**High Cost Insurance Plans Excise Tax**

**Summary:** Levis an excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan that is above the threshold of $10,200 for single coverage and $27,500 for family coverage. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The tax would apply to the amount of the premium in excess of the threshold, multiplied by the health cost adjustment factor and increased by the age and gender excess premium amount. An additional threshold amount of $1,650 for singles and $3,450 for families is available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.

**Next steps:**
- January 1, 2018 – Provision goes into effect

**Additional information:**
- Health Affairs article on topic -- [http://content.healthaffairs.org/cgi/content/abstract/hlthaff.2008.0430v1](http://content.healthaffairs.org/cgi/content/abstract/hlthaff.2008.0430v1)

**Long summary:**

Sec. 9001. Excise tax on high cost employer-sponsored health coverage (as modified by sec. 1401 of HCERA).

Beginning in 2018, the Act imposes a nondeductible 40 percent excise tax on the “excess benefit” provided in any month under any employer-sponsored health coverage for an employee (including former employees, surviving spouses and other primary insured individuals).

**Definition of “employer-sponsored health coverage.”** Employer-sponsored health coverage is health coverage offered by an employer to an employee without regard to whether the employer provides the coverage or the employee pays the coverage with after-tax dollars. In the case of a self-employed individual, employer-sponsored health insurance coverage is coverage for which a deduction is allowable with respect to all or any portion of the coverage.
Definition of “excess benefit.” An excess benefit is a benefit the cost of which, on an annual basis, exceeds $10,200 a year for individuals or $27,500 for families, multiplied by the health cost adjustment factor and increased by the age and gender excess premium amount. The health cost adjustment factor is equal to 100% plus the amount, if any, by which the per employee increase in the cost of coverage under the Blue Cross/Blue Shield (BC/BS) standard benefit option under the Federal Employees Health Benefits Plan (FEHBP) for the period 2010 to 2018 exceeds 55% (using the 2010 benefits package). For 2019, the thresholds, as established for 2018, are indexed annually to the CPI-U plus one percentage point, rounded to the nearest $50. For 2020 and beyond, the thresholds are indexed to the CPI-U rounded to the nearest $50. The age and gender adjustment is equal to the amount by which the premium cost of the FEHBP BC/BS standard option priced for the age and gender of the employer's employees exceeds, if at all, such coverage priced for the age and gender of the national workforce.

Increased thresholds for certain individuals. Adjusts the threshold for the excise tax in the case of certain individuals, including retirees and “high risk” professions. For retired individuals over the age of 55 and for plans that cover employees engaged in high-risk professions, the threshold amount is increased by $1,650 for individual coverage and $3,450 for family coverage. In 2018, these threshold amounts will be indexed annually to the CPI-U plus 1 percentage point. After 2019, the threshold amounts will be indexed annually to CPI-U. Eligible retirees are those age 55 and older who are not Medicare eligible and are receiving employer-sponsored retiree coverage. Employees in high risk professions are defined as those working for an employer with a majority of employees engaged in a high risk profession or employed to repair or install electrical or telecommunications lines. High risk professions include law enforcement, fire protection, out-of-hospital emergency medical care, longshore work, construction, mining, agriculture (excluding food processing), forestry, and fishing. Retirees with at least 20 years employment in these professions are also eligible for the increased threshold. However, the threshold amount cannot be increased by more than $1,650 for individual coverage or $3,450 for family coverage, even if the individual would qualify for an increased threshold both on account of his or her status as a retiree over age 55 and as a participant in a plan that covers employees in a high-risk profession.

