

WILL HEALTH CARE REFORM CAUSE EMPLOYERS TO DROP THEIR EMPLOYEE HEALTH CARE PLANS?

In the wake of the passage of the Patient Protection and Affordable Care Act and the Health Care Education and Reconciliation Act, several commentators and political observers have suggested that employers will be financially overburdened to the point where they will need to eliminate their employee healthcare plans, thus depriving employees of health coverage and driving up the cost to taxpayers of funding the federally operated insurance exchanges. Several recent events have fueled this speculation:

- 3M Corporation announced that effective 2013, retirees who qualify for Medicare will lose their current employer-sponsored health benefits, and instead will receive a health reimbursement account with which to buy a Medicare plan; in 2015, this will extend to all 3M retirees. [Retirees who do not qualify for Medicare can use their account to purchase insurance through the federal insurance exchange.] According to the Wall Street Journal, 3M asserted that the decision was motivated by the fact that “the recently enacted health care reform law has fundamentally changed the health care insurance market.”
- Boeing Corporation sent out a letter asking 90,000 non-union employees to pay “significantly more” for health care. In addition, Boeing is increasing, for all plans, individual deductibles from \$200 to \$300, and family deductibles from \$600 to \$900, annually. In the letter, Boeing Senior Vice President for Human Resources Rick Stephens wrote that “[t]he newly enacted health care reform legislation, while intended to expand access to care for millions of uninsured Americans, is also adding cost pressure as requirements of the new laws are phased in over the next several years.”
- Gov. Phil Bredesen, D. Tenn, asserted that his state would save \$146 million by eliminating its employee health care program, even after paying the \$2,000 per employee penalty and providing state employees with raises to allow them to purchase health insurance through the federal exchange.
- Thirty companies and organizations, including McDonald’s, Jack in the Box, and the United Federation of Teachers Welfare Fund (New York) obtained a “coverage waiver” from the Department of Health and Human Services which exempts them providing the minimum level of coverage. These institutions

have low cost health plans in place which cover part time or low wage employees; they argued that without a waiver they would be forced to eliminate coverage for these workers.

It is clear that, given the current economic conditions, some employers may choose to either require their employees to pay higher premium and/or deductible costs, or to eliminate their sponsored health plans altogether, over the next few years. What is less clear, however, is the extent to which these decisions will be the result of “ObamaCare” as opposed to the general economic malaise.

HEALTH CARE COSTS HAVE SIGNIFICANTLY INCREASED IN THE PAST DECADE

The first fact that the critics and commentators do not take into account is the extent to which healthcare costs have increased for employers and employees over the past decade, which of course is prior to the enactment of health care reform. According to the Kaiser Family Foundation website, American workers now pay 47% more than they did in 2005 for the family health coverage they get through their employment, while wages have increased only 18% during the same period. Employers pay, on average, 20% more toward their employees’ health insurance than they did five years ago.

Looking back 10 years paints an even bleaker picture. The average health insurance premiums for employer-sponsored coverage rose during the period 1999-2009 from \$5,791 annually to \$13,375, a 131% increase. The average worker contribution during that same time frame rose by 128% (\$1,543 to \$3,515).

These statistics highlight a fundamental point: health care premiums have been increasing substantially for the past several years, and in the absence of health care reform, this trend was virtually certain to continue. The causes of these increases is beyond the scope of this article. It may be noted, however, that hospitals blame the profit motive of the insurance carriers; insurance carriers blame the medical decisions of physicians, and the hospitals’ efforts to recoup the cost of caring for the uninsured; and physicians blame the carriers and the hospitals.

