Bloomberg BNA

Health Insurance Report™

VOL. 18, NO. 40 OCTOBER 10, 2012

Cadillac Tax Could Jeopardize the Viability of Employer-Based Plans

BY MARK LUTES AND ADAM SOLANDER

It has been roughly two-and-a-half years since the Affordable Care Act ("ACA") was enacted. Since that time, employers have focused primarily on the immediate compliance and implementation issues, as well as preparing their health benefit plans for 2014, when a majority of the law's employer-centric provisions take effect. This focus on compliance, while necessary, may have caused some employers to lose sight of what may be the issue with the greatest long-term impact on their health benefit plans. To date, the "Cadillac Tax" provision, which is one of ACA's principal "Pay Fors," has been largely ignored. While its 2018 implementation date may appear distant, it is time for employers to act to lower costs and avoid the tax.

Lutes is a member of the firm in Epstein Becker & Green PC's Health Care and Life Sciences practice, in the Washington office. He may be reached at mlutes@ebglaw.com. Solander is an associate in Epstein Becker & Green PC's Health Care and Life Sciences practice, in the Washington office. He may be reached at asolander@ebglaw.com. For more information about Epstein Becker & Green PC, visit http://www.ebglaw.com.

I. Cadillac Tax

In 2018, employers with plan costs that exceed statutorily defined thresholds will be subject to a 40 percent nondeductible tax on plan costs in excess of such thresholds. In 2018, the thresholds are set to $10,200 for single coverage or $27,500 for family coverage. By way of example, if the cost of family coverage in an employer's plan is $28,000 in 2018, the employer will be subject to a 40 percent tax on the amount in excess of the thresholds, or $500.

While the thresholds are indexed for inflation, such indexing is based on the consumer price index, which has a historically slower growth rate than medical inflation. As a result, most employers can expect their plan costs to grow at a higher proportional rate than the thresholds and, at some point; most employers' plan costs will exceed the thresholds.

II. A Tough Pill to Swallow

For employers with plan costs that will exceed the Cadillac Tax thresholds, the continued provision of health benefits will be a "tough sell" to the C-suite. The tax's impact will run counter to the traditional tax-advantaged and employee-focused psychology supporting current benefit plans. For affected employers, the tax will grow in amount each year, and thus the amount spent each year on health benefits will grow dispropor-

COPYRIGHT © 2012 BY THE BUREAU OF NATIONAL AFFAIRS, INC. ISSN 2154-8986

tionately without providing additional benefits to employees.

To date, the ''Cadillac Tax'' provision, which is one of ACA's principal ''Pay Fors,'' has been largely ignored. While its 2018 implementation date may appear distant, it is time for employers to act to lower costs and avoid the tax.

Many employers will plan to cut the ''richness'' of their plans, and thus the cost of their benefit package, to avoid the Cadillac Tax. Yet this strategy will erode one of the primary benefits of self-funded benefit plans. By cutting the ''richness'' of plan benefits each year, employers will quickly lose the ability to tailor their plan to meet the unique needs of their populations. If a self-funded plan does not address specific issues within the employer's population, the effectiveness of the benefit program will decrease and metrics of effectiveness, such as employee absenteeism and productivity, will begin to erode.

Further, one of the traditional justifications employers have relied on for the provision of health benefits has been the tax benefit the employer receives for the benefits it provides. The Cadillac Tax limits the tax-preferred status of an affected employer's benefit spending. Simply put, should the Cadillac Tax be triggered for a given employer, there are strong arguments that the amount spent on health benefits would be better spent in ways that benefit the employer and employee. This rationale will only be strengthened by the fact that employers can discontinue the provision of health benefits and only be subject to a $2,000 per employee penalty under the employer mandate—arguably a cheaper and less burdensome route for the employer.

III. Solutions

Though it creates this looming liability for employers, ACA also provides several potential tools through which employers might improve their employees' health and lower plan costs potentially sufficiently to address cost escalation that might trigger the Cadillac Tax. The likely solutions also have the byproduct of improving the health, and, consequently, the productivity of workers.

ACA provides opportunities to employers in two ways. First, ACA Medicare value-based purchasing has created an environment whereby providers are more willing to move from traditional fee-for-service and be paid for care based on the quality of the care they provide. Additionally, ACA increased the amount of incentive an employer can provide to an employee, up to 30 percent of premiums, for participation in a wellness program.

Together, these developments allow employers to incent high-cost employees to address their health issues in partnership with health care providers who are becoming better prepared to handle the costly chronic conditions that have driven up costs for self-funded plans.

a. Employer Value-Based Purchasing

In the Medicare context, ACA emphasizes the idea of the Accountable Care Organization (''ACO''). At its most basic level, an ACO comprises providers who agree to take financial and quality responsibility for a population of Medicare beneficiaries. In return for this increased role, the provider agrees to be paid, at least in part, based on the quality and cost of the outcomes achieved and not the number of procedures performed. For high quality providers, these arrangements can increase compensation.

Prudent employers are beginning to seize upon the work being done in the Medicare arena, and are directly, or through an intermediary, engaging providers who are willing to install, or already have, systems in place to be paid based on the quality of the care they provide and on reducing the total expense of care of a population.

