March 16, 2015

FREQUENTLY ASKED QUESTIONS: 40 PERCENT EXCISE TAX ON HIGH-COST EMPLOYER-SPONSORED HEALTH COVERAGE

[Note: These FAQs were originally published by the American Benefits Council on September 18, 2014. They have been updated to reflect IRS Notice 2015-16, which was released by the Department of Treasury and IRS in February 2015.]

Q1. WHAT IS THE EXCISE TAX?

A1. The Patient Protection and Affordable Care Act (PPACA) imposes a 40 Percent Excise Tax on coverage that exceeds specified thresholds, effective 2018.

Q2. WHAT IS THE STATUTORY BASIS FOR THE EXCISE TAX, AND IS THERE ANY REGULATORY GUIDANCE RELATING TO THE EXCISE TAX?

A2. The Excise Tax was added by Section 9001(a) of PPACA and can be found in Internal Revenue Code Section 4980I.

On February 23, 2015, the Department of Treasury and IRS ("Treasury") released Notice 2015-16, which is the first piece of guidance released regarding Code Section 4980I. Notice 2015-16 describes the approaches Treasury is considering with regard to a number of issues under Section 4980I and requests comments on many issues. **Those comments must be submitted by no later than May 15, 2015.**

In addition, Notice 2015-16 advises that it will be followed by another notice describing and inviting comments on potential approaches to a number of additional issues under Code Section 4980I. After considering the comments on both notices, proposed regulations under Code Section 4980I will be issued.

Q3. WHAT IS THE PURPOSE OF THE EXCISE TAX?

A3. The Excise Tax reflects the belief of policymakers that health plans that provide very high levels of coverage (i.e., low or no deductibles, copayments, or other cost-

sharing) promote over-consumption of health care, ultimately raising costs for everyone. In addition, the tax under Code section 4980I raises revenue to finance the cost of other provisions of the PPACA.

Q4. WHEN DOES THE EXCISE TAX TAKE EFFECT?

A4. The Excise Tax becomes effective for taxable years beginning after December 31, 2017. If the Excise Tax is owed for 2018 coverage, it will presumably first be payable sometime in 2019.

Q5. DOES THE EXCISE TAX APPLY ON A CALENDAR-YEAR OR A PLAN-YEAR BASIS?

A5. The Excise Tax applies on a calendar-year basis. Thus, for plans with plan years that are not calendar years, employers may have to look at portions of two separate plan years in determining Excise Tax liability.

Q6. WHAT COVERAGE IS RELEVANT TO THE DETERMINATION OF THE EXCISE TAX?

A6. The Excise Tax applies to "applicable employer-sponsored coverage" of "employees". (See Q&A 11 and 14 for more information regarding what constitutes "Applicable employer-sponsored coverage" for purposes of the Excise Tax.) The definition of "employee" includes former employees, surviving spouses, and other "primary insureds", the last of which is undefined. Given the broad definition of "employee" as set forth in the statute, it appears that the Excise Tax will apply to coverage for retirees as well as active employees. It also applies to most governmental plans, although Treasury has indicated that a plan maintained primarily for members of the military by the United States or an individual state or governmental entity is not subject to the Excise Tax. Finally, the Excise Tax also applies to coverage for self-employed individuals.

Q7. HOW IS THE EXCISE TAX DETERMINED?

A7. The amount of the Excise Tax due for a calendar year is equal to 40 percent of the "excess benefit" provided by an employer-sponsored plan for each month in the calendar year. "Excess benefit" is determined on a monthly basis, and, for this purpose, means the amount, if any, by which the "aggregate cost" of an employee's applicable employer- sponsored coverage for the month exceeds 1/12 of the "annual limitation" for the calendar year including that month. The "annual limitation" is a dollar threshold adjusted for inflation and other factors, as discussed below.

Q8. WHAT ARE THE DOLLAR THRESHOLDS FOR PURPOSES OF THE EXCISE TAX?

A8. The dollar thresholds will vary from year to year depending on a number of factors. For 2018, the base dollar threshold is (i) $10,200 for self-only coverage, and (ii) $27,500 for coverage other than self-only coverage, but these base limits will be adjusted by a variety of factors, discussed directly below.

Q9. WHAT DOLLAR THRESHOLD APPLIES IF AN EMPLOYEE HAS BOTH SELF-ONLY AND OTHER THAN SELF-ONLY COVERAGE SIMULTANEOUSLY (e.g., AN EMPLOYEE WITH SELF-ONLY MAJOR MEDICAL COVERAGE AND AN HRA THAT COVERS DEPENDENTS)?

A9. This will be determined through future rulemaking, but Treasury sets forth two possible approaches in Notice 2015-16. Under the first approach, the applicable dollar limit for an employee would depend on whether the employee's primary coverage/major medical coverage is self-only coverage or other-than-self-only coverage. For this purpose, an employee's primary coverage/major medical coverage would be the type of coverage that accounts for the majority of the aggregate cost of applicable coverage.

