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Employee Benefits & Executive Compensation ADVISORY ■

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The (Poorly Named) "Cadillac Tax" Part Two: IRS Provides Further Guidance in Notice 2015-52

Introduction

The so-called "Cadillac Tax" (Internal Revenue Code Section 4980I) applies starting in 2018 and was intended to provide a means to address what were perceived as overly rich employer-provided health benefit plan designs, as well as to provide a revenue source to finance other objectives of the Affordable Care Act (ACA). To achieve the intended goals, the Cadillac Tax imposes a nondeductible 40 percent excise tax on health benefit coverage provided for or arranged by an employer (even if paid for 100 percent by the employee) in excess of a statutorily determined amount. These amounts are initially set at $10,200 for single coverage and $27,500 for family coverage[1] (with higher thresholds in certain situations, such as high risk occupations).

Despite the fact that health care inflation has far outstripped general inflation, future increases in the Cadillac Tax thresholds are generally limited to the consumer price index (CPI). Recent studies confirm that for most employers the issue is not *whether* the tax will apply, but *how soon* it will apply. Studies also confirm that health flexible spending arrangement (FSA) participation will likely cause far more employers to face the tax immediately in 2018 (or much sooner than it would otherwise apply).[2] Given the broad impact the tax is expected to have, it is now widely recognized that the term "Cadillac Tax," with its implication of luxury, is a misnomer and best referred to simply as the "excise tax."

The IRS first addressed issues under the excise tax in February of this year in IRS Notice 2015-16. That notice provided insight into the IRS's views and requested comments on the following topics: (1) the definition of coverage subject to the tax ("applicable coverage"); (2) how the cost of that coverage is determined; and (3) the application of the statutory dollar limit to the cost of coverage. Notice 2015-16 is covered in more detail in our prior advisory.

On July 30, 2015, the IRS issued Notice 2015-52 (the "Notice"), which provides important insight (and requests public comment) on who is liable for paying the excise tax, how the tax is paid, how the tax is allocated among coverage providers and employers, additional information regarding the calculation of applicable coverage, and issues regarding employer aggregation. The IRS also proposed a special "smoothing" rule for determining the cost of coverage under account-based plans (such as FSAs, HRAs and HSAs).

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1 Code Section 4980I provides that all coverage under a multiemployer plan is treated as family coverage.

2 See, for example, the Kaiser Family Foundation article "How Many Employers Could Be Affected by the Cadillac Plan Tax," August 25, 2015, at http://kff.org/health-costs/issue-brief/how-many-employers-could-be-affected-by-the-cadillac-plan-tax/.

Practice Pointer: Notice 2015-52 does not provide guidance employers or others may rely on, but provides valuable insight into what the IRS is thinking and offers opportunity for comment. Comments on the Notice should be submitted no later than October 1, 2015. After the IRS has reviewed all the comments, the next step in the regulatory process is expected to be issuance of proposed regulations. There will be an opportunity to comment on the proposed regulations.

Who Will Be Responsible for Paying the Tax?

The statute provides that the "coverage provider" is responsible for paying the excise tax. Who the coverage provider is depends on the type of coverage provided.

If the coverage is through a…:	…then the coverage provider is the:
Fully-insured group health plan	Health insurance issuer
HSA or Archer MSA to which the employer makes contributions	Employer
All other coverage	"[P]erson that administers the plan benefits"

Currently, there is no definition for "the person that administers the plan benefits." The IRS is proposing two possible definitions. Under the first, the person that administers the plan benefits would be the entity responsible for performing day-to-day administrative functions. Generally, this will be a third-party administrator (TPA), although it may in some instances be the employer or other plan sponsor, depending on how benefits are administered. Under the second proposed definition, the person that administers the plan benefits will be the entity that has the ultimate authority over administration of the plan. Generally, this will be the employer in the case of a single employer self-funded plan. In the case of multiemployer plans, this would generally be the plan sponsor, i.e., the joint board of trustees. In all cases, the IRS expects that the person liable for the tax will generally be an entity, rather than an individual.

