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Perspectives for Employers on the Proposal for Health Reform About to Be Voted on in the House

Important Note: Congress Pulled this Bill from Consideration and Voting on March 24, 2017

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Congress is scheduled to vote on the revised proposal to "repeal and replace" the Affordable Care Act (the "ACA"). This bill is currently called the American Health Care Act of 2017 (the "2017 Bill"). It is important to remember that Thursday's scheduled vote is only the House voting on this proposal, there are still a number of steps and votes and committee conferences that will need to take place before we actually have any change to the law. The initial proposal was scored by the CBO last week and the numbers were released on estimated loss of health coverage and those numbers have been questioned and debated. The initial score indicated an estimated loss in health care coverage for 24 million people. Employers need to be concerned about such a drop in coverage because it means that there will likely be more uncompensated care which health care providers will then translate into increased charges to health plans and insurers. While the size of the coverage loss may be debated, a lower percentage of the population coverage has historically translated into increased costs for employer sponsored group health plans.

The 2017 Bill permits a higher differential in costs related to older individuals. While this means that the costs for individual coverage for older persons will increase, it also will impact employers that still maintained coverage for retirees under the age of 65 because increased costs on the individual market for early retirees will mean more early retirees wanting to stay on the employer's retiree coverage or delaying retirement. While the 2017 Bill currently adds back the deduction for employers who incur costs toward receiving the Medicare Part D retiree drug subsidy so employers will be able to again obtain the subsidy and deduct expenses for obtaining the subsidy, this is probably not one of the larger concerns.

The 2017 Bill brings back federal support for what appears to be similar to the state high risk pools that provided coverage to persons who could not obtain health insurance coverage from an insurer that existed under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a little touch of déjà vu.

The changes in the cost and likely availability of individual coverage for persons considering early retirement may impact and employer's expected turnover which in turn impacts other plan costs and human resources staffing planning.

The 2017 Bill takes a unique approach at changes to the employer shared responsibility tax and the individual mandate tax and instead of fully repealing the provisions (e.g., repeal and remove Code sections 4980H and 5000A), it proposes to amend the dollar amount of the penalty to zero, while leaving the full structure for the penalty in place. While this reduces the employer's tax penalty and the individual's penalty risks for as long as that number remains zero, it does not remove the mechanism for imposing such taxes. The proposal also does not alter the employer's responsibility to report on the coverage offered and provided, but instead relies on it as one element of proof of continuous coverage. The reports on the coverage provided will be permitted to be used by individuals to avoid the temporary increase in the premium for a period of a lapse in coverage of greater than 63 days. It is curious that the Internal Revenue Code's mechanisms for imposing the employer and individual mandate taxes were retained.

The coverage mandates added by the Patient Protection and Affordable Care Act (the "ACA") (e.g., no lifetime dollar limits or annual dollar limits on health benefits, coverage of dependents to age 26, the expanded claims procedures, including external review, coverage of certain experimental treatments for participants in approved clinical trials, limited discrimination in premium rates (3:1) prohibited health status based discrimination, guaranteed renewability, and waiting period limitations) were essentially unchanged other than the discrimination ratio permitted which increased to 5:1. Preventive care is proposed to be modified for certain politically charged areas that have been subject to extensive litigation. While many mandates remained, the requirement to provide essential health benefits in a qualified health plan

or individual insurance policy on the exchange is not required for such coverage on an exchange for plan years after December 31, 2019.

Pre-existing condition exclusions are still prohibited under the 2017 Bill as they have been since the ACA became effective. Without a penalty amount to drive individuals to maintain coverage under the individual mandate and with no pre-existing condition exclusion permitted, employers have little to prevent adverse selection resulting from individuals buying coverage only when needed aside from restricting enrollments and special enrollments to the extent permitted under the ACA and other tax rules. The proposal attempts to address this by permitting a temporary premium surcharge of 30% that can be imposed by a health insurance issuer in the individual or small group market (please note: as this is currently written, this does not permit an employer providing coverage outside of the small group market or on a self-insured basis to charge the surcharge as employers are still subject to the nondiscrimination in premiums mandates that have been part of the law under HIPAA and the ACA) if an individual went without coverage for 63 days or more in the 12 months preceding the individual's enrollment in coverage, there is a special rule for dependents aging out of plans at 26 years. The surcharge has a very limited duration so it is not likely to offset costs group health plans would suffer from adverse selection. Thus, it will be important for group health plans to maintain and communicate clear rules regarding when individuals may enroll at initial eligibility and pursuant to special enrollments and annual enrollments, if applicable.

The 2017 Bill also does not repeal the tax commonly referred to as the Cadillac tax which applies when the health benefit coverage exceeds a dollar amount established as the limit for the year. Instead it is not effective until 2025. The continuation of the Cadillac tax will be a concern for employers because it may apply even more broadly as the costs are likely to increase for group health plans and health insurance policies as the proposal as currently scored will result in more uncompensated care the cost of which will be translated into higher costs for the group health plans and insurance policies. The continuation of the Cadillac tax along with virtually no reduction in the coverage mandates will present issues for some traditionally rich plans that are likely to trigger the Cadillac tax for an employer with budget limitations on costs.

The current proposals also add a new Code section requiring reporting of certain information regarding health insurance premiums paid for any month and also requires reporting of the amount of advance payments made on behalf of the individual. The current reporting required on Forms 1095-B and 1095-C is not repealed by the 2017 Bill, but instead there are additional requirements added to the items required currently to be reported on either the Form 1095-B by insurers or for reporting by self-insured employers together with the information on the Form 1095-C. Another section is added for health insurers to provide other reporting information.

The 2017 Bill increases the limit on the deduction for contributions to health savings accounts to the amount of not only the deductible expenses the individual must incur for the year, but to also permit a contribution for the out of pocket maximum the individual must pay under the coverage for the year.

The 2017 Bill removes the limit on contributions to health flexible spending accounts and removes the requirement that such accounts only reimburse prescribed drugs, so reimbursement of over-the-counter drugs may return. This does not mean that employers cannot chose to impose a limit on the amount they permit employees to elect, but if enacted, employers will want to review how their plan describes or incorporates any limit from the statute.

The 2017 Bill also makes changes related to the Medicare tax imposed which employers are required to withhold. So there may be payroll withholding implications as well as other changes.

This is just a summary of the 2017 Bill as it is currently pending about to be voted on in the House of Representatives. This is a long way from being a change in the law that needs to be addressed. The purpose of this alert is solely to look at the potential impact of the 2017 Bill as it is currently drafted and what it might mean for employers and their group health plans and retiree medical plans. We are still a long way from final legislation approved by both the House and Senate, so stay tuned. We are just at the beginning of the story.

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