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As the U.S. Congress and the White House finalize sweeping health care reform legislation that reconciles the House-passed and Senate-passed bills, employers should be prepared for significant new requirements that could fundamentally alter the nature of employer-sponsored health care. There are ten key questions employers should consider as they analyze the implications of the overhaul of the nation's health care system.

What Does Health Care Reform Mean for Employers? The Top 10 Questions Employers Should Ask About Health Care Legislation

By Ilyse W. Schuman and Steven J. Friedman

On December 24, 2009, the U.S. Senate voted along party lines to approve the Patient Protection and Affordable Care Act (H.R. 3590), bringing health care legislation to its final stage before enactment. The U.S. House of Representatives approved its own health care bill, the Affordable Health Care for America Act (H.R. 3962) on November 7, 2009, by a vote of 220-215. Both bills would require most legal U.S. residents to obtain health insurance and would provide government subsidies to help lower-income individuals do so. The Senate bill, with a price tag of $871 billion, is expected to reduce the number of uninsured individuals by 31 million, leaving about 23 million nonelderly residents uninsured. The House bill, which costs $1.052 trillion is expected to reduce the number of uninsured residents by 36 million.

While the two bills share the same goal of reducing the number of uninsured individuals, their approaches contain important distinctions that now need to be reconciled. Most notably, the House bill would create a government-run public health insurance plan, commonly referred to as the "public option," that would be available through a nationwide health insurance exchange. A health insurance exchange is essentially a "virtual" marketplace in which some individuals and groups can shop for health insurance plans and purchase a plan that best meets their needs. Under the House bill, individuals and families with incomes up to 400% of the federal poverty level, about $88,000 for a family of four, would receive a sliding scale federal subsidy in the form of an "affordability credit" to purchase health insurance through the exchange. The Senate bill, in contrast, does not include the so-called "public option." Instead, the Senate bill directs the Office of Personnel Management to contract for two multi-state insurance plans, one of which must be non-profit, that would be available in state health insurance exchanges. The Senate bill would provide sliding scale refundable federal tax credits to individuals and families up to 400% of the federal poverty level to purchase health insurance from a plan in the exchange.

While the final legislation is expected to more closely reflect the Senate bill, which is generally less onerous on employers, the bill President Obama hopes to sign early in

2010 would impose significant new responsibilities on employers nationwide and could, over time, fundamentally alter the nature of employer-sponsored health care. As employers look ahead to understand the implications of this sweeping legislation, they should focus on the following ten questions.

1. Do we have to provide health care benefits to our employees?

Answer: Yes, if you want to avoid paying a penalty.

Under both the House and Senate bills, employers who do not offer health insurance to their workers will be penalized. The House bill imposes a "pay-or-play" mandate requiring larger employers to either offer their employees health insurance or contribute funds on their behalf to help subsidize the coverage they would instead obtain through the health insurances exchanges. Specifically, employers who do not provide at least a 72.5% premium contribution for individuals, 65% for families, would have to pay a tax equal to 8% of average payroll. Small firms with less than $500,000 in annual payroll are exempted from the penalty, which is phased-in up to the full 8% for firms with a payroll of $750,000 or more. The Congressional Budget Office (CBO) estimates that the cost of the employer penalty under this pay or play mandate would amount to $135 billion collected from 2013 to 2019. Employers would be required to make a proportional premium contribution for part-time workers. Employers would also be required to certify that they offer employees an opportunity to enroll in a health benefits plan and to report the names of employees who are covered under such plans.

While not as onerous as the House bill, the Senate bill would nonetheless penalize employers who fail to provide "affordable" or sufficient health insurance to their workers. Beginning in 2014, employers with more than 50 full-time employees that do not offer coverage must pay a penalty to the government of $750, indexed over time, for each full-time worker who obtains federally subsidized insurance. If the employer offers coverage that is deemed "unaffordable" because the employee has to pay more than 9.8% of his or her income, indexed over time, or the employer contributes less than 60% of the actuarial value of the plan, the employer must pay the lesser of $3,000 for each full-time employee getting a federal subsidy or $750 times the number of full-time employees. The CBO estimates that the cost of this penalty to employers will be $28 billion through the year 2019. Larger employers must also report to the Secretary of Health and Human Services whether they offer their employees coverage, the types of coverage offered, and the Social Security numbers and names of full-time employees receiving coverage. Full-time employees are defined as those working on average more than 30 hours per week calculated on a monthly basis. Beginning with the 2011 tax year, employers would also have to report the value of employer-provided health benefits on their employees' Form W-2.

