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Issues for Employers as Health Care Legislation Moves to the Senate

Although the American Health Care Act, as passed by the U.S. House of Representatives, mainly affects the individual and small group health insurance markets, it has implications for large employers. The repeal of the employer mandate, the replacement of the individual mandate with a continuous coverage requirement, the delay of the Cadillac tax, and changes to requirements for individual market coverage will affect the choices available to private sector employers. Now that the Senate is drafting its own bill, employers will want to understand their stake in the legislation.

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The U.S. House of Representatives passed the American Health Care Act, H.R. 1628 ("House Bill") on May 4, 2017. Although the legislation is often characterized as repealing and replacing the Affordable Care Act ("ACA"), in fact, most of the 10 titles of the ACA are not affected. The House Bill does repeal the individual and employer mandates, and it makes other substantial changes to provisions affecting private health insurance and Medicaid. The House Bill also delays or repeals the taxes that were enacted to pay for the ACA. The House waited to send the legislationto the Senate for further action until the Congressional Budget Office ("CBO") released its analysis of the legislation on May 24, 2017, so that it could confirm that the legislation achieved the deficit reduction necessary to satisfy the Fiscal Year 2017 budget reconciliation instructions Congress adopted early this year.

Senate leaders have stated that the Senate is drafting its own bill. To proceed under budget reconciliation procedures, which limit debate and amendments and allow for passage with a simple majority, the Senate bill must reduce the federal deficit for the years 2017 through 2026 by $2 billion ($1 billion from Senate Finance jurisdiction, and $1 billion from Senate Health, Education, Labor and Pensions jurisdiction). The Senate's bill must also be free of "extraneous" material that does not affect federal revenues or outlays. No particular timeline has been announced for Senate legislation, though September 30, 2017, is a likely deadline for passage as that is when the current fiscal year will end, and the opportunity to pass a bill using a simple majority under budget reconciliation rules should expire.

SIGNIFICANT IMPLICATIONS FOR EMPLOYERS

Although most of the provisions in the House Bill, by their terms, affect the individual and small group health insurance markets, the House Bill does have significant implications for large employers:

- Repeal of the employer mandate gives employers more flexibility in deciding which employees should be eligible for coverage and how generous the coverage should be.
- If states change the rules for their individual health insurance markets as the House Bill allows, and as CBO projects would occur in states where half the U.S. population lives, inexpensive, narrow-scope plans could become available, which would be attractive to healthier and younger people, particularly if employer coverage is more expensive. These employees could then return to the employer plan during open enrollment in a later year if they get sick and want broader coverage.
- The tax credit subsidy will be more broadly available, but generally smaller, and the availability of individual health coverage in some markets may be uncertain. These factors may affect the importance of health coverage for employee recruitment and retention. Indeed, CBO anticipates that employers will consider the availability, cost, and scope of benefits in the individual market when determining whether and to whom to offer active and retiree coverage.
- Under an additional bill (H.R. 2579) passed by the House Ways and Means Committee on May 24, 2017, employers that offer self-insured plans will be required to certify their COBRA coverage if they do not subsidize the cost for separated employees and to make arrangements with the Treasury Department to accept advance payments of the House Bill's tax credit subsidy to offset the cost of unsubsidized COBRA coverage for separated employees.
- Repeal of the employer mandate and the increased Medicaid costs that states are likely to face may result in states imposing their own penalties or fees on employers. The Massachusetts legislature is close to enacting legislation that would give the governor two options for imposing an assessment on employers to help the state pay for Medicaid. Either employers with more than five employees would pay an additional annual assessment on employee wages or employers with 25 full-time equivalents or more would pay a per employee assessment if they failed to make a minimum qualifying offer of coverage or made an offer but did not get sufficient employee uptake of coverage. The minimum qualifying offer, minimum uptake, and assessment levels would be set by regulation.
- Delay of the Cadillac tax avoids the near term financial consequences for employers who offer generous health coverage, but delay is not repeal. Employers will continue to face uncertainty, not knowing whether to design their benefits in anticipation of either the Cadillac tax, or a cap on the tax exclusion for employer provided health coverage (the economic equivalent of the Cadillac tax), which several senators have previously proposed.