The second contemplated approach would apply a composite dollar limit 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 provided to the employee.

Q10. WHAT ADJUSTMENTS ARE MADE FOR PURPOSES OF DETERMINING THE APPLICABLE DOLLAR THRESHOLDS?

A10. For 2018, the dollar thresholds are multiplied by a "health cost adjustment percentage" and increased by an age and gender adjustment. This adjustment is designed to ensure that the dollar thresholds are adjusted upward for 2018 if health care inflation is in excess of congressionally mandated benchmarks.

In 2019 and later years, the dollar thresholds (as calculated following application of the 2018 health cost adjustment percentage) are adjusted for age and gender and also increased for inflation.

The threshold amounts are also increased for (i) "qualified retirees" and (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 or telecommunications lines".

The statute defines the term "qualified retiree" to mean 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. (Notice 2015-16 requests comments on how an employer would determine that an employee is not eligible for Medicare.)

The term "employees engaged in a high-risk profession" means certain law enforcement officers, certain employees in fire protection activities, individuals who provide out-of-hospital emergency medical care, certain individuals whose primary work is longshore work, and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. The term 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. (Notice 2015-16 requests comments on how an employer determines whether the majority of employees covered by a plan are engaged in a high-risk profession, what the term "plan" means in that context, and how an employer determines that an employee was engaged in a high-risk profession for at least 20 years. Comments are also requested on whether further guidance on the definition of "employees engaged in a high risk profession" would be beneficial.)

Additionally, any coverage provided under a multiemployer plan (as defined in Code section 414(f)) shall be treated as coverage other than self-only coverage. This means that the $27,500 dollar threshold (as adjusted) applies to any coverage offered by a multiemployer plan, including self-only coverage.

Q11. WHAT COVERAGE IS SUBJECT TO THE EXCISE TAX?

A11. The Excise Tax applies to "applicable employer-sponsored coverage," which generally means coverage under any group health plan made available to the employee by an employer that is tax-exempt, or that would be tax-exempt if it were employer-provided coverage. This means that both the employer- paid and employee-paid costs of coverage are generally taken into account in determining whether the Excise Tax applies. However, the one exception is that employee after-tax contributions to HSAs and Archer MSAs are <u>not</u> taken into account (although employer contributions to HSAs and Archer MSAs are).

Notice 2015-16 confirms that Treasury currently believes all of the following are taken into account when determining "applicable employer-sponsored coverage":

- HRAs;
- FSAs;
- On-site medical clinics, except to the extent they offer only *de minimis* or limited services to employees;
- Executive physical programs and HRAs
- As noted above, employer contributions to HSAs and Archer MSAs, also

including pre-tax salary reduction contributions.

"Applicable employer-sponsored coverage" encompasses insured and self-funded plans.

Q12. DOES THE EXCISE TAX APPLY TO RETIREES?

A12. Absent guidance to the contrary, it appears the Excise Tax applies to retirees. The definition of "employee" for purposes of the Excise Tax includes former employees, surviving spouses, and other "primary insureds". It also appears that the Excise Tax applies to retiree-only plans.

Q13. DOES THE EXCISE TAX APPLY TO GRANDFATHERED PLANS?

A13. Yes. The Excise Tax applies regardless of whether the plan is grandfathered under the PPACA.

Q14. WHAT COVERAGE IS NOT SUBJECT TO THE EXCISE TAX?

A14. The statutory language provides that the following are excluded from the definition of applicable employer-sponsored coverage:

- Coverage (whether through insurance or otherwise) described in Code section 9832(c)(1) (*other than coverage for on-site medical clinics*):
    - 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;
    - Workers' compensation or similar insurance;
    - Automobile medical payment insurance;
    - Credit-only insurance; and
    - 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.

- Insured stand-alone vision and dental plans. (The statutory language does not provide a similar, explicit exemption for self-funded stand-alone vision and dental plans. However, in Notice 2015-16, Treasury indicates that it is considering proposing an approach under which self-insured limited scope

dental and vision coverage that qualifies as an excepted benefit would be excluded from applicable coverage.)

- Coverage for a specified disease or illness described in Code section 9832(c)(3) if offered as an independent, non-coordinated 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 described in Code section 9832(c)(3) if offered as an independent, non-coordinated benefit and paid for with after-tax dollars (or, in the case of a self-employed individual, coverage that is not deductible).

In addition, Notice 2015-16 suggests that Treasury is considering excluding employee assistance plans ("EAPs") that qualify as an excepted benefit, under regulations released in October 2014.

