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Understanding the New Healthcare Act: A Primer for Employers

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Background Facts

Sixty percent of the US population is covered by employer-sponsored group health insurance plans. The average premium cost nationwide for those employer-sponsored plans for a family of four is $13,400. On average, employees pay 27% of this cost or roughly $3,600 per year, usually withheld from paychecks in installments of $300 per month. Health care expenditures are expected to rise by 6.2% per year over the next 10 years, taking the average premium cost for this group health care coverage to a whopping $25,000 by 2018, which would bring 27% of the premium cost to $600 per month.

The Patient Protection and Affordable Care Act or Affordable Care Act (ACA) is supposed to raise monies to pay for healthcare coverage for that 40% of the US population not now covered by a group health care plan, but it does little to address the anticipated rising cost numbers for the already insured. However, these rising costs will likely drive the decisions of employees and employers alike as they respond to the "pay or play" scheme devised to raise revenues to cover the uninsured. If you don't "play" as proscribed, you will have to "pay" a penalty. These play or pay mandates don't start until January 1, 2014, but there are decisions being made today which will greatly impact employers come 2014. It is worth understanding the ACA now and planning ahead.

How Play Or Pay Will Work for the Individual

Every individual with a household income greater than 138% of the poverty level[2] will be required to enroll in a healthcare plan with minimum essential coverage or pay a penalty to the IRS. Thus, if the individual plays and enrolls in a qualifying health insurance plan (presumably one offered by their employer or from an exchange), he or she won't have to pay a penalty. Assuming an employer requires their employees to pay 27% of insurance premium costs, the average primary wage earner uses between $2,000 - $4,000 per year of their income for insurance coverage. If that wage earner chooses not to play by refusing to participate in healthcare coverage, the penalty is comparatively small -- from $95 in 2014 to $695 in 2016. It's fair to be concerned that younger and healthy persons will decline to participate, and instead, pay the penalty, until such time as they believe they will actually need such health care coverage.

How Play or Pay Will Work for Employers

Before one can understand an employer's choices in the Play or Pay scheme, several terms need explication:

A "Minimum Essential Plan" is: 1) any employer-sponsored group health plan; or any 2) "qualified health plan" offered through exchanges. Those plans must have all the essential benefits required by the ACA; they must limit out of pocket and deductible expenses for enrollees; and meet certain underwriting requirements. However, exchanges do not have to be up and running until January 1, 2014.

The ACA does not obligate an employer to offer a health plan. However, if an "Applicable Larger Employer"

(ALE) does not play, they will have to pay. An ALE is an employer with 50 or more full-time equivalent employees (FTEE's). If an ALE does not play, their pay penalty is: $2,000 times the actual number of full-time employees (FTE's) over the number 30 (as opposed to FTEE's). Further, even if an ALE sponsors a group health benefit plan, if it is not affordable, then that employer must pay a penalty of $3,000 times the number of actual FTE's over the number 30, who are eligible for the new health care credit and who enroll in a health plan offered through an exchange.

An affordable plan is one that does not cost the employee more than 9.5% of house household income. Thus, if the plan requires an employee premium contribution exceeding 9.5% of the employee's household income, it is not affordable. Also, it is not affordable, if the plan pays for less than sixty percent (60%) of covered health care expenses. Finally, all employers with 200 or more FTEE's, who offer at least one healthcare plan, will be required to enroll any new employees into a plan.

Grandfathered Health Plans (GHP's) are any plans in existence on March 23, 2010 and they are exempt from some of the requirements imposed on new health plans and exchanges. However, an employer's GHP status can be lost simply by changing one's carrier and/or changing the premium contribution. The federal government issued interim regulations on July 12, 2010 which explain how GHP status can be lost and the analysis is fact intensive. (45 CFR Part 147 at pp. 38-43). Employers today facing steep increases in healthcare premiums are facing difficult decisions as changes today can cause loss of GHP status. Section D, below, analyzes the importance of GHP status.

The Employer's Pay or Play Choices

The ACA implements a free choice voucher (FCV) system which becomes effective January 1, 2014. All employers offering a group health plan (whether GHP or not), where some portion, but not all, of the premium is paid by an employee, must also provide FCV's to each qualified employee. A qualified employee is anyone who declines the employer's offered healthcare plan, but if the employee had accepted the healthcare plan, the employee would have been required to make premium contributions to the employer plan in amounts greater than 8% and less than 9.8% of the employees household income for the taxable year, whose household income is not greater than 400% of the federal poverty level for the employee's family size, and is not participating in the plan offered by the employer.[3] That FCV must be equal to the monthly amount the employer would have contributed for that employee toward the employer's healthcare plan. An exchange will then credit the amount of the voucher to the monthly premium of an exchange plan in which the qualified employee is enrolled.

