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Taxes and Fees Introduced by the ACA

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While much of the funding necessary to implement the Patient Protection and Affordable Care Act (ACA) was intended to come from general government revenues, the ACA did contain several revenue-raising provisions taking the form of new federal taxes, fees or penalties. (Of course, in one famous instance—the individual shared responsibility payment—one such provision had been called a "penalty" only for Chief Justice Roberts, critically, to conclude that it in fact was a "tax.")

This article[1] focuses on three specific taxes or fees introduced by the ACA that have proven to be of significant interest to actuaries, namely:

- **Transitional reinsurance fee or reinsurance contribution (RC)**, which is levied under ACA Section 1341 primarily for purposes of providing funding for the individual market's 2014 to 2016 transitional reinsurance program
- **Health insurer fee (HIF)**, levied under ACA Section 9010, starting in 2014
- **Excise tax on high-cost health plans or "Cadillac tax,"** levied under ACA Section 9001, starting in 2018.

From our current vantage in 2015, five years after ACA enactment, we know that the RC will pass into history in the near future, while the HIF has moved from an area of significant concern to an ongoing fact of life. Meanwhile, the Cadillac tax is starting to loom large and will likely be a focal point of energy over these next five years.

REINSURANCE CONTRIBUTION

ACA Section 1341 provides that, during the years 2014 to 2016, $20 billion will be made available to carriers in the individual market under a government-provided reinsurance program. In addition, ACA Section 1102 provided that, between enactment and 2014, up to $5 billion would be made available to employers under what was known as the temporary reinsurance program for early retirees.

In an effort to generate an offsetting $25 billion in government revenues, ACA Section 1341 created a new fee on health insurers and self-funded health plan sponsors, generally known as the reinsurance contribution (RC). Unlike the other items discussed in this article, the RC is explicitly temporary, starting in 2014 and sunsetting after 2016.

The statute provided flexibility for regulators to assess the RC on either a percentage-of-premium basis or a per capita basis, but only on commercial major medical coverage (i.e., by statute the RC does not apply to Medicare or Medicaid coverage). Draft regulations implementing Section 1341 proposed the percentage-of-premium approach, under the theory that it would create better state-level alignment between the funding of the reinsurance program and the associated expenditures, as it would lead to higher RC amounts in states where health care is more expensive. However, the final regulations issued in early 2012 switched to the per capita basis, largely on administrative simplicity grounds. Because self-funded plan sponsors are part of the RC funding base, implementing a percentage-of-premium approach would have necessitated calculation of "premium equivalents" for self-funded plans; a per member charge may be less equitable in theory but was clearly going to be far less complex in practice.

So, by mid-2012 it was known that an insurer's RC expense

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for 2014 would be calculated by taking a per member per month (PMPM) rate promulgated by the Centers for Medicare and Medicaid Services (CMS) and multiplying by its 2014 commercial member months. As such, contracts with effective dates of Feb. 1, 2013, or later would, in principle, contribute to the insurer's 2014 RC expense. Consequently, shortly after the ACA was upheld by the Supreme Court in the summer of 2012, insurers needed to consider taking actions to incorporate a load for the RC into pricing.

A very common pricing approach for a contract with a mid-2013 effective date was as follows: Take the load that would be appropriate for a contract on Jan. 1, 2014, multiply by the fraction of the contract year that overlaps 2014, and include that PMPM load in all 12 months' premiums. For example, if you expected the 2014 RC rate to be $6.00 PMPM, then for a contract of March 1, 2013, you'd seek to include two-twelfths of that, or $1.00 PMPM, in premiums. This approach preserved the ability to have level premiums over the contract year while still collecting the cash needed to fund the insurer's expense, albeit with the side effect that some of the premiums collected in 2013 were intended to cover an expense in 2014. An alternate approach, involving a defined premium step-up in the middle of the contract year (i.e., at Jan. 1, 2014), was less commonly used but had the advantage of better matching revenue and expense across years.

