



AMERICAN BENEFITS COUNCIL

January 5, 2010

PRIORITY EMPLOYER ISSUES FOR CONSIDERATION OF HOUSE AND SENATE HEALTH CARE REFORM LEGISLATION

Coverage Priority Issues

1. Employer Responsibilities

Council Position: Ultimately, if unintentionally, the cumulative effect of rigid requirements on employer-sponsored health coverage is likely to lead more companies to simply “pay” rather than “play” (*i.e.* sponsor a plan). This would lower the level of active employer engagement and the important role employers play as innovative and demanding purchasers of health care services. Health care reform will involve many new responsibilities for employers. They must continue, however, to have flexibility to design benefit plans that meet the unique needs of their workforce and should not be required to meet highly prescriptive, “one-size-fits-all” coverage standards set by federal regulations or make specified contributions for the mandated coverage.

Conference Recommendations:

- Delete House “pay or play” provisions that require employers to meet minimum benefit requirements, minimum premium contribution requirements and a 70 percent minimum actuarial value standard or else pay a penalty of 8 percent of payroll.
- Employer responsibility provisions should be no more restrictive than those included in the Senate bill.
- Apply employer responsibilities only with respect to full-time employees.
- Define full-time work as a minimum of 390 hours per quarter, so that employers are not subject to penalties if coverage is not provided to temporary or seasonal workers.
- Allow up to a 90-day waiting period, without penalty, so that employers with high turnover in the workforce are not required to enroll employees until the end of this period.

2. “Free Choice “ Vouchers and Penalties for Employees Who Opt-out of Employer Plan

Council Position: While it is important to address the needs of those who may find their employer-provided coverage too expensive and who may not otherwise qualify for a federal subsidy, employers that sponsor generous plans for their employees should not also be required pay a penalty or provide a voucher to employees who opt out of their employer plan. A better solution is to make lower-cost catastrophic coverage plans available if their employer plan options are not affordable, rather than limit those lower-cost plans only to young adults.

Conference Recommendations:

- Delete House provision subjecting employers to a penalty for each employee who opts out of an employer plan and obtains coverage in a health insurance exchange.
- Delete Senate “free choice” provisions requiring employers to provide vouchers to certain employees obtaining coverage in a health insurance exchange.
- Expand the availability of lower-cost catastrophic health plan coverage in a health insurance exchange to any individual, regardless of age, whose employer-sponsored coverage is not affordable (e.g. exceeds a specified percent of income).

3. Public Health Insurance Plan Option

Council Position: Transitioning from the market rules in place today to a reformed market with new insurance exchanges available in every state is a dramatic and positive change in current practices. Achieving a reformed and well-regulated private market is essential and should be a central focus of health care reform. This core element of health reform will be challenging enough without attempting to introduce public plan options that risk destabilizing the insurance market at the same time it will be undergoing significant change and meeting demanding new standards. Our view on this issue has consistently been that vibrant competition among private health plan options in a reformed market should be given every opportunity to succeed.

Conference Recommendations:

- Delete House provisions establishing a public health insurance plan option.
- Include Senate provisions establishing multi-state, private health plan options offered through health insurance exchanges and under oversight by the Office of Personnel Management (OPM).
- Include Senate provisions allowing non-profit cooperatives to sponsor health plans through the health insurance exchanges.

4. Preservation of ERISA Framework for Employer-Sponsored Coverage

Council Position: The regulatory framework established by the Employee Retirement Income Security Act of 1974 (ERISA) is absolutely essential to employers. It allows employers to design benefit plans that meet the needs of their employees, permits multi-state employers to consistently administer these essential benefits without being subject to conflicting state or local regulations and establishes a federal framework governing any litigation involving employer-sponsored benefits.

Conference Recommendations:

- Delete Senate provisions allowing waivers to be granted to states by the Secretary of Health and Human Services and the Secretary of Treasury for numerous aspects of the federal health reform rules, including the “employer responsibility” provisions. Although these waivers do not extend to provisions governed by ERISA, they could nonetheless undermine the uniformity of new federal rules that employers will be required to comply with when they offer benefits to employees.
- Delete House provision applying state law rights and remedies to employer-sponsored health coverage obtained in a health insurance exchange.
- Delete House provisions restricting changes to retiree health coverage.
- Delete House provision limiting “grace period” to five years and include Senate “grandfathering” provision that does not limit the continuation of plans in effect as of the date of enactment.
- Modify House and Senate appeals provisions to require the Secretary of Labor to establish internal and external appeals requirements applicable to both insured and self-insured employer-sponsored health plans.

