

MAGNIFYING A 2020 VISION: A CLOSER LOOK AT SELECTED PROPOSALS TO STRENGTHEN EMPLOYER-SPONSORED HEALTH BENEFITS

In June 2014, the Board of Directors of the American Benefits Council (the Council) approved a long-term public policy strategic plan, *A 2020 Vision: Flexibility and the Future of Employee Benefits*. It describes broad goals for the employer-sponsored benefit system to help ensure Americans' health and financial well-being. The strategic plan also sets forth 46 specific policy recommendations to help achieve those goals.

In the months since *A 2020 Vision* was released, the Council has urged Congress to adopt these recommendations. We are gratified that a number of these ideas have earned bipartisan support.

This report, "Magnifying A 2020 Vision: A Closer Look at Selected Proposals to Strengthen Employer-Sponsored Health Benefits," highlights six serious challenges the Council has identified and describes our legislative proposals to fix them.

The Patient Protection and Affordable Care Act (PPACA) has dramatically changed the ground rules for employer-sponsored coverage. While debate over its ultimate fate continues, right now employers – the source of health coverage for over 150 million Americans – are obligated to comply with the law. Their ability to do so and continue providing health benefits coverage that meets the needs of employees and employers depends on necessary changes to PPACA.

To underscore the Council's pragmatic approach to addressing serious obstacles facing the employer-sponsored health system, this report offers alternative recommendations to solve the problems we have identified. So while the ideal proposed solution is set forth for each issue, we also describe other options in the event the best outcome cannot be immediately achieved.

American employers need prompt action on these six significant challenges. We urge Congress and the administration to address them now.

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TABLE OF CONTENTS

1. Expand Health Reimbursement Arrangements To Increase Flexibility	3
2. End the Forty Percent Tax on Health Benefits	4
3. Modify the Employer Shared Responsibility Requirement.....	6
4. Simplify Employer Reporting Requirements.....	7
5. Repeal the Automatic Enrollment Requirement	8
6. Improve Health Savings Accounts	9

1. EXPAND HEALTH REIMBURSEMENT ARRANGEMENTS TO INCREASE FLEXIBILITY

Background

PPACA prohibits group health plans and health insurance issuers offering group or individual coverage from imposing annual limits on the dollar value of essential health benefits. PPACA also requires all new plans to cover certain preventive care without imposing cost sharing.

Internal Revenue Service (IRS) Notice 2013-54 and subsequent Frequently Asked Questions documents state that a stand-alone Health Reimbursement Arrangement (HRA) cannot satisfy PPACA's prohibition on annual dollar limits or its preventive care requirements and, therefore, is generally not a viable option for providing employer-sponsored health coverage to active employees. However, an HRA that is "integrated" with a group health plan that meets these market reform requirements is PPACA-compliant. Thus, an HRA must be only available to employees enrolled in qualifying major medical coverage. Notice 2013-54 also reiterates that, under the PPACA, an employee cannot pay for exchange-based individual insurance through an employer's Internal Revenue Code (Code) Section 125 cafeteria plan.

Issue

Employers are considering various strategies for health benefits design, including a "defined contribution" approach that would permit employees to purchase individual policies on public or private exchanges. As discussed above, however, IRS guidance prevents the use of HRAs, cafeteria plans or other tax-favored arrangements to purchase such coverage.

Proposals

- Permit employers to establish stand-alone HRAs (or similar, tax-favored accounts) that can be used to purchase individual coverage inside or outside the exchanges (both public and private). Employers and employees could share responsibility for funding the vehicle. Amounts credited to these accounts could be used both to purchase qualifying coverage and to pay for qualified health expenses. To avoid paying PPACA's shared responsibility penalty, employers would need to make a contribution meeting the "affordability" test. "Double dipping," in which employees receive employer money *and* a public exchange government subsidy, would be prohibited. Employees would not be permitted to cash out or use the funds for non-qualified health care expenses. To ensure a viable, individual insurance market, there must be adequate protections against adverse selection or risk segmentation.
- Permit employees to purchase individual coverage through a public exchange on a pre-tax basis using the employer's cafeteria plan.