In addition to the penalty for not providing health insurance to workers, both the House and Senate bill would require employers to automatically enroll their employees in their health plans. However, the automatic enrollment provisions in the Senate bill only apply to firms with more than 200 employees. Under the Senate bill, large employers who wait more than 60 days to enroll their employees in coverage will pay a fine of $600 per full-time employee.

Both the House and Senate bills provide assistance for small employers providing health insurance to their workers in the form of a tax credit. Under both bills, the premium tax credit would be limited to firms employing less than 25 employees.

Whatever form the final legislation takes, it will almost certainly include a penalty on larger employers that do not offer health care benefits and will have a critical influence on the direction of employer-sponsored health care when viewed in conjunction with other new requirements contained in the legislation. The "pay or play" mandate in the House bill, requiring employers to make a minimum premium contribution or pay the payroll tax penalty, would significantly restrict an employer's flexibility in offering and designing workers' health care benefits. Even the less restrictive Senate penalty provisions reflect a shift away from the current voluntary and flexible nature of such benefits that employers should be prepared to address.

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2. Do we have to pay a penalty if our employees decide to drop out of the employer sponsored plan?

Answer: Yes, in certain circumstances.

Beginning in 2014, under the House bill, employers would be required to pay the payroll tax penalty referenced above even if the employee declines employer-sponsored health insurance and obtains coverage through the health insurance exchange instead. As described above, the Senate bill would require employers that offer coverage to their workers to pay a penalty if the coverage is "unaffordable" or the employer-provided benefit is not at least 60% of the actuarial value of the coverage offered to the employee. In other words, the plan has to cover at least 60% of medical costs. In addition, the Senate bill would allow certain low-income employees who do not qualify for a federal subsidy to opt-out of employer-sponsored coverage. These employees would receive "free-choice vouchers" from their employers equal to the value of the benefits of the employer plan that could be used to join an exchange plan. The "free choice vouchers" would be available to workers whose health insurance premium contribution exceeds 8% but not 9.8% of their income and who are low-income and whose family income is up to 400% of the poverty level. The employees could cash-in the amount of the voucher in excess of the cost of purchasing insurance through the exchange, which may prompt some workers to opt to forgo employer coverage.

Accordingly, employers who offer benefits to their workers face the prospect of new direct costs, in the form of either a penalty or a voucher, if the benefits are not deemed sufficient or certain employees decide to obtain coverage through the health insurance exchange. Some employers could also see their health care costs increase as lower-income healthier workers leave employer-sponsored plans to obtain insurance through the exchange.

3. Can we provide our employee's health insurance through the health insurance exchange?

Answer: Initially, smaller employers would be able to offer health insurance through the exchange once the exchange becomes operational in 2013 under the House bill and in 2014 under the Senate bill. Larger employers may eventually be able to do so as well.

The House bill creates a national health insurance exchange through which qualified health insurance plans with different levels of coverage would be offered. The health insurance exchange would also include a public health insurance plan, commonly referred to as the "public plan," administered by the Department of Health and Human Services, which would negotiate reimbursement rates with health care providers. States could operate the health insurance exchange if they meet federal standards. In 2013, the exchange would be open to individuals without other coverage and employers with less than 25 employees. In 2014, employers with 50 or fewer employees could participate in the exchange. In 2015 this would expand to cover employers with 100 or fewer employees, and the Health Choices Commissioner, a newly created federal position, would have the discretion to cover larger employers as well. Employers that offer coverage through the exchange must make the minimum contribution towards such coverage and allow their employees to choose any plan within the exchange.

The Senate bill would require states to create health insurance exchanges offering different levels of qualified health insurance plans beginning in 2014. The Senate bill does not create a public health insurance option. Instead, the Office of Personnel Management would contract for two multi-state qualified private health insurance plans, one of which must be non-profit, that would be available through the state exchanges. Initially, the state exchanges would be open to individuals and small employers with 100 or fewer employees, unless the state wants to limit this to firm of 50 or fewer workers. Beginning in 2017, states have the option to expand the exchange to larger employers.

