

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

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As a consequence of recent votes taken in the U.S. Senate, and barring some major unforeseen event(s), federal health care reform appears all but inevitable. While the final contours of the new law are not yet settled, certain broad themes are emerging. These include an individual mandate, major insurance reforms, a national or various state-level health insurance clearinghouses or “exchanges,” and—of particular interest to employers—a mandate requiring employers to provide health coverage to employees or pay some sanction, fine or fee to the government.¹

The current bills that remain to be melded into final legislation are the House version, the *Affordable Health Care for America Act* (H.R. 3962), and the Senate proposal, the *Patient Protection and Affordable Care Act* (H.R. 3590). Both are comprehensive, lengthy, and detailed, and each would make major changes to the financing of health care and the structure of health care insurance in the United States.

This client advisory focuses on the likely impact of federal health care reform on employers. It explains the key features of both bills; assesses the likely impact on employers (cost and administrative complexity); and speculates on what the final legislation may look like. For employers domiciled or with operations in Massachusetts, some of what is described here will be familiar. For others, the Massachusetts experience with the employer mandate adopted in 2006 furnishes clues about the problems and issues that may arise in implementing the final version of the national legislation.

There is no specification as to which components of the House and Senate bills are “employer-related.” Nonetheless, we focus in this advisory on what we believe are those items that are likely to be of greatest interest to employers—*i.e.*, provisions that are costly, that are administratively challenging, and that may well require wholesale changes in benefits programs and structures. In an effort to simplify the scope of our presentation, 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.** These requirements include the pay-or-play or free rider surcharge, and the requirements of a basic benefit package.
2. **Requirements imposed on health insurance carriers.** These requirements include insurance rules and mandates (*e.g.*, guaranteed issue and renewability, and the bans on pre-existing

condition exclusions and lifetime limits) that, while directed at carriers, will have an important, indirect effect on employers.

3. **Other important provisions likely to affect employers.** Here we include the individual mandate, the role of health insurance exchanges, and financing issues.

I. Direct Employer Mandates

The Pay-or-Play Requirement

Under both bills, employers would be required to offer employer-subsidized coverage to their employees. Any employer that does not offer the coverage must pay a penalty to the government. While this employer mandate is of critical importance to all employers, it will impact some more than others. For example, there may be less of an impact on large employers in sectors that traditionally offer generous health benefits. But, depending on which approach is finally adopted, much will depend on how part-time employees are treated (and even what constitutes a “full-time” vs. a “part-time” employee).

House Bill (§ 411)

Under the House bill, employers would have to:

1. offer for purchase, and pay a set amount of the premium cost of, coverage under a Qualified Health Benefits Plan (defined below), **or**
2. make contributions to an insurance “exchange” (described below).

A Qualified Health Benefits Plan (QHBP) is one that covers services required to be part of an “essential benefits package.” An “essential benefits package” includes preventive services and well child care with no cost-sharing; hospitalization; outpatient hospital and outpatient clinic services, including emergency department services; physician and other health professional services; prescription drugs; rehabilitative services; mental health, behavioral health and substance use services; durable medical equipment, prosthetics and orthotics; maternity care, well baby and well child care; and oral health, vision, hearing services, equipment and supplies for persons up to 21 years of age. The out-of-pocket maximum for such a package is \$5,000 for individuals and \$10,000 for families, indexed to the Consumer Price Index, and annual and lifetime limits are prohibited.

To satisfy the contribution requirement, the employer would have to offer to pay, on behalf of full-time employees, at least 75% of the cost of the lowest cost of a QHBP for individuals and 65% of such cost for families. These amounts would be prorated for part-time employees. Alternatively, the employer may forgo offering coverage entirely and instead pay an annual amount to the government equal to 8% of its payroll. However, this payment is not required of

employers with annual payroll of less than \$500,000, and is reduced for employers with annual payrolls of between \$500,001 and \$750,000.

