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After more than a year of debate over reforming our nation's health care system, on March 23, 2010, President Obama signed into law The Patient Protection and Affordable Care Act (PPACA). The new law will impose significant new responsibilities on employers nationwide that could, over time, fundamentally alter the nature of employer-sponsored health care and the employer-employee relationship.

## Health Care Reform – What are Key Considerations for Employers?

By Ilyse W. Schuman and Steven J. Friedman

After more than a year of debate over reforming our nation's health care system, on March 23, 2010, President Obama signed into law The Patient Protection and Affordable Care Act (PPACA). Enactment of a package of amendments to this legislation through a separate bill, the Health Care and Education Affordability Reconciliation Act of 2010, is expected later in the coming week. With a price tag of \$938 billion, health care reform legislation is expected to reduce the number of uninsured individuals by 32 million, leaving about 23 million nonelderly residents uninsured.

This legislation would require most legal U.S. residents to obtain health insurance and would provide government subsidies to help lower-income individuals obtain health insurance through newly created state health insurance exchanges. 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. The new law also 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 legislation 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.

The new law will impose significant new responsibilities on employers nationwide that could, over time, fundamentally alter the nature of employer-sponsored health care and the employer-employee relationship. As employers look ahead to understand the implications of this sweeping legislation, we have provided questions and answers below to some of the most pressing issues they are likely to face. Additionally, Littler Mendelson is committed to educating employers about this legislation. To this end, we will be providing additional publications relating to how these new rules affect the following:

- Small employers
- Collectively bargained employees

- Wellness programs
- Contingent workforce
- Plan design

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

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

While employers are not required to provide health insurance to their employees, those who do not will be penalized.

Beginning in 2014, under the reconciliation legislation, employers with more than 50 full-time employees that do not offer coverage must pay a penalty to the government of \$2,000 multiplied by the number of full-time workers if any employee received a federal subsidy to purchase health insurance through an exchange. 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 \$3,000 for each full-time employee getting a federal subsidy up to a cap of \$750 multiplied by the number of full-time employees.

Pursuant to the reconciliation bill, employers would be able to subtract the first 30 full-time workers from the calculation of this penalty payment. 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 will 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, employers with more than 200 employees will be required to automatically enroll their employees in their health plans with each employee being provided the opportunity to opt out of the plan. The legislation will provide assistance for small employers that provide health insurance to their workers in the form of a tax credit. The tax credit would be limited to firms employing fewer than 25 employees.

The new “employer responsibility” penalty 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. Though not a strict “play-or-pay” mandate, the penalty provisions reflect a shift away from the current voluntary and flexible nature of such benefits.

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

*Answer:* Yes, in certain circumstances.

As described above, the PPACA will 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 addition, the PPACA 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. These vouchers 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 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. This 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 if certain employees decide to obtain coverage through a 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. Will we be able to provide our employees' health insurance through the health insurance exchanges?**

*Answer:* Initially, smaller employers would be able to offer health insurance through the exchanges once they become operational. Larger employers may eventually be able to do so as well.

States are required to create health insurance exchanges offering different levels of qualified health insurance plans beginning in 2014. Instead of the much discussed public health insurance option, 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 organizations with 50 or fewer employees. Beginning in 2017, states have the option to expand the exchange to larger employers.

### **4. Will we have to change our benefit plan?**

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

Even though the legislation includes "grandfathering," or preserving the ability of group health plans to operate as they do today, there are exceptions that could eventually erode the current structure of the Employee Retirement Income Security Act (ERISA) created for employers to provide health insurance to their workers.

Under the reconciliation legislation, "grandfathered" plans in effect as of the date of enactment would be subject to certain insurance market reforms, such as the prohibition of lifetime limits, prohibition on rescissions and the requirement to provide coverage for non-dependent children up to age 26. The grandfathering provision is silent with respect to the impact of plan changes made 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 legislation states that the agreement must be ratified before the legislation's 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 decide to revisit the attractiveness of providing health benefits to their employees, especially in light of the new restrictions and mandates and the trajectory that health care costs may take. However, the alternative to coverage will be a penalty. Some employers, may decide to take a hard look at the costs of providing employees with health coverage versus the costs incurred by paying the penalty.

