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B&B REVIEW

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HEALTH CARE REFORM – IMPLICATIONS FOR EMPLOYERS

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ELEMENTS OF REFORM

In March, Congress passed, and the President approved, comprehensive health care reform legislation. This bulletin summarizes some of the provisions of the legislation that will be of particular interest to employers.

The new law is expected to increase the percentage of Americans under 65 receiving health care coverage from 83% to 95% by 2016 according to the Congressional Budget Office (CBO). This will be accomplished through extensive changes to the manner in which employers and individuals acquire and pay for health insurance coverage. Federal jurisdiction over health care coverage provided through employer-based group health plans will be significantly expanded, although the states will retain a significant role in the regulation of commercial health care insurance products. New insurance market rules and penalties against employers and individuals who fail to offer or obtain coverage will directly affect all but the smallest employers.

Among the most significant of the changes made by the reform legislation are:

- New federal standards for commercial health care insurance including requirements of guaranteed issue and renewal, elimination of exclusions for pre-existing conditions as well as annual and lifetime benefit caps, limits on risk factors (e.g., gender, health status, age) that may be taken into account for premium setting limits on annual cost-sharing, restrictions on policy rescission or cancellation, coverage of children through age 25, and rights of appeal for adverse coverage determinations;

- The creation of state-administered health insurance Exchanges though which individuals and employers will be able to access and compare premiums for commercial insurance coverage;

- Imposition of tax penalties on employers with 50 or more full-time employees that fail to offer health care coverage meeting minimum essential coverage and affordability standards;

- Limited tax credits for small businesses (25 or fewer full-time employees) that elect to offer health care coverage;

- A mandate that virtually all U.S. citizens and legal residents (and their dependents) obtain health care coverage or pay a tax penalty for non-compliance;

- Premium and cost sharing subsidies available to individuals and households with incomes between 100% and 400% of the Federal Poverty Level ($43,200 for individuals and $88,200 for families in 2009) to purchase coverage through an Exchange;

- Elimination of tax deductibility for federal payments to employers for retiree prescription drug programs;

- Simplified tax rules for cafeteria plans sponsored by small employers;

- Incentives for employers and employees to participate in wellness programs; and

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- Expanded Medicaid eligibility for working adults with incomes up to 133% of the Federal Poverty Level ($14,404 for an individual and $29,326 for a family of four in 2009).

Most of the changes will become effective in 2014, although some will go into effect earlier.

Employer-sponsored plans in effect on the date of enactment will be permanently exempt from some but not all of the new requirements. The extent of changes that may be made to such plans without losing grandfather status will be clarified through regulation.

The new law will preserve the federal tax deductibility of costs and benefits of employer-sponsored health benefit plans. The ERISA preemption of state benefit mandates and remedies with respect to employer self-insured plans will also remain in effect.

Summaries of implementation timelines as well as the effect of key features of the reform legislation on large and small businesses are attached.

COST AND FUNDING OF REFORM

The CBO estimates that the cost of expanding health care coverage under the new law will increase federal spending over the next 10 years by $904 billion. This increase is expected to be offset by tax penalties against employers and individuals who fail to offer or obtain qualifying health care coverage, Medicare spending reductions, health industry fees, and new taxes on high-income households to yield a net $119 billion reduction in the federal deficit through 2019. The most significant of the new penalties and taxes include:

- A non-deductible excise tax applied to employers with an average of 50 or more full-time employees who i) fail to offer minimum essential coverage or ii) offer minimum essential coverage that is unaffordable to one or more employees; (i.e. premiums exceed 9.5% of household income or the actuarial value of the plan is less than 60%) (Effective 2014);

- A non-deductible excise tax applied to individuals (and their dependents) who fail to obtain minimum essential coverage (Effective 2014);

- A 0.9% Medicare tax on annual income in excess of $200,000 ($250,000 for joint filers) and a 3.8% Medicare tax imposed on net investment income (including interest and dividends) of persons with modified Adjusted Gross Incomes exceeding $200,000 ($250,000 for joint filers) (Effective 2014);

- A 40% excise tax on the benefit value (excluding dental and vision benefits) of health care plans in excess of $10,200 for single coverage and $27,500 for family coverage, subject to adjustments for age, gender, retirees over age 55, and high-risk professions (Effective 2018);

- New federal fees on health insurance companies equal to $8 billion in 2014, increasing to $14.3 billion in 2018 and thereafter;

- Federal fees on medical device and prescription drug manufacturers (Effective 2014); and

- Limits on annual pre-tax contributions to employee flexible spending accounts of $2,500 (Effective 2013).