Senate Bill (§§ 1513, 10108)

Like the House bill, the Senate bill would require “applicable large employers” to make coverage available to 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 receives a premium tax credit (*i.e.*, a government subsidy for his or her benefit coverage). A “full-time” employee is one who works 30 hours or more on average per week. Seasonal employees would be excluded. For employers that do not offer health insurance, the assessment would be equal to \$750 per full-time employee (including employees who do not receive premium tax credits). For employers that do offer coverage but have one or more employees receiving a premium tax credit (*i.e.*, because the coverage does not meet minimum standards and the employee opted out of it), the assessment would be 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 would be determined month-by-month. Any employer that imposes a waiting period of over 60 days would have to pay an additional penalty of \$600 for any employee to whom the waiting period applies.

Employers that offer coverage would also have to offer an optional voucher arrangement (a “free choice voucher”) to those employees:

- with incomes 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, and
- who chose to decline employer coverage and instead enrolled in a plan offered through the Exchange.

The voucher payment would be equal to what the employer would have paid to provide coverage to the employee under the employer’s plan. Employers providing free choice vouchers would not be subject to penalties for employees that receive premium credits in the Exchange.

Comment: The Senate bill is clearly more employer-friendly: penalties are assessed only with respect to full-time employees. Moreover, the House bill’s 8% of payroll standard is pretty steep. While the consensus is that the final product will look more like the Senate bill, this subject has not garnered a lot of attention, at least in the mainstream media. Therefore, there is the risk that the conferees might choose to favor the House approach.

Medical FSA Limits (Senate § 9005, House § 532)

Both bills cap medical flexible spending account contributions at \$2,500, but the Senate bill includes a cost-of-living adjustment. Also, the bills have differing effective dates. The Senate bill would take effect January 1, 2011, while the House bill would take effect January 1, 2013.

Comment: Medical FSA contributions will almost certainly be capped. Whether the cap will be subject to adjustment, and when it will take effect, is anyone's guess.

Over-the-Counter Drugs (Senate § 9003, House § 531)

Both bills would deny coverage for over-the-counter drugs under medical FSAs, health reimbursement accounts, health savings accounts, and Archer medical savings accounts.

Comment: Given that the bills are in general agreement, we expect that this provision will appear in the final version of the legislation.

Automatic Enrollment (Senate § 1511, House § 412)

Taking a page from the success of 401(k) plan automatic enrollment, both bills include automatic enrollment requirements. Under the House bill, employers that offer coverage would have to automatically enroll employees into the employer's lowest cost premium plan. The Senate bill would require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. In neither case would employees be required to accept coverage.

Comment: An automatic enrollment requirement is a virtual certainty. The conference committee will, however, need to reconcile different effective dates (the House bill takes effect January 13, 2013, while the Senate bill takes effect a year later).

Employer Reporting Requirements (Senate § 1514, House § 501(b))

Both bills require employers that provide coverage to report information on enrollment to the Internal Revenue Service.

Comment: Additional employer reporting requirements are to be expected, if not in the statute then by regulation.

Tax on the Medicare Retiree Drug Subsidies (Senate § 9012)

The Medicare Modernization Act of 2003 established a "Medicare Retiree Drug Subsidy" (RDS) program for qualifying group-health-plan sponsors. The Medicare RDS 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 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 would eliminate favorable tax treatment of the RDS subsidy; the House bill has no provision on the topic.

Comment: The Senate proposal has generated a good deal of resistance from the business community, which points to a Congressional Budget Office study saying that the change would result in 37% of all retirees with employer-based drug coverage losing their prescription drug coverage as a result.

Small Employer Premium Subsidies

House Bill (§ 521)

The House bill provides that, beginning in 2013, “small employers” (*i.e.*, those with fewer than 25 employees and average wages of less than \$40,000) would receive a health coverage tax credit of 50% of premium costs for up to two years. A credit of 100% of premium costs would be available to employers with 10 or fewer employees and average annual wages of \$20,000 or less. The credit would be phased out based on the size of the employer and its average wages. No credit would be available for employees earning more than \$80,000 per year.

