
Assessing proposed geography-based adjustments to the ACA's excise tax on high-cost plans

An addendum to Milliman's December 2014 report: "What does the ACA excise tax on high-cost plans actually tax"

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EXECUTIVE SUMMARY

The Affordable Care Act's (ACA) 40% excise tax on high-cost employer-sponsored health coverage has been the subject of much debate among policymakers and industry stakeholders since the passage of the ACA in 2010. In 2014, Milliman was retained by the National Education Association (NEA) to assess the extent to which this excise tax actually taxes a health plan's benefits versus factors exogenous to the plan's benefits. When an alternate tax threshold methodology was proposed in February 2016, NEA once again retained Milliman to examine the proposal's impact on what would actually be taxed. This paper is intended to be an addendum to that original Milliman report.

As noted in our original report, the ACA's excise tax has the potential to penalize employer-sponsored health plans based on factors unrelated to plan design. In 2014, we found, "Unexpected consequences of the tax, therefore, include imposing a tax on moderate-benefit plans based primarily on geography, age, and gender, while failing to impose a tax on rich-benefit plans for the exact same reasons."¹ Recently, the Office of Management and Budget (OMB) and the Department of the Treasury released a methodology along with the proposed FY 2017 federal budget that intends to correct for the fact that tax liabilities could potentially be driven by geographic differences in health care costs. As the White House noted, the methodology was designed to "protect employers from paying the tax only because they are in high-cost areas."² The 2017 budget proposal did not address the original statute's inconsistent correction for the potential impact of age and gender on tax liabilities, another issue we documented in our original report.

There are two primary sets of challenges we see with the specific methodology. First, by using statewide average premiums, the methodology does not adequately address health care cost variations between or within states. Based on area factors calculated by Milliman, we demonstrate that underlying health costs can vary greatly both within and between states. The proposed methodology could in some circumstances lead to higher taxable thresholds for certain higher-cost states, but the upward adjustment of taxable thresholds, where they did exist, would not consistently account for the full impact on tax liabilities of geographic health care cost variations.

Second, the proposal establishes an alternate taxable threshold for each state that begins with the silver plans with the lowest premiums in the individual Marketplace. Such plans are vastly different from the high-cost plans in the employer-sponsored health coverage market that the excise tax is intended to address, creating a case of actuarial apples and oranges. While the methodology includes an adjustment for actuarial value differences (which, as proposed, could misstate the true differences in benefit level), several other issues persist as a result of basing each state's tax threshold on silver-level Marketplace products.

In short, the changes to the excise tax proposed with the FY 2017 federal budget do not effectively address the prevalence of geographic cost differences within or between states, and do not attempt to address other variations in cost based on age, gender, industry and other factors that are correlated with the cost of providing health coverage benefits.

¹ Dobson, R. & Rachlin, S. (December 9, 2014). What does the ACA excise tax on high-cost plans actually tax? Milliman client report. Page 1. Retrieved March 8, 2016, from https://www.nea.org/assets/docs/Milliman--What_Does_the_Excise_Tax_Actually_Tax.pdf.

² Office of Management and Budget. Budget of the U.S. Government: Fiscal Year 2017. Page 60. Retrieved March 8, 2016, from <https://www.whitehouse.gov/sites/default/files/omb/budget/fy2017/assets/budget.pdf>.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was enacted into law in March 2010. One of the provisions of the ACA is an excise tax on high-cost employer-sponsored health plans. The law provided for this tax to take effect in 2018; however, the provision was delayed until 2020 in December 2015 as part of a spending and tax bill. The excise tax is based on the aggregate cost of employer-sponsored coverage and is calculated as 40% of the cost over a specified threshold.

In a previously released paper,³ we explored the elements that go into premium determination for employer-sponsored health insurance in order to evaluate what the excise tax is actually taxing. We also illustrated the variability that results from each element, which in turn sheds light on the unintended consequences that will result from taxing based on premium levels. We did this by addressing the elements commonly included in a manual rating approach and evaluating the variability of each item using the Milliman Health Cost Guidelines™ (the Guidelines).