IMPLICATIONS OF REFORM

Employers will face a number of challenges and opportunities as elements of health care reform are implemented over the next several years. In particular, many details on the structure and operation of state-based insurance Exchanges will have to await state legislative action. Nevertheless, employers should begin considering the likely effect of reform on insurance markets as well as the various incentives and penalties associated with offering or not offering employer-based health care coverage – a "pay" or "play" decision. Small employers will be interested in how the combination of insurance market reforms and individual coverage requirements will affect the cost and availability of coverage in local group markets. This should include the potential availability of more affordable coverage options outside of the workplace for low

and moderate-income persons as a result of premium and cost-sharing subsidies available through the Exchanges as well as an expansion of Medicaid eligibility for working adults.

As the effects of the legislation on insurance markets becomes clearer, careful attention to regulatory and market developments will allow employers to make informed decisions about the costs and benefits of offering, or continuing to offer, employee health care coverage under the new regulatory framework.

Attachments:

- Summary of Key Employer-Related Provisions in Health Care Reform Legislation

- Health Care Reform Implementation Timetable for Employer-Related Provisions

- Effects of Health Care Reform on Businesses – By Size

SUMMARY OF KEY EMPLOYER-RELATED PROVISIONS OF HEALTH CARE REFORM LEGISLATION

Insurance Market Reforms	For plan years beginning on or after 9/23/10, health care plans may not impose lifetime benefit limits or unreasonable annual benefit limits (to be defined by regulation) and may not rescind coverage absent evidence of fraud or deliberate misrepresentation. Plans may not impose exclusions for pre-existing conditions for children under 19 and must continue to cover children through age 25. Employers with more than 200 full time employees will be required to auto-enroll new hires into coverage, subject to an opt-out opportunity. A national high-risk pool for persons with pre-existing health conditions and a reinsurance program for early retirees will be established by HHS. For plan years beginning on or after 1/1/11, health insurance plans must maintain a Medical Loss Ratio (the portion of premiums used to pay plan benefits) of at least 85% (for large group plans) and 80%, (for small group and individual plans), or issue rebates to policyholders. For plan years beginning on or after 1/1/14, health care plans may not exclude coverage of pre-existing conditions for adults, impose coverage waiting periods of longer than 90 days, and must make coverage available on a guaranteed issue and renewal basis. Annual benefit limits will no longer be permitted. Application of ERISA non-discrimination rules to insured plans. Premium setting for insured plans will not be able to take into account gender or health condition. Premium variation based on age will be limited to 3:1.
Required Plan Benefits	Effective 1/1/14, all <u>individual</u> and <u>small</u> group plans (generally up to 100 employees) offered in the U.S. must offer a "minimum health benefits package" including a comprehensive set of medical services not more extensive than a typical employer plan, an actuarial value of at least 60%, and annual cost sharing limits equal to those for high-deductible Health Savings Accounts (*i.e.,* $5,950 for self and $11, 900 for family coverage in 2009). <u>Large</u> group plans will be subject to cost-sharing limits, but not benefit design or actuarial value requirements unless offered through a Health Insurance Exchange.
Health Insurance Exchanges	Authorizes grants to establish state-administered Health Insurance Exchanges by 2014 through which health insurers may offer small group (100 or fewer employees) and individual Qualified Health Plans (QHPs). Plans must include a "minimum health benefits package" and will be organized into four benefit tiers based on actuarial value (the portion of covered benefits paid by the plan) ranging from 60% to 90% – plus a special catastrophic plan for persons under 30 who cannot otherwise afford coverage. Exchanges may decline to include plans with a pattern of "unreasonable" premium increases. Exchanges could offer large group (more than 100 employees) coverage beginning 2017. Federally administered Exchanges will be created if states fail to act.
Public Insurance Option	No formal public insurance option. The Office of Personnel Management is authorized to contract with health insurers to offer multi-state individual and small group coverage through state Exchanges based on the current Federal Employee Health Benefit Plan model.
Interstate Sale of Insurance	Effective 1/1/15, interstate compacts would be permitted for the sale of individual health care coverage across state lines in accordance with standards to be developed by the National Association of Insurance Commissioners.