Aggregate cost. In determining the aggregate cost, all employer-sponsored health insurance coverage is taken into account, including coverage in the form of reimbursements under a Health FSA or an HRA, contributions to an HSA, and supplementary coverage (including on-site medical clinics offering more than a de minimis amount of medical care, and executive physical programs) without regard to whether the cost is paid by the employer (and excludable by the employee) or by the employee with after tax dollars. The following employer-sponsored coverage is not included: coverage for treatment of the mouth or eye provided under a separate policy, long term care insurance, accident/disability coverage, workers’ compensation insurance, general liability and automobile liability insurance, supplements to liability insurance, automobile medical insurance, credit-only insurance, and other similar medical care coverage that is secondary or incidental to other insurance. Specific disease or fixed hospital or other indemnity insurance is excepted unless any portion of the coverage is employer-provided. The value of coverage is calculated in same manner as that used to determine the COBRA premiums. Separate individual and family premiums must be calculated for this purpose. The value of an FSA is equal to the dollar amount of salary reduction for the year. To determine value for retirees, employers may treat pre-65 and post-65 retirees together. The excise tax is allocated among all insurers providing benefits to employees based on the ratio of the value of the benefits provided by the insurer to the total benefits provided by the employer to the employee. Employers are to notify insurers of the amounts subject to the excise tax; the insurers pay the tax to IRS.
**Coverage provider implications.** The excise tax is imposed proportionately on each coverage provider. To the extent that coverage is provided under an employer plan provided through insurance coverage, the issuer of the coverage is liable for the tax. The plan administrator must pay the tax in the case of a self-insured group health plan, a health flexible spending arrangement (FSA), or a health reimbursement arrangement (HRA). The employer must pay with respect to employer contributions to a health savings account (HSA) or medical savings account (MSA).

**Penalties for undervaluing.** Employers will be penalized for undervaluing the insurance cost subject to the excise tax. The penalty will equal the amount of any additional excise tax that the insurer or administrator would have owed if the employer had reported correctly, plus interest to be accrued from the date the tax otherwise would have been paid to the date the penalty is paid. All of part of the penalty may be waived by the Secretary of Treasury for showing reasonable cause or if a correction is made within 30 days.

**Effective date.** The high-cost plan excise tax applies to taxable years beginning after December 31, 2017.

**Legislative text:**

SEC. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.
(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1513, is amended by adding at the end the following:

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"SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER‐SPONSORED HEALTH COVERAGE."
"(a) IMPOSITION OF TAX.—If—"
"(1) an employee is covered under any applicable employer‐sponsored coverage of an employer at anytime during a taxable period, and"
"(2) there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit."
"(b) EXCESS BENEFIT.—For purposes of this section—"
"(1) IN GENERAL.—The term ‘excess benefit’ means, with respect to any applicable employer‐sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.
"(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—"
"(A) the aggregate cost of the applicable employer‐sponsored coverage of the employee for the month, over"
"(B) an amount equal to 1⁄12 of the annual limitation under paragraph (3) for the calendar year in which the month occurs.
"(3) ANNUAL LIMITATION.—For purposes of this subsection—"
"(A) IN GENERAL.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.
"(B) APPLICABLE ANNUAL LIMITATION.—"
"(i) IN GENERAL.—Except as provided in clause (ii), the annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.
"(ii) MULTIEmployER PLAN COVERAGE.—Any coverage provided under a multiemployer plan (as defined in section 414(f)) shall be treated as coverage other than self-only coverage.
"(C) APPLICABLE DOLLAR LIMIT.—"
"(i) 2018.—In the case of 2018, the dollar limit under this subparagraph is—"
"(I) the percentage by which the per employee cost for providing coverage under the Blue Cross/ Blue Shield 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, over"
"(II) 55 percent.
"(ii) HEALTH COST ADJUSTMENT PERCENTAGE.—For purposes of clause (i), the health cost adjustment percentage is equal to 100 percent plus the excess (if any) of—"
"(I) the percentage by which the per employee cost for providing coverage under the Blue Cross/ Blue Shield 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, over"
"(II) 55 percent.
"(iii) AGE AND GENDER ADJUSTMENT.—"
"(I) IN GENERAL.—The amount determined under subclause (I) or (II) of clause (i), whichever is applicable, for any taxable period shall be increased by the amount determined under sub- clause (II).
"(II) AMOUNT DETERMINED.—The amount determined under this subclause is an amount equal to the excess (if any) of—"
"(aa) the premium cost of the Blue Cross/ Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the type of coverage provided such individual in such taxable period if priced for the age and gender characteristics of all employees of the individual's employer, over"
"(bb) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce.
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“(iv) EXCEPTION FOR CERTAIN INDIVIDUALS.—In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—