This paper serves as an addendum to our previously released paper and explores the administration's recently proposed adjustment to the tax. The adjustment attempts to factor in the geographic cost variation that exists in the United States.

While our previous paper discussed many issues related to the excise tax's calculation, only the geographic variability component of the excise tax's calculation was addressed by the administration's budget proposal. As such, this addendum only focuses on this issue; other sources of cost variation addressed in the original paper (such as age, gender, industry factors and group size factors) are not addressed by this proposed adjustment and therefore could continue to drive excise tax liabilities.

THE PROPOSED ADJUSTMENT

The proposed adjustment attempts to account for geographic cost variation; the excise tax as originally drafted does not account for whether or not a plan that exceeds the tax threshold operates in a higher-cost geographic area. Although the excise tax is intended to tax benefit richness, plans in high-cost areas are measured against the same threshold as plans in low-cost areas and are not necessarily on a level playing field in terms of benefit richness.

The proposed methodology to adjust for this is spelled out in the Office of Management and Budget's (OMB) Fiscal Year 2017 proposed budget.⁴ Page 60 of the budget states:

Improving the Excise Tax on High-Cost Employer Coverage. *The ACA included an excise tax on the highest-cost employer-sponsored health insurance plans to give employers an incentive to make those plans more efficient. The Budget proposes to modify the threshold above which the tax applies to be equal to the greater of the current law threshold or the average premium for a Marketplace gold plan in each State. This reform would protect employers from paying the tax only because they are in high-cost areas and ensure that the tax remains targeted at the highest-cost plans in the long term.*

³ Dobson, R. & Rachlin, S. (December 9, 2014). What does the ACA excise tax on high-cost plans actually tax? Milliman client report. Retrieved March 8, 2016, from https://www.nea.org/assets/docs/Milliman--What_Does_the_Excise_Tax_Actually_Tax.pdf.

⁴ Office of Management and Budget. Budget of the U.S. Government: Fiscal Year 2017. Retrieved March 8, 2016, from <https://www.whitehouse.gov/sites/default/files/omb/budget/fy2017/assets/budget.pdf>.

The Department of the Treasury further expands on the specific methodology that would be utilized to implement this proposal. Page 152 of the Treasury’s “General Explanations” document⁵ states:

To ensure that the tax is only ever applied to higher-cost plans, the proposal would increase the tax threshold to the greater of the current law threshold or a “gold plan average premium” that would be calculated and published for each State. The State average gold plan premium would be a weighted average of the premiums for the lowest-cost silver self-only Marketplace plans offered for each age and county in the State, multiplied by 8/7 to simulate the cost of an actuarially-equivalent gold plan. The threshold for family coverage would be constructed by multiplying the single-plan threshold by a ratio reflecting the current average relationship between single and family plan premiums. The threshold applicable to coverage provided by an employer would be based on the State of residency of its employees enrolled in coverage as of the beginning of the prior plan year (or a weighted average, for employers with employees in multiple States). The age and gender, occupation and retiree adjustments provided under current law would be added to the State gold plan threshold, in the same way that they are added to the current law threshold.

The budget proposal also addresses two other corrections to the excise tax calculation: a study on the potential effects on firms with unusually sick employees and a simplified calculation for employers offering flexible spending arrangements (FSAs). While these do indeed identify other potential issues with the original calculation of the excise tax, this paper is not addressing these topics.

Finally, it is important to note that this proposed adjustment will only have an impact in states where the weighted average of annual premiums of the lowest-cost silver self-only Marketplace plans—multiplied by 8/7—exceeds the current threshold of \$10,200 (plus inflation adjustments from 2018 to 2020). Predicting the prevalence of this adjustment by forecasting premiums in the individual market in 2020 is still subject to a great amount of uncertainty and is outside the scope of this report. Instead, this paper analyzes how well the proposed adjustment addresses the geographic variation issue discussed in our original report assuming it is implemented in a state. To the extent that Marketplace premiums in 2020 are low enough to not trigger this alternate methodology in a particular state, the issues discussed in the original report will remain in that state; that is, even if the alternative methodology would not lead to upward adjustments in the taxable thresholds in a state, tax liabilities in that state could still be driven by geography, age and gender among other factors.