5. Additional Requirements on Employer-Sponsored Health Coverage

Council Position: Health care reform should strike a balance when adding any new requirements affecting employer-sponsored coverage. Making health care coverage more affordable for employers of all sizes is the best way to ensure the continuation of the extremely high level of participation by larger employers in offering health coverage and increase the level of participation by smaller employers who are struggling to make health coverage a reality for their employees.

Conference Recommendations:

- Modify House and Senate provisions related to coverage of adult child dependents up to age 26 to not apply with respect to large group coverage obtained outside of a health insurance exchange. At a minimum, if this requirement is applied to large group coverage, it should only apply until such

time as insurance exchanges are established, at which point individual market coverage will be broadly available.

- Include Senate provision that permits plans to determine plan design with respect to specific benefits.
- Include Senate provision limiting rating rules solely to insured coverage.
- Delete House requirement permitting individuals who become eligible for COBRA continuation coverage to remain enrolled in their former employer plan until the establishment of health insurance exchanges.

6. Individual Responsibility for Obtaining Health Coverage

Council Position: A reformed and stable insurance market requires broad participation so that individuals do not wait to obtain health insurance only when they or a member of their family has an imminent need for medical services. Achieving broad participation in the marketplace requires a combination of minimum standards that assure the availability of affordable coverage and adequate financial incentives to encourage individuals to obtain and maintain coverage.

Conference Recommendations:

- Include Senate provision that permits coverage under an employer-sponsored plan that meets federal requirements to satisfy the individual mandate.
- Strengthen both House and Senate individual mandate enforcement provisions to encourage timely and continuous enrollment in health coverage.

7. Workplace Wellness Incentives

Council Position: Workplace wellness programs are an important component of health care reform and help to reduce health costs, improve productivity, and promote personal responsibility for achieving and maintaining a healthy lifestyle. Provisions were included in the Senate bill, with bipartisan support, to allow employers to offer premium or cost-sharing discounts to encourage employer participation in workplace wellness programs.

Conference Recommendations:

- Include Senate provisions permitting employers to discount up to 30 percent of the premium or cost-sharing requirements for participants in a workplace wellness program (with discretion given to the Secretary of Health and Human Services to permit discounts up to 50 percent).
- Include Senate provisions that codify current law protections in HIPAA regulations to safeguard the privacy of employee health information and to assure that wellness programs meet appropriate non-discrimination standards. These include requirements that any rewards offered by an employer must be

available to all “similarly situated” individuals and provide that there must be a reasonable alternative available to those people whose medical conditions make it impossible to achieve the reward, or for whom it is medically inadvisable to attempt to achieve the reward.

8. The Community Living Assistance Services and Support Program (CLASS Act)

Council Position: The Council supports public and private efforts to better meet the long-term care needs of elderly and disabled individuals, but believes that the CLASS Act and other approaches to meeting these needs should be more thoroughly examined by Congress before the establishment of a major new entitlement obligation for the federal government. This is particularly important since Social Security and Medicare already face critical shortfalls and will likely compete for adequate resources with the new commitments being enacted as part of health reform legislation.

Conference Recommendations:

- Delete House and Senate provisions establishing a new national long-term care assistance program (CLASS Act). Instead direct the Secretary of HHS to provide recommendations on alternative public and private approaches to strengthen coverage and support for those with significant restrictions to daily living.

Revenue Priority Issues

1. Taxation of Retiree Drug Subsidies

Council Position: The Medicare Modernization Act of 2003 provided subsidies to encourage employers to maintain retiree drug coverage for their Medicare-eligible retirees and excluded these subsidies from taxation so that as many employers as possible would continue this valuable benefit for their retirees. Employers who provide this benefit save federal funds since it costs more for Medicare to provide the same benefits to its beneficiaries than what it spends to encourage employers to maintain this coverage.

Conference Recommendations:

- Delete House and Senate provisions requiring employers to reduce their tax deductions by the amount they receive as subsidies for maintaining prescription drug coverage for Medicare-eligible retirees. Deleting this provision will help to avoid significant losses of employer-sponsored retiree drug coverage and higher federal budget costs if retirees obtain drug coverage under the Medicare Part D program rather than an employer plan.

