

RE: Health Care Reform Implications for Public Employers
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On February 26, 2009, President Obama outlined eight principles for health care reform, indicating that comprehensive health reform should:

- Reduce the long-term growth of health care costs for businesses and governments;
- Protect families from bankruptcy or debt because of health care costs;
- Guarantee a choice of doctors and health plans;
- Invest in efforts to improve disease prevention and wellness;
- Improve patient safety and the quality of care;
- Assure affordable, quality health care coverage for all Americans;
- Maintain health coverage when people change or lose their jobs; and
- End barriers to coverage for people with pre-existing medical conditions.

A year later, contentious debate and compromise have culminated in the passage of two health care reform bills: the “Patient Protection and Affordable Care Act of 2010” (P.L. 111-148) and the “Health Care and Education Reconciliation Act of 2010” (H.R. 4872), which were signed into law by President Obama on March 23, 2010 and March 30, 2010 respectively. The new laws address many of the President’s health care reform principles by:

- Requiring most individuals to have health insurance;
- Addressing access and insurance practices in the small employer and individual markets;
- Establishing an essential benefits package;
- Calling for the development of a national strategy to improve the nation’s health; and
- Supporting comparative effectiveness research that evaluates the clinical effectiveness of medical treatments.

The new laws will *not* put an end to our current employment-based system. However, it does not appear that the new laws will do much to address the cost issues related to our health care system and employers should not anticipate any immediate relief from these pressures. Given this, public employers will need to continue to actively manage their health plans if they wish to deliver meaningful health care benefits to their employees and retirees in a cost-efficient manner.

While many of the new provisions address access and insurance practices in the small employer and individual markets, the laws will have an impact on larger public employer and public retirement system health plans. The following discussion summarizes some of the key provisions in the laws that are relevant to public employers, but is not intended to be a comprehensive description of the laws. It should also be noted that many of the details

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regarding implementing the new laws are still to be determined and will evolve over the coming months and years.

Health Plan Standards

The laws set new standards related to health plan design and access. In so doing, they make a distinction between new health plans and “grandfathered” plans. Generally, a “grandfathered” plan is an existing health plan in which an individual was enrolled on March 23, 2010.¹ Grandfathered plans are not subject to certain changes in the health laws. Nevertheless, new plans and grandfathered plans are both subject to the following changes in health plan standards. Except as otherwise noted, these provisions are effective 6 months after enactment:

- Elimination of lifetime dollar limits.
- Extension of dependent coverage up to age 26 for covered employee’s children. (Effective 6 months after enactment for children lacking access to other employer coverage and 2014 for other covered employee’s children.)
- Restrictions on annual dollar limits.
- Elimination of annual dollar limits. (Effective 2014)

In addition to the provisions above, the following apply to plans that are not grandfathered or that lose their grandfathered status:

- Elimination of limits on pre-existing conditions. (Effective 6 months after enactment for covered children under age 19 and 2014 for all enrollees.)
- Elimination of cost-sharing for preventive services.
- Elimination of emergency services preauthorization.
- Elimination of OB-GYN preauthorization.
- Providing enrollees with a choice of primary care physician.
- Elimination of waiting periods exceeding 90 days. (Effective 2014)
- Tying annual cost-sharing limits to HSA limits. (Effective 2014)

Implications for Public Employers: All public employers will have to review their existing plans and may need to make some changes to be compliant with the law’s provisions. New plans will have even more restrictions. Additional regulations will be required to provide guidance regarding: (1) whether a grandfathered plan can make any changes and still remain grandfathered, and (2) whether an existing employee can change from one grandfathered plan into another.

Employer Requirements

The new laws do not require employers to offer employees health care coverage, but do require employers with more than 50 employees to pay a fee if one or more of their employees receives a “premium tax credit.” Premium tax credits are credits provided to eligible individuals and families with incomes between 100-400% of the federal poverty level (FPL). The credits are used to purchase health insurance in the state-based health “Exchanges” established under the new laws. Beginning in 2014, states are required to create health insurance Exchanges where individuals and small businesses can purchase health insurance.

¹ Grandfathered plans may also allow for the addition of family members to an individual’s plan or the addition of new employees and their dependents to a group health plan.