ANALYZING THE PROPOSED GEOGRAPHIC ADJUSTMENT METHODOLOGY

Milliman’s original December 2014 report on the ACA excise tax pointed out that geographical area was the single manual rating factor with the largest variability⁶ that was not normalized for in the calculation of the tax threshold. The report also noted that age and gender, if unadjusted, can generate more variability than any other rating element. Age and gender are adjusted for in the original statute, though we found that the adjustment did not consistently correct for the impact of age and gender on premiums; geographic area, however, remained the single largest source of variation between an employer sponsor’s health plan costs and the tax threshold. This budget proposal is intended to alleviate the impact of the geography component.

⁵ Department of the Treasury. General Explanations of the Administration’s Fiscal Year 2017 Revenue Proposals. Retrieved March 8, 2016, from <https://www.treasury.gov/resource-center/tax-policy/Documents/General-Explanations-FY2017.pdf>.

⁶ Dobson, R. & Rachlin, S. (December 9, 2014). What does the ACA excise tax on high-cost plans actually tax? Milliman client report. Pages 8 and 13. Retrieved March 8, 2016, from https://www.nea.org/assets/docs/Milliman--What_Does_the_Excise_Tax_Actually_Tax.pdf.

The proposed adjustment recognizes that the excise tax should only apply to higher-cost plans on the basis of benefit richness and not on the basis of geography, as underlying healthcare costs can vary significantly by geographic area. When we use the area factors contained within the Milliman Health Cost Guidelines, we see that the magnitude of geographic health cost variation within a state can be even greater than the magnitude of geographic health cost variation between states. As a result, we find that the specific proposal—by using an assumed statewide gold plan average premium—does not accurately reflect the true nature of geographic health cost variations across the country.

For example, if a certain area of a state has underlying healthcare costs that are higher than the state average, this proposal will not calculate an adjusted threshold that reflects the degree to which this employer-sponsored plan's costs are higher due to its location. At the same time, if a similar cost area in a different state is at or below that state's average cost, the employer-sponsored plan in that state will be more likely to have an adjusted, higher threshold in their calculation for the excise tax. The end result is that health plans in similar-cost geographic areas in different states may now have an excise tax calculation based on different thresholds, depending on how much each area's costs differ from its state average.

This proposal if implemented could also create challenges for metropolitan areas that cross state borders but have a similar underlying cost throughout the region. For example, the Cincinnati metropolitan statistical area (MSA) spans parts of three states: Ohio, Kentucky and Indiana. Groups with all of their employees in the Cincinnati suburbs of northern Kentucky will not likely have complete relief from the higher Cincinnati area health costs because their statewide threshold is based on a Kentucky state average, where average costs are lower. Meanwhile an employer group in the Cincinnati suburbs of Indiana, on the other hand, would be taxed based on yet a different threshold.

In summary, employer-sponsored plans with enrollment concentrated in higher-cost areas within a state will be evaluated against a lower overall state average threshold and will likely face a higher tax than a plan with the same level of benefit richness in a more average or lower cost area of that state.

Figure 1 demonstrates how geographic cost differences would and would not be accounted for in the proposed methodology. The area factors are average commercial billed factors for all benefits by MSA taken from the 2016 Milliman Health Cost Guidelines (Guidelines), a nationally recognized reference tool that is used for manual rating, among other things such as benchmarking and pricing new products. While the authors recognize that managed care discounts can and typically do vary by region, it was deemed that the average billed area factors for the commercial market provided a reasonable measure to illustrate underlying health cost variation due solely to geography. The table shows how the methodology might impact four different types of states: those with low average cost and a low variation from smallest to largest area factor (e.g. Hawaii), high average cost/low variation (e.g. Nevada), low average cost/high variation (e.g. Virginia), and high average cost/high variation (e.g. Pennsylvania).

