



AMERICAN BENEFITS COUNCIL

March 10, 2010

PRIORITY EMPLOYER ISSUES FOR CONSIDERATION OF THE PRESIDENT'S HEALTH CARE REFORM PROPOSAL

1. Employer Responsibilities

Council Position: Ultimately, if unintentionally, the cumulative effect of rigid requirements on employer-sponsored health coverage would likely lead many 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.

President's Proposal: The president's proposal generally follows the employer responsibility provisions of the Senate bill and thereby avoids the kind of highly prescriptive mandate such as the one contained in the bill approved by the House of Representatives. However, the president's proposal does increase the penalty on employers that do not offer coverage to employees. Except for small employers with fewer than 50 workers, employers that do not offer health coverage would be assessed \$2,000 for the total number of full-time employees in their workforce if even one full-time employee obtains an income-based premium tax credit for coverage in a health insurance exchange. Also, employers would be assessed \$3,000 for each full-time employee who is not offered “affordable” health coverage and who obtains an income-based tax credit for coverage in a health insurance exchange. “Affordable” coverage is defined as coverage where the employee's share of the premium does not exceed 9.8 percent of household income or where the plan's actuarial value is less than 60 percent. No penalties would be assessed for initial coverage waiting periods up to 90 days.

Council Recommendations:

- Apply employer responsibilities only with respect to full-time employees, as in the president's proposal and the Senate measure, and not to part-time employees. Also, only full-time employees should be included for purposes of determining if a small employer has 50 or more employees and is therefore subject to the employer responsibility provisions.
- 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.

- Maintain the president’s proposal that allows employers to establish up to a 90-day waiting period, without penalty, so that industries 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.

President’s Proposal: The president’s proposal maintains the so-called employee “free choice” voucher provisions in the Senate bill. Under these provisions, employers are required to provide a voucher to employees if their share of the cost for health coverage offered by an employer is between 8 percent and 9.8 percent of household income. Qualified employees must also have household income below 400 percent of the federal poverty level. Employer vouchers would be equal to the “largest portion” of premium that the employer contributes to a health plan offered to employees. Employees who qualify for the vouchers would use these funds to obtain coverage in a health insurance exchange and would be permitted to retain any amount of the voucher that is in excess of the cost of the coverage they elect.

Council Recommendations:

- Delete the “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. 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.

President’s Proposal: The president’s proposal does not include any changes to the Senate-passed bill that generally maintains the ERISA regulatory framework. However, the bill also includes provisions allowing the Secretary of Health and Human Services and the Secretary of Treasury to waive certain non-ERISA provisions of the legislation to give states greater flexibility to establish their own requirements.

Council Recommendations:

- Delete the 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.
- Do not include provisions from the House-passed bill applying state law rights and remedies to employer-sponsored health coverage obtained in a health insurance exchange.
- Do not include House provisions restricting post retirement changes to retiree health coverage.
- Retain the Senate “grandfathering” provisions that do not limit the continuation of plans in effect as of the date of enactment (although as modified by the president’s proposal, these provisions would require that grandfathered plans meet certain requirements such as covering preventive health care services on a first-dollar basis by 2018.)
- Modify the 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, so that these important plan requirements are not established by non-federal entities and so that the procedures are subject to public review and comment.

4. Workplace Wellness Incentives

Council Position: Workplace wellness programs are an important component of health care reform and help 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.

President’s Proposal: The president’s proposal maintains the Senate provisions allowing employers to provide greater incentives to encourage participation in workplace wellness programs.

Council 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.

5. Health Savings Accounts

Council Position: The Council strongly supports allowing the full range of plan designs to be available to consumers inside and outside of health insurance exchanges, including qualified high deductible health plans (HDHPs) that are offered in connection with Health Savings Accounts (HSAs).

President's Proposal: In a March 2, 2010 letter to congressional leaders, the president indicated that he believed that his health reform proposal already permitted the offering of high deductible health plans in health insurance exchanges, but also state that he was open to "including language to ensure that [result] is clear" and recognized that "this could help to encourage more people to take advantage of HSAs."

Council Recommendations:

- For plans subject to the minimum benefits package requirements in the individual and small group markets, clarify that the Secretary of Health and Human Services may not establish coverage requirements that would preclude a high deductible health plan from being eligible to be offered in a health insurance exchange.
- Clarify that high deductible health plans that cover preventive health care services on a first-dollar basis according to standards established by the U.S. Preventative Services Task Force (as required under the legislation) shall not fail to be considered qualified high deductible health plans under standards established for coverage by HDHPs by the Department of Treasury.
- Require the Secretary of Treasury to issue regulations that take into consideration any voluntary employer contributions to HSAs for the purposes of determining whether the HDHP coverage offered by the employer meets the 60 percent minimum actuarial value standard in the legislation.