The premium tax credits are intended to keep health care premiums from exceeding a certain percentage of income and are scaled to the FPL. For example, for people with incomes up to 133% of FPL, the credit would limit the premium paid for the baseline health plan to 2% of the enrollee's income. For people with incomes between 300-400% of FLP, the credit would limit the premium paid for the baseline plan to 9.5% of income. The baseline health plan premium is determined using premiums for certain low to moderately priced plans in the Exchange.

Employer Fees: Under the new laws, employers would pay the following fees if an employee receives a premium tax credit, regardless of whether the health benefits are insured or self-funded. These rules are effective starting in 2014.

- **Employers with 50 or more employees that do not offer coverage** and have at least one full-time employee who receives a premium tax credit must pay a fee of \$2,000 per full-time employee per year.
- **Employers with 50 or more employees that offer coverage** and have at least one full-time employee receiving a premium tax credit must pay a fee equal to the minimum of \$3,000 per employee receiving a tax credit or \$2,000 per full-time employee.
- **Employers with more than 200 employees that offer coverage** must automatically enroll employees in health care coverage, if the employee does not opt-out.

Free Choice Vouchers: In addition, employers that offer coverage must provide a “free choice voucher” to employees who have incomes less than 400% of the FPL and whose share of the premium is between 8% and 9.5% of their household income and who choose to enroll in a plan offered by the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage under the employer's plan and is used to offset the premium costs for the Exchange plan in which the employee enrolls. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective 2014)

Implications for Public Employers: Most public employees that are offered employer-sponsored coverage will not be eligible for premium tax credits in the Exchange. However, an employee may be eligible to receive a premium tax credit if the employer-sponsored coverage does not provide a benefit at least equal to 60% of covered benefits or the required employee contribution is greater than 9.5% of household income. If an employee does opt for coverage in the Exchange and receives a premium tax credit, then the employer will have to pay a penalty of \$3,000 per year for that employee. Most public employers currently meet the coverage thresholds, but some may require employee contributions that exceed 9.5% of household income. These employers should evaluate their liability for penalties and consider whether benefit or employee contribution changes are prudent.

In addition, the requirements for automatic enrollment and vouchers may add to the employer's administrative costs and complexity.

Essential Health Benefits Package

The new laws establish an “essential benefits package” that provides minimum comprehensive health services, covers at least 60% of the actuarial value of the covered benefits, and limits cost-sharing to the HSA limits (\$5,950 per individual and \$11,900 per family in 2010), effective 2014.

Implications for Public Employers: While providing the essential benefits package is not a direct requirement of employers, an employee who does not have access to these minimum benefits at a contribution rate that is less than 9.5% of household income is eligible to receive premium tax credits in the Exchange. Employers must pay fees if any employees receive premium tax credits in the Exchange.

Reinsurance for Retiree Health Coverage

The new laws provide a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. The program would reimburse employers for 80% of claims between \$15,000 and \$90,000. The program is effective 90 days after enactment and ends January 2014. Initial funding for this program is \$5 billion.

Implications for Public Employers: Whether reimbursements from the reinsurance program reduce a public employer's or retirement system's costs (and therefore the GASB Statement No. 45 liabilities and expenses) or only reduce the costs for retirees is currently uncertain and will depend on further guidance regarding the use of the payments. The reinsurance program is only intended to provide employers with an incentive to maintain benefits until the health insurance Exchanges are operational. At that time, employers may have less incentive to provide retiree health care benefits to early retirees, and these same early retirees may have less need for their former employers to provide retiree health care benefits.

The Secretary of Health and Human Services has indicated that the application for the reinsurance program will be available in June 2010. The program's initial funding of \$5 billion is not expected to last long. Plan sponsors should be vigilant of the process for applying for and receiving reimbursement from the program in case additional funding is not procured.

Medicare Part D Coverage Gap

When Medicare Part D first became effective in 2006, the provisions for prescription drug coverage under the standard Part D plan included a coverage gap (also referred to as the "donut hole"). The coverage gap requires plan enrollees to pay 100% of prescription drug costs that are over a certain amount, until they qualify for catastrophic coverage. For example, in 2010, once enrollees reach \$2,830 in prescription drug costs under the standard Part D plan, they are required to pay 100% of additional prescription drug costs until their total out-of-pocket drug costs reach \$4,440. At that point, the standard Part D plan's catastrophic coverage provisions pay most of the remaining costs for the year.