There are five important ways in which the HIF, by statute, differs from typical state premium taxes.

At the time that rates for early 2013 effective dates were being set in late 2012, insurers still needed to estimate what the 2014 RC rate would be. The statute indicated that the RC was supposed to produce $12 billion in government revenues in 2014. Given that objective, one could estimate the 2014 RC rate by first estimating how many people in the United States would have commercial major medical coverage (whether insured or self-funded) in 2014. Based on materials from late 2012, most insurers expected that the 2014 RC rate would be in the $5.70 to $6.00 PMPM range, consistent with an expectation that somewhere around 165 million to 175 million members would be subject to the RC in 2014.

In December 2012, CMS published a regulation setting the 2014 RC rate at $5.25 PMPM, implying that it expected about 190 million members to be subject to the RC. As of this writing, it is not clear whether or not the $5.25 PMPM rate for 2014 has proven to be adequate to generate the intended $12 billion of 2014 revenue; any shortfalls in the revenue raised by the RC could have implications for the collectability of insurers' 2014 transitional reinsurance receivables. A December 2014 regulation has set the 2016 RC rate at $2.25 PMPM, which is consistent with an assumption that 185 million members will pay the RC in 2016, a year where by statute the goal is to generate $5 billion of revenue. However, because the deadline for 2014 RC submissions had been extended to January 2015, the 2016 rate would have been set without knowledge of actual 2014 collections.

One last technical item of interest regarding the RC involves income statement presentation. For an insurer not participating in the individual market, the insurer's entire RC payment is treated as an administrative expense. For an insurer participating in the individual market, however, a more nuanced treatment was adopted: A portion of the insurer's RC payment arising from its individual members is deemed to be a premium paid for by the government-provided reinsurance coverage funded by the RC, while the remainder of the RC payment is treated as administrative expense. The appeal of this approach is obscure, given that the amount deemed via this process to be reinsurance premium is surely far less than what a private reinsurer would seek to charge for the associated reinsurance protection.

HEALTH INSURER FEE

ACA Section 9010 is titled "Imposition of Annual Fee on Health Insurance Providers." It created a new premium-based federal tax, starting in 2014. This revenue-raiser has been known by a number of different names, but for purposes of this article we will refer to it as the health insurer fee (HIF).

There are five important ways in which the HIF, by statute, differs from typical state premium taxes.

First, the statute defines an exact amount of revenue to be raised via the HIF in each calendar year, rather than specifying a tax rate to be applied. This feature has led to a process whereby insurers report their premiums to the Internal Revenue Service (IRS) on newly created Form 8963, and then the IRS apportions to each insurer a share of the statutory revenue target (which was $8 billion in 2014) based on that insurer's proportion of total industry-wide reported premiums.

Second, the statute defines the HIF as being a nondeductible excise tax. As a consequence, from 2014 forward health insurers are reporting much higher effective tax rates (meaning, the ratio of income taxes to pretax income) than in the past, because pretax income is reduced by HIF expense whereas taxable income is not.

Third, the HIF expense that is due for the current year is not connected directly to the insurer's premiums for the current year. Instead, while it is the act of writing health insurance coverage in the current year that creates the insurer's obligation for HIF in the current year, the IRS uses insurers' reported premiums from the previous calendar year in the HIF apportionment calculation. (This has similarities to how the high-

risk pool assessments of many states worked historically.)

Fourth, the statute carves out certain classes of insurers for special treatment. One class is not-for-profit insurers that garner at least 80 percent of their revenues from Medicare Advantage and/or Medicaid; these insurers are exempted from the HIF. Another class is insurers that are exempt from federal income taxation; these insurers get to haircut their reported premiums by 50 percent.

Finally, the HIF does not apply to all types of health insurance premiums. Although dental, Medicare Advantage and Medicaid premiums are included alongside major medical in the HIF's scope (unlike the RC), other coverages such as Medicare Supplement, long-term care (LTC), disability and stop-loss are excluded.