Q15. WHAT ABOUT THE FACT THAT MY COMPANY IS LOCATED IN A GEOGRAPHIC AREA THAT HAS HIGHER-THAN-AVERAGE CLAIMS COSTS? DOES MY COMPANY GET AN INCREASED DOLLAR THRESHOLD FOR PURPOSES OF THE EXCISE TAX?

A15. The dollar threshold is not adjusted based on either the location of the employer or above-average claims costs. However, as discussed in more detail below, Notice 2015-16 suggests that employers may be able to categorize different employees based on their geographic location for purposes of determining the cost of coverage.

Q16. WHEN MEASURING AN EMPLOYEE'S COVERAGE AGAINST THE DOLLAR THRESHOLDS, DO YOU LOOK TO THE COVERAGE IN WHICH THE EMPLOYEE IS ENROLLED OR MERELY ELIGIBLE?

A16. It appears based on Notice 2015-16 that it is the coverage in which the employee is enrolled. While the statute is ambiguous as to whether, in measuring against the "annual limitation," an employer should look only at the coverage in which the employee is actually enrolled, or whether an employer should instead look at some or all of the coverage options for which the employee is eligible, Treasury clarified in Notice 2015-16 that its position is the excise tax is based on the applicable coverage in which the employee is enrolled.

Q17. HOW IS THE AGGREGATE COST OF APPLICABLE EMPLOYER-SPONSORED COVERAGE DETERMINED?

A17. The aggregate cost of applicable employer-sponsored coverage is determined by adding up the costs of each type of applicable employer-sponsored coverage. Under Code Section 4980I, the cost of coverage is determined using rules similar to those that apply for purposes of determining the cost of coverage for COBRA purposes. In order to determine the cost of coverage for employees, employers need to know how to determine the different costs for different groups of "similarly situated employees" (similar to how employers can charge different COBRA rates for different employees, based on the cost to the plan for "similarly situated beneficiaries" under the COBRA rules). Please see Q&As 18-21 below for more information on how to value the coverage for purposes of the Excise Tax.

Q18. HOW DOES AN EMPLOYER CATEGORIZE ITS EMPLOYEES FOR PURPOSES OF DETERMINING DIFFERENT GROUPS OF "SIMILARLY SITUATED BENEFICIARIES?"

A18. Notice 2015-16 sets forth a general approach that Treasury is considering for allowing employers to identify how to categorize groups of "similarly situated employees." Under Treasury's contemplated approach, there would be a 4-step process:

Step 1- Mandatory Aggregation Based on Benefit Package. The initial groups of similarly situated employees would be determined by aggregating all employees covered by a particular benefit package provided by the employer (e.g., if an employer offered an HMO, two PPOs, and a high-deductible health plan, each would be considered a separate benefit package- resulting in the employer having four separate benefit packages).

Step 2- Mandatory Disaggregation Based on Self-Only or Family Coverage. All employees covered by a benefit package would then have to be disaggregated based on whether the employee was enrolled in self-only or other-than-self-only coverage.

Step 3- Permissive Aggregation Within Other-Than-Self-Only Coverage. Treasury is considering whether an employer would not have to determine separate "costs of coverage" for employees receiving family coverage based on the number of individuals covered in addition to the employee.

Step 4- Permissive Disaggregation Based on Other Distinctions. Treasury is considering whether to allow (but not require) an employer to subdivide further the group of employees that would be treated as similarly situated, based on either a broad standard (for example, bona fide employment related criteria such as compensation, job categories, union groups, etc.) or a more specific standard (for example, current vs. former employees, bona fide geographic distinctions, number

of individuals covered in addition to the employee).

Q19. HOW DOES A SELF-INSURED PLAN DETERMINE THE COST OF APPLICABLE COVERAGE?

A19. In Notice 2015-16, Treasury indicates that the methods currently prescribed by COBRA for self-insured plans to compute the COBRA applicable premium — the "actuarial basis" method and the "past cost" method – will also apply for determining the cost of applicable coverage for self-insured plans under Code Section 4980I. The actuarial basis method provides that the COBRA premium (or cost of coverage) can be determined by a plan on an actuarial basis, while the past cost method provides that the COBRA premium (or cost of coverage) can be determined based on the cost to the plan for similarly situated beneficiaries during a preceding determination period, adjusted for inflation. A plan must use the actuarial basis method unless the plan administrator elects to use the past cost method and the plan is eligible to use that method.

Treasury suggests that under the actuarial basis method, the cost of applicable coverage for a group of similarly situated individuals would be equal to a reasonable estimate of the cost of providing coverage under the plan for individuals in that group for the determination period, using reasonable actuarial principles and practices. Under this standard, an estimate of cost would be an estimate of the actual cost the plan is expected to incur for a determination period, not the minimum (or maximum) exposure that the plan could have for that period.