The ACA contemplates that the free choice voucher scheme will be cost neutral for employers sponsoring health care plans; that is the employer will either pay the employer's share of the premium to its insurer or it will pay the same amount to an exchange in the form of a voucher. However, it assumes the cost will not cause the employer to stop providing health care coverage. The cost to self-insured employers will not be cost neutral: costs will rise or fall, depending upon their plan's actual claims experience for the year versus the expected claims volume upon which the gross premium for the year was established.

ALEs must evaluate their penalty exposures -- regardless of whether the employer offers a health care plan. ALEs will need to know and monitor this potential exposure if their workforce has employees who fall between the 138% to 400% of the federal poverty level. ($22,500.00 to $88,000 for a family of 4) against the cost to the employee and the employer to provide health care coverage. Likewise, they will need to weigh the risk of abandoning health insurance coverage altogether and their continued ability to attract and retain their employees. Obviously, for employers that sponsor healthcare plans, the fewer the number of full time employees, the lower the employer's potential penalty. For example, if an employer has slightly more than 50 FTEE's and no healthcare plan, the employer should consider reassigning tasks or contracting out some tasks to reduce their number of FTEE's.

Benefits of Having GHP Status

GHPs are forever exempt from some, but not all, of the mandates of the ACA.[4] Other mandates apply to a GHP later than they would otherwise apply to a non-grandfathered plan. Also, GHP's can enroll new employees/families and can require family coverage, but only if they were requiring family coverage participation on March 23, 2010.

Here, in chronological order, are the trigger dates for GHP's to make required changes: September 23, 2010: For plan years beginning on or after September 23, 2010, GHP's:

1. Cannot deny coverage to enrollees under the age of 19 with preexisting conditions. [ACA §1251(a)(4)(B)(i)].
2. Cannot have lifetime or annual limits for the dollar value of "essential health benefits" except that for plan years beginning before January 1, 2014, these plans may impose annual limits on "essential health benefits" to be defined by the Secretary of Health and Human Services as "restricted". [ACA §1251(a)(4)(B)(ii)].
3. Will be restricted on the use of rescissions [ACA §1251(a)(4)(A)(ii)].
4. Will be required to offer coverage of dependents who are children, until the date the child attains age 26, regardless of whether the child qualifies as a dependent for tax purposes, is married, or is a student. But for plan years beginning prior to January 1, 2014, a grandfathered group health plan may still restrict coverage to adult children who are not eligible to enroll in an employer-sponsored health plan other than the grandfathered plan. Thereafter, the grandfathered plans are subject to the same requirements as the non-grandfathered plans described above. [ACA §1251(a)(4)(A)(iv) and (a)(4)(B)(ii)].

March 23, 2011: GHP's must comply with §1251(a)(3), by supplying a standardized summary of benefits and coverage explanation as will be described in standards to be created by the Secretary of Health and Human Services.

January 1, 2014: For plan years beginning on or after January 1, 2014, GHP's:

1. Will not be able to deny coverage to any enrollee with a preexisting condition. [ACA §1251(a)(4)(B)(ii)].
2. Will be prohibited from eligibility rules based on health status related factors.
3. Will be permitted to have wellness program related rewards up to 30% of the cost of the employee-only coverage.
4. Will not be allowed to have waiting periods that exceed 90 days. [ACA §1251(a)(4)(A)(i)].

Here Are the Obligations Not Required of GHP's:

- The annual review process beginning in the 2010 plan year of unreasonable increases in premiums for health insurance coverage.
- The prohibition on discrimination in favor of highly compensated individuals. New healthcare plans must comply with the non-new discrimination rules in IRC §105(h)(2). Prior to the ACA, only self-insured plans were prohibited from discriminating in favor of highly compensated individuals on issues of eligibility to participate or benefits.
- By September 23, 2010: All plans, except GHP's will be required to:
    - Provide for preventive health services;
    - Freedom to choose health care professionals without being limited to a certain list;
    - No limits on the access to emergency services based on prior authorization;
    - Plans must afford in-and-out of network providers with the same coverage limits and cost sharing; and

    - Cannot require referrals for OB/GYN services.
- No requirement to report annually on the use of provider reimbursement structures and initiatives to improve health outcomes, reduce errors and implement health and wellness activities.
- No need to determine the amount of premiums using adjusted community rating rules.
- Not prohibited from denying routine patient costs of individuals with respect to participation in approved clinical trials involving cancer or other life threatening conditions.
- Not subject to the non-discrimination requirements on group health plans and issuers, in the individual and group markets, with respect to plans and insurer choices of health care providers that may serve as participating health care providers.

Planning for the Future

An employer with a GHP may desire to retain the benefits of that status. However, given the current inexorable rise in health care costs, employers must anticipate facing significant increases in the cost of their plans from their current insurance carrier. While the ACA does not address at what point changes to a group health plan in existence on March 23, 2010 are significant enough to change GHP status, recently published interim regulations say that GHP status will be lost if the employer changes health insurance carriers (or, if the plan is self-insured, changes third party administrators), unless the employer is subject to a collective bargaining agreement (cba). As a result, an employer that leaves its current health insurance carrier to go to a more competitively priced plan, even with the same level of benefits, will lose GHP status, unless the employer has a cba, in which case union-represented employers can change insurers so long as still abiding by the terms of a cba. However, changes in insurers after termination of a cba can extinguish GHP status.