These comparatively unusual facets of the HIF created a host of interesting issues for health insurers and their actuaries to confront over the past few years, as we now discuss.

The threshold question that insurers faced was whether they should seek to fully pass through the cost of the HIF to their customers, via premium increases. Although at first glance one might think the answer is obviously "yes," there is more to think about here than meets the eye.

An important and unusual consideration here is the non-deductibility of the HIF. If a taxable company seeks to fund a $10 million nondeductible expense, then increasing revenues by $10 million will not make the company whole, because the company would need to pay income taxes on 100 percent of the incremental revenue. So, for an insurer paying federal taxes at the normal corporate rate of 35 percent, revenues would need to increase by $15.4 million, or $10 million divided by (1 – 35%), in order to generate $10 million in after-tax dollars.

As a result, the HIF structurally places "fully taxable" insurers at a competitive disadvantage relative to other classes of insurers. As shown in the illustrative table in Figure 1, the amount by which the insurer would need to increase its premiums to make itself whole with respect to the HIF (ceteris paribus, i.e., assuming no change in volume) can vary widely based on the insurer's tax status.

Figure 1

Premium Increases to Pay for HIF

	Est. HIF as % of prem. (pretax)	Required make-whole prem. incr.
"Fully taxable" insurers (i.e., paying 35% corporate rate)	1.50%	2.31%
Insurers paying 20% alternative minimum tax (AMT) rate (some Blue Cross/Blue Shield plans)	1.50%	1.88%
Nontaxable insurers	0.75%	0.75%
Exempt nonprofit Medicare/Medicaid plans	0.00%	0.00%

Now suppose you're a fully taxable insurer in a market that has competitors with different tax statuses. How elastic do you believe demand for your product is, relative to that of your competitors?

If you believe that demand is very elastic, then you might conclude that the economically rational thing to do is to not fully pass the HIF costs through to customers via premium increases, out of a fear that if you tried to increase your rates by 2.3 percent while your nontaxable competitor increased them by 0.8 percent, you might lose enough volume that you're worse off in the end on an underwriting margin basis. Conversely, if you believe that your product is sufficiently differentiated from competitors that customers will be sticky when faced with a 1.5 percent price differential shock, then you'd go ahead and seek to fully recoup the HIF costs via premiums, despite the theoretical competitive disadvantage.

With these dynamics in play, and with all the players needing to stake out their pricing strategies at roughly the same time, it was conceivable that different companies would pursue different strategic pricing paths—some deciding to fully pass the HIF costs on to customers, and others deciding to absorb some or all of the costs in the hope of making it up through volume. In the end, however, it appears that all of the major fully taxable insurers chose to fully pass the HIF costs through and take their chances with respect to maintaining volume. History would seem to judge that this was the right strategy; the implementation of the HIF does not appear to have resulted in a significant shift of market share toward nontaxable insurers, despite the unlevel playing field it created.

After reaching the decision to pass through HIF costs to customers via premiums, insurers still faced a number of interesting decisions about precisely how to do that. In discussing that, we first take a detour into accounting considerations, as they became relevant to the selection of pricing tactics.

As noted above, under the statute an insurer's 2014 cash HIF payment was to be calculated as a function of its 2013 premiums, with the caveat that, if the insurer did not write any health insurance in 2014, then it would owe no HIF. Given these facts, in which year's income statement ought the insurer to recognize expense for the 2014 HIF payment: the year the cash will be paid (2014), or the year whose premiums were used in the calculation of the payment amount (2013)?

A similar issue had been addressed in GAAP many years earlier. A pronouncement from the American Institute of CPAs (AICPA) called Statement of Position (SOP) 97-3 contained guidance for how insurers should account for pre-

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mium-based, insurance-related assessments, e.g., an assessment on workers' compensation premiums to fund the operating budget of a state workers' compensation board. Under the AICPA SOP 97-3 model an insurer would record a liability, and hence also administrative expense, for a premium-based assessment in the year whose premiums were being used to determine the amount of the assessment, even if the assessment itself was not due until the subsequent year.