4. Do we have to change our benefit plan?

Answer: Yes, if it does not comply with certain new requirements.

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The House and Senate bill take different approaches to "grandfathering" or preserving the ability of group health plans to operate as they do today. The House bill would eventually erode the current structure the Employee Retirement Income Security Act (ERISA) creates for employers to provide health insurance to their workers. In the year 2018, after a five-year grace period, employer-based health plans would have to meet the same minimum requirements as qualified health benefits plans offered through the exchange with respect to essential benefits, affordable coverage, and consumer protection. Even during the five-year grace period, grandfathered group health plans would have to meet other new insurance reform requirements, such as the "pay or play" mandate described above, coverage of dependent young adults though age 26, immediate restrictions on pre-existing condition exclusions, and a ban on lifetime benefit limits. The House bill would also require that employers allow individuals who become eligible for COBRA to stay in their former employer's plan until 2013 when the health insurance exchange becomes operational.

The Senate bill includes a "grandfathering" provision that exempts group health plans in effect as of the date of enactment from most of the new health insurance market reforms otherwise applicable to group health plans, including many of the same restrictions contained in the House bill. The Senate grandfathering provision is silent with respect to the impact of plan changes subsequent to the law's enactment, creating some uncertainty about how subsequent plan changes will impact grandfathered status. With respect to health care coverage pursuant to a collective bargaining agreement, the Senate bill states that the agreement must be ratified before the date of enactment for the grandfathering protection to apply and will only extend through the date on which the last of the collective bargaining agreements relating to the coverage terminates. Large group health plans would not have to cover the essential benefits package that plans in the individual and small group market would have to cover. Even so, employers would have to pay a penalty if their coverage is deemed "unaffordable" or the employer-provided benefit is less than 60% of the actuarial value of the coverage and an employee obtains a subsidy for coverage in the health insurance exchange. Fully-insured group health plans would also be subject to an external appeals process for coverage denials that comply with any applicable state process. Self-insured plans would be subject to standards established by the Secretary of Health and Human Services.

Employers may revisit the attractiveness of providing health benefits to their workers, especially in light of the new restrictions and mandates and the trajectory health care costs may take. However, their alternative would be a penalty for not providing benefits to their workers. In other words, employers will have to determine if it would become more costly to provide employee health coverage or pay the penalty?

5. What is a "Cadillac" plan?

Answer: If you offer a high-premium health insurance plan to your workers, you may be subject to a new excise tax on these so-called "Cadillac" plans.

To help pay for the cost of expanding health care coverage, the Senate bill would, beginning in 2013, impose a 40% excise tax on employment-based health plans whose premiums exceed $8,500 for singles and $23,000 for family plans, indexed for inflation plus 1%. The tax would be on the amount exceeding this threshold and would be paid by insurers, or, in the case of self-insured plans, by the employer. The CBO estimates that the excise tax on high premium plans would raise $149 billion in revenue from 2013 through 2019. The CBO also estimates that 19% of employment-based policies would exceed the threshold by 2016. While the premium amount triggering the excise tax would be adjusted for inflation plus 1%, the increase in the threshold could be significantly lower than the increase in health care costs based on historical trends, resulting in a greater number of plans becoming subject to the excise tax. The CBO has noted that most employers would probably respond to the tax by offering premiums at or below the threshold. According to the CBO, "employers could achieve lower premiums through some combination of cost-sharing (which would lower premiums directly and also lower them indirectly by leading to less use of medical services), more stringent benefit management, or coverage of fewer services." For this reason, labor unions, many of whom have negotiated generous health benefits that may be deemed "Cadillac" plans, strongly oppose this excise tax, which is not contained in the House bill. This provision has been among the most contentious in negotiations

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between the House and Senate as efforts have been made to eliminate the high-premium plan excise tax, raise its threshold, or exempt collectively bargained benefits from the tax.