Figure 1. Geographic Cost Differences — Milliman Health Cost Guidelines™

Commercial Billed Area Factors for All Benefits by MSA

The greater the area factor difference between an MSA and the state average, the greater the potential for a geographic cost disconnect

State	Average Area Factor	Smallest Area Factor	Largest Area Factor	Increase from Average to Largest
Hawaii	0.69	0.67 (non-MSA areas)	0.70 (Urban Honolulu)	+1.45%
Nevada	1.16	0.96 (non-MSA areas)	1.22 (Las Vegas-Henderson-Paradise)	+5.17%
Virginia	0.90	0.74 (Winchester, VA-WV)	1.21 (Richmond)	+34.4%
Pennsylvania	1.12	0.70 (Gettysburg)	1.67 (Philadelphia)	+49.1%

The national average area factor in the Guidelines is 1.00. For a state such as Hawaii with a low average health cost as well as lower relative costs throughout the state, it is not as likely that the state average premiums will be high enough to trigger a higher threshold for calculating the tax. That may be acceptable in such a state, however, as each MSA in the state has a low average cost similar to the state average.

In a state such as Nevada where the population is concentrated in a higher-cost area, the proposed methodology is more likely to provide some geographic cost relief. Nevada’s commercial billed charges are 16% higher than the national figure on average, which one would expect to be reflected in the state’s average Marketplace premium. Billed charges in the Las Vegas MSA are on average only an additional 5.2% higher than the state average. This *additional* geographic variation from the state average would tend to not be accounted for in the state threshold and therefore plans in the Las Vegas area may still be subject to the 40% excise tax to some extent due to geographic variation, as the adjustment is likely not to be fully adequate for the highest cost parts of the state. Of course, if the calculated “gold plan average premium” remains below the statutory threshold, the original calculation will remain and there will still be no adjustment for geographic variation.

Health plans in states with a greater variation in underlying costs are potentially more exposed to the excise tax than the states mentioned above. In Virginia, although Richmond’s average commercial billed charges are 21% higher than the national average, Virginia’s billed charges as a whole are 10% lower than the national average. Therefore, it is not as likely that Virginia’s state average premium (even if weighted by membership in the state) would be high enough to generate an adjusted tax threshold in comparison with a higher-cost state like Nevada. In this case, employer-sponsored coverage in Richmond is more likely to face tax liabilities driven in part by geography-specific health care costs.

In Pennsylvania, Philadelphia’s average billed charge is 67% higher than the national average. However, the state average threshold would only be based on Pennsylvania’s average premiums, where underlying billed charges are only 12% higher than average. Billed charges in the Philadelphia MSA are almost 50% higher than the state average billed charges. This additional geographic variation from the state average would clearly not be accounted for in the Pennsylvania state threshold. So while the state as a whole would likely have a threshold that is adjusted upward,

plans in the Philadelphia area may still be subject to the 40% excise tax to some extent due to geographic variation, as the adjustment is likely not fully adequate for the plans in this part of the state.

It must be acknowledged that there are several other factors that influence a state's average premium under the proposed methodology beyond a state's average billed charges. Individual Marketplace premiums also contain varying levels of non-claim expense loads, discounts, and/or adjustments for narrower networks, among other things.

CALCULATING THE GOLD AVERAGE PLAN PREMIUM

In addition to the proposal to set the threshold to the greater of current law or a "gold plan average premium" for each state, there are also some potential issues regarding how this average premium is calculated. Below is a high-level summary of a handful of such potential issues.

- **Using adjusted lowest silver plan premiums as a proxy for average gold premiums may understate plan richness.** For several reasons other than actuarial value (AV), the lowest-priced silver plan in each market may not appropriately measure the benefit richness of average gold plans, even after adjusting for AV. The existence of cost-sharing subsidies for silver plans as well as the fact that the premium subsidies are based on the price of the second-lowest silver plan means that the lowest-priced silver plan in each market will be a tremendous value for highly subsidized Marketplace enrollees. This incentive may lead to increased price competition among issuers for silver plans or a greater variety of silver plans being offered with lower administrative fees, lower profit targets, or narrower networks (none of which are accounted for in AV). As a result, premiums used in the methodology could be abnormally low relative to underlying health care costs, leading to excise tax adjustments that could be lower than necessary to account for geography-specific health care costs.
- **Marketplace-based premiums are based on products that are fundamentally different from the employer market.** The budget proposal uses the individual Marketplace plans as the basis for this adjustment. There are several differences between the individual health insurance market and the employer-sponsored market. Most notably, the rating and underwriting rules of the ACA generally do not apply to the large employer and self-insured markets. Therefore, premiums from the individual market cannot consistently and reliably be used as a basis to generate accurate taxable thresholds for the employer market.
- **Weighting the state average by Marketplace enrollment in silver plans may skew the average.** Using the enrollment in individual market silver plans as the basis for determining the average gold premium presents a problem because silver plans will likely have a different enrollment distribution than gold plans or the employer-sponsored coverage market. As a result, employer-sponsored plans will be compared to an average that is calculated based on where individual silver plans are more prevalent by comparison. This would lead to a mismatch between geography-specific health care costs in these markets and, therefore, adjustments that do not necessarily compensate for those costs. In addition to a different geographic mix, individual Marketplace plans may have a very different age and gender mix of enrollees than typical employer-sponsored coverage, leading to another mismatch between premium adjustments and geography-specific health care costs.