Senate Bill (§ 1421)

The Senate bill would provide 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. For tax years 2010 through 2013, the credit would be up to 35% of the employer’s contribution, provided the employer contributes at least 50% of the total premium. For tax years 2014 and later, small employers that purchase coverage through an Exchange would be eligible for a tax credit of up to 50% of the employer’s contribution, provided that the employer contributes at least 50% of the total premium cost. In each case, a tax credit equal to 100% of the employer’s contribution would be available only to employers with 10 or fewer employees and average annual wages of less than \$25,000. The credit would be phased out as firm size and average wage increases. Tax-exempt small employers would be eligible for the tax credits.

Comment: Small employer subsidies are a near certainty because of the similarities of the two bills on this issue.

Retiree Medical Reinsurance Program (Senate § 1102, House § 111)

The House bill proposes a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. The program would provide for reimbursement to employers for 80% of retiree claims between \$15,000 and \$90,000. The Senate bill calls for a similar temporary reinsurance program.

Basic Benefit Plan Design Features

Both the House and Senate bills would establish 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 it provides 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. In addition to the basic package, both bills also establish several tiers of plans offering enhanced coverage.

House Bill (General Definitions, § 222)

The House bill would establish three levels of benefit categories—basic, enhanced, and premium—that vary by their percentage of actuarial equivalent value of the “essential benefits package” (which forms the basis of a QHBP). The basic, enhanced and premium levels provide an actuarial equivalent value of 70%, 85%, and 95%, respectively, of the reference benefits package. All plans would be required to offer at least the basic benefit plan. Under a transitional rule, certain “grandfathered” plans are treated as satisfying the requirements of an essential benefits package for a period of five years. “Grandfathered plans” in this context are generally employers’ existing group health plans, but only if there are no changes to the plan’s terms or conditions, including benefits and cost-sharing, from those in place when the requirements go into effect on January 1, 2013.

Senate Bill (§ 1301 et seq.)

The Senate bill also mandates a basic benefits package—referred to as a “Qualified Benefit Plan”—that provides a comprehensive set of services and covers at least 60% of the actuarial value of the covered benefits. 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 and rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. The bill establishes four coverage packages (bronze, silver, gold and platinum) of varying actuarial values, and all individual and small group insurers would have to offer, at minimum, plans in the silver and gold levels. The Secretary of Health and Human Services (HHS) is directed to promulgate and update the basic benefit packages.

Comment: Basic coverage standards are critical to the operation of health care reform, and the two proposals are very similar. The conference committee should be able to merge these provisions without too much effort. But the bar on lifetime limits may have a profound effect on self-funded plans, since stop-loss carriers may be unwilling to underwrite exposure that is potentially unlimited.

II. 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. Both the House and the Senate have approached these reforms by starting with a series of temporary measures aimed at particular underwriting practices, followed

by a set of permanent reforms. While the bills differ in some of their particulars, they are generally in agreement as to their broad purposes and objectives.

Temporary and Transitional Provisions

House Bill

On enactment, the House bill would establish a temporary national high-risk pool to provide health coverage to individuals and their spouses and dependents with pre-existing medical conditions. Individuals who have been denied coverage, have been offered unaffordable coverage, have an eligible medical condition, or have been uninsured for at least six months would be eligible to enroll in the national high-risk pool. (§ 101) Individuals eligible for COBRA continuation coverage would be able to retain COBRA coverage until the Exchange is established or they obtain acceptable coverage. (§ 113) Separately, and of critical importance to employers, is a provision that would prohibit reductions to retiree benefits unless reductions also apply to current employees. (§ 110)

Beginning six months after enactment, the bill would prohibit health plans from placing aggregate dollar lifetime limits on coverage, (§ 109) and prohibit insurers from rescinding coverage except in cases of fraud. (§ 103)

Senate Bill

The Senate bill would provide immediate access to a high-risk insurance pool for people with pre-existing conditions, and it would create a temporary insurance program with financial assistance for those who have been uninsured for several months and have a pre-existing condition. (§ 1101) These provisions would terminate when the Exchanges become operational in 2014.