Prudent employers are beginning to seize upon the work being done in the Medicare arena, and are directly, or through an intermediary, engaging providers who are willing to install, or already have, systems in place to be paid based on the quality of the care they provide and on reducing the total expense of care of a population. This approach allows those employers to target specific cost drivers in their health plans by holding providers ''accountable,'' using cost and quality metrics, for the care they provide.

For a typical employer-sponsored plan, there are a handful of disease states that account for a disproportionate amount of overall costs. Because employers do not have the bandwidth of a government program, it is important that employers target their efforts to address the health care conditions that have the biggest opportunity for return on investment.

In selecting conditions to address with this methodology, employers will want to consider:

- the cost of the disease condition to the plan;

To request permission to reuse or share this document, please contact permissions@bna.com. In your request, be sure to include the following information: (1) your name, company, mailing address, email and telephone number; (2) name of the document and/or a link to the document PDF; (3) reason for request (what you want to do with the document); and (4) the approximate number of copies to be made or URL address (if posting to a website).

- whether the amount spent on plan beneficiaries with the condition can be affected by new care paths and more active management by physician-directed teams of nurses, health coaches, nutritionists and others;
- whether metrics exist by which to grade the quality of the care provided; and
- whether the outcome metrics are widely accepted by providers so that contract incentives around such metrics will be feasible.

After the employer has identified several of the cost-driving conditions in its plan, the employer will likely follow one of two popular approaches to engage providers in addressing them.

The first is the ''direct contracting'' approach whereby an employer, either through a request for proposalprocess or direct negotiation with a group of providers, translates the quality and cost metrics into contractual language. Under this model, the provider typically takes responsibility for the care of a subpopulation of employees with the specified disease condition and a portion of compensation is based on the amount of savings achieved relative to that population.

The second approach to employer value-based purchasing is through negotiation with a third-party administrator or insurer. This approach is more hands off. At contract negotiation time, the employer negotiates terms requiring the TPA or insurer to reduce costs and address quality with respect to certain disease conditions. Failure to meet these targets will result in a penalty of some sort. Thus, the employer relies on the TPA or insurer to design the program.

The downside to both approaches has been that many employers do not have enough covered lives/employees in any one area to cost-effectively negotiate with, or to make the endeavor worthwhile for, the provider group or the insurer/TPA. As a result, most examples of value-based purchasing have occurred at the state or municipal government level where plan beneficiaries are geographically concentrated or at the largest employment centers of multistate employers.

In order to address this lack of negotiating power, some employers are joining health care purchasing coalitions or purchasing insurance through other aggregating structures (e.g., corporate exchanges). The purpose of these aggregating structures is, for the most part, to harness the economies of scale and get a better deal on the care they purchase.

It is important to note however that, if these aggregating structures simply negotiate better fee-for-service prices, they are not addressing the volume issues, the total cost of care, or inefficient care patterns. Simply put, they are still buying inefficient unaccountable care; they are just buying it at a discounted price.

Further, in the TPA setting, employers must be careful that they are contracting for the care pattern change that they seek. If the employer plan is of sufficient size, the administrative services only (ASO) vendor may be willing to enter the contract and treat the value-based penalty as a discount without seriously trying to effect new care patterns that the plan hopes will produce savings.

Regardless of the contracting route pursued, if employer plans are to be viable post-2018, employers must rethink their approaches to disease and case management. Self-funded employers must also change the way they pay for care, paying for value over volume, so that plan costs can be contained and employee presenteeism can improve.

b. Incentives

In addition to creating an environment where providers may be willing to change the way in which they are paid to address total cost of care as well as quality, ACA also provides a method for engaging employees in the chronic care management and other systems that providers are creating to address their health concerns. ACA allows employers to provide their employees with incentives, valued at up to 30 percent of their premiums, in return for participation in an employer-sponsored wellness program.

Prudent employers will use this provision as a way in which to incent those portions of their populations that drive the greatest percentage of costs to accept care management from provider groups that have implemented specialized programs to address the utilization patterns of those with such chronic conditions. Wellness programs that incent participation in the active chronic care management programs of local providers will provide the foundation for the self-funded plan's success in improving quality and addressing costs in advance of the looming Cadillac Tax.

IV. Takeaway—ACA's Hidden Opportunities

It is often argued that ACA jeopardizes the future of the employer-provided health care system. Certainly the looming Cadillac Tax will be one ACA-induced reason for employers to revisit the cost and outcomes of self-funded benefit plans.

However, in considering how to address the Cadillac Tax exposure, plan sponsors should pay attention to the other ''game changers'' arising out of ACA.

Specifically, thanks to the value-based purchasing being done by Medicare and Medicaid, self-funded plans can now buy health care and disease management services directly from provider systems utilizing methodologies that address the total cost of care for specific populations and its quality. When this strategy is supported by wellness plan designs, there are real opportunities for improvement in the value of self-funded plan expenditures.

Perhaps the Cadillac Tax can be looked on as a galvanizing event—an event of sufficient magnitude to command C-suite attention and interest in solutions that go beyond telephonic disease management and mere volume discounts—solutions that create, in partnership with local providers, new patterns of care that effectively deploy the self-funded plan's assets.