AN OVERVIEW OF THE CADILLAC TAX
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The “Cadillac Tax” was created as part of the Patient Protection and Affordable Care Act of 2010 (PPACA). The Cadillac Tax is an excise tax that was designed to generate revenue to help in paying the Federal Government’s cost of the Affordable Care Act. It was also to serve as a deterrent against the purchase of high-cost plans. When you have a plan where members have larger personal out of pocket, those enrolled would tend to become better consumers and in turn help hold down the growing cost of healthcare.
The law imposes a 40% excise tax on the cost of employer-sponsored health and prescription drug coverage that exceeds a certain threshold. This excise tax is a non-deductible tax. This simply means that the payer would have to pay the tax regardless of any loss from operations. The tax will be imposed starting for taxable years beginning in 2018. The initial thresholds are $10,200 for Single coverage and $27,500 for Non-Single coverage. The rate limits are adjusted upward for retirees aged 55-64 and for high risk professions. No guidance has been issued as to what this adjustment will be.

The tax applies to any employer that provides coverage to their employees. This will include employers that have not been subject to federal taxation such as municipalities, schools and religious organizations. Union health and welfare plans (multi-employer plans) will also be included in the tax. Multi-employer thresholds are based on the non-single limit.

**THE EVOLVING CADILLAC TAX REGULATIONS**

On February 23, 2015, the Internal Revenue Service issued the first piece of guidance on the “Cadillac Tax” (IRS Notice 2015-16). The notice provided an overview of, and general background on, the direction they are considering and also welcomed comment on issues related to the tax prior to the release of final regulations.

The Notice discusses the purpose of the Cadillac Tax. It also defines certain terms, such as “applicable coverage” and “applicable dollar limit,” which are relevant to determining the amount of the tax if any.

On July 30, 2015, the Internal Revenue Service published a second document concerning guidance of the tax. There were a couple of very notable items that we have included in this document for your consideration.

**APPLICABLE COVERAGE**

A new term was inserted in the IRS release called Applicable Coverage. The Cadillac Tax will be based on the cost of Applicable Coverage. Applicable Coverage is defined as “Coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income.” The wording of the definition should make it clear that this cost will not just include the basic cost of the coverage.

The cost of Applicable Coverage would include the amount that both the employer and employee pay for the coverage. This clarifies that the portion of the cost that is paid by the employee as contribution is also used to calculate the Cadillac Tax.

If the excise tax is imposed, it must be paid by the insurance provider (in the case of an insured plan), the employer (if self-funded for example), or the plan administrator (which is also often the employer). Practically speaking however, the employer will be responsible for the tax, as insurance providers and third party administrators will pass on the cost in the form of higher premiums and fees. Also an important item to note is that the employer will be required to provide information to their carrier if fully insured, to assist in calculating the tax. Employers that provide inaccurate information may be subject to fines and other penalties in line with other tax fraud statutes.
SO, WHAT CONSTITUTES APPLICABLE COVERAGE?

The chart that follows outlines the cost that makes up Applicable Coverage. Keep in mind that the definition states that basically anything that is provided without taxation to the employee is considered in the determining the cost of Applicable Coverage.

<table>
<thead>
<tr>
<th>EMPLOYER SPONSORED BENEFIT</th>
<th>SUBJECT TO THE CADILLAC TAX?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Sponsored Medical and Prescription Drug Coverage</td>
<td>Yes</td>
</tr>
<tr>
<td>Employer Pre-Tax Contributions to H.S.A.’s</td>
<td>Yes</td>
</tr>
<tr>
<td>Employer Pre-Tax Contributions to H.R.A.’s</td>
<td>Yes, but likely on an Actuarial Value or Past Cost basis like COBRA rates are currently calculated for H.R.A. plans.</td>
</tr>
<tr>
<td>Employee Pre-Tax Contribution to H.S.A.</td>
<td>Yes</td>
</tr>
<tr>
<td>Employee Pre-Tax Contributions to Health Flexible Spending Accounts (not dependent care accounts)</td>
<td>Yes</td>
</tr>
<tr>
<td>Employee Pre-Tax contributions to Medical Savings Accounts</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The early regulations had implied that employer and employee amounts that are on a pre-tax basis would be included in the tax calculation. There was much speculation that the employee pre-tax portion would not be included. The February regulations did not eliminate these contributions.

