Health Care Reform Advisory: Assessing the Impact of Federal Health Care Reform on Employers and Employer-Sponsored Group Health Plans

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On March 21, 2010, the U.S. House of Representatives adopted without change the Patient Protection and Affordable Care Act (H.R. 3590), which was passed by the U.S. Senate on December 24, 2009. At the same time the House also passed the Health Care and Education Reconciliation Act of 2010, which includes a series of amendments to H.R. 3590 previously negotiated and agreed upon by the Democratic leadership of the House and Senate. The resulting overhaul of the country's health care financing system is perhaps the single most important—and contentious—piece of federal social legislation in more than a generation. As of this writing, the Senate has yet to act on the House amendments, but it is widely anticipated that the Senate will do so despite intense and unified Republican opposition.

This advisory explains the key features of federal health care reform as it affects employers and group health plans. It assumes that the Senate will pass the amendments adopted by the House. For purposes of this advisory, the term "Act" means the provisions of the Senate bill that are unaffected by the House amendments; "Senate bill" means those provisions of H.R. 3590 that are subject to further change as a result of the House amendments; and "House amendments" means the changes proposed by the House to distinguish them from the provisions of the Senate bill.

Background

There has been a broad consensus for some time that *something* must be done to expand affordable health care coverage, reduce U.S. health care costs, increase health care quality, and reduce systemic waste and inefficiencies in the U.S. health care system. There is also a general (albeit in some quarters sometimes grudging) consensus that the U.S. is not ready for a European or Canadian-style "single-payer" system. Instead, the political center of gravity has coalesced around a market-based solution, balanced by some regulatory oversight. The earliest iterations of this type of "market-based" approach to health care reform date back to the Nixon administration, and the most current exemplar is the 2006 Massachusetts health care reform act.[1]

The major components of this market-based health care reform include:

- an individual mandate (under which U.S. citizens and legal residents would be required to obtain and maintain a certain level of health insurance coverage)
- some obligation on the part of employers to make a certain level of health care coverage available to their employees (variously referred to as "pay-or-play," "fair share contribution," or "free rider surcharge")[2]
- a basket of insurance reforms (*e.g.*, guaranteed issue and underwriting, limits on pre-existing condition limitations, and expanded dependent coverage)
- various state-level health insurance clearinghouses or "exchanges"
- some sort of tax-based financing mechanism to support persons who otherwise might find adequate health coverage unaffordable.

Health care reform is a vast undertaking that affects a large swath of the U.S. economy and makes substantive changes to many diverse areas of law. This advisory focuses on those elements of the Act, as modified by the House amendments, that are likely to be of greatest interest to employers and employer-sponsored group health plans—*i.e.*, provisions that are costly, that are administratively challenging, and that may well require significant changes in benefits programs and structures. We have organized our analysis into the following three broad categories (recognizing that there is some overlap from category to category):

1. Requirements imposed directly on employers, including the pay-or-play or free rider surcharge and the services to be included in the basic benefit package
2. Requirements imposed on health insurance carriers, including insurance rules and mandates (*e.g.*, guaranteed issue and renewability and bans on pre-existing condition exclusions and lifetime limits) that, while directed at carriers, will have an important, indirect effect on employers
3. Other provisions likely to affect employers, such as the individual mandate, the role of health insurance exchanges, and financing issues.

Most the of Act's substantive provisions, including the House amendments, take effect in 2014, though certain insurance reforms take effect sooner, as specifically noted below.

Direct Employer Mandates

The Employer Coverage Mandate

The Act requires that "applicable large employers" make coverage available to full-time employees or pay a penalty. An applicable large employer is an employer that employs "an average of at least 50 employees on business days during the preceding calendar year." Applicable large employers must pay an assessment if one or more of their full-time employees receive a premium tax credit, *i.e.*, a government subsidy for his or her benefit coverage (discussed below). A "full-time" employee is one who works 30 hours or more on average per week. Seasonal employees are excluded. Under the Senate bill, employers that fail to offer health insurance are subject to an annual assessment of $750 per full-time employee. For employers that do offer coverage but have one or more employees receiving a premium tax credit (*i.e.*,

because the coverage is "unaffordable"), the assessment is the lower of (a) $3,000 for each employee receiving a tax credit, or (b) $750 for each full-time employee (including those not receiving credits). In each case, penalties are determined monthly. While retaining the basic structure of the Senate bill, the House amendments increase the amount of the annual assessment to $2,000 from $750, but exclude the first 30 employees from the penalty calculation.