SUMMARY OF HOUSE BILL PROVISIONS OF NOTE TO EMPLOYERS

The following are provisions in the House Bill of interest to employers.

Employer Mandate Repeal

The House Bill would retroactively repeal the employer mandate effective January 1, 2016, by reducing the tax penalty for failing to offer employees minimum essential coverage to $0.[1] Repeal of the employer mandate will give employers latitude in deciding whether to offer health coverage to different segments of their work force. The combination of the repeal of the employer mandate and the repeal of the individual mandate, discussed below, will also allow employers to offer less expensive, basic coverage without risking penalties for themselves or their employees.

Replace the Individual Mandate with a Continuous Coverage Requirement

The House Bill would retroactively repeal the individual mandate effective January 1, 2016, by reducing the tax penalty that applies to individuals who fail to maintain minimum essential coverage to $0.[2] In an effort to counteract the adverse selection in the individual health insurance market that repeal of the individual mandate could trigger, the House Bill would create a continuous health coverage requirement.[3] This provision requires health insurers in the individual market to increase an individual's monthly premium by 30 percent during the first year of enrollment if he cannot prove that he had creditable coverage continuously during the 12-month period prior to his date of enrollment, ignoring any gap in that coverage lasting less than 63 consecutive days. This continuous health coverage requirement is effective beginning with the 2019 plan year, or for enrollments during a special enrollment period in 2018.

Health insurance companies have expressed concern about the impact of a repeal of the individual mandate on the viability of the market for individual health insurance, particularly in certain parts of the country. It is not clear whether the substitution of a continuous coverage requirement and premium penalty will stabilize those markets enough to keep individual coverage for sale in all counties across the country. Senators working on the Senate's health reform bill have raised the possibility of a two-year transition from the ACA, leaving the individual mandate and cost-sharing reductions (which subsidizes coverage for lower income individuals who also receive tax credit subsidies) in place through 2019 to help stabilize the market in the interim period.

Tax Credit Subsidy Changes

The House Bill would replace the ACA's tax credit for individual health insurance coverage with a new credit effective January 1, 2020. [4] The ACA credit guarantees that an enrollee will pay no more than a set amount of income for insurance. The credit covers the difference between that set amount and whatever a benchmark policy sold in the market actually costs. The House Bill offers a fixed monthly credit, which varies based on the covered individual's age but does not vary with the insurance premiums actually charged in the market. Individuals receiving credits under the House Bill could find themselves paying substantially more of their income for insurance comparable to what they purchase today, particularly if they are older or live in a part of the country where premiums are high. Some senators have expressed interest in varying the credit amount based on income as well as age.

Like the existing tax credit, the replacement credit would be advanceable (payments could be made to the insurer each month to cover part of the premium) and refundable (the taxpayer receives the full credit even if it exceeds the amount of tax otherwise owed). The credit is not available for an individual who is eligible for coverage through an employer group health plan, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or TRICARE. However, the new credit would be available to individuals enrolled not only in individual market coverage, but also in unsubsidized COBRA coverage with their former employers if additional House legislation (H.R. 2579) is incorporated into the Senate bill. The employers would have to make arrangements with the Treasury Department to accept advance payments of the credit to offset the cost of unsubsidized COBRA coverage.

With the elimination of the employer mandate, employers would no longer face consequences if an employee received a premium tax credit. However, employers would still have to submit information reports about the health coverage they offer so that the IRS could check whether employees were eligible for the credits they claimed. In addition to leaving in effect the employer reporting already required for each full-time employee on Form 1095-C, the House Bill requires employers to report additional information on an employee's

Form W-2, showing each month for which the employee was eligible for the employer's group health plan.

Medicaid Funding Changes

Since its inception, Medicaid has been a federal-state partnership in which the federal government matches amounts spent by the states on health care for eligible Medicaid beneficiaries. Under current law, the federal government pays a share of the state's Medicaid expenditures, determined by the state's Federal Medical Assistance Percentage. The percentage varies from state to state and may also vary from category to category of eligible beneficiaries.