<table>
<thead>
<tr>
<th>EMPLOYER SPONSORED BENEFIT</th>
<th>SUBJECT TO THE CADILLAC TAX?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The cost of On-Site medical clinics (unless care is “de-Minimis” – Latin for minimal things)</td>
<td>Yes</td>
</tr>
<tr>
<td>Retiree Coverage</td>
<td>Yes</td>
</tr>
<tr>
<td>Multiemployer plan coverage (includes union health and welfare funds)</td>
<td>Yes, but likely on an Actuarial Value or Past Cost basis like COBRA rates are currently calculated for H.R.A. plans.</td>
</tr>
<tr>
<td>Specified disease and hospital or other fixed indemnity health coverage</td>
<td>Yes</td>
</tr>
<tr>
<td>Executive physical programs</td>
<td>Yes</td>
</tr>
</tbody>
</table>
THE TAX LIABILITY IS CALCULATED ON A MONTHLY BASIS:

This is a very important distinction that was included in the February IRS regulations. With the inclusion of this clause, we now have the potential for a very complex calculation that needs to be done on a monthly basis. Let’s consider for a moment the basic tracking that this will involve. The tax will be imposed on a monthly basis on the amount of coverage the employee receives that is over the “applicable dollar limit” or threshold for that month.

For 2018, the applicable dollar limit is $10,200 which would be $850 per month - for self-only coverage, and $27,500 or $2,292 per month for coverage other than self-only coverage. This is an important part of the definition that we will touch more on later.

To put the monthly limits in the perspective of your current rates, let’s back out a middle of the road number for trend and see what 2015 rates would look like that just hit the monthly limits.

<table>
<thead>
<tr>
<th></th>
<th>2018 RATES</th>
<th>2017 RATES</th>
<th>2016 RATES</th>
<th>2015 RATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$850.00</td>
<td>$772.73</td>
<td>$702.48</td>
<td>$638.62</td>
</tr>
<tr>
<td>Family</td>
<td>$2,292.00</td>
<td>$2,083.64</td>
<td>$1,894.21</td>
<td>$1,722.01</td>
</tr>
<tr>
<td>Trend Factor Used</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

To determine tax liability, the fully insured employer must first combine the elements listed in the preceding charts and then report that to the insurer on an employee by employee basis. The insurer in turn will determine the tax liability.

If the employer were self-funded, they would again combine the elements in the chart and determine their own liability on an employee by employee basis.

Two similarly situated employees could end up creating different tax liability. One employee may only have the base medical and drug plan along with whatever the employer contributes to an H.S.A. Another employee may have that amount plus a pre-tax contribution to their H.S.A that was taken out of their pay. Each employee would be considered separately.

One important change that came from the July 30, notice was the account for H.S.A., F.S.A. and M.S.A. contributions. The original regulations were such that the accounting for these amounts would be based on the month the funds were deposited. This was changed in the latest release to allow the amounts to be prorated across the entire year regardless of the timing of the deposit.

While earlier interpretation of the rules seemed to be that employers would need to stop prefunding these accounts, this change may allow employers to continue to do so for a bit yet. The February regulations clarified that employee H.S.A. or F.S.A. contributions done of a post-tax basis are not included in the tax calculation.