Under the Senate bill, any employer that imposes a waiting period of over 60 days must pay an additional penalty of $600 for any employee to whom the waiting period applies. The House amendments cap waiting periods at 90 days, but drop the additional per-employee penalty.

Employers that offer coverage must offer an optional voucher arrangement (a "free choice voucher") to those employees:

- with incomes of less than 400% of the Federal Poverty Level (FPL)
- whose share of the employer coverage premium cost is greater than 8% but less than 9.8% of their income
- who choose to decline employer coverage and instead enroll in a plan offered though a health insurance exchange, as described below.

The voucher payment is equal to what the employer would have paid to provide coverage to the employee under the employer's plan. Employers providing free choice vouchers are not subject to penalties for employees who receive premium credits when accessing coverage through an exchange.

Medical FSA Limits

The Senate bill caps medical flexible spending account (FSA) contributions at $2,500, subject to cost-of-living adjustments. The House amendments delay implementation of this provision until 2013.

Over-the-Counter Drugs

The Act denies coverage for over-the-counter drugs under medical FSAs, health reimbursement accounts, health savings accounts, and Archer medical savings accounts.

Automatic Enrollment

The Act includes an automatic enrollment requirement, under which employers with more than 200 full-time employees must automatically enroll employees into health insurance plans offered by the employer. Employees would not, however, be required to accept coverage.

Employer Reporting Requirements

The Act requires employers that provide coverage to report information on enrollment to the Internal Revenue Service.

Tax on the Medicare Retiree Drug Subsidy

The Medicare Modernization Act of 2003 established a "Medicare Retiree Drug Subsidy" (RDS) program for qualifying group-health-plan sponsors. The Medicare RDS program provides financial incentives, in the form of direct payments to employers, to continue to provide prescription drug benefits for their retirees, instead of dropping coverage for the drug benefits in response to the inclusion of such benefits under Medicare. The Medicare RDS subsidy is intended to reduce or eliminate employer costs of contributions to their own prescription drug coverage plans for retirees. Payments received under the Medicare RDS program are not included in taxable income. The Senate bill eliminates favorable tax treatment of the Medicare RDS subsidy immediately; the House amendments defer this change to 2013.

Small Employer Premium Subsidies

The Act provides a tax credit to small employers (*i.e.*, those with fewer than 25 employees and average annual wages of less than $50,000) that purchase health insurance for employees. A tax credit equal to 100% of the employer's contribution is available to employers with 10 or fewer employees and average annual wages of less than $25,000. For other small employers, for tax years 2010 through 2013, the credit will be equal to 35% of the employer's contribution, provided the employer contributes at least 50% of the total premium; and for tax years 2014 and later, the credit will be up to 50% of the employer's contribution, provided that the employer contributes at least 50% of the total premium cost and purchases coverage through an exchange. The credit phases out as firm size and average wages increase.

Basic Benefit Plan Design Features

The Act establishes a set of baseline benefit plan design requirements that comprise a core element of health care reform. These requirements set the standard against which compliance by individuals with the requirement to obtain coverage is measured, and they provide a benchmark for employers to determine whether the coverage they offer will comply with the employer mandates or, in the alternative, require them to pay a penalty. The Act also establishes several tiers of plans offering enhanced coverage.

The basic benefit package is referred to as a "Qualified Benefit Plan," which is a plan that provides a comprehensive, predefined set of medical services and benefits, and with respect to which the employer must pay at least 60% or more of the premium costs. There are limits on annual cost-sharing that are tied to the currently effective Health Savings Account limits ($5,950/individual and $11,900/family in 2010). Each Qualified Benefit Plan must include coverage for ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care). The Act establishes four coverage packages (bronze, silver, gold, and platinum) of varying actuarial values, and all individual and small group insurers must offer, at minimum, plans at the silver and gold levels. The Secretary of Health and Human Services (HHS) is directed to issue further guidance on, and update, the basic benefit packages.