For self-funded plans, the ultimate decision regarding the entity that is liable for the tax could have a number of implications beyond merely who must send the check to the IRS, including both administrative issues and potentially the amount of tax paid. For example, under the first approach (i.e., the person with day-to-day responsibility is liable for the tax), it is likely that there will be multiple coverage providers for a single plan. This could occur, for example, if prescription drug benefits are administered by a pharmacy benefit manager (PBM) and major medical benefits are administered by a different TPA. This could make determination of the tax more difficult.

Practice Pointer: Regardless of which entity is liable for the tax as the "coverage provider," the employer is responsible for determining the amount of "excess benefit" (i.e., the amount in excess of the dollar thresholds) and notifying coverage providers and the IRS of the amount of excess benefit and the share of the excess allocated to each coverage provider. This task may be more difficult the more coverage providers there are.

If a third party is liable for the tax, it can be expected that they will look to pass the tax back to the employer/plan sponsor. Because the tax is nondeductible, any such pass through will also likely include a gross up to reflect any additional income tax estimated by the coverage provider to be owed as a result of the excise tax. The IRS proposes to adjust the cost of coverage for determining the excise tax so that cost excludes both the tax itself and any gross up; however, this may be a cumbersome process and might still result in tax being calculated on the tax. If the employer is the coverage provider, this issue may be minimized for self-funded plans. Note that for fully insured plans, the coverage provider is the health insurer, so these pass-through issues will arise in that context.

How Will the Tax Be Calculated and Paid?

Determination of the "excess benefit"

A first step in determining the amount of the tax is determining the "excess benefit," meaning the excess of the cost of the applicable coverage over the dollar threshold. Regardless of what entity or entities are responsible for paying the tax, it is the employer's responsibility to determine the excess benefit and notify each coverage provider and the IRS of the amount of excess benefit attributable to each coverage provider. In the case of multiemployer plan coverage, the plan sponsor is required to calculate the excess benefit and provide the notification.

The IRS is considering both the form and timing for the notification and is seeking comments on issues associated with this process.

Monthly calculation; annual payment

The tax will be paid once for each "taxable period." The IRS anticipates that the taxable period will be the calendar year.

Although the tax is only paid once for each year, it is determined on a monthly basis. It is the employer's responsibility to determine the amount of excess benefit for each month in the taxable period.

The IRS is considering how much time will be needed for health insurance issuers, TPAs and employers to accurately report and submit the amount of tax due over the taxable period. In some cases (such as when a plan year ends after the end of a calendar year) this determination may be difficult.

Submission of the tax

The IRS anticipates that coverage providers will remit any excise tax due by filing Form 720. Although this form is called the Quarterly Federal Excise Tax Return, it would be used only once a year for the 4980I excise tax. The IRS anticipates designating a particular quarter during the calendar year during which Form 720 will be used by the coverage provider to pay the excise tax. This is similar to the process currently being used for the Patient-Centered Outcomes Research Institute (PCORI) fee.

How Does the IRS Propose to Make Sure That the Cost of Applicable Coverage Excludes the Excise Tax?

Code Section 4980I explicitly provides that the cost of applicable coverage does not include "any portion of the cost of such coverage which is attributable to the tax imposed under [Section 4980I]."

The tax may be paid by a coverage provider entity that is not the employer, such as the health insurance issuer or a TPA. In these instances, it is expected that the coverage provider will pass the cost of the tax through to the employer acting as plan sponsor. If this occurs, the Notice states that the reimbursement of the excise tax costs from the employer to the coverage provider will trigger additional taxable income to the coverage provider. Further, the excise tax is not deductible to the coverage provider. Thus, the coverage provider may also seek reimbursement from the plan sponsor to cover the increased amount of taxes due to the excise tax reimbursement.

The Notice indicates that the IRS is considering excluding from the cost of coverage not only the excise tax itself but also any related income tax gross up that is passed through. The Notice includes possible alternative ways to determine the amount of any gross up, including a standard formula. The Notice indicates that the excise tax and any related income tax adjustment would be excluded only if such amounts are separately billed and identified by the coverage provider. Comments are requested on these issues.

Note, it may be possible to avoid these pass-through issues for self-funded coverage if the employer or other plan sponsor is liable for the tax. However, because the statute states that insurers are the coverage provider for fully insured coverage, the pass-through questions will arise for such coverage.

How Will the Cost of Applicable Coverage Be Calculated?