For Flex Credits under an F.S.A., the July 30, release went into great detail on how these funds may impact the tax liability. The regulations allow an employer to either track the liability based on actual usage or based on the funds available. The funds available will most likely be the popular approach since there is not as much recordkeeping required and this method provides for a controlled amount each year.
CLARIFYING WHAT IS NOT APPLICABLE COVERAGE

The chart below lists the items specifically excluded from the calculation of Applicable Coverage:

<table>
<thead>
<tr>
<th>军事相关保险覆盖</th>
<th>是否受卡迪拉克税征税？</th>
</tr>
</thead>
<tbody>
<tr>
<td>军事相关保险覆盖</td>
<td>否</td>
</tr>
<tr>
<td>特定例外利益，如事故或残疾收入, 责任保险, 工人赔偿, 自动医疗支付, 信用仅, 特定疾病和医院或其他固定补偿健康保险（如果购买于非税基础上）。</td>
<td>否</td>
</tr>
<tr>
<td>长期护理</td>
<td>否</td>
</tr>
<tr>
<td>员工H.S.A.或M.S.A.贡献于非税基础上完成</td>
<td>否</td>
</tr>
<tr>
<td>员工援助计划</td>
<td>否</td>
</tr>
<tr>
<td>受保和自保有限制的牙科和视力保险</td>
<td>否 – 技术上自保是包括的，但预计会是一个技术性的纠正。</td>
</tr>
</tbody>
</table>

It is so good to see that Military Based Coverage is not included as well as Long Term Care. By definition, anything not taxable to the employee would be included. The mention then of after-tax contributions is not a surprise.

When the release by the IRS first came out, there was a flurry of concern over self-funded dental and vision plans. The IRS did point out in the release that they intended to correct this within the final regulations. Please remember, that employees must be able to opt out of any dental or vision plan while taking the medical or the dental and/or vision plan will be subject to the Affordable Care Act.
LOOKING AHEAD

The threshold limit will be adjusted yearly to reflect cost-of-living changes. The factor to be used will be CPI + 1%, which has traditionally lagged behind general medical inflation for most of the years it has been measured. The Congressional Budget Office anticipates that medical inflation will grow by 5.6% annually over the next 10 years, while the overall inflation factor will be about 2% per year.

Milliman released a study in 2015 where they observed that general inflation as measured by the CPI-U ran at 2.3% between 2004 and 2014. The medical component of the CPI-U ran at 5.3% over the same time.

With the results of both of these studies then it is inevitable that the thresholds will eventually be met and exceeded based on the difference in the growth of overall inflation and medical inflation. These studies too are only looking at medical inflation. Another important cost component is the utilization as new technology brings improved (a more costly) ways to treat illness. This will cause the actual trend used in the calculation of your cost to increase at a rate that is even faster than the Congressional Budget estimates.

The chart below is to help you understand the inevitability of the tax. In the example we are starting with an individual plan that cost $600 per month. We assume a 5.3% growth in annual cost as shown in the CBO and Milliman studies. We would suspect actual growth in cost to be greater than 5.3% once you compensate for technology changes so this is a conservative look.

We start with a beginning annual cost of $7,200 (600 Per Month) and by 2040 the cost is $26,184. The tax threshold has risen to $21,523. The actual tax due for this individual over the total time period would be $28,456 which is 8% of the total cost over the next 25 years.
STEP ONE:

Unless regulations are changed, over time all employers will become subject to the Cadillac Tax Test. If you are able to delay reaching the threshold then you are obviously saving tax dollars. We recommend an initial step that you can take that may help postpone the tax.

We have noted that a four tier rate will generally get you to a Cadillac Tax liability sooner than a two tier rate. The reason for this is that the family rate under a 4 tier system is about 3.4 times the single rate. For a 2 tier system, the family rate is around 2.5 times the single rate. In many examples that we have run, we have found that rating based on 2 rather than 4 tiers will keep your cost under the threshold of the tax longer than a 4 tier.

There is nothing under the current regulations that would prevent you from having a 2 tier rate structure and a 4 tier contribution structure. Changing to 2 tiers would impact your COBRA rates however. The carriers have shown hesitation in allowing small employers to make the switch to two tier rates. This is likely due to the impending Modified Community Rating which we will discuss later. Whether your account is large or small, we will want to have a conversation early with your carrier if this is the course you would like to take.