With regard to the past cost method, Treasury is considering whether to issue guidance providing that plans choosing the past cost method may use as the 12-month measurement period for a current determination period any 12-month period ending not more than 13 months before the beginning of the current determination period. The measurement period would have to be applied consistently. The costs that must be taken into account in computing costs under the past cost method could include (1) claims, (2) premiums for stop-loss or reinsurance policies, (3) administrative expenses, and (4) reasonable overhead expenses (such as salary, rent, supplies, and utilities) of the employer, with those reasonable overhead expenses being ratably allocated to the cost of administering the employer's health plans. Those costs could include either claims incurred during the measurement period (whether paid or unpaid) or claims submitted during the measurement period (regardless of when incurred).

Q20. WILL A SELF-INSURED PLAN USING THE ACTUARIAL COST METHOD BE ABLE TO SWITCH TO THE PAST COST METHOD (OR VICE VERSA)?

A20. Treasury is considering proposing a rule (that would apply for both COBRA and 4980I purposes) that generally would require a plan to use the valuation method that it chooses for a period of at least five years. The only exception would be based on the

prohibition under COBRA rules on using the past cost method if there is a significant difference between periods in coverage under, or in employees covered by, the plan. In that case, the plan might be required to use the actuarial basis method for the two years following the significant change.

Q21. IS IT POSSIBLE TO MEASURE THE COST OF COVERAGE FOR THE PURPOSE OF THE EXCISE TAX WITHOUT USING RULES THAT ARE BASED ON COBRA PRINCIPLES?

A21. In determining the cost of coverage under Code Section 4980I, the statute refers 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. Therefore, Code Section 4980I appears to require that the cost of coverage be determined in accordance with COBRA principles. However, in Notice 2015-16 Treasury acknowledges that it has been suggested that the cost of applicable coverage could instead be determined by reference to the cost of similar coverage available elsewhere (for example, based on actuarial values, metal levels, or the cost of coverage available on an Exchange). Therefore, Treasury is soliciting comments on whether any alternative approaches to determining the cost of applicable coverage would be consistent with the statutory requirements of Code Section 4980I and, if so, would be useful.

Q22. WHO CALCULATES THE EXCISE TAX?

A22. The sponsoring employer is generally responsible for determining the amount of the Excise Tax. Once it has calculated the amount of the Excise Tax, the sponsoring employer must allocate the amount among those entities liable for paying the tax (see Q24).

Q23. WHEN WILL AN EMPLOYER KNOW IF THERE IS LIABILITY IN A PARTICULAR YEAR FOR THE EXCISE TAX?

Based on Notice 2015-16, Treasury is contemplating that the method for calculating the cost of applicable coverage would be elected prior to the determination period for which the cost is determined. For example, a self-insured plan using the calendar year as the 12-month determination period would elect the method (actuarial or past cost) before the beginning of the calendar year. If the plan elected the past cost method, it would also have elected its measurement period as well. Under these rules, the amount of any Excise Tax would generally be known at the beginning of the taxable year generating the liability.

However, Treasury also is soliciting comments on the feasibility of a method for

determining the cost of applicable coverage using actual costs: that is, for a self-insured plan, basing the cost of applicable coverage for a year on the actual costs paid by the plan to provide health coverage for that year. If such a methodology was allowable, the employer would obviously not know if there was liability in a particular year until after the fact.

Q24. WHO IS LIABLE FOR THE EXCISE TAX?

A24. The following entities are liable for paying the portion of the Excise Tax attributable to its share of the coverage:

- The health insurance issuer is liable for paying the share of the Excise Tax attributable to health insurance coverage that it underwrites.
- The employer is liable for paying the share of the Excise Tax attributable to HSA and MSA contributions that are applicable employer-sponsored coverage.
- The "person that administers the plan benefits" is liable for paying the share of the Excise Tax attributable to any other applicable employer-sponsored coverage.

Q25. WHAT PENALTIES APPLY IF THE EXCISE TAX IS CALCULATED INCORRECTLY?

A25. If an employer does not accurately calculate the portion of the excess benefit, and, as a result, a responsible party pays insufficient tax, the responsible party must pay the amount of the additional tax owed, and the employer will have to pay a penalty equal to 100 percent of the missed portion of the Excise Tax that was underpaid due to the miscalculation (in addition to any Excise Tax it must otherwise pay).

Q26. CAN THE COST OF THE EXCISE TAX BE CHARGED AGAINST ERISA PLAN ASSETS?

A26. With respect to self-funded plans, because the Excise Tax is imposed upon the employer and/or the plan administrator, and not the plan itself, the extent to which any Excise Tax liability could be charged back to the plan is unclear.

Q27. IS THE EXCISE TAX DEDUCTIBLE?

A27. No. The statutory language is clear that the Excise Tax is a *nondeductible* tax. The overall effect is that it increases the cost to the party liable for the tax.