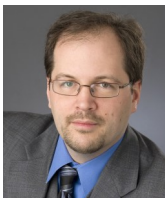

# ANTICIPATING THE "CADILLAC TAX" IN THE AFFORDABLE CARE ACT

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The Affordable Care Act (ACA) has launched through two enrollment periods and, despite considerable technical trouble with the initial enrollment, appears to have established a solid continuing foundation. Several elements of the ACA, however, were designed to begin in staggered steps over the first few years. One of the more important of these additional rules is the excise tax on high value employer provided health plans, popularly known as the Cadillac Tax. It is set to take effect on January 1, 2018.

The foundational premise of the ACA is to stabilize and reduce overall healthcare costs by pushing from both the bottom and the top of the marketplace. Pushing from the bottom means expanding healthcare coverage to as many people as possible. Thus, the law mandates that every employer of a certain size must offer coverage, and individuals who are not employed by an employer covered by the Act must secure their own coverage through the state (or federal) insurance exchange marketplaces. The goal is universal health insurance, thereby avoiding (or at least minimizing) consumers without insurance seeking medical care through emergency rooms and at the last possible moment. It should reduce overall costs by getting people medical attention earlier and more efficiently, and by allowing insurers to pool risk among a broad base of insured clients.

Pushing from the top means moving as many people as possible away from insurance plans that encourage overuse of health providers. It may seem counter-intuitive to think that doctors can be overused, but from a cost containment perspective it is absolutely a real phenomenon, measured by the "utilization rate" of the consumer. In the school context, the vast majority of collective bargaining agreements in the Commonwealth include language providing PPO plans to employees at the district's expense. Our clients who have examined the utilization rates for their employees have discovered that their employees utilize medical services at more than twice the national average rate. PPO plans result in overuse of medical services.

The Cadillac Tax is designed to encourage people to abandon insurance plans that cover everything and encourage them to move to health plans wherein the consumer has at least some "skin in the game." These plans, including high deductible and high co-pay plans, result in consumers using doctors less, lowering the utilization rate and thus reducing overall costs.

Determining whether a healthcare plan is a Cadillac plan is straightforward - in principle. If the cost of the plan for single coverage exceeds $10,200 on January 1, 2018, then the excess value, that is the value above the $10,200, will be taxed at 40%. For example, if the PPO plan provided for single coverage costs $12,000, then each plan would be subject to a $720 tax. 26 U.S.C.A. § 4980I. For plans covering the employee and any additional family member, the threshold is $27,500. The actual mechanism by which the excise tax is calculated in each situation can be more complicated, and the IRS continues to provide guidance on the process. As of 2015, a typical PPO plan for single coverage costs more than $9,000. Assuming the premiums increase by 7% for the next two years, the plan will be subject to the tax when January 1, 2018 arrives.

The PPO plans which are provided in most collective bargaining agreements are, therefore, Cadillac plans, and will in

almost all cases be subject to the excise tax as of January 1, 2018. Furthermore, the Act provides for the threshold to increase by the Consumer Price Index, which has not exceeded 3.8% in the last decade, and over the last five years has averaged just 2%. Health insurance premiums, by contrast, have increased at a much higher rate. As a consequence, the difference between the value of the plan and the threshold for the tax will likely only grow, resulting in a higher tax bill.

As districts negotiate new agreements with their employees, most of which last from three to five years, they must be sure to address the imminent imposition of this tax. In fact, one client estimated that the tax would result in an approximately additional $300,000 of costs if the PPO plans were retained. Districts are understandably reluctant to expand their financial exposure to healthcare costs at a time when budgets are getting tighter and tighter. This means that districts should be negotiating to move employees to plans that will not be subject to the tax. Several of our clients have already done so. This should not be considered a concession from the unions. It is possible to structure the plan change in a way that actually reduces cost for both parties and avoids the tax.

It is, of course, possible that Congress will change or eliminate the tax before 2018. However, it should be noted that the tax is most likely to apply to unionized employees and highly compensated executives. In this political climate it is hard to say whether this unusual combination makes it more or less likely that action will be taken. Either way, it would be irresponsible for districts to ignore the issue in the mere hope that it will go away, particularly when mutually beneficial solutions are available.

Clients who have questions regarding issues discussed in this article, or any education law matter, should feel free to call us at 215-345-9111.