6. 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. The Council is particularly concerned about the fiscal integrity of the new entitlement program established by the CLASS Act because participant contributions would begin several years before benefits would begin to be paid out, thereby erroneously portraying the CLASS Act as a net revenue raiser for financing other aspects of health care reform legislation. The need to have a more careful evaluation before a new entitlement program is established 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.

President's Proposal: The president's proposals includes the House and Senate CLASS Act provisions but a summary of the president's proposal states that he intends to include several unspecified changes intended to "improve the CLASS program's financial stability and ensure

its long-run solvency.” [Note: details of these provisions were not included in the summary of the president’s proposal.]

Council 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.

7. 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.

President’s Proposal: The president’s proposal includes the provisions in the House and Senate bills to limit the allowable deductions that employers may take for their retiree health expenses when they participate in the retiree drug subsidy program. The president proposed to delay this change in tax policy from 2011 to 2012 relative to the Senate bill’s effective date.

Council Recommendations:

- Delete the provisions that change a tax policy that was adopted in 2003 on a bipartisan basis in order to allow retirees to keep the coverage they have from their former employers. Deleting this provision will help to avoid:
 - employer sponsors of retiree prescription drug coverage from being required under financial accounting standards to immediately reflect on their financial statements the present value of this new tax liability,
 - losses of employer-sponsored prescription drug coverage for millions of retirees, and
 - higher federal budget costs resulting from retirees obtaining drug coverage under the Medicare Part D program rather than their former employers’ plans.

8. High Cost Plan Excise Tax

Council Position: Eliminate or reduce the 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 slower rate than health care costs. Health plan costs may also be higher than average because of factors such as geographic variations and 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 reductions are made in health benefits in to avoid the tax, thereby resulting in

many Americans either losing some valuable health benefits or increasing the cost-sharing for their benefits employer-sponsored coverage.

President's Proposal: The president's proposal delays the effective date of the high cost plan excise tax until 2018 and establishes tax thresholds in that year of \$10,200 for single coverage and \$27,500 for family coverage. As in the Senate bill, health care costs in excess of these thresholds would be subject to a 40 percent excise tax. The president also proposes to exempt dental and vision care benefits from the calculation of health coverage that is subject to the tax, provides adjustments for health plan costs attributable to the age and gender of the workforce and retains the indexing of the tax thresholds at CPI + 1 percent in years following 2018.

Council Recommendations:

- Increase the tax thresholds so that fewer plans will face taxation.
- Index the tax thresholds to the medical component of CPI, or at a minimum, by a blend of the CPI and the medical component.
- 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 or health savings accounts for tax calculation purposes.
- Maintain the first 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 to employees and their aggregate average value is below the tax thresholds.

9. 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.

President's Proposal: The president's proposal includes the \$2,500 FSA contribution limit from the House and Senate bills. The proposal would be effective in 2014 and indexed by CPI thereafter.

Council Recommendations:

- Increase the contributions limits to flexible spending arrangements above the \$2,500 level in the president's proposal.
- Index the limits to the medical component of CPI in future years (not simply the overall CPI as now included in both the House and Senate bills and as proposed by the president).
- 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.

10. 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.

President's Proposal: The president's proposal provides "tax equity" for dependents up to age 26 who would be required to be covered under separate provisions of health reform legislation, but does not include broader provisions such as those in the House-passed bill to extend the same tax treatment to domestic partners or others who may be eligible for coverage under the terms of an employer-sponsored health plan.

Council 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.

11. Effective Dates

Council Position: Health care reform legislation will require numerous complex changes in that can only be implemented properly if employers and plan administrators have adequate lead time and clear agency guidance before the provisions are effective. Failure to provide adequate time for the massive new regulatory requirements that will need to be developed will create significant uncertainty and confusion for sponsors of health plans and jeopardize coverage for individuals covered by these plans.

President's Proposal: While the president's proposal includes delays in several tax provisions to "ensure effective implementation", many other provisions are likely to be effective without adequate lead time or before agency guidance is available.

- Effective dates should apply to the first plan years beginning no sooner than 12 months after the issuance of final guidance from the appropriate agencies, with a safe harbor for plan sponsors and health plans that have acted in good faith compliance with the new law prior to the availability of final rules.