The House Bill would convert federal Medicaid financing from a match for state spending on care consumed to an annual per capita allotment, which would be a fixed amount for each beneficiary in a category that would not vary with the cost or amount of care consumed. [5] A state that prefers more certainty in its federal Medicaid funding stream may elect to receive a 10-year block grant rather than the per capita allotment for each category of enrollees, which varies from year to year based on the number of beneficiaries who enroll in the state that year.

The House Bill would repeal the Medicaid expansion, meaning that no federal funding would be guaranteed for nonelderly childless adults whose income does not exceed 133 percent of the federal poverty line and who enroll in Medicaid on or after January 1, 2020. Some senators have indicated interest in preserving expanded eligibility for nonelderly childless adults.

Although the proposed Medicaid changes would not affect employers directly, they could affect employers indirectly if more states face larger state financial burdens for Medicaid and seek to tax employers or collect revenue from them to offset the cost of health care.

Health Coverage Consumer Protections Changes

Essential Health Benefits. The ACA requires all coverage in the individual and small group markets to cover 10 categories of statutorily prescribed essential health benefits (e.g., emergency services, hospitalization, maternity care).[6] The House Bill[7] would permit states to receive a waiver from HHS that would allow the state to create its own definition of essential health benefits that would have no required categories. The state could apply its definition for plan years beginning on or after January 1, 2020.

If a state were to remove one or more categories of essential health benefits from its definition, insurers offering individual and small group coverage in that state would not have to include those nonessential health benefits in their policies. Depending on the definition adopted by the state, insurers could offer catastrophic/minimum benefits coverage with lower premiums. Alternatively, insurers could include the nonessential health benefits but subject them to annual or lifetime dollar limits, a change that could also lower premiums.

If a state were to reduce the scope of essential health benefits, it is likely that employer-sponsored plans could once again apply annual or lifetime limits to benefits that the state removes from the definition of essential health benefits. The prohibition on annual and lifetime limits applies only to essential health benefits. Since employers are not required to offer essential health benefits, they are permitted to refer to any state's essential health benefits benchmark for purposes of demonstrating compliance with the ban on annual and lifetime limits. Employers need a benchmark plan for reference because the categories are not otherwise sufficiently specific. For example, if a state were to remove prescription drug coverage from essential health benefits, employers could limit the amount of coverage for certain specialty drugs or continue to require copays and coinsurance for certain tiers of drugs beyond the statutory out-of-pocket maximum, which applies only to essential health benefits provided by in-network providers.

Actuarial Value of Plans. The ACA requires all plans sold in the individual and small group market to fit within one of four standardized coverage levels (i.e., bronze, silver, gold, and platinum).[8] The House Bill eliminates this requirement for plan years starting January 1, 2020.[9] Large employers are not subject to these actuarial value requirements, although the ACA's employer mandate does put large employers at risk for a penalty if they offer a plan with an actuarial value below 60 percent. The repeal of the employer mandate in the House Bill would eliminate that potential adverse consequence if they chose to offer employees a less generous plan. Nondiscrimination rules would continue to apply, limiting the ability of employers to offer very generous plans to highly-compensated employees and less generous plans to the rest of the work force.

Age Factor in Setting Premiums. Under the ACA, the premium that an insurer may charge to a 64 year-old in the individual or small group market may be no more than three times the premium the insurer charges to a 21 year-old.[10] Under the House Bill, that ratio would increase from 3:1 to 5:1 for plan years beginning on or after January 1, 2018.[11] In addition, a state could apply for a waiver that would allow it to set a higher ratio.[12]

While these ratios do not directly impact large employers, decisions about offering retiree health benefits may become more difficult for employers if retirees who are not yet eligible for Medicare face very expensive premiums in the individual market.

High Risk Pools and Invisible Risk Sharing. The House Bill would establish and fund the Patient and State Stability Fund to provide money for states to help provide access to coverage in the individual and small group markets and to promote access to health care.[13] Within the Patient and State Stability Fund, the House Bill also establishes a $15 billion Federal Invisible Risk Sharing Program, which would provide payments to health insurers for claims incurred by individuals who have certain health conditions, with the goal of lowering premiums for coverage in the individual market. Self-insured employers would not have to pay a fee as they have for three years under the ACA to fund reinsurance for the individual market.

