an employee with individual coverage in 2019, if standard FEHBP coverage priced for the age and gender characteristics of the workforce of the employee’s employer is $11,400 and the Secretary estimates that the premium cost for individual standard FEHBP coverage priced for the age and gender characteristics of the national workforce is $10,500, the threshold for that employee would be increased by $900 ($11,400 less $10,500).

Is the cost of coverage based on the coverage provided, or the coverage offered? The language of Section 4980I does not provide a clear answer to this question. Section 4980I(a) states if “an employee is covered under any applicable-employer sponsored coverage... and... there is any excess benefit with respect to the coverage,” then the 4980I tax applies. This would suggest that an employer should look only at the coverage in which the employee is actually enrolled in determining the cost of coverage. However, Section 4980I(d) defines “applicable-employer sponsored coverage” as “with respect to any employee, coverage under any group health plan made available to the employee by an employer...” In addition, Section 4980I(b)(1) defines “excess benefit” as “with respect to any applicable employer-sponsored coverage made available by an employer to an employee... the sum of the excess amounts...” These provisions suggest that the determination of cost of coverage should be based on the coverage made available to an individual, regardless of whether the individual is enrolled in such coverage.

Employers would prefer a rule that allows the calculation of the “excess benefit” based on the lowest value option available to employees, but it is far from clear that regulators will agree to such a rule, and it may also pose logistical difficulties (if an employer offers multiple health benefit arrangements, such as major medical, FSAs, HRAs, and ancillary benefits, it would be difficult to determine what the lowest value option would be).

Are contributions to an HSA considered “applicable employer sponsored coverage?” Interestingly, contributions made to an HSA by an employee through a cafeteria plan or by an employer with pre-tax contributions likely would count toward “applicable employer-sponsored coverage,” but after-tax contributions may not. This is because after-tax contributions to an HSA are deductible under Code Section 223, whereas applicable employer sponsored coverage only encompasses amounts that are (or would be) excludable under Code Section 106.

Do self-funded stand-alone vision and dental plans constitute “applicable employer-sponsored coverage?” Under Section 4980I(d)(1)(B)(ii), insured stand-alone vision and dental plans are specifically excluded from the definition of “applicable employer-sponsored coverage,” but no such exemption applies to similar self-funded plans. This may have been a legislative oversight that could be subject to a regulatory fix.

Conclusion

Employers and insurance issuers have faced a litany of compliance challenges since the passage of the ACA in 2010, and preparing for the Section 4980I excise tax will be a particularly daunting one. The Department of Treasury and IRS will almost certainly issue regulations that will provide additional guidance regarding the application of the Section 4980I tax, but employers and issuers may not have the luxury of waiting until those regulations are finalized before they begin to address how their benefits will need to be modified.