Carrier Mandates

Insurance reform is a critically important feature of health care reform, with the principal focus being on underwriting reforms such as guaranteed issue and renewability and limits on pre-existing condition exclusions. The Act starts with a series of temporary measures aimed at particular underwriting practices, followed by a set of permanent reforms.

Temporary and Transitional Provisions

The Act provides immediate access to a high-risk insurance pool for people with pre-existing conditions, and it establishes a temporary insurance program with financial assistance for those who have been uninsured for several months and have a pre-existing condition. These provisions will terminate when the exchanges become operational.

Guaranteed Issue/Renewability

The Act establishes broad-based rules relating to guaranteed issue, premium rating, and prohibitions on pre-existing condition exclusions in the insured group market and in the exchanges.

Extended Dependent Requirements

Carriers must cover dependents up to age 26. (Special rules apply before 2014, under which coverage need not be extended where the child has access to other coverage.)

Annual and Lifetime Limits

Effective six months following enactment, the Act as modified by the House amendments prohibits individual and group health plans from placing aggregate dollar lifetime limits on coverage. Beginning in January 2014, similar rules will apply to annual limits, pre-existing condition limitations, and waiting periods longer than 90 days. Before then, the extent to which a plan may impose annual limits is determined by the Secretary of HHS.

Nondiscrimination Testing

The Act, for the first time, extends the nondiscrimination rules that have applied to self-funded group medical plans to fully insured arrangements. While the IRS currently enforces discrimination rules for self-insured plans, the Act confers jurisdiction on the Secretary of HHS over the non-discrimination rules that apply to fully insured plans. These rules may require a fundamental redesign of the coverage provisions of many employer-sponsored group health plans.

Other Important Requirements

The Individual Mandate

The purpose of the individual mandate is two-fold: it expands coverage by requiring virtually all U.S. citizens to obtain and maintain coverage, and it protects insurance carriers (who are now subject to guaranteed underwriting and renewability requirements) against adverse selection.

The Act requires all American citizens and legal residents to purchase "qualified health insurance coverage." Qualified health insurance coverage includes public program coverage, coverage purchased through the individual market, and qualified employer-sponsored coverage. Exceptions are provided for individuals who cannot afford coverage, religious objectors, individuals not lawfully present in the United States, and incarcerated individuals. Individuals must report on their federal income tax returns the months of the year during which they had qualified health insurance coverage. Health plans must also provide coverage documentation to both covered individuals and the IRS. Under the Senate bill, the penalty for not maintaining coverage is an excise tax penalty of $95 in 2014, $495 in 2015, $750 in 2016, and indexed thereafter. These amounts are halved for individuals under the age of 18. The House amendments retain this regulatory structure but change the dollar amounts to $325 (from $495) in 2015, and to $695 (from $750) in 2016.

Under the Senate bill, the tax on individuals without qualifying coverage is capped for low-income individuals at $750 per year per person for whom a taxpayer is liable, up to a maximum of the greater of: (a) three times that amount or (b) 2% of household income when fully phased in. The House amendments reduce the dollar amount to $695, but increase the percentage limit to 2.5%. (Note that this approach has been criticized for being too modest. If an individual can choose to ignore the individual mandate by instead paying $695, which is far less than the annual cost of coverage, particularly in the individual market, then he or she will be able to purchase coverage only when it is needed. Thus, it would appear that the Act not only permits adverse selection, but it also creates the legal and regulatory structures that enable it.)

Health Insurance Exchange(s)

The first health insurance "exchange" was established in Massachusetts in 2006. Its purpose is to facilitate the purchase of coverage, principally by individuals and small groups. The general consensus is that the Massachusetts Health Connector (the designation for the Massachusetts exchange) has been very successful at providing access to coverage. The idea of a connector, or exchange, has been a part of each of the current rounds of federal health care reform proposals. The Act mandates state-based exchanges, which will offer web-based portals to direct individuals to insurance options, and otherwise facilitate access to coverage.