Even staying with the same insurer can result in loss of GHP status if there is a "new policy, certificate or contract of insurance". Employers involved in mergers, acquisitions or multiple healthcare options should review 29 CFR Part 2590, et seq.; 26 CFR Part 54 and 45 CFR Part 147 of the interim regulations for rules applicable to these unique situations.

Loss of GHP status can also occur when there is: 1) an elimination of a benefit that previously diagnosed or treated particular condition; 2) an increase in the percentage cost-sharing requirement from March 23, 2010 percentages; 3) an increase in a fixed-amount cost sharing requirement other than a co-pay (i.e. deductible or out-of-pocket limit); 4) increases in fixed amount co-payments that exceed medical inflation; 5) certain decreases in contribution rates by employers or employee organizations whether based on the cost of coverage or based on formulas; and 6) changes in annual limits.

Conclusion

Employers are currently facing decisions about health care coverage because of the rising cost of insurance and healthcare. It is critical to understand that changes made to deal with these rising costs will likely result in the loss of GHP status. One can anticipate fewer and fewer GHP's as time passes. Employers with over 50 employees and whose workforce includes persons paid between $22,000 and $88,000 will have play or pay cost options to consider; while those with collective bargaining agreements will have opportunities different than union-free employers. By 2014, the voucher system and its penalty may look more and more attractive to company management.

Employers who may be exposed to the employer pay or pay penalty (50 or more full time equivalent employees) may be tempted to abandon healthcare coverage altogether. That may not be cost effective. If employees no longer receive employer subsidized health care coverage, they may expect pay raises. Those are far less tax-friendly to the employer than employer-paid health care subsidies: those subsidies are not subject to employment taxes; those salary increases will attract FICA taxes. The additional tax burden, when added to the employer pay or play penalties, may prove more expensive than providing subsidized health care. we may see employers exploring greater offerings of wellness plans, concierge medicine

benefits and retiree benefits while providing employees their FCV's for use at the exchanges in order to attract and keep talented employees.

How should those employers weigh the short term costs associated with rising health care premiums against the potential loss of grandfathered status? That may depend in large part on whether the employer's plan is fully insured or self-insured:

- Smaller employers probably are indifferent. They are limited to the fully insured plan marketplace. Since the health insurance carriers will be required to provide rebates if their plans' medical loss ratio exceeds 80% (85% in the large group marketplace), health insurers will be incentivized to reduce administrative overhead. One sure way to accomplish that is to avoid offering two parallel sets of products, one of which is grandfathered and one of which is not. Therefore, smaller employers (those without substantial health insurance market clout) should anticipate only having non-grandfathered plan designs from which to choose. Therefore, most employers sponsoring fully insured plans should continue to behave as they have in the past: shop for the health benefit plan design that provides coverage at an affordable cost, and place little value on grandfathered status.
- Wherever there is a general rule, there is an exception. The Affordable Care Act broadens the reach of the nondiscrimination rules that heretofore have only applied to self-insured plans. Those nondiscrimination rules will apply to all employer sponsored health benefit plans -- except grandfathered plans. Therefore, employers whose health benefit plans do not currently satisfy those nondiscrimination requirements must either (i) stick with their current insurer and forego the potential savings associated with switching insurers, or (ii) determine the cost that will be incurred by broadening coverage of nonhighly compensated full time employees sufficient to satisfy the nondiscrimination requirements and compare that increased cost to the savings from switching carriers.
- How about employers that sponsor self-insured health benefit plans? For these employers, changing plan cost-sharing features are the changes that will imperil continued grandfathered status. These employers must weigh foregoing those cost savings against the costs they may incur to comply with the other requirements that do not otherwise apply to grandfathered plans. They may discover that is not a big price.

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(1) The author relied heavily on the work and thoughtful ideas of William Freedman of Dinsmore & Shohl's Cincinnati, OH office. Freedman is a healthcare attorney and frequent speaker on the ACA.
(2) The 2009 poverty level for a single person is $10,830 and $22,050 for a family of four. Thus, any individual making over $15,000 or anyone who has a family of four and is making over $30,500 will be required to "play or pay". (Note: the poverty level is higher in Hawaii and Alaska.)
(3) Roughly, 400% of the 2009 federal poverty level for a family of four is $88,000.
(4) However, there are other mandates in the ACA that will likely effect the design and cost of sponsoring a group health plan and care must be taken to comply with those provisions as well. For example, employers must disclose on an employee's annual Form W-2 the value of the employee's health insurance coverage sponsored by the employer beginning in 2011. Also, employers with GHP's can be subject to penalties if the coverage offered is not affordable, as defined by the ACA.