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Todd A. Zigrang, MBA, MHA, ASA, FACHE, Publisher • Jessica L. Bailey, Esq., Editor ©

ACA's Cadillac Tax Delayed Until 2020

As a sign of the continued evolution of healthcare reform, on December 18, 2015, President Barack Obama signed the *Consolidated Appropriations Act, 2016* into law,[1] which delayed the implementation on the excise tax on high-cost employer health benefits packages, known as the "*Cadillac Tax*," from 2018 until 2020.[2] Since its inclusion into the *Patient Protection and Affordable Care Act* (ACA), the "*Cadillac Tax*," meant to help curb healthcare spending through employer-sponsored health insurance, has faced heavy opposition from legislators, as well as many employers who would bear the brunt of the excise tax.[3] While many legislators and employers in opposition to this excise tax are seeking to transform the two-year delay on the implementation of this noteworthy ACA provision into full repeal,[4] other market forces may already be driving many employers to reduce the costs associated with their benefits plans, which could affect overall healthcare spending and ultimately achieve the goals behind this controversial ACA provision.[5] This Health Capital Topics article will detail the basics of the "*Cadillac Tax*," present the reaction of employers and others in the healthcare industry on the provision's two-year delay, and discuss how, even with the implementation delay, employers are nevertheless modifying healthcare benefits packages for their employees and its ultimate impact on healthcare expenditures.

Section 9001 of the ACA, entitled, "*Excise tax on high cost employer-sponsored health coverage*,"[6] created a 40 percent *excise tax* against employees with *high-cost health coverage*, i.e., an employer-sponsored health insurance plan that provides the employee *excess benefit* above certain thresholds.[7] These thresholds include the following: (1) for employees possessing self-only coverage, the product of $10,200 and the health cost adjustment percentage for such employees based on cost of living; and, (2) for employees possessing any other type coverage, the product of $27,500 and the health cost adjustment percentage for such employees based on cost of living.[8] Certain exceptions apply to these threshold cost figures, including long-term care coverage, disability income insurance, fixed indemnity insurance, and coverage for a particular disease or illness.[9] According to March 2015 financial projections from the *Congressional Budget Office* (CBO) and the *Joint Committee on Taxation* (JCT), the "*Cadillac Tax*" would raise a total of $70 billion in revenue from 2016 to 2025, a decrease from its previous estimate of $144 billion.[10]

At the time of passage of the ACA, the primary purposes behind the "*Cadillac Tax*" were: (1) to generate revenue for the federal government needed for funding provisions the ACA;[11] and, (2) to ameliorate rising healthcare costs by incentivizing employers to provide more cost-effective health insurance.[12] The need to generate revenue to cover other ACA initiatives, including Medicaid expansion and the creation of health insurance exchanges, was, and continues to be, substantial. At the time of the ACA's passage in 2010, full implementation of the law was estimated to cost over $900 billion by 2019.[13] From 2016-2015, the CBO and JCT estimated that full implementation of the ACA is expected to "*result in a net cost to the federal government of $1,207 billion.*"[14] However, the CBO and JCT noted the potential volatility in its projections, due to likely changes in private health insurance spending on the exchanges.[15] While potential volatility in private health insurance spending on the exchanges may impact implementation costs, proponents of the *Cadillac Tax* argue that the tax would help curtail the growth of health expenditures by incentivizing employers to keep the costs of their employer-sponsored health plans below the tax threshold.[16] Currently, employer payments that cover premiums for employee-related health insurance policies are exempt from federal income taxes as an exclusion from gross income.[17] Many economists believe that this tax exclusion for employer-sponsored health insurance resulted in an overutilization of healthcare services, which helped drive the growth in *national healthcare expenditures* (NHE).[18] As support, economists note that total NHE in the U.S. have risen consistently, averaging 9.3% annual growth from 1960 to 2012, reaching a projected $3.2 trillion in 2015.[19] Further, NHE per capita has steadily increased over the last several years; NHE per capita is projected to reach $10,125 in 2015, and $15,618 by 2024.[20]

Opponents of the "*Cadillac Tax*" argue that, in the process of curbing healthcare spending, the excise tax will incentivize employers to shift the tax burden to workers through increased deductibles and co-payments,[21] which may negatively affect low-income workers, who often lack disposable income, and the

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chronically ill, who most utilize health benefits.[22] By 2023, the percentage of employers with at least one health plan that would trigger the "*Cadillac Tax*" amounts to an estimated 30%; by 2028, this percentage is estimated to increase to 42%.[23] Many employers whose employee health-benefit plans are likely to be subject to this excise tax have expressed a willingness to modify these plans in order to avoid liability under the "*Cadillac Tax*."[24] As discussed in the August 2015 *Health Capital Topics* article, entitled "*King v. Burwell: What's Next?*", a *Towers Watson* report estimated that 62% of companies facing potential tax liability under the "*Cadillac Tax*" are working to alter their coverage provisions to avoid this tax liability.[25] In an effort to avoid liability under this excise tax, opponents fear that employers will be motivated to increase employee cost-sharing requirements.