The Notice expands on the information provided earlier in Notice 2015-16 regarding how the cost of "applicable coverage" subject to the excise tax is calculated in certain situations

Contributions to account-based plans

The IRS is considering providing that contributions to account-based plans, such as HSAs, Archer MSAs, FSAs and HRAs, will be allocated on a pro-rata basis over the plan year, regardless of when the contributions actually are made to the account. This should help smooth out annual accruals under account-based plans.

Practice Pointer: The extent to which employer contributions to HSAs are taken into account under the excise tax is not yet clear. Notice 2015-16 indicated that the IRS was anticipating that such contributions would be subject to the tax. However, the statute requires that applicable coverage must be a "group health plan." Although there are situations in which HSAs could qualify as group health plans, they rarely do. Thus, the statute, read literally, indicates that only in the rare case that an HSA is a group health plan should the contributions be included in the determination. Numerous comments on Notice 2015-16 made this point and, in the alternative, argued that if the IRS persists in subjecting HSAs to the tax, at least salary reduction contributions should be excluded. It is expected that the IRS will address this issue in proposed regulations.

Contributions to FSAs with employer flex credits

Generally, the amount of applicable coverage of a nonelective flex credit would be the amount that is actually reimbursed in excess of the employee's salary reduction election for the year.

The IRS is considering a safe harbor to avoid double counting salary deferral amounts that are carried over from one plan year to another. The safe harbor varies depending on whether there are nonelective flex credits available.

Under the safe harbor in which nonelective flex credits are not available, the employee's salary reduction for the plan year without regard to carryover amounts would be the cost of applicable coverage. This means that while unused amounts will be taken into account one year, they will be disregarded for the year into which they are carried over.

When nonelective flex credits are available, the safe harbor would provide that an FSA could be treated as funded solely by salary reduction if the amount elected by the employee for the FSA is less than or equal to the ACA cap on salary reduction contributions ($2,550 for 2016).

Self-insured coverage includible in income

Code Section 105 excludes reimbursements from an employer-provided accident or health plan from an employee's income, unless the reimbursements are paid to a highly-compensated individual (HCI) under a self-insured plan that discriminates in favor of HCIs. This means that HCIs pay income tax on this reimbursement. The Notice indicates that although this reimbursement is already being taxed at the individual level, the excess reimbursements will still need to be included in the cost of applicable coverage when determining any excise tax liability. The IRS anticipates that W-2 reporting will eventually be required for these amounts as well (contrary to transitional guidance provided in Notice 2012-9).

Practice Pointer: Multiemployer plans have a different structure than single employer plans and often present different issues. Code Section 4980I and IRS Notice 2015-52 address some, but not all, of these issues. For example, in the case of coverage under a multiemployer plan, the plan sponsor is responsible for providing the notice of excess benefits to coverage providers and the IRS, rather than the contributing employer. Notice 2015-52 specially requests comments on issues relating to multiemployer plans.

Age and gender adjustments to the applicable dollar limit

The excise tax is 40 percent of the excess of the aggregate cost of the applicable coverage over the applicable dollar limit. Code Section 4980I defines the 2018 applicable dollar limits as $10,200 for self-only coverage and $27,500 for coverage other than self-only coverage. Various adjustments may apply to these limits. As noted in the earlier Notice 2015-16, the IRS intends to promulgate rules regarding adjustments that employers can make to these limits and seeks comments on these issues.

The current Notice provides additional discussion of the adjustments permitted based on the age and gender characteristics of the employees of the employer. On average, older employees and female employees have higher health care costs than younger employees and male employees, respectively. Employers with a higher than average concentration of older or female employees may be able to raise their applicable dollar limit amount and thus avoid some or all of the excise tax.

In order to take advantage of the adjustment, employers will need to compare their employee population to the population of the national workforce. The IRS is considering a requirement that employers must use the first day of the plan year as a snapshot date for determining the composition of its employee population. The IRS is seeking comment on whether this date would be a representative date.

Finally, it is anticipated that the IRS will publish adjustment tables to facilitate the employer's calculation of the age and gender adjustment.

Conclusion

The 4980I excise tax will present challenges for all plan sponsors. Sponsors should be considering now what plan design changes may be appropriate to try to reduce plan costs and avoid the excise tax.

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