Employer Penalties	Effective 1/1/14, employers with an average of 50 or more full-time employees will be subject to non-deductible excise tax penalties if: i) they fail to offer minimum essential coverage (*i.e.,* any insurance coverage purchased through the large or small group markets) to all full-time employees (30 hours or more per week) and dependents; or ii) such coverage is deemed unaffordable because premiums for coverage exceed 9.5% of income for one or more employees or the actuarial value of the plan is less than 60%. The penalty for failing to offer coverage will be equal to $142.86 per month ($2,000 annually) for each full-time employee in excess of 30 if at least one full-time employee receives a premium or cost-sharing subsidy for coverage purchased through an Exchange (regardless of how many employees may receive such subsidies). The penalty for failure to offer affordable coverage will be $250 per month ($3,000 annually) for each full-time employee who receives a premium or cost-sharing subsidy for Exchange-based coverage up to a cap equal to what the employer would have paid if it did not offer coverage at all. Penalty amounts will be subject to inflation adjustment. Seasonal workers are generally excluded from the calculation of full-time employees. Part-time workers (less than 30 hours per week) are counted on a pro-rated basis. *Revenue Estimate:* $52 billion through 2019. Employees with household income of less than 400% of the Federal Poverty Level (FPL) who would be required to pay more than 8% but less than 9.8% of household income for employer-based coverage will be eligible for employer-paid "free-choice" vouchers to enroll in an Exchange-based QHP. The amount of the voucher will equal the cost of coverage under the employer-based plan. Unlike tax penalties, vouchers expenses will be deductible by employers.
Small Employer Tax Credits	Beginning 1/1/10, tax credits of up to 35% of the cost of offering health care coverage to employees will be available to small employers (25 or fewer full-time equivalent employees whose average annual wages is not more than $50,000). Employers must subsidize a uniform percentage (not less than 50%) of employee premiums. In 2014, the credit will increase to 50%, but only for coverage obtained through an Exchange. Employers will only be able to qualify for 50% tax credits for a maximum of two years. (Full-time equivalent employee calculations will generally exclude seasonal workers but will include part-time workers.) *Cost Estimate:* $40 billion through 2019.
Individual Coverage Mandate and Penalties	Effective 1/1/14, all U.S. citizens and legal residents (and their dependents) must have minimum essential coverage or pay a monthly non-deductible tax penalty equal to the greater of: i) an annualized amount starting at $95 in 2014, increasing to $695 in 2016 (subject to a cap of 300% of such amount per household) or ii) a percentage of household income in excess of the threshold amount for federal tax income filing purposes ($9,350 for single filers and $18,700 for joint filers in 2010) starting at 1.0% in 2014, increasing to 2.5% in 2016. Penalties will be capped at the national average premium for basic QHP coverage. Flat dollar penalties under i) above for dependents under 18 will be reduced by 50%. Penalties will not be applied to

	persons for whom i) the premium of an employer-based plan or the least costly available Exchange-based individual QHP exceeds 8% of household income, ii) household income is less than the federal tax filing threshold, or iii) a religious or financial hardship applies. *Revenue Estimate:* $17 billion through 2019.
Premium and Cost-Sharing Subsidies	Effective 1/1/14, Individuals and families i) with incomes between 133% and 400% of the FPL; ii) not eligible for government-sponsored health care coverage; and iii) not offered employer-based minimum essential coverage with an actuarial value of at least 60% and a premium not exceeding 9.5% of annual income will be eligible for premium and cost sharing subsidies for coverage purchased through an Exchange. Subsidy amounts will vary based on household income. *Cost Estimate:* $466 billion through 2019. *Average Subsidy:* $6,000 in 2019.
Employer-Sponsored Cafeteria Plans	Beginning 1/1/11, non-discrimination rules will be simplified for cafeteria plans offered by small employers with 100 or fewer average employees that meet minimum employee participation and employer contribution requirements.
Flexible Spending Accounts (FSAs)	Beginning 1/1/13, annual employee pre-tax FSA contributions will be limited to $2,500, adjusted for inflation. Costs of non-prescription over-the-counter medications (other than insulin) will be excluded from FSA coverage. *Revenue Estimate:* 13.0 billion through 2019.
Wellness Plans	Effective 1/1/14, employers will be able to offer up to 30% health care plan premium discounts for participation in wellness programs. The percentage may be increased to 50% by regulation.