The SOP 97-3 framework, had it been applied to the HIF, would have implied that insurers would recognize the 2014 HIF payment as an expense in their 2013 financial statements. And that, in turn, would have suggested that insurers ought to collect a load for the HIF in the premiums earned in 2013, in order to avoid a material mismatch between income and expense in 2013.

However, a contrary accounting precedent was established in GAAP shortly after the ACA's adoption, with respect to yet another ACA-introduced fee: the Section 9008 fee on pharmaceutical manufacturers. This revenue-raiser was structured very similarly to the HIF, except that it took effect three years earlier, in 2011. As a result, there was an immediate post-adoption need for accounting guidance on this issue: Did pharmaceutical companies need to recognize an expense in 2010 for the 2011 payment? The conclusion of the Financial Accounting Standards Board (FASB) in 2010 was that no, the expense did not need to be recognized until 2011 even though 2010 sales figures would be used to determine each manufacturer's share of the total industry fee burden. The logic was that, under the statute, the activity triggering the manufacturer's liability for 2011 was not sales that had been made in 2010, but rather the first sale made in 2011.

Several months later, the FASB issued a pronouncement called Accounting Standards Update (ASU) 2011-06, which extended the same reasoning to the HIF, clarifying that the HIF was deemed to not be an "insurance-related assessment" (thus placing it outside the scope of SOP 97-3), and implying that for GAAP purposes health insurers would not recognize any HIF expense until 2014. Ultimately—although not without considerable debate and controversy—the same answer was reached by the National Association of Insurance Commissioners (NAIC) for statutory accounting.

In light of not only these accounting considerations, but also the general uncertainty that existed throughout the first half of 2012 about whether the ACA would survive Supreme Court review, insurers in general did not include any load for the HIF in premiums for policy years starting Jan. 1, 2013, or earlier.

From the cohort of Feb. 1, 2013, onward, however, most insurers started to include a pro rata HIF load, as part of premium rates that would remain level for 12 months, in a manner similar to that discussed above for the RC. So, if an insurer was of the view that a 2.4-percent-of-premium load would be required for the cohort of Jan. 1, 2014, then rates for the cohort of March 1, 2013, would include two-twelfths of that, or 0.4 percent. Other insurers preferred an approach that used a defined mid-contract premium step-up at Jan. 1, 2014.

One drawback with the approach of including an HIF load in some of the premiums collected in 2013 was the interaction with medical loss ratio (MLR) rebate requirements. The federal definition of MLR allows insurers to reduce premiums by taxes/fees; so in the steady state, if an insurer is collecting the right amount in each year's premiums to cover its taxes/fees expense paid out that year, then its federal MLR is unaffected. However, 2013 was a special case: Insurers had increased premiums in order to start funding their 2014 HIF and/or RC, but had no HIF or RC expense to recognize, so the net effect was to lower the reported federal MLRs, which may have increased rebates in some cases. The industry made an effort to lobby the U.S. Department of Health and Human Services (HHS) for relief from this phenomenon in 2013 federal rebate calculations, without success.

The next key issue that insurers faced in thinking about incorporating the HIF into pricing was how to compute the required load. In theory, an insurer would have needed to estimate each of the following variables in order to determine what its HIF load for the Jan. 1, 2014 cohort, ought to be:

- The 2013 premiums that the insurer would report to the IRS on Form 8963
- The total 2013 premiums that the industry would report to the IRS on Form 8963
- The amount of the insurer's 2014 premiums to which the HIF load will be applied
- The insurer's 2014 (federal and state) income tax rate.

Given that these estimates needed to be made in early 2013, it should not have been surprising that there was a lack of uniformity across the industry in the assumptions made for the Jan. 1, 2014 cohort's HIF load. In general, however, most of the fully taxable insurers came up with estimates in the range of 2.2 to 2.6 percent of premium.