### **5. What is the "Cadillac" plan excise tax?**

*Answer:* If you offer a high-premium health insurance plan to your employees, 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 new legislation would, beginning in 2018, impose a 40% excise tax on employment-based health plans whose premiums exceed \$10,200 for singles, \$27,500 for family plans, \$11,850 for retirees and \$30,950 for employees in high-risk occupations, indexed for inflation. The reconciliation bill delays the original 2014 effective date in the PPACA. The tax would be on the amount exceeding the relevant threshold and would be paid by insurers, or, in the case of self-insured plans, by the employer. These threshold levels could be increased for plans that have significant numbers of women and/or older workers. The cost of dental and vision benefits would not be factored into health care costs for excise tax purposes. 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 over time. With respect to the PPACA, which contained a lower threshold, the Congressional Budget Office (CBO) 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.”

## 6. Will health insurance plans be taxed?

*Answer:* Yes, the legislation will impose a new premium tax on group health plans to fund comparative effectiveness research. New annual fees on health insurers and device manufacturers may also be passed on to employers.

The new premium tax would be imposed on fully-insured and self-insured group health plans to fund comparative effectiveness research. In addition the new annual fees on health insurers and medical device makers are, according to the CBO, likely to be passed through to private payers. The health insurance provider fee would begin at 2014. Third party administration agreement fees for self-funded plans are not included in the allocation of the annual fee. An annual excise tax of 2.9% on medical device makers would start in 2013. The legislation also imposes an annual fee on prescription drug manufacturers beginning in 2011 that would be allocated based on sales to government programs.

It is important to note that the tax deduction for employers that receive a federal subsidy for offering prescription drug coverage for retirees will end in 2013. The Medicare Modernization Act of 2003 provided subsidies to employers to maintain prescription drug coverage for Medicare-eligible retirees. Ending the deductibility of the subsidy will add 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” health care activities.

The health care legislation imposes minimum medical loss ratios on health insurers. 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. 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.

## 8. Can we change our retiree health benefits?

*Answer:* Unlike the earlier House-passed version of health-care reform, the final bill does not restrict the ability of employers to change retiree health benefits.

However, the PPACA will provide \$5 billion to 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 will pay 80% of the cost of benefits provided per enrollee between \$15,000 and \$90,000. The employer will be required to use funds to lower the cost of the plan and these funds may not be used for other purposes.

## 9. What happens to Flexible Spending Accounts?

*Answer:* Employers that offer flexible spending accounts (FSA's) and employees who utilize them will face new contribution limits.

Employers that have utilized FSA's 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 FSA's. Beginning in 2013, salary reductions for FSA's will be limited to \$2,500. This amount will be indexed for inflation. However, if health costs continue to rise at a higher rate than inflation, the effective value of FSA's may diminish over time.

## 10. Will the PPACA reduce health care costs?

*Answer:* The ultimate question for employers is whether or not 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 opined that the PPACA "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.

In other words, the CBO expects employer-sponsored health insurance costs under the PPACA 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 employees, 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 is provided with the authority to raise this amount to as much as 50%.

## 11. How will this legislation impact employer-provided health care?

The CBO projects that 3 million fewer people will obtain employer-provided health insurance by 2019. While an additional 6 to 7 million people would have employer coverage relative to under current law, between 8 and 9 million people would lose their employer-provided coverage and between 1 and 2 million people would opt-out of employer-provided coverage to obtain insurance through the exchanges.

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 health benefits. Given these dynamics, employers may wish to factor into their consideration of the health plans to offer their employees, the cumulative effect of new restrictions, mandates and the likely trajectory of

health care costs in the wake of this sweeping legislation. And it may not be easy to quantify the impact of these changes, as the CBO concluded, “considerable uncertainty . . . 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 must 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, some employers may be driven to reevaluate the cost of providing health care coverage to their employees relative to the penalty for not providing coverage. For some, it may become more cost-effective to pay the penalty than provide the coverage. In addition, employers may turn increasingly to contingent workers to eliminate the cost of providing health insurance or the penalty for not doing so. And as the health insurance exchanges become available to larger employers, fewer workers are likely to obtain health insurance through their employers. As employers re-examine the compensation and composition of their workforce, health care reform is likely to transform not only employee benefits, but the nature of the employment relationship itself.

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