A reported deal has been reached between the White House and union leaders regarding the proposed excise tax on high cost healthcare plans for inclusion in the final healthcare overhaul bill. The compromise would reportedly exempt collectively-bargained as well as state and local healthcare plans from the excise tax until 2018, five years after all other plans would be subject to this tax. In addition, the tax would apply to family health policies that cost more than $24,000, and single plans that exceed $8,900, up from the $23,000 and $8,500 thresholds outlined in the Senate bill. These threshold levels would reportedly be increased for plans that have significant numbers of women and/or older workers. The cost of dental and vision benefits would no longer be factored into healthcare costs for excise tax purposes starting in 2015. Under this deal, individuals in collectively bargained plans could begin purchasing health care coverage through the health insurance exchange in 2017. These provisions, if included in the final healthcare bill, could make collectively-bargained healthcare plans comparatively more attractive.[1]

6. Will health insurance plans be taxed?

Answer: Yes, both the House and Senate bills would impose a new premium tax on group health plans to fund comparative effectiveness research. Annual fees on health insurers and device manufacturers may also be passed on to employers.

Both bills include a new premium tax on fully-insured and self-insured group health plans to fund comparative effectiveness research. The tax would be two dollars times the average number of covered lives for plan years ending after September 30, 2012 (one dollar during fiscal year 2013 in the Senate bill), and is indexed to the cost of medical inflation. The Senate bill also contains annual fees on health insurers and medical device makers that are, according to the CBO, likely to be passed through to private payers. The health insurance provider fee would begin at $2 billion for 2011 increasing up to $10 billion for years after 2016. Third party administration agreement fees for self-funded plans are not included in the allocation of the annual fee. An annual fee on medical device makers would start at $2 billion in 2011, increasing to $3 billion in 2018. The House bill includes a 2.5% excise tax on medical device manufactures beginning in 2013. The Senate bill also imposes a $2 billion annual fee on prescription drug manufacturers beginning in 2010 that would be allocated based on sales to government programs.

It is also important to note that both bills would end the tax deduction for employers who receive a federal subsidy for offering prescription drug coverage for retirees, making the provision of these benefits more expensive. The Medicare Modernization Act of 2003 provided subsidies to employers to maintain prescription drug coverage for Medicare-eligible retirees. Under the House bill, this Retiree Drug Subsidy would no longer be deductible beginning in 2013. The Senate bill would end deductibility of the subsidy in 2011. The final health care bill is expected to eliminate this deduction, although the effective date is uncertain, adding to the cost of employer-provided retiree drug coverage.

7. What is a medical loss ratio and why should employers care?

Answer: A medical loss ratio is the percentage of health insurance premium revenues that must be spent on clinical services and quality.

Both the Senate and House bills impose minimum medical loss ratios on health insurers. Under the Senate bill, beginning in 2011, large fully-insured group health plans, including grandfathered plans, that spend less than 85% of premium revenue on clinical services and "activities that improve health care quality" must rebate the difference to enrollees. The House bill would require fully-insured group health plans to meet the minimum medical loss ratio of 85% effective January 1, 2010 or as soon as practicable thereafter. Questions remain about what would be considered administrative costs versus clinical services or "quality" activities. For example, under what category would a wellness or disease management program fall? With administrative costs capped at 15% of premium revenue, fully-insured plans will have to carefully monitor administrative costs and may find that their flexibility in allocating premium revenue is reduced.

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8. Can we change our retiree health benefits?

Answer: The House bill significantly restricts the ability of employers to change retiree health benefits, while the Senate bill does not.

The House bill would amend ERISA to prohibit employers from changing retiree health benefits after retirement if the change either reduces the actuarial value or increases premiums by more than 5%, unless the same change is made in to benefits for active employees. This restriction would be effective upon enactment and would apply to employer-sponsored group health plans even during the five-year grace period for compliance with other new benefits requirements. This restriction is a significant departure from the current structure of ERISA, which allows employers flexibility to design and modify benefits. The Senate bill does not contain a similar restriction.

Both the House and Senate bills would create a federal reinsurance program to provide reimbursement for employers that provide health insurance for retirees aged 55 to 64 and their families. The government would pay 80% of the cost of benefits provided per enrollee between $15,000 and $90,000. The employer would have to use funds to lower the cost of the plan and could not be used for other purposes. The House bill would allocate $10 billion to fund the program, while the Senate would allocate $5 billion.