Below is a sample of a Cadillac Tax Test exhibit that we have run for many of our clients. In this example, we are taking their current 2015 rates and increasing them by 10% for each year between now and 2018. At 10% the $600 Employee Rate for example is up to $798.60 by 2018. If there was an H.R.A. or H.S.A. contribution this would also need to be added. NOTE: We have not put anything in for Employee Pre-Tax contributions to an H.S.A. or F.S.A. These would also need to be considered.

Sample

McGohan Brabender Projection Cadillac Tax Test
January 1, 2015

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Plan</td>
<td>$600.00</td>
<td>10</td>
<td>$600.00</td>
<td>$728.00</td>
<td>$798.60</td>
<td>$9,583</td>
<td>$10,200</td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$1,320.00</td>
<td>20</td>
<td>$1,452.00</td>
<td>$1,597.20</td>
<td>$1,756.92</td>
<td>$21,083</td>
<td>$27,500</td>
<td></td>
</tr>
<tr>
<td>Employee/Spouse</td>
<td>$1,080.00</td>
<td>15</td>
<td>$1,188.00</td>
<td>$1,306.80</td>
<td>$1,437.48</td>
<td>$17,250</td>
<td>$27,500</td>
<td></td>
</tr>
<tr>
<td>Employee/Child</td>
<td>$2,040.00</td>
<td>30</td>
<td>$2,244.00</td>
<td>$2,468.40</td>
<td>$2,715.24</td>
<td>$32,583</td>
<td>$27,500</td>
<td>$5,083</td>
</tr>
<tr>
<td>Family</td>
<td>$2,040.00</td>
<td>30</td>
<td>$2,244.00</td>
<td>$2,468.40</td>
<td>$2,715.24</td>
<td>$32,583</td>
<td>$27,500</td>
<td>$5,083</td>
</tr>
<tr>
<td><strong>Total Annual Cost</strong></td>
<td><strong>$1,317,600</strong></td>
<td>75</td>
<td><strong>$1,449,360</strong></td>
<td><strong>$1,594,296</strong></td>
<td><strong>$1,753,726</strong></td>
<td><strong>$17,537,26</strong></td>
<td><strong>$27,500</strong></td>
<td><strong>$5,083</strong></td>
</tr>
<tr>
<td><strong>Change in Cost</strong></td>
<td>10.0%</td>
<td>10.0%</td>
<td>10.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: An annual trend of 10.0% used for future periods. The Cadillac Tax is calculated by taking 40% of the excess cost for each coverage tier that is expected to exceed the Tax limit. While final regulations have not been released, recent updates indicate that employee pre-tax contributions to H.S.A. accounts or Medical FSA accounts will also be included as part of the Tax calculation. In addition, current regulations would add any self-funded Dental or Vision cost also be included. It is expected that this will be reversed by the IRS as part of the technical corrections.
The estimated tax in 2018 would be $60,995. In the exhibit that follows, we have changed
the rates to two tiers (Employee and Family). As you can see, this has a very positive
impact and eliminates the tax.