EMPLOYERS ARE NOT CURRENTLY REQUIRED TO PROVIDE INSURANCE COVERAGE

In the post-WWII employment boom, employers were encouraged to offer health insurance instead of pay raises as means of attracting and keeping employees. At present, approximately 150 million workers and their families are covered by some form of employer provided health care. However, it is also true at present that employers are under no obligation either to institute or to maintain health insurance. While ERISA governs the establishment and maintenance of employer sponsored healthcare plans,

nothing in ERISA mandates that employers **must** provide health insurance. There are a couple of exceptions, most notably Massachusetts's universal coverage act, Rhode Island's "large employer" exception, and San Francisco's "Healthy San Francisco" program. However, the general rule is that employers are free to modify or eliminate health care plans as they see fit.

In fact, the percentage of firms offering health benefits has decreased over the last ten years. According to the Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 66% of all firms offered health benefits in 1999; as of 2009, that number was down to 60%. Thus, prior to the inception of the Administration's health care reform programs, the trend was already in place. In the absence of reform, there was nothing in the economy or the marketplace pointing towards a reversal of this trend.

HEALTH CARE REFORM'S IMPACT ON EMPLOYERS

The second area that the doomsayers minimize or skip past altogether is a review of the fundamental aspects of health care reform that directly affect employers. The essential principles are:

- All employees will be required to purchase some form of health insurance;
- Small businesses (less than 50 employees) are exempt from the requirement of providing coverage;
- Employers may either provide coverage at or above a specified minimum, or pay a "penalty" that will help to fund a federally operated insurance "exchange"; employees who do not have coverage through their employment will be able to purchase insurance from these exchanges;
- Employers will continue to enjoy a tax exemption for insurance premiums, except that starting in 2018, a 40% tax will apply to the value of coverage *above* \$10,200 for individual coverage and \$27,500 for family coverage;
- Businesses with 25 employees or less are entitled to a tax credit equivalent to up to 35% of the premium costs in 2010, increasing to a maximum of 50% in 2014 (phasing out gradually for firms with average wages of \$25,000 - \$50,000 and/or for firms with 10-25 workers);
- Employees who make less than four times the federal poverty level will be provided tax credits for insurance premiums paid;
- Employees of large employers who are considered "low income" and who spend between 8 – 9.8% of their income on insurance premiums can obtain a voucher from their employer that is equal to the amount of the employer's premium contribution. This assists the employee in purchasing insurance through an insurance exchange at no additional cost to the employer.

It is generally acknowledged that one of the main purposes of the Affordable Care Act was to expand the scope of health insurance coverage. The presumption that this will necessarily mean increased costs for all employers, or a significant percentage of employers, is less clear.

The first argument is that the Act will ultimately result in insurers raising rates (either because of the elimination of the “pre-existing coverage” limitations and/or the extension of dependent coverage to age 26). While this may be true, it is far from certain. Rate increases must be approved by the state insurance commissioners, who as of this writing have recently submitted (through the National Association of Insurance Commissioners) to the Department of Health and Human Services their recommendations for defining the minimum “loss ratio” that insurers must meet as of January 1, 2011. [While the Act generally provides that plans sold to individuals and small groups must spend 80% of premiums on actual medical care as opposed to administrative costs, and plans sold to large groups must spend 85% of premiums on medical care as opposed to administrative costs, what constitutes “medical care” versus “administrative costs” is still being discussed.] The notion that insurance commissioners, who in many states (including California) are elected rather than appointed, will blithely approve any and every rate increase requested by the insurance industry, is unsupported by industry history, custom, and practice.

The second argument is that employers will lose the coverage they currently have in place, and will be forced to switch to more expensive coverages as a result of the Act’s reforms. In fact, plans that were in place as of March 2010 are considered “grandfathered” plans; employer are allowed to retain those plans, and to add both newly hired employees and existing employees who were not previously covered, to those plans. A plan retains its “grandfathered” status as long as it does not significantly increase employee premiums, co-payments or deductibles, significantly decrease the employer contribution, or eliminate covered benefits necessary to diagnose or treat a condition. There are certain provisions of the Act which do apply to “grandfathered” plans, such as the extension of dependent coverage to age 26; prohibition on lifetime limits of coverage; prohibition of pre-existing condition exclusions; and prohibition of waiting periods longer than 90 days. However, maintaining status as a “grandfathered” plan does require employee notifications and increased record keeping. This does not appear to generate the type of cost increases that would compel employers to discontinue their employee health plans in order to continue to do business.