- **The 8/7 adjustment does not account for all possible actuarial value variation.** The 8/7 adjustment is based on the 80% and 70% statutory AVs of gold and silver Marketplace plans, respectively. However, the allowed AV de minimis of +/- 2% means AVs could range from 78% to 82% and 68% to 72%, respectively. Since the methodology specifies the lowest-cost silver plan, it is likely that the lowest-cost silver plan lies more toward the low end of the allowed AV range, which means that an 8/7 adjustment may not be enough to fully quantify the AV difference between the lowest-cost silver plan and an average gold plan. To illustrate this, note that $.80/.70$ equals 1.1428, but $.82/.68$ equals 1.2059, which is over 5.5% greater than the 8/7 calculation. As plans will have different AV's within the allowable range in different markets, there is no single ratio that will produce an accurate adjustment across the country.
- **The 8/7 adjustment does not account for other pricing differences beyond actuarial value.** There are several reasons why plan premiums would vary beyond the calculated actuarial value. Plans typically have different provider networks, reimbursement levels, and/or administrative fee structures, all of which impact premiums between metal levels and between carriers. In addition, plans of different metal levels are often responsible for different levels of total healthcare costs beyond those measured purely by actuarial value. One example of this is utilization levels being influenced by the cost sharing design of the plan. Even for the same population, utilization of healthcare services tends to increase as cost sharing decreases (i.e., AV increases). For example, people are more likely to go to the doctor if their office visit copay is \$5 as opposed to \$25.

CONCLUSION

Overall, there are two primary issues with the proposed methodology that is intended to protect employers in high-cost areas from being subject to this excise tax on that basis. First, setting a single taxable threshold for each state ignores the reality of significant geographic cost variation within many individual states. Second, the use of low-cost silver individual Marketplace plans to develop the threshold for each state does not recognize the significant differences between these plans and high-cost employer-sponsored coverage that the excise tax is intended to address.

In addition to the two aforementioned issues with the proposed methodology, there are several other issues with the original excise tax calculation methodology that were mentioned in our original report. The budget proposal does not address any of these other concerns.

CAVEATS AND LIMITATIONS

The work was performed by Milliman as requested by the National Education Association (NEA). However, the opinions expressed in this paper are those of the authors and not necessarily those of the NEA or other Milliman consultants.

In order to provide the information requested by the NEA, we have used the Milliman Health Cost Guidelines. Differences between the Guidelines and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis.

The results of our analysis are based on our understanding of the excise tax statute and budget proposals. As of this writing, no regulations have been issued related to the statute, although regulators have released two notices on the topic. To the extent that regulations are promulgated, our work may be subject to change. Milliman is not a law firm. Nothing in this paper should be

construed as legal advice. In the event that a legal interpretation is required, we recommend review by your legal counsel.

The services provided for this project were performed under the consulting services agreement between Milliman and the NEA, effective June 2, 2014.

This work product was prepared for the NEA to assist in the understanding of the factors that drive premium rates for employer-sponsored health insurance plans subject to the ACA excise tax on high-cost plans. It may not be appropriate to use for other purposes. Milliman does not intend to benefit and assumes no duty of liability to other parties who receive this work product. Any third-party recipient of this work product who desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its own specific needs.