**Sample**

**McGohan Brabender Projection Cadillac Tax Test - Two Tier Version**

**January 1, 2015**

<table>
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<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Plan</td>
<td>$600.00</td>
<td>10</td>
<td>$660.00</td>
<td>$726.00</td>
<td>$798.60</td>
<td>$9,583</td>
<td>$10,200</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$1,596.92</td>
<td>20</td>
<td>$1,756.62</td>
<td>$1,932.28</td>
<td>$2,125.50</td>
<td>$25,506</td>
<td>$27,500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee/Spouse</td>
<td>$1,596.92</td>
<td>15</td>
<td>$1,756.62</td>
<td>$1,932.28</td>
<td>$2,125.50</td>
<td>$25,506</td>
<td>$27,500</td>
<td></td>
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<tr>
<td>Employee/Child</td>
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<td>30</td>
<td>$1,756.62</td>
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<td>$2,125.50</td>
<td>$25,506</td>
<td>$27,500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>$1,756.62</td>
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<td>$27,500</td>
<td></td>
<td></td>
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<tr>
<td><strong>Total Annual Cost</strong></td>
<td>$1,317,600</td>
<td>75</td>
<td>$1,449,360</td>
<td>$1,594,290</td>
<td>$1,753,726</td>
<td>$1,753,726</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Change in Cost</strong></td>
<td></td>
<td></td>
<td>10.0%</td>
<td>10.0%</td>
<td>10.0%</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Note: An annual trend of 10.0% used for future periods. The Cadillac Tax is calculated by taking 40% of the excess cost for each coverage tier that is expected to exceed the Tax limit.
While final regulations have not been released, recent updates indicate that employee pre-tax contributions to H.R.A accounts or Medical FSA accounts will also be included as part of the Tax calculation. In addition, current regulations would add any self-funded Dental or Vision cost also be included. It is expected that this will be reversed by the IRS as part of the technical corrections.

We are urging our clients to make this move as soon as possible. Many provisions
implemented in this law will allow a past practice to continue, but not permit a change
after the regulation has been issued. Discuss this option with your current carrier or
consultant.

But don’t get complacent if you do not believe that you will hit the tax limits in 2018. This
part of the law will continue indefinitely and you will eventually hit the limit. That is why
we have designed a new set of reports that will help you understand when and how the
tax will hit you.

When you arrived today you received a packet at the registration desk. In the packet you
either found an exhibit expressly designed for your group, or you found a sample. For
our clients that are community rated, the regulations have not addressed the handling of
these rates so we are uncertain of how to project the cost at this time. If you are not
currently a client, or are a client but did not receive a custom made report for your group,
please contact your account manager and we will be happy to prepare one for you.

The report begins with a look at the Pay or Play regulations and cost considerations.
Then we move to looking at the Potential Cadillac Tax. The spreadsheet has been set up
to project cost from 2015 through 2022. We are using a 10% annual trend. If you would
prefer an alternative figure, please contact your account manager.
The report provides details on the calculations along with a graph that shows your distribution of cost over time. We have assumed that any H.S.A. or H.R.A amounts are unchanged over time. Please note, that we have included nothing on employee pre-tax contributions.

The last couple of pages lay out an exhibit very similar to the earlier ones where we are looking at the cost of hitting the tax limits. Below is a glimpse at the graph that is included in the packet for your reference.

In this example, the employer see’s their first hit of the tax limit in 2019. Notice how the tax rapidly rises over the years following. In 2020 the tax has increased 22 times. Then in 2021 it increase by almost 5 times, with a doubling in 2022. The reason for this leveraging that we see is that for every $1.00 that exceeds the limit, there is a $.40 cent tax.
**PLAN DESIGN CONSIDERATIONS**

Depending on your current level of coverage, you may be able to postpone the "The Tax" by changing your plan design. There is a diminishing rate of return on this approach though. If you have a PPO plan with a $100 Deductible/80% Coinsurance and $2,500 Out of Pocket, changing to a $500 would lower your cost by about 2.5%. Going from the $500 to a $2,000 deductible would only lower your cost by an additional 3.3%.

If you moved to a HDHP type of plan where all payments are after the deductible, then you would see more movement in cost. A $2,000 Deductible plan/80% Coinsurance to a $4,000 Out of Pocket limit would reduce the cost by about 10% from the $100 plan. Of course your employees would have quite a change in their plan design

**WELLNESS STRATEGIES**

As we get closer to 2018, there will be a rapidly rising interest in self-funding. The rating regulations will restrict the use of medical information in the formulation of fully insured rates for small employers. What will occur then is that the healthiest employer will receive the largest increase in cost. For smaller clients, the insurers have developed self-funded programs that allow the employer to pay a level rate for the coverage during the plan year, thereby resulting in a feel of being fully insured.