In particular, the Act requires each state to create:

- an exchange so as to facilitate the sale of qualified benefit plans to individuals
- SHOP (Small business Health Options Program) Exchanges to help small employers purchase coverage.

These two functions can be combined into a single exchange serving both the individual and group market. Plans offering coverage through the exchange must submit evidence justifying premium increases in advance, and exchanges will be permitted to use this information and premium increase patterns to deny a carrier the ability to sell exchange-based policies.

Tax Credits for Low-Income Individuals

The principal mechanism whereby coverage is made affordable to low-income individuals is the "premium credit"—also known as "affordable premium credits"—that help certain individuals pay for health insurance. These credits will be available to limit the amount that individuals pay for premiums based on their income. Eligibility is determined with reference to income as a percentage of the FPL.

The Act makes premium credits available to individuals and families with incomes between 100% and 400% of the FPL to purchase insurance through a state exchange. Availability is restricted to U.S. citizens and legal immigrants who meet the specified income limits. Credits are tied to a benchmark plan offered through the exchanges, based on a sliding scale. In the Senate bill, premium contributions are generally limited to 2.8% of income for those with incomes up to 100% of the FPL, rising to 9.8% of income for those between 300% and 400% of the FPL. Under the House amendments, these limits are 2% of income for those with incomes up to 133% of the FPL, rising to 9.5% of income for those between 300% and 400% of the FPL. Cost-sharing subsidies are available to individuals and families with incomes between 100% and 200% of the FPL under the Senate bill (up to 400% under the House amendments). Individuals with incomes less than 133% of the FPL should be eligible for Medicaid coverage. Employees who are offered employer-sponsored coverage are ineligible for premium credits, unless the employer coverage did not have an actuarial value of at least 60% or if the employee share of the premium exceeded 9.8% of the employee's income, under the Senate bill, or 9.5% of the employee's income under the House amendments.

Financing

The Senate bill imposes an excise tax of 40% on health plans with premiums in excess of $8,500 for individuals and $23,000 for families. Plans that exceed these limits are often referred to as "Cadillac" plans. Under the Senate bill, a plan's status as a Cadillac plan is determined by taking into account both basic health benefits and ancillary benefits (such as medical FSAs and health reimbursement accounts). Under the Senate bill, this tax goes into effect in 2013. The House amendments raise the Cadillac plan dollar thresholds to $10,200 and $27,500, respectively, push back the effective date to 2018, and exclude stand-alone dental and vision plans from the calculation of the tax. In addition, under the House amendments, if by 2018 the increases are higher than anticipated, the starting index amounts will be adjusted upward. Lastly, the House amendments make permanent a provision, which is only temporary in the Senate bill, that raises the dollar thresholds to $11,850 (for individual coverage) and $30,950 (for family coverage) for older individuals and individuals in "high-risk" professions.

The Act also provides for an increase in the Medicare payroll tax from 1.45% to 2.35% for individuals earning more than $200,000 per year and joint filers earning more than $250,000 per

year ("high income individuals"). The penalty for "taxable distributions" for non-qualified medical expenses from Health Savings Accounts is increased to 20%. Employers must also report the value of health benefits on W-2 forms, whether or not the benefits are taxable. Lastly, the Act increases the threshold for itemized medical deductions from 7.5% to 10%. In addition, the House amendments add a 3.8% tax on unearned income from interest, dividends, annuities, royalties, rents, and capital gains of high income individuals.

Conclusion

The Act's adoption signals a new era in the government's efforts to expand coverage, control medical costs, and assure quality. It will take years to determine whether the Act achieves these ambitious goals. Although certain of the Act's provisions may be modified by future legislation, and there is a likelihood that some or all of the Act may be challenged on constitutional or other legal grounds, these eventualities should not distract employers and their advisors from the enormity of the task at hand. The new requirements and rules adopted under the Act, as it may be modified by the House amendments, will first need to be absorbed and then ultimately integrated and reflected in the basic design and operation of the medical benefit programs of all U.S. employers.

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