9. What happens to Flexible Spending Accounts?

Answer: Employers who offer flexible spending accounts (FSAs) and workers who utilize them would face new contribution limits under both the House and Senate bills.

Employers who have utilized FSAs to promote consumer-driven health care as a means of controlling rising health care costs will face caps on the salary amount that can be directed to FSAs. Beginning in 2011, salary reductions for FSAs will be limited to $2,500. This amount will be indexed for inflation beginning in 2012. However, if health costs continue to rise at a higher rate than inflation, the effective value of FSAs will diminish over time.

10. Will this reduce our health care costs?

Answer:The ultimate question for employers is whether or not the current health care legislation will, in fact, bend the cost-curve or, in other words, reduce employers' ever-increasing health care costs. For employers grappling with the impact of rising health care costs in the competitive global economy, the answer is far from certain.

The CBO opines that the Senate bill "could have broader or longer-term effects on the level or growth of health care spending and health insurance premiums," but cautions that the "uncertainties involved in accessing the magnitude of these effects are especially great." Even so, in the CBO's judgment, "those effects are unlikely to be large – especially by 2016." The excise tax on high-premium plans, changes to Medicare payments, and other pilot and demonstration projects could encourage the development of less costly ways to deliver health care. However, while changes in Medicare payments could have a spillover effect on the private sector and decrease spending for health care relative to its current path, the impact on employer health care costs, at least in the near term, is likely to be small according to the CBO. The impact of the excise tax on the cost and efficiency of care is also estimated to be small at that point.

In other words, the CBO expects employer-sponsored health insurance costs under the Senate bill to remain generally in-line with the status quo, at least in the near term. In the small group market of firms with 50 or fewer workers, the CBO estimates that the average premium from the Senate bill would range from an increase of 1% to a decrease of 2% in the year 2016 relative to what it would otherwise be under current law. In the large group market, the change in average premium would range from zero to 3% lower than it would be relative to current law.

Another important consideration is how the legislation will promote or inhibit activities employers are currently undertaking to control health care costs and improve the health of their workers. The Senate bill promotes the use of wellness programs by raising from 20% to 30% the premium or cost-sharing discount employers can provide to participate in a wellness program. Under the bill, the Secretary of Health and Human Services could raise this amount to as much as 50%.

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How will this legislation impact employer-sponsored health care? The CBO projects that the House bill will increase the number of people obtaining health insurance coverage through employers by six million by the year 2019. In contrast, under the Senate bill, the number of people obtaining employer-provided health insurance is projected to be 4 million lower in 2019. While an additional 6 million people would have employer coverage relative to current law, between 8 and 9 million people would lose their employer coverage and between 1 and 2 million people would opt-out of employer coverage to obtain insurance through the exchanges.

Whatever final form health care legislation takes, employers face dramatic changes in the scope and content of employer provided health insurance and uncertainty about whether these changes will, in fact, reduce the rising costs of providing such benefits. Given these dynamics, employers should consider the cumulative effect of new restrictions, mandates and the likely trajectory of health care costs in the wake of this sweeping legislation before evaluating the attractiveness of offering health care to their workers versus the costs of non-compliance. These considerations, as the CBO concludes, "serve to emphasize the considerable uncertainly that surrounds any estimate of the impact of any proposal that would make substantial changes in the health insurance and health care sectors, given the size and the complexity of those sectors."

Conclusion

Employers need to be prepared for a myriad of new requirements that will arise from the health care bill currently being finalized. Compliance with these new requirements, some of which may take effect immediately, begins with an awareness of how this complex legislation will impact employers and a review of current employee benefit plans and practices. As new benefits, penalties, and programs become effective, employers will likely be driven to reevaluate the cost of providing health care coverage to their workers relative to the penalty for not providing coverage. The answers to some of the key questions employers should ask about health care reform are summarized above. However, the uncertainty surrounding whether and to what degree the nascent delivery system reforms and cost containment strategies contained in final legislation will reduce the current path of rising health care costs leaves perhaps the most important question unanswered.

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[1] *See* Robert Pear and Steven Greenhouse, *Accord Reached on Insurance Tax for Costly Plans*, New York Times, January 15, 2010.

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