Whatever type of self-funded arrangement you are in, being self-funded brings with it an increased interest in your claims utilization. You will suddenly have a vested interest in making sure your claims cost is under control.

The greatest component of the cost of your coverage is claims. That should not be a surprise to anyone. There are ways that you can control that piece of your cost that will help you in holding down your cost and, as a result, holding off any tax liability.

What we have found most effective is a wellness strategy in which your employees are rewarded for their healthy lifestyle. Our most consistent plan brings a biometric screening together with the absence of tobacco use to your employee contribution strategy. In general, this type of plan will stunt future growth in cost by about 1/3rd of what we would otherwise expect. And that savings compounds over time as employees become more knowledgeable about their health and more willing to do something about it to avoid higher personal cost.

Over the next few pages I present some case studies that support our findings.
CASE #1:

The data that follows is from an actual client that implemented a full wellness strategy along with an incentive based contribution program.

This program was implemented on January 1, 2012. Employees were required to participate in a biometric screening that tested glucose, triglycerides, blood pressure, and cholesterol and waist circumference. Employees who passed three of these five tests and were non-tobacco users were allowed to keep their contribution the same as it was in 2011.

Employees that did not satisfy either the biometric screening or the tobacco usage but did satisfy the other had their contribution increased by 5% of the total cost of single coverage. If they did not satisfy either of the requirements there was an additional 5% added. If they refused to participate at all a final 5% was added for a total of 15% of the entire cost of single coverage. Since we did not include the spouse, the incentive was only based on the employee rate regardless of the tier.

Keep in mind that current regulations today would allow 30% to be added plus an additional 20% (50% total) with tobacco usage as a component. These limits do conflict with a recent EEOC ruling that set the maximum limit at 30% including tobacco. These regulations are not final but should be considered when designing a program.

What resulted? The chart that follows shows the client’s trend going into the program. The line that jumps around is their monthly cost of claims on a per employee per month basis. The red line represents a 12 month moving average calculation which is a way of helping to smooth out the data.
The data points show that their moving average cost crossed the $800 level in August, 2010. The month before the program was implemented, December, 2011, the moving average was at nearly $930 and climbing.

What is most interesting about this case is that the employer conducted the testing six months before the incentive program was implemented. When we look at the claims that were incurred near the end of the year after the testing we found a combination of increased drug usage, office visits and a spike in elective procedures. A spike in elective procedures is usually symptomatic of unrest or uncertainty among the employees.

Where was the cost heading? For the next chart I added a trend line. It is a linear regression line which is a mathematical way of finding a line that you can draw through all the monthly points in the data. Then I continued to extend that line out beyond the data points to see where it was heading. By the end of 2013 this trend line suggested that the cost would reach $1,000 PEPM by December, 2013. Over that three plus year period their claims cost had risen by over 12% per year. Not the worst I have seen, but not the best either.

By the way, this client had already implemented a high deductible plan back in 2010 in an effort to get their cost under control. That is why you see the dips in cost around the beginning of the year. Deductibles are kicking in.

The client was heading for $1,000 PEPM. Then they added a full wellness plan at the beginning of 2012. And the result:
Look at the dip in cost that occurred in January, 2012. Since they started the program well before the incentive contribution kicked in, they went through a discovery period in the second half of 2011. The extreme drop was caused by a combination of the high deductible and the fact that everyone had taken care of their elective procedures. And remember the projection of a $1,000 December, 2013? The cost in that month was $784. This was 22% less than the original forecast. If I add a trend line and run a projection out two more years like I did before, their claims cost at the end of 2016 is expected to be about $820. This gets them back to 2010 level cost.

As we update the results even further we bring in data for 2014 and the first 6 months of 2015. The chart that follows shows the monthly cost and current trend. On a moving average basis, the client finally reached the $800 level in December, 2014. After that the cost fell back under and still remains less than $800 PEPM. The current annual trend is running at about 4% annual.
CASE #2:

This client implemented a Wellness program in January. While you would not expect to see improvement in the health of your employees in such short order, there is a phenomenon that you can expect to see that may cause you a little concern shortly after the Wellness Program is implemented. Below is a chart of paid claims that will illustrate my point.