The new laws include a number of provisions that help to fill the donut hole. In 2010, enrollees with prescription drug spending within the coverage gap will receive a \$250 rebate. In 2011, drug manufacturers will provide a 50% discount on brand-name drugs in the coverage gap (except for individuals receiving low income subsidies and for those with incomes over \$85,000 for individuals and \$170,000 for couples). By 2020, additional subsidies will reduce the portion paid by enrollees to around 25% of prescription drug costs in the coverage gap.

Implications for Public Employers: The Medicare Modernization Act of 2003 offers employers a tax-free Retiree Drug Subsidy if they provide prescription drug benefits that are actuarially equivalent to the standard Part D benefit. The subsidy equals 28% of annual prescription drug costs (up to a certain limit) incurred for Medicare-eligible retirees that are covered by the

employer's plan. However, existing retiree drug plans that have been receiving the Retiree Drug Subsidy will no longer qualify if they are not actuarially equivalent to the new Part D benefit. Any public employer that is providing prescription drug benefits to Medicare eligible retirees should review their options and the financial implications of those options. By improving the Part D benefit without changing the Retiree Drug Subsidy levels, the new laws may make participation in Part D (through Employer Group Waiver Plans) more attractive for employers, relative to using the Retiree Drug Subsidy.

Public employers will not be affected by new provisions in the laws that prevent private-sector employers from taking a tax-deduction for the subsidy. Public employers are already tax-exempt entities.

Tax Provisions

The new laws include a number of provisions for increasing taxes and fees to pay for the health care reforms. The tax provision that may have the largest impact on public employers is the excise tax, also referred to as the "Cadillac tax." This is an excise tax, effective in 2018, on insurers or self-funded plans with total health care benefit values exceeding \$10,200 for individual coverage and \$27,500 for family coverage. The tax is 40% of the amount in excess of the threshold value, and is levied on the insurer or plan (whether or not it is self-funded) rather than the individual.

For retirees age 55 or older who are not eligible for Medicare, the threshold is increased by \$1,650 per individual and \$3,450 per family. Additionally, the threshold can be increased if the age and gender of all of the employer's employees would be expected to have a higher cost than the employees with the age and gender characteristics of the national workforce. The test is on the total cost regardless of employee/retiree contributions and includes reimbursements under a health FSA, HRA, and employer contributions to an HSA.

Implications for Public Employers: The excise tax threshold is based on fixed dollar amounts with CPI escalators and the minimum coverage and contribution restrictions are based on a percentage of an actuarial value. If health care inflation is not curbed, the cost of benefits will escalate faster than the excise tax limit. Therefore, over time, some plans may find little room between the minimum coverage required to avoid penalties and the excise tax threshold.

Employer Reporting Requirements

The new laws also establish new federal reporting requirements for employers (including governmental employers):

- Effective for the 2011 tax year, employers will need to report the value of health care coverage (including medical, dental, vision, and supplemental coverage) on employees' W-2 tax forms.
- By March 23, 2012, employer-sponsored health plans will need to provide participants with a "Universal Explanation of Coverage" that clearly and briefly (within 4 pages) summarizes the plan's covered benefits, exclusions, and cost-sharing provisions.
- Effective 2014, employers with 50 or more employees will need to report the details of employer-provided health coverage, including: (1) whether the employer offers minimum essential coverage to full-time employees; (2) the length of any related waiting periods; (3) the monthly premium for the lowest cost option; (4) the employer's share of total allowed benefit costs; and (5) the number of full-time employees for each month during

the year. In addition, the employer must report information about each full-time employee covered by the health plan, including name, address, tax identification number, and months (if any) of health plan coverage.

- Also effective 2014, employers must provide employees with information about the availability of coverage through the state-based Exchanges, including possible eligibility for a subsidy if the employer plan's share of total costs is less than 60%, as well as information about premium tax credits and free choice vouchers.

Implications for Public Employers: As a result of the new laws, public employers will need to review their health care plans and develop strategies for coming into compliance with the benefit provisions and reporting requirements. In addition, they will need to monitor future guidance and regulations that will be forthcoming from the various government agencies.

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