2. High Cost Plan Excise Tax

Council Position: Eliminate or reduce the Senate measure's 40 percent high cost plan excise tax to make it fairer and less disruptive. Large numbers of employer plans (both public and private) are certain to exceed the new tax thresholds, not because they offer “Cadillac” or “gold-plated” benefits, but simply because health care costs are increasing by an average of 7 or 8 percent a year while the tax thresholds would only be indexed to CPI + 1 percent and therefore will increase at a much lower rate than health care costs. Health plan costs may also be higher than average because of geographic variations, the average age of the workforce and for health benefits offered to retirees. Because of these factors, eventually a large number of employers could face payment of the 40 percent excise tax unless significant benefit changes are made to avoid these costs.

Conference Recommendations:

- Increase the tax thresholds so that fewer plans will face immediate taxation.
- Provide a multi-year transition rule for plans already above the thresholds in tax year 2010.
- Index the tax thresholds to the medical component of CPI, or at a minimum, by a blend of the CPI and the medical component.
- Include adjustments to reflect cost differences related to the average age of the workforce.
- Establish a “safe harbor” for plans that would not be subject to the excise tax, such as plans that do not exceed the actuarial value of plans available in the health insurance exchanges.
- Exempt employee contributions to health plans and retiree health plans from the calculations toward the tax thresholds.
- Do not count contributions to flexible spending accounts, health savings accounts or supplemental benefits such as vision care, dental care plans or wellness programs.
- Maintain the initial year increase in the tax thresholds for benefits provided in high-cost states on a permanent basis.
- Exempt plans from the excise tax if multiple plan options are offered and their aggregate average value is below the tax thresholds.

3. Annual “Fees” on Self-Insured Plans and Other Health Industry Stakeholders

Council Position: The Congressional Budget Office (CBO) has correctly advised Congress that any annual “fees” on insurers, third-party administrators of self-insured health plans, and pharmaceutical and medical device manufacturers are highly likely to be passed along in the form of higher prices paid by employers, employees and other purchasers and consumers of health care services, increasing their costs.

Conference Recommendations:

- Eliminate or reduce the annual “fees” included in both the House and Senate bills on health insurers and other health industry stakeholders (e.g. medical device and pharmaceutical manufacturers).
- Do not apply annual tax on insurers to third-party administrators or self-insured plans.

4. Additional Premium Taxes on Employer Plans

Council Position: Health care reform legislation should not include new premium taxes that will directly increase the cost of health coverage for employers and employees.

Conference Recommendations:

- Eliminate the premium taxes included in the House and Senate bills on insured and self-insured plans to fund the comparative effectiveness program and a reinsurance program for individuals in the non-group insurance market. Employers strongly support the objectives of the comparative effectiveness program and the need for reinsurance in the non-group market. However, premium taxes are a highly inappropriate financing solution for these programs since they will directly increase employer and employee costs for health coverage and establish a precedent for meeting future revenue needs by increasing these taxes, or establishing new ones, by adding to premium expenses.

5. Flexible Spending Accounts

Council Position: Limiting contributions to employee flexible spending accounts (FSA) will raise health care costs for individuals with high unreimbursed health care expenses, particularly chronically or seriously ill individuals with costly prescription drug or medical equipment needs.

Conference Recommendations:

- Increase the contributions limits to flexible spending arrangements above the \$2,500 level in both the House and Senate bills.
- Index the limits to the medical component of CPI in future years (not simply the overall CPI as now included in both bills).
- Direct the Secretary of Treasury and the Secretary of Health and Human Services to provide a report and recommendations to Congress on the impact of contribution limits on individuals with high unreimbursed health care costs due to chronic illness or serious health care conditions.

6. Tax Equity for Domestic Partners and Others Covered by Employer-Sponsored Health Plans

Council Position: Health reform legislation should eliminate the federal tax inequities for domestic partners and other non-spouse, non-dependent beneficiaries who are eligible for coverage under an employer-sponsored health plan. The Internal Revenue Code currently excludes from income the value of employer-provided benefits received by employees for coverage of a spouse and dependents, but does not extend this treatment to coverage of domestic partners or other persons who do not qualify as spouse or dependent (such as certain grown children living at home who are covered under a parent's plan or certain children who receive coverage through a grandparent or parent's domestic partner). In addition, when calculating payroll tax liability, the value of non-spouse, non-dependent coverage is included in the employee's wages, thereby increasing both the employee's and employer's payroll tax obligations.

Conference Recommendations:

- Include the tax equity provisions in Section 571 of the House bill (no comparable provisions were included in the Senate bill) that will extend the same tax treatment to domestic partners (and other persons who do not qualify as spouses or dependents) who are eligible for coverage under an employer-sponsored health plan.