“(I) the dollar amount in clause (i)(I) shall be increased by $1,650, and

“(II) the dollar amount in clause (i)(II) shall be increased by $3,450, sic-final punctuation incorrect;

“(v) SUBSEQUENT YEARS.—In the case of any calendar year after 2018, each of the dollar amounts under clauses (i) (after the application of clause (ii)) and (iv) shall be increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—by

“(I) such amount as so in effect, multiplied

“(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for ‘1992’ in subparagraph (B) thereof), increased by 1 percentage point in the case of determinations for calendar years beginning before 2020. If any amount determined under this clause is not a multiple of $50, such amount shall be rounded to the nearest multiple of $50.

“(c) LIABILITY TO PAY TAX.—

“(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

“(2) COVERAGE PROVIDER.—For purposes of this subsection, the term ‘coverage provider’ means each of the following:

“(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer.

“(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

“(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan.

“(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider’s applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—

“(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

“(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

“(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—

“(A) IN GENERAL.—Each employer shall—

“(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable share of such excess benefit for each coverage provider, and

“(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

“(B) SPECIAL RULE FOR MULTIEmployer PLANS.—In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).

“(C) APPLICABLE EMPLOYER-SPONSORED COVERAGE; COST.—For purposes of this section—

“(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—

“(A) IN GENERAL.—The term ‘applicable employer-sponsored coverage’ means, with respect to any employee, 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 section 106).

“(B) EXCEPTIONS.—The term ‘applicable employer sponsored coverage’ shall not include—

“(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1) (other than subparagraph (G) thereof) or for long-term care, or As revised by section 10901(b)(4)

“(ii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(j) is not allowable.

“(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

“(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(j) with respect to all or any portion of the cost of the coverage.

“(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

“(2) DETERMINATION OF COST.—

“(A) IN GENERAL.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

“(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

“(i) the amount of employer contributions under any salary reduction election under the arrangement,

“(ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

“(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal
to the amount of employer contributions under the arrangement.

"(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to months in a taxable period on such basis as the Secretary may prescribe.

"(E) EMPLOYEE.—The term 'employee' includes any former employee, surviving spouse, or other primary insured individual. As added by section 1401(a)(5) of HCRERA

"(f) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

"(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

"(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4)) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

"(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the under-payment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

"(2) LIMITATIONS ON PENALTY.—

"(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

"(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

"(i) such failure was due to reasonable cause and not to willful neglect, and

"(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

"(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

"(D) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

"(2) QUALIFIED RETIREE.—The term 'qualified retiree' means any individual who—

"(A) is receiving coverage by reason of being a retiree,

"(B) has attained age 55, and

"(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

"(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The term 'employees engaged in a high-risk profession' means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b))), determined without regard to paragraph (2) thereof, and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment. As revised by section 10901(a)

"(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1).

"(5) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—

"(A) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

"(B) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term by section 9832(b)(2).

"(6) PERSON THAT ADMINISTERS THE PLAN BENEFITS.—The term 'person that administers the plan benefits' shall include the plan sponsor if the plan sponsor administers benefits under the plan.

"(7) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

"(8) TAXABLE PERIOD.—The term 'taxable period' means the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes.

"(9) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

"(10) DENIAL OF DEDUCTION.—For denial of a deduction for the tax imposed by this section, see section 275(a)(6).

"(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this section.

"(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code, as amended by section 1513, is amended by adding at the end the following new item:

"Sec. 4980I. Excise tax on high cost employer-sponsored health coverage."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2017.