The trend lines above are tracking paid claims from July, 2013 to June, 2015. This client implemented their program in January, 2015. Immediately there was a spike in cost that slowly comes back down over the next few months. The spike hits in March which was caused by the time delay in submitting and paying claims.

As part of their program, employees were given biometric screening and the results. We used our data analytics tool to see what was driving this increase in cost to confirm what we suspected. Prior to January, there were about 70 members who had been diagnosed with one or more chronic conditions. We used our predictive modeling tools to look at the risk score of this account based on data through April. That report showed a very high risk score with an anticipated significant increase in cost predicted for the next month. We then reran the numbers through June and found a large decrease in the risk score. What caused this were the original diagnosis codes that were submitted in claims that had no record of treatment or maintenance. All of these chronic conditions then were classified as non-managed.

When we ran the data through June we found that the risk score had dropped significantly. This was an indication that prescribed drugs and physician records were now showing that the conditions were being managed.

An effective Wellness Program will usually cause a rise in cost for the first 6 months or so of the plan. This is a byproduct of the discovery of illness and the subsequent treatment. You may also experience a prolonged increase in drug cost as members begin to treat their condition(s) with medication. We expect that we will see continued improvement in cost over the next couple of months, followed by a sustained lower trend.
CASE #3:

The first time that we ran our Cadillac Tax exhibit for this client, we found that they had already hit the limits using their 2014 rates. The potential penalty was very significant. Benefits were rich, contributions low and there were also union agreements.

We urgently recommended a multiple year strategy to bring this under control before 2018. The first accomplishment was to get the unions to agree to open up the contracts. Once that was done, we were able to get the client and labor to accept our proposal and begin an aggressive wellness strategy coupled with changing benefits from very rich plans to high deductible plans.

The first step in a three year plan began on January, 2105. In the chart below you can see the results:

Notice that there was a large upswing in cost at the end of 2014. We attribute that to a large increase in elective procedures being performed. Most likely everything that had been delayed for whatever reason was taken care of before a high deductible plan was put in place.

The large dip in cost is a combination of the lack of elective procedures (since many had been recently done) and the impact of the large deductible starting in January. A full wellness screening will come into play in the next year. That is likely when we will see the 6 month increase in cost caused by the discovery of disease and the subsequent treatment.

We reran the Cadillac Tax estimate based on the most recent data and found our current projection is now down by ¾ of the original estimate. Once the impact of the Wellness Program is felt we are confident that we will eliminate any liability in 2018.
COMMUNITY RATED ACCOUNTS

In the past, traditional community rating was based on age and gender. Carriers developed rating models that set the rates for the oldest members of the group anywhere from 8 to 12 times the youngest. Community rating was usually reserved for the smallest accounts as well.

With the Affordable Care Act community rating itself has changed. Under Modified Community Rating, the carriers are no longer permitted to use gender in their underwriting. Rating bands may only be up to a 3:1 ratio rather than an 8:1 or 12:1.

Quite often we have found that the change to the new rating platform will cause a substantial increase in cost. Because of this many employers are shifting their plan renewals to different dates in order to postpone having to comply with the Modified Community Rating regulations. The latest date that you will be able to shift your renewals to avoid Community Rating will be September 30, 2017.

One additional area of Modified Community Rating that has not been addressed yet through the Cadillac regulations is the question of how the Cadillac Tax would be applied to community rates.

To help illustrate my point, I have taken a few actual rates from a rate table to show you what your rating will become if you are Community Rated in 2017.