Moreover, for a large insurer operating through multiple statutory entities or with multiple, separately managed lines of business, the insurer faced a philosophical decision: Should the HIF load be estimated at the holding-company level and applied equally across all entities and lines, resulting in some implicit cross-subsidization; or should different calculations be made for different entities and lines, reflecting differences in expected rates of premium growth from 2013 to 2014 or in income tax rates? Based on our inspection of 2014 rate filings, major insurers came down on both sides of this question.

One other issue of note involves the impact of the HIF on Medicaid rates. As noted above, Medicaid premiums are included in the scope of the HIF, although some nonprofit Medicaid insurers may qualify for an exemption from the HIF. As such, in order for a taxable insurer accepting Medicaid risk to be made whole, the capitation rate paid to the insurer from the state Medicaid program ought to include not only the HIF expense but also a provision for incremental income taxes. In March 2015 the Actuarial Standards Board (ASB) adopted Actuarial Standard of Practice (ASOP) 49 on Medicaid managed-care capitation rate development, and the new ASOP acknowledges this, stating (in Section 3.2.11.d) that the actuary should include in the capitation rate an adjustment to reflect the income tax impact of any nondeductible taxes that the insurer is required to pay out of the capitation rate.

As we move forward beyond 2015, much of these uncertainties and transition concerns lie behind us. The overall industry HIF burden is growing by statute, from $8 billion in 2014 to $11.3 billion in 2015 and 2016 and then on to $13.8 billion in 2017. This has led to an increase in HIF loads from 2014 to 2015, with current loads typically being around 3.0 percent for fully taxable insurers; also, the ability to estimate future HIF load requirements is enhanced by the fact that the industry has now been through one HIF reporting and collection cycle. Most observers expect that HIF loads will not need to increase materially beyond the current level in the foreseeable future. As such, now that the HIF's existence has been taken into account in pricing, future changes in the HIF are not expected to be a material contributor to future rate increases; the shock has been absorbed.

Despite that, HIF repeal remains of interest to many stakeholders. A 2013 bill whose sole purpose was to repeal ACA Section 9010 attracted 231 co-sponsors in the U.S. House of Representatives, yet died in committee; a similar bill introduced in February 2015 has attracted 196 House co-sponsors as of the end of March. Another 2013 bill would instead have delayed HIF implementation until 2016 and obligated insurers to return to their customers any amounts that had been collected for purposes of funding 2014 or 2015 HIF payments; it attracted 98 co-sponsors in the House but also died in committee. As this latter bill highlights, a practical difficulty with simply eliminating the HIF at this point is how to do so without creating windfall profits for insurers.

EXCISE TAX OR "CADILLAC TAX"

ACA Section 9001 is titled, "Excise Tax on High Cost Employer-Sponsored Health Coverage." It amended Internal Revenue Code Section 4980I to create an "excess benefit" tax on employer-sponsored health care coverage, beginning in 2018. This provision is often referred to as the "Cadillac tax," in reference to the high value of benefits provided by a number of employer health plans.

This provision is one of the key revenue drivers of the ACA, and beyond the initial legislation there has been little additional information provided about how the Cadillac tax will be implemented and operationalized. However, on Feb. 23, 2015, the IRS and U.S. Treasury issued Notice 2015-16, which is "intended to initiate and inform the process of developing regulatory guidance regarding the excise tax on high cost employer-sponsored health coverage."

While Notice 2015-16 did not provide us with all of the answers we have been seeking for the past five years, it did attempt to clarify some of the existing language, as well as suggesting some approaches to handle other aspects of the calculation. The notice was also very clear that Treasury and the IRS are very interested in receiving public comments to inform the proposed regulations. Comments were to be submitted by May 15, 2015. At the very least, the notice seems to indicate the government is moving full steam ahead to implement the Cadillac tax, so those employers that were maintaining status quo while holding out hope for a repeal or delay may need to change course.