A more significant concern is the “Cadillac Plan” tax, which as noted above commences in 2018. For employers with such Plans, the necessary analysis is whether to reduce the premiums paid (thus losing the “grandfathered” status) below the threshold amount, or to continue to fund the plan at current levels and pay the tax. The third option, i.e., terminating the healthcare plan and simply paying the \$2,000 per

employee “penalty” appears to be the least sensible option, financially speaking. Termination of the plan would mean, in addition to payment of the “penalty”, the loss of the tax deduction for the premiums, and diminished attractiveness of the company to prospective employees. Should the employer choose to pay the difference directly to the employee in the form of salary or bonus, the employer would incur additional tax liability in the way of payroll tax, social security, and FICA, as well as subjecting the employee to an additional tax liability. (Gov. Bredesen’s analysis identified above did not appear to take these additional tax liabilities into consideration) Moreover, as President Obama recently noted during an appearance on the Daily Show, there is no guarantee that the “penalty” will remain static at \$2,000 per employee. If a greater than anticipated number of employers discontinue their health benefit plans, placing an additional burden on the health insurance exchanges which are funded in large part by the “penalty” payments, it is certainly possible that Congress will increase the amount of the “penalty” to reduce the otherwise additional burden on individual taxpayers. The cost/benefit analysis for an employer might be quite different at a “penalty” of \$3,000 per employee rather than \$2,000.

Employers with more than 50 employees who do not currently provide healthcare coverage to their employees will need to either purchase insurance or commence payment of the “penalty.” [As noted, the employer responsibility provisions of the Act do not apply to businesses with fewer than 50 employees.] This will, undoubtedly, lead to an increased cost of doing business for these companies. However, the increase will apply equally to all companies in a given industry, so no individual company should be placed at a competitive disadvantage (please note that competitors from the EU and many other foreign nations already pay for universal health care as part of their costs of doing business). The insurance exchanges are also designed to offer cost effective benefit plans to small employers as well as to individual employees; until these exchanges are fully implemented in 2014, any ultimate financial decision regarding insurance coverage would be premature.

Another argument is that particular provisions in the Act will force companies to limit or reduce coverages. For example, 3M’s decision coincided with the enactment of the elimination of the tax deduction for retiree prescription drug coverage. In 3M’s case, this created a situation in which it made better business sense to direct their retirees to obtain their prescription medications through the Medicare system. Undoubtedly, as the Act’s provisions are fleshed out over the next several years, and the Act is coordinated with Medicare and ERISA, these system “tweaks” do not (at least initially) suggest a wholesale exit by employers from the insurance market.

The final argument is that companies with large numbers of low wage earners, for whom they are providing minimum levels of coverage, will be forced to discontinue those plans. As noted above, a couple of fast food restaurant chains have obtained a

waiver from compliance with the Act's provisions until 2014, when the insurance exchanges and the tax credits for low income wage earners, are both in place. The State of Massachusetts also obtained a waiver, in order to address the approximately 5,000 state residents between the ages of 18 and 26 who have been unable to obtain health coverage through work or otherwise. A spokesman for Massachusetts' state insurance program noted that the waiver would provide the state "time to implement the transition plan in a manner designed to mitigate premium increases."

CONCLUSION

While some commentators have criticized the Administration for not undertaking a massive overhaul of the entire U.S. healthcare system, the Act provides fundamental changes and clearly imposes new requirements on employers. However, the assertion of one consultant that "the bill as written provides a mechanism [to find an exit strategy for employers seeking to stop providing benefits]" appears to be an exaggeration. Instead, the opinion of MIT economist Jon Gruber that "[t]his is a brave new world with uncertainties . . . [but] the best available evidence suggests a small erosion in employer coverage . . . [i]t's not going to go down wildly" better fits the facts as we know them today.