Guaranteed Issue/Renewability (Senate § 2703, House § 212)

Both the House and Senate bills would establish broad-based rules relating to guaranteed issue, premium rating, and prohibitions on pre-existing condition exclusions in the insured group market and in the Exchange(s). The House bill would take effect January 1, 2013; the Senate bill would take effect a year later.

Extended Dependent Requirements (Senate § 2714, House § 216)

Both bills would extend dependent coverage. Under the House bill, coverage would be provided up to age 27; under the Senate bill, up to age 26.

Annual and Lifetime Limits

House Bill (§ 109)

Effective six months following enactment, the House bill would prohibit individual and group health plans from placing aggregate dollar lifetime limits on coverage.

Senate Bill (§ 1001(5))

Effective six months following enactment, the Senate bill would prohibit individual and group health plans from placing aggregate dollar lifetime limits on coverage. Beginning in January 2014, similar rules would be extended to annual limits. Before then, the extent to which a plan may impose annual limits would be determined by the Secretary of HHS.

Nondiscrimination Testing (Senate § 1001(5))

The Senate bill would impose nondiscrimination rules on insured medical plans that are currently applicable only to self-insured plans. The House bill has no similar feature.

III. Other Important Requirements

The Individual Mandate

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

House Bill (§ 501)

The House bill would require all U.S. citizens and legal residents to maintain “acceptable coverage” or pay a federal income tax penalty equal to the lesser of:

1. 2.5% of the excess of the taxpayer’s adjusted gross income over the threshold amount or the average premium in the Exchange, or
2. the applicable national average premium for individual or family coverage.

The tax is prorated for portions of the year when the taxpayer did not have “acceptable” coverage. Hardship waivers are available. “Acceptable coverage” includes qualified health benefit plans, grandfathered plans, Medicare, Medicaid, and tribal, TRICARE and VA coverage. Any entity providing acceptable coverage to individuals must furnish annual documentation of coverage.

Senate Bill (§ 1501(b))

The Senate bill would require all American citizens and legal residents to purchase “qualified health insurance coverage.” Qualified health insurance coverage means and 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 and incarcerated individuals. Individuals would have to report on their federal income tax returns the months of the year for which they had qualified health insurance coverage. Health plans would also have to provide coverage documentation to both covered individuals and the IRS. The penalty for not maintaining coverage would be 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 bill would impose a tax on individuals without qualifying coverage, to be phased in beginning in 2014, of \$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.

Comment: The Senate approach has been criticized for being too modest. If an individual can choose to ignore the individual mandate by instead paying \$750 (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. The result will be not only to permit adverse selection but to create 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 a major success. The idea of a connector has been a part of each of the current rounds of federal health care reform proposals. The House and the Senate bills both envision that the Exchanges will feature one or more web-based portals to direct individuals to insurance options, and otherwise facilitate access to coverage.

House Bill (§ 301 et seq.)

The bill would create a single, national “Health Insurance Exchange,” which would be administered by a new federal agency called the “Health Choices Administration.” Individuals and small businesses would be able to purchase coverage through the Exchange. The commissioner of the Health Choices Administration would have the authority to expand the Exchange to larger groups after a three-year transition period. Once individuals qualify for coverage under the Exchange, they would remain eligible until they qualify for Medicare. States may also elect to establish their own Exchanges (one per state), but the commissioner has the authority to terminate a state Exchange.

Senate Bill (§ 1311)

The Senate bill departs from the House bill in one important respect. Under the Senate bill, beginning January 1, 2014 each state would be required to create:

1. an Exchange so as to facilitate the sale of qualified benefit plans to individuals, and
2. “SHOP (or Small business Health Options Program) Exchanges” to help small employers purchase coverage.