Delay or Repeal of Taxes

The taxes enacted as part of the ACA would be delayed or repealed by the House Bill. Most would be repealed permanently. However, it appears that to avoid incurring a revenue loss outside of the 10-year budget window, as currently required under rules for budget reconciliation legislation, the Cadillac tax would not be repealed but instead would be delayed until 2026.

- The 3.8 percent net investment income tax would be repealed effective January 1, 2017.[14] If legislation passes quickly and the effective date does not change, payors of this tax may want to adjust their estimated tax payments for the remainder of 2017.
- The additional 0.9 percent Hospital Insurance tax imposed on employee wages (under FICA) and self-employment income (under SECA) above $200,000 per year ($250,000 for married couples) would be repealed effective January 1, 2023.[15]
- The 40 percent excise tax ("Cadillac tax") on high cost employer sponsored health coverage would not go into effect until January 1, 2026.[16]
- The deduction for expenses related to retiree drug costs would be reinstated, effective January 1, 2017, even when such expenses are taken into account in determining the amount of Part D subsidies.[17]
- The 2.3 percent excise tax imposed on the sale of certain medical devices would be repealed effective January 1, 2017.[18] The tax is suspended for 2017, so no payments would be affected by repeal.
- The annual tax imposed on health insurers under ACA Section 9010 is repealed effective January 1, 2017.[19] The tax is currently suspended, so no payments would be affected during 2017.
- The tax imposed on entities that manufacture or import brand name pharmaceuticals under ACA Section 9008 is repealed effective January 1, 2017.[20] This tax is paid annually in September. Depending on what effective date is finally adopted, pharmaceutical manufacturers might pursue refunds of tax already paid during 2017.
- The 10 percent tax on tanning services is repealed effective July 1, 2017.[21] Excise taxes are paid quarterly. Depending on what effective date is finally adopted, payors of this tax might pursue refunds of tax already paid during 2017.
- The threshold for deductible medical expenses is reduced from 10 percent to 5.8 percent of adjusted gross income, effective January 1, 2017.[22]
- The rules for health savings accounts (HSAs), health flexible spending arrangements, and health reimbursement arrangements would be changed to permit such accounts to reimburse participants on a tax-free basis for purchases of over-the-counter drugs without need for a prescription.[23] Under the ACA, drug purchases are reimbursable from these tax-favored accounts only if they are prescribed by a health care provider or are insulin. This change is effective January 1, 2017.
- The annual dollar limit on contributions to health flexible spending arrangements would be repealed effective January 1, 2017.[24]
- The limit on the deduction health insurance companies may take for compensation paid to executives is repealed effective January 1, 2017. [25]

Changes to Health Savings Accounts

The annual dollar limit on HSA contributions would be increased to match the maximum out-of-pocket expenses (including the deductible) permitted under a high deductible health plan, effective January 1, 2018.[26]

HSA account holders would be permitted to use their accounts to pay for medical expenses incurred prior to the establishment of the HSA, as long the account holder establishes the HSA within 60 days after the date he becomes covered under a high deductible health plan.[27] This change would be effective January 1, 2018.

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ENDNOTES

1 House Bill Section 205.

2 House Bill Section 204.

3 House Bill Section 133, adding new section 2710A to the Public Health Service Act.

4 House Bill Section 214.

5 House Bill Section 121, adding new Section 1903A to the Social Security Act.

6 42 U.S.C. § 18022(b)(1).

7 House Bill Section 136.

8 42 U.S.C. § 18022.

9 House Bill Section 134.

10 Public Health Service Act Section 2701.

11 House Bill Section 135.

12 House Bill Section 136.

13 House Bill Section 132, adding new Title XXII to the Social Security Act.

14 House Bill Section 251.

15 House Bill Section 213.

16 House Bill Section 206.

17 House Bill Section 211.

18 House Bill Section 210.

19 House Bill Section 222.

20 House Bill Section 221.

21 House Bill Section 231.

22 House Bill Section 212.

23 House Bill Section 207.

24 House Bill Section 209.

25 House Bill Section 241.

26 House Bill Section 215.

27 House Bill Section 217.

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