Health Care Reform
Implementation Timetable for Employer-Related Provisions

Year	Provision
2010	*Insurance Market Reforms:* Elimination of lifetime benefit caps and unreasonable annual benefit limits, elimination of pre-existing condition exclusions for children and extension of coverage for children through age 25, restrictions on rescission of coverage (except for fraud or deliberate misrepresentation), establishment of a national high risk pool and a reinsurance program for early retirees. *Tax Credits:* Small businesses with 25 or fewer full-time employees with average wages of less than $50,000 eligible for 35% tax credit on the cost of employee health care coverage.
2011	*Insurance Market Reforms:* Group health care insurance plans must maintain Medical Loss Ratios of at least 85% (large groups) or 80% (small group and individual plans) or pay rebates to policyholders.
2013	*Individual Taxes:* Additional 0.9% Medicare tax imposed on wages over $200,000 ($250,000 for joint filers). 3.8% Medicare tax imposed on net investment income of persons with modified Adjusted Gross Income exceeding $200,000 ($250,000 for joint filers). *Flexible Spending Programs:* Annual pre-tax contributions limited to $2,500. Non-prescription drugs excluded from coverage.
2014	*Insurance Market Reforms:* Elimination of annual benefit limits, all small group and individual health care plans (except grandfathered plans) required to offer a minimum health benefits package meeting federal guidelines, guaranteed issue and renewal requirements, restrictions on insurance premium rating, limits on coverage waiting periods, non-discrimination rules, and elimination of coverage restrictions based on pre-existing conditions. *Insurance Exchanges:* State insurance Exchanges become operational (premium and cost-sharing subsidies available to exchange participants with incomes up to 400% of the Federal Poverty Level). Individuals and small businesses with 100 or fewer employees eligible to purchase coverage through an exchange. *Individual Coverage Mandate:* Virtually all U.S. citizens and lawful residents (including dependents) must obtain health care coverage or pay a penalty. *Employer Penalties:* Employers with 50 or more full-time employees that fail to offer minimum essential coverage or to make coverage affordable to all employees will be subject to tax penalties. *Tax Credits:* Small businesses with 25 or fewer full-time employees with average wages of less than $50,000 will be eligible for a 50% tax credit on the cost of obtaining health care coverage through a state Exchange.

Medicaid: Medicaid eligibility expanded to include working adults with incomes at or below 133% of the Federal Poverty Level.

2017 *Insurance Exchanges:* States may allow businesses with more than 100 employees to purchase coverage through an Exchange.

2018 *Tax on High Value Plans:* 40% excise tax on health care coverage that exceeds $10,200 for individual plans or $27,500 for family plans, subject to adjustments for age, gender, and high-risk professions.

Effects of Health Care Reform on Businesses – By Size

<table>
<tr><th>Full Time Employees</th><th>Tax Credits</th><th>Penalties</th><th>Eligibility to Purchase Coverage Through an Insurance Exchange</th></tr>
<tr><td>1-25</td><td>Beginning in 2010, tax credits of up to 35% of the cost of coverage will be available to small employers with 25 or fewer full-time employees with average wages of less than $50,000. Beginning in 2014, credits of up to 50% will be available only for qualified coverage obtained through an insurance Exchange. 50% credits will be available for a maximum of two years.</td><td rowspan="2">None</td><td rowspan="3">Beginning in 2014, small employers will be eligible to purchase health insurance coverage through state-based insurance Exchanges.</td></tr>
<tr><td>26-49</td><td rowspan="3">None</td></tr>
<tr><td>50-100</td><td rowspan="2">Beginning in 2014, a non-deductible excise tax will be applied to employers with an average of 50 or more full-time employees who i) fail to offer minimum essential coverage or ii) offer minimum essential coverage that is unaffordable to one or more employees.</td></tr>
<tr><td>Over 100</td><td>Beginning in 2017, states may permit large employers (more than 100 employees) to purchase coverage through an Exchange.</td></tr>
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