It should be noted that the prevalence of employee cost-sharing, a central concern of opponents of the "*Cadillac Tax*," is already increasing for reasons independent of the controversial provision. The potential of the "*Cadillac Tax*" has contributed, but only in part,[26] to the shift from the traditional U.S. employer health coverage system of "*defined benefits*" (where employers provide a package of defined benefits to their employees) to a system of "*defined contributions*" (where employers contribute a set amount and then require employees to decide how much of their health benefit dollars to spend by selecting from a range of benefit plans).[27] Due to rising NHE, employers already were seeking to limit their exposure to potential double-digit health insurance premium rate increases in order to sustain certain levels of benefits.[28] In an effort to avoid bearing the brunt of increased premiums, employers began requiring a greater share of health benefits costs from employees, through high deductibles, coinsurance, and co-payments.[29] While the consumer is becoming increasingly responsible for healthcare spending, these alterations to employer health benefits packages may lead to decreased overall NHE; a March 2015 paper released by the *National Bureau of Economic Research* noted that employers offering high-deductible health plans saw reduced growth in healthcare spending.[30] However, this reduction may be fleeting, as questions have been raised as to whether this reduced growth in healthcare spending stems from foregone care, such as preventive care, which may later require the provision of more expensive healthcare services, such as a hospital visit.[31]

The future of the "*Cadillac Tax*" – and its ability to produce revenue to cover other provisions of the ACA – remains uncertain In light of the December 2015 delay of the "*Cadillac Tax*," as well as a recent modification by the Obama administration looking to modify the statutory tax thresholds to regional "*gold*" level thresholds on the health insurance exchanges.[32] Despite this uncertainty, many employers have already instituted efforts to reduce the costs associated with their healthcare benefits packages. It remains to be determined whether these reductions in healthcare spending growth, through increased employee cost-sharing, reflect a short-term trend of relatively marginal NHE growth, or a long-term decline in healthcare spending growth.[33] The ultimate fate of the "*Cadillac Tax*" – including delay, repeal, or implementation[34] – could have a substantial impact on the answer to the overall problem of rising NHE.

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Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, serves as Chief Executive Officer of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Master in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Institution of Chartered Surveyors (FRICS – Royal Institution of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, and is the author of several books, the latest of which include: "*Adviser's Guide to Healthcare – 2nd Edition*" [2015 – AICPA]; "*Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services*" [2014 – John Wiley & Sons]; "*Accountable Care Organizations: Value Metrics and Capital Formation*" [2013 - Taylor & Francis, a division of CRC Press]; and, "*The U.S. Healthcare Certificate of Need Sourcebook*" [2005 - Beard Books].

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS).

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of the "*Adviser's Guide to Healthcare – 2nd Edition*" [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).

John R. Chwarzinski, MSF, MAE, is Senior Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC). Mr. Chwarzinski's areas of expertise include advanced statistical analysis, econometric modeling, as well as, economic and financial analysis. Mr. Chwarzinski is the co-author of peer-reviewed and industry articles published in *Business Valuation Review* and *NACVA QuickRead*, and he has spoken before the Virginia Medical Group Management Association (VMGMA) and the Midwest Accountable Care Organization Expo.

Mr. Chwarzinski holds a Master's Degree in Economics from the University of Missouri – St. Louis, as well as, a Master's Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. He is a member of the St. Louis Chapter of the American Society of Appraisers, as well as a candidate for the Accredited Senior Appraiser designation from the American Society of Appraisers.

Jessica L. Bailey-Wheaton, Esq., is Senior Counsel of **HEALTH CAPITAL CONSULTANTS** (HCC), where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey is a member of the Missouri and Illinois Bars and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law, where she served as Fall Managing Editor for the *Journal of Health Law & Policy*.

Kenneth J. Farris, Esq., is a Research Associate at **HEALTH CAPITAL CONSULTANTS** (HCC), where he provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services, and tracks impact of federal and state regulations on healthcare exempt organization transactions. Mr. Farris is a member of the Missouri Bar and holds a J.D. from Saint Louis University School of Law, where he served as the 2014-2015 Footnotes Managing Editor for the *Journal of Health Law & Policy*.