The remainder of this section addresses the following key questions:

- Who has responsibility for calculating and paying the Cadillac tax?
- How is the amount of the Cadillac tax determined?
- What coverage is included in the calculation?
- How is the cost of coverage determined?
- What are the next steps?

Who has responsibility for calculating and paying the Cadillac tax?

In terms of calculating the tax, the responsibility falls on the employer to both calculate the amount of the excess benefit and notify the HHS secretary and each "coverage provider" of the amount. For multiemployer plans, the plan sponsor is required to perform the calculations and provide the notice to coverage providers.

Ultimately, it is the responsibility and liability of the coverage provider to pay the tax. However, there has been some confusion as to what entity actually bears this responsibility. While it seems clear that, in a fully insured plan, it is the insurance provider that will pay this cost, the language regarding self-insured plans is less straightforward, noting "the person that administers the plan benefits" will be liable for paying the tax, which is further defined to include the plan sponsor if the plan sponsor administers benefits under the plan.

Regardless of what entity ultimately pays the tax, the expectation is that any payable tax will ultimately flow back to the employer in the form of higher insurance rates and/or administrative expenses, even if it is the third-party administrator (TPA) or insurance carrier that is responsible for paying the tax.

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How is the amount of the Cadillac tax determined?
At its most basic level, the tax will be determined as follows:

- For any employee with an "excess benefit," the employer will pay an amount equal to 40 percent of the excess benefit.
- The excess benefit is defined as the monthly cost of the applicable employer-sponsored coverage of the employee less one-twelfth of the annual limitation.
- The annual limitation is defined as:
  - $10,200 for an employee with self-only coverage
  - $27,500 for an employee with coverage other than self-only.

Additionally, there are some potential adjustments to the annual limitation to consider, such as:

- **The health cost adjustment percentage.** If the percentage by which the per employee cost for providing coverage under the Blue Cross/Blue Shield (BCBS) standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010 by more than 55 percent, the excess of that amount will be used to increase the annual limitation.
  - For example, if the BCBS standard benefit option increases by 65 percent from 2010 to 2018, the health cost adjustment percentage will be 110 percent (100% + 65% - 55%), and the annual limitations would be $11,220 and $30,250 for self-only and other-than-self-only coverage, respectively.
  - Through 2015, the BCBS standard benefit option has increased by only 18 percent over 2010, which seems to indicate there will be no adjustment for this factor.
- **Age and gender adjustment.** After any application of the health cost adjustment percentage, if the premium for the BCBS standard benefit option for the age and gender characteristics of the employer is greater than the premium determined for the age and gender characteristics of the national workforce, then the excess amount would also be used to calculate the annual limitation.
  - It should be noted that there is very little information available regarding the exact methodology to be used for this adjustment. However, Notice 2015-16 is seeking comment regarding this provision.
- **Exception for qualified retirees and those engaged in high-risk professions.** For these individuals, the dollar amounts noted above are increased by $1,650 for self-only coverage and $3,450 for other-than-self-only coverage, resulting in the following amounts:
  - $11,850 for an employee with self-only coverage.
  - $30,950 for an employee with coverage other than self-only.
  - It should also be noted that these amounts cannot be stacked (i.e., a qualified retiree who was engaged in a high-risk profession would only receive one adjustment, not both).
  - A qualified retiree is defined as an individual who is receiving coverage by reason of being a retiree, has attained age 55, and is not entitled to benefits or eligible for enrollment under the Medicare program.
  - While some high-risk professions have been clearly identified (e.g., those who repair or install electrical or telecommunications lines, law enforcement officers, paramedics), there is still uncertainty regarding what other professions may qualify as high-risk. Notice 2015-16 is seeking comment on this topic as well.

After 2018, the annual limitation (including the health cost adjustment percentage and exception for retirees and high-risk professions) will be equal to the prior year's annual limitation increased by the consumer price index (CPI), with the exception of 2019 where the increase will be the CPI plus 1 percent, rounded to the nearest $50.