These two functions could be combined into a single Exchange serving both the individual and group market. Plans offering coverage through the Exchange would have to submit premium increase justification through the Exchange prior to implementation, and the Exchange could use this information and premium increase patterns to deny a carrier the ability to sell Exchange-based policies.

Comment: The key differentiator between these bills is the presumed locus of the Exchange. The House prefers a national Exchange; the Senate has opted for a state-centric approach. While it may not be immediately apparent, there is a great deal riding on which approach is adopted in final legislation. The McCarran–Ferguson Act of 1945² allows the states to regulate the business of insurance, generally without federal government interference. It does, however, empower Congress to pass laws in the future that would have the effect of regulating the business of insurance. The adoption of a national Exchange would likely be considered by state regulators as a major encroachment on their traditional regulatory authority. On the other hand, multi-state employers would rather deal with a single, national Exchange than one exchange per state.

Tax Credits for Low-Income Individuals

The principal mechanism whereby coverage is made affordable to low-income individuals is the “premium credit”—a.k.a. “affordable premium credits”—which help certain individuals pay for health insurance. These credits would be available to limit the amount of money individuals would pay for premiums, based on income. Eligibility would be determined with reference to income as a percentage of the FPL.

House Bill (§ 344 et seq.)

Under the House bill, premium credits would be available only to individuals enrolled in a plan offered through the Exchange, and would be determined with reference to the average cost of the three lowest cost basic health plans in the geographic area. Affordability premium credits would be available only to U.S. citizens and lawful residents who meet the income limits and who are not enrolled in an employer plan, individual coverage, or governmental coverage (*e.g.*, Medicare, Medicaid, TRICARE, etc.), with certain exceptions. Those individuals who have access to employer-based coverage would qualify for the affordable premium credit only if the cost of the employee premium exceeded 12% of his or her modified adjusted gross income. Affordable

premium credits and cost-sharing subsidies would be available to individuals and families with incomes up to 400% of the FPL.

Senate Bill (§ 1401 et seq.)

The Senate bill would make premium credits available to individuals and families with incomes between 100 and 400% of the FPL to purchase insurance through the state exchanges. Like the House bill, availability would be limited to U.S. citizens and legal immigrants who meet the specified income limits. Credits would be tied to a benchmark plan offered through the Exchanges, based on a sliding scale under which premium contributions would generally be limited to 2.8% of income for those at 100% of the FPL to 9.8% of income for those between 300 and 400% of the FPL. Cost-sharing subsidies would be available to individuals and families with incomes between 100 and 200% of the FPL. Individuals with incomes less than 133% of the FPL should be eligible for Medicaid coverage.

Employees who are offered employer-sponsored coverage would be 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 income.

Comment: Should the conferees adopt the Senate “free rider surcharge” approach to the employer mandate, then employers who don’t offer coverage will be very interested in the extent to which their employees are eligible for the affordability premium credit. An employer that provides no health coverage pays nothing to the government if it has no employees eligible for the credit. If such an employer has eligible employees, it will be required to pay an assessment that can vary based on the number of such employees in its employ.

Financing

Financing for the additional federal costs associated with health care reform has proved something of a flashpoint, with the House and Senate taking fundamentally different approaches. The House prefers a broad-based tax surcharge on high-income individuals. In contrast, the Senate has chosen a narrower approach, the core feature of which is a tax on “Cadillac” health plans. While issues like abortion and the public option have dominated the popular press, financing is equally divisive and daunting.