The plan design in this illustration is not as important as the actual rates to prove my concern. A 21 year old would have a single rate of $268.97. A 64 year old would have a rate of $806.91. If you divide the 64 year old rate by the 21 year old rate you get a factor of 3. These are 2015 rates. If we follow my earlier assumption about future rate increases being 10%, the 21 year old rate will be $358 in 2018. The 64 year old will be $1,074. Multiply the 21 year old rate by 12 and the annual cost is /44,296 which is well under the limit. However, the 64 year old rate is $12,888 which is $2,688 over the limit for a tax of $1,075.

Another very important consideration in the area of community rating is that the size limit for Modified Community Rating is being expanded from 50 to 99. An employer with less than 100 employees (all employees) will be subject to the Modified Community rating in the next couple of years. For some employers this is good news. For the majority though, this is not good news at all.

Who will get the good news versus the bad? Ironically it will be the oldest and least health accounts that will benefit by the new rating tables. On the flip side the young and healthy accounts will be the hardest hit. We have run many samples of what this could mean for accounts over 50 lives and found several cases where the cost will double.

When it comes time for your next renewal, check out what an ACA compliant rate will look like for you. If it works out favorably for you then you will want to switch to that platform as soon as possible. If it does not work out very favorably, then read on.

Primarily for small employers, the best
option as you move into Modified Community Rating may well be to simply stop being able to offer your employees coverage. Send your employees to the exchange where there are multiple options available for them.

While an employer cannot pay this premium for the employee, you can contribute money to an H.S.A. that the employee may use to supplement their High Deductible Health Plan. You may also choose to use some or all of your savings by increasing the compensation to your employees. One employer that I worked with decided to contribute the savings to their employee’s 401K.

The other consideration that makes the dropping of coverage for smaller employers a realistic option, is that employers under 51 lives are not subject to the Pay or Play rules and the corresponding penalties. These are currently $2,080 (times FTE’s-30 in 2016) for not offering coverage and $3,120 (for each employee with non-affordable coverage that gets a subsidy) for not offering affordable coverage.

Any employer that will be subject to Modified Community Rating will also want to consider self-funding as an option. For many years we have cautioned the smaller employer to avoid self-funding due to the unpredictability of cost for a smaller employer. However, the taxes and fees that are associated with fully-insured accounts through the ACA are much greater than in the past which makes this option a good consideration.

A group composed of young employees will usually represent a very favorable risk. Insurance companies would positively and aggressively rate these groups. With Modified Community Rating, the young and assumed healthy group will be the type that will get hit the hardest with the Modified Community Rating.

Under self-funding the carrier is still permitted to use health statements. For the young and healthy group example, the cost under self-funding could be much lower than Modified Community Rating.

Recently approved legislation in Ohio has expanded options under Multi Employer Welfare Arrangements (MEWA’s). Additional options available through MEWA type programs, along with a new host of self-funding options aimed at small employers that the major carriers have developed, will afford many opportunities for self-funding.

The market has recognized that the traditional self-funding approaches will not work very well with smaller accounts. Because of this we are seeing a “re-birth” of what we used to call “split-funded” or “minimum premium” plans. The employer will pay a monthly cost that is in line with the traditional premium that has been paid in the past. After the end of the plan year, there is a look back that will determine if the financial outcome represents a gain or loss.

At this point there are variations in how any gain or loss in handled. Most of the time though any deficit will be carried forward and offset future gains. With gains you may see reductions in future premiums to offset the excess premium.

Self-funding should be an option that you keep in mind over the next couple of years as we continue to migrate through the Affordable Care Act. This can be a very plausible way for you to postpone meeting the Cadillac Tax Thresholds.
SUMMARY

There are many parts to the Cadillac Tax regulations that we are still unclear about. The regulations that were issued by the IRS in July will be open for comments until October 1, 2015. The timing of when we will receive final regulations is uncertain with this additional release.

This document has proposed options that are available at this time for your consideration. Make sure you do the test, either with your broker or on your own. See for yourself what the cost could mean to your organization. You need to have a clear strategy worked out that includes the design of your plans, the treatment of employee pre-tax contributions, how your coverage will be funded, and even if you will continue to offer coverage at all.