One additional key note is that, with respect to the annual limitation, any coverage provided under a multiemployer plan will be treated as other-than-self-only coverage.

What coverage is included in the calculation?
The definition of applicable employer-sponsored coverage is "coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106)."

The term "group health plan" refers to a plan (whether self-insured or fully insured) that provides health care (directly or otherwise) to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship or their families. In addition, it does not make a difference whether the employer or the employee pays for the coverage, and the full amount of the benefit is includable in the calculation.

While the regulations regarding what's in and what's out are very detailed, complex, and require a significant amount of research to understand, we can attempt to boil it down to the most basic level that most employers would be concerned about. In general, the most significant items employers and multiemployer plans should be

concerned about are the following:

- Medical and pharmacy coverage
- Tax-free contributions to accounts (flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), health savings accounts (HSAs) and medical savings accounts (MSAs))
- Dental and vision coverage, if they are attached to the medical plan election
- Coverage for on-site clinics (if not de minimis)
- Executive physical programs.

Notice 2015-16 addresses a number of these items and over the next couple of years the details will be worked out. As it stands today, in early 2015, as employers assess their potential liabilities, the focus will be on the items listed above.

How is the cost of coverage determined?

According to the regulations, the cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), which apply for purposes of determining the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applicable premium. However, any portion of the cost that is attributable to the excise tax cannot be taken into account. The regulation also states that the amount shall be calculated separately for self-only coverage and other-than-self-only coverage.

While the ACA only dedicated about a half-page to this discussion of determination of cost, Notice 2015-16 dedicated nearly 11 pages to the discussion of this topic. Some of the most important topics addressed in the notice are the following:

- A discussion of the two methods prescribed under the COBRA regulation, which are:
  - The actuarial basis method
  - The past cost method.
- A suggested approach to prevent abuse of switching between methods.
- A discussion of whether there should be specific standards or factors that need to be satisfied, and whether assumptions and methods should be prescribed under these two methods.
- Confirmation that "applicable coverage" is based on coverage in which the employee is enrolled, rather than coverage offered to the employee but in which the employee does not enroll.
- A discussion of how to determine which enrollees are "similarly situated," including:
  - Separating employees by benefit package election
  - "Mandatory disaggregation" into self-only and other-than-self-only coverage
  - "Permissive aggregation" in the other-than-self-only bucket, i.e., combining employee + spouse, employee + child(ren), and family tiers together
  - The potential for "permissive disaggregation" into other categories, such as collective bargaining status or bona fide geographic distributions.
- A discussion regarding the appropriate methodology to determine HRA costs.
- A discussion of the determination period.

To summarize, although a number of unknowns remain in terms of determination of cost, Notice 2015-16 provides a great deal of insight regarding the key issues that still need to be addressed. For the time being, we expect plans will continue to evaluate costs in a COBRA-like manner until the comments are sorted out and proposed regulations are developed.

With respect to retirees, whatever the ultimate guidance on aggregating plans for excise tax, there will be no impact on the requirements for financial statement determinations of liability—calculations will still need to reflect the "true" cost of the plan for each participant.

What are the next steps?

Employers and actuaries have waited five years for guidance on how the Cadillac tax will be implemented. With the release of Notice 2015-16, some additional insight has been gained, but many questions still remain. First and foremost, there was an opportunity to submit comments about the notice in an attempt to help shape the proposed regulations and future guidance. But most importantly, for employers, the window to implement a long-term cost containment strategy is closing. In less than two years from now (early 2017), employers will be working toward finalizing their 2018 benefits program offerings. While a number of employers have been focused on this issue over the past few years (and simply need to stay the course), those who were taking a "wait and see" approach just received a clear indication that waiting is no longer a prudent alternative. ■

ENDNOTE

[1] Rowen Bell authored the sections of the article discussing reinsurance contribution and the health insurer fee. Mike Gaal authored the section discussing the excise tax on high-cost plans.

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