House Bill

Beginning in 2011, the House bill would impose a surtax on adjusted gross income of 5.4% for joint filers earning \$1 million and single filers earning \$500,000 or more. (§ 551) In addition, it would increase the tax on distributions from Health Savings Accounts that are not used for qualified medical expenses from 10% to 20% (§ 533), and would impose a 2.5% excise tax on medical devices. (§ 552)

Senate Bill

The Senate bill would impose an excise tax of 40% on premiums in excess of \$8,500 for individuals and \$23,000 for families. (§ 9001) For certain qualified retirees and individuals in high-risk professions, these thresholds would be \$9,850 for individuals and \$26,000 for families. Plans that exceed these limits are referred to colloquially as “Cadillac” plans, and a plan’s status as such would be determined by taking into account both basic health benefits and ancillary benefits (such as medical FSAs and health reimbursement accounts). The bill also calls 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. (§ 9015) Like the House bill, the Senate bill would increase the penalty for “taxable distributions” for non-qualified medical expenses from Health Savings Accounts. (§ 9004) Under the Senate bill, employers would also have to report the value of health benefits on W-2 forms. (§ 9002) The bill also would increase the threshold for itemized medical deductions from 7.5% to 10%. (§ 9013)

Comment: If the conferees adopt the Senate’s approach, employers are likely to scale back their coverage to avoid paying this tax. This might mean eliminating ancillary benefits.

The Impact on Employers and Group Health Plans: Lessons from Massachusetts

With more than three years of experience with health care reform in Massachusetts, there are a handful of lessons that are likely to be especially relevant should federal health care reform materialize. First and foremost, the day-to-day administration of the employer mandate is more complex than anticipated, despite good faith efforts by regulators to adopt rules intended to facilitate administration. This experience is likely to be repeated at the federal level, which means that employers will need to rely more on their in-house human resource staffs and their external brokers, consultants, and other advisors to ensure initial and ongoing operational compliance.

The second lesson from Massachusetts is that the burdens of health care reform are not evenly spread. Certain industries and sectors (large manufacturers, financial services, and higher education, for example) find compliance relatively simple, while restaurants, retailers, and many small businesses struggle. Particularly hard hit is the staffing industry, where employment status raises a host of compliance issues, only some of which are related to health care.

The third, and perhaps most important, lesson from Massachusetts is that the process of implementing and adapting can be wrenching and require wholesale structural change. Like most major changes, the process appears impossible at the outset, then proceeds to difficult, and ultimately (hopefully) arrives at easy. In the case of federal health care reform, this last state may be a long time coming.

Conclusion

There is broad consensus that “something” must be done to reduce health care costs, increase health care quality, reduce systemic waste and inefficiencies, and expand affordable health care coverage. There is far less consensus about the ways in which to achieve these goals. Owing to some confluence of politics and political necessity, it appears that some federal health care reform measures along the lines described above will pass in early 2010. In the process, much has been written about the parallels to the Massachusetts experience, and the parallels are indeed striking.

It would be a mistake, however, to give too much credit to Massachusetts. The antecedents of the current health care reform proposals go back much further—at least as far back as the Nixon Administration. On February 19, 1971, the Nixon White House released a health care reform proposal that was in part intended to counter Democratic proposals for universal health care. Entitled the “The Family Health Insurance Plan,” the proposal called for health insurance coverage for all poor and unemployed Americans with incomes up to \$5,000. The very poor would get free coverage, while those with higher incomes would pay some portion of the premium cost. The plan also included an employer mandate to provide coverage, and a nationwide network of HMOs. The bill never became law, but its failure serves as a reminder that these issues have been with us for a long time. It also serves as an indicator of the shifting political sands on which the health care debate is taking place.

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Endnotes

¹ This latter requirement is variously referred to as a “pay-or-play” or “free rider surcharge.” While technically different concepts, they are now used in many quarters interchangeably to refer to the employer’s obligations, and they are also referred to summarily in this advisory as the “employer mandate” or the “employer coverage mandate.”

² 15 U.S.C. §§ 1011-1015.

For further information regarding this or any issue related to Health Care Reform, please contact one of the attorneys listed below or the Mintz Levin attorney who ordinarily handles your legal affairs.

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