2. END THE FORTY PERCENT TAX ON HEALTH BENEFITS

Background

The 40 percent tax, scheduled to be implemented in 2018, is a nondeductible excise tax created under Code Section 4980I, as added by PPACA. The tax will be imposed on “applicable employer-sponsored coverage” in excess of statutory thresholds (in 2018, \$10,200 for self-only, \$27,500 for family). “Applicable employer-sponsored coverage” is defined broadly to mean coverage under any group health plan offered by an employer, without regard to whether the employer provides the coverage (and thus it is excludable from the employee’s gross income) or the employee pays for it with after-tax dollars. Employer contributions to Health Savings Accounts (HSAs), Medical Savings Accounts (MSAs), and health Flexible Spending Accounts (FSAs), as well as notional amounts attributed to HRAs, are considered “applicable employer-sponsored coverage” and count toward the thresholds.

Generally, the thresholds will be adjusted in 2018 to the extent the actual growth in the cost of U.S. health care between 2010 and 2018 exceeds the projected growth for that period (as measured based on the increase in the cost of the standard Blue Cross/Blue Shield option under the Federal Employees’ Health Benefit Plan). The limits are generally adjusted each year after 2018 to reflect changes in the Consumer Price Index for Urban Consumers (CPI-U), except that the CPI-U adjustment percentage will be increased by an additional one percent in 2019. The thresholds also may be increased based on certain age and gender adjustments and for some retirees and for plans covering individuals in certain high risk professions.

Issue

The 40 percent tax on health benefits is prompting employers to reduce coverage and increase cost sharing by imposing higher deductibles and copayments. Employers’ ability to alter benefit design to stay below the excise tax thresholds is constrained by PPACA’s benefit mandates, out-of-pocket limits and prohibitions on lifetime and annual dollar limits.

Additionally, indexing limits based on changes to the CPI-U likely will not be adequate to keep up with the cost of medical inflation. Historically, medical costs have increased at a much faster rate than general inflation, so the tax likely will be imposed on many more plans each year. Also, there are no adjustments to the limits for the size or type of plan, the type of employer (other than limited “high risk” professions), the health status of the employees, or geographical differences in plan cost.

Proposals

- Repeal the 40 percent tax on health benefits.

- Limit the 40 percent tax to major medical coverage. This approach is similar to the calculation of the transitional reinsurance program fee, which, among other things, excludes wellness programs, on-site medical clinics, contributions to HSAs, health FSAs and integrated HRAs.
- Establish a safe harbor that excludes any plan with an actuarial value at or below that of a Platinum level plan (i.e., 90 percent actuarial value) from the 40 percent tax. This approach would only subject plans to the excise tax if they have very low cost-sharing and as a result, the plan's actuarial value exceeds 90 percent as well as the statutory dollar thresholds. It would therefore exempt plans that are high cost simply because of regional, industry or employee population characteristics.
- Change the inflation indexing so that adjustments are based on actual or expected medical inflation. For example, the indexing percentage could be based on:
 - the federal government's National Health Expenditure data, which tracks the inflation rate for all U.S. health-care spending;
 - adjustments to the cost for Blue Cross/Blue Shield coverage under the federal employees' plan; or
 - at a minimum, changes in the CPI-U plus an additional two or three percent.

3. MODIFY THE EMPLOYER SHARED RESPONSIBILITY REQUIREMENT

Background

PPACA's employer shared responsibility provision is set forth in Code Section 4980H. It requires employers with 50 or more full-time equivalent employees to offer substantially all of its "full-time employees" (those employed on average at least 30 hours per week) and their dependents the opportunity to enroll in minimum essential coverage. This coverage must meet an affordability standard and provide minimum value or the employer will pay a penalty if a full-time employee receives a tax credit or cost-sharing subsidy for coverage purchased on an exchange.

Issue

Code Section 4980H final regulations include many complex rules for determining who is a full-time employee. The rules provide complicated methods for crediting hours of service, breaks in service and changes in employment status. Compliance with Code Section 4980H is extremely complex, particularly with respect to employees who work a variable schedule (rather than a regular 30 or more hour schedule) and temporary, seasonal or similar contingent workers. Therefore, we propose amending the employer shared responsibility provision to relieve administrative costs and burdens on employers that might create disincentives for employing "full-time employees."

Proposals (Could Adopt One or More)

- Increase from 30 hours per week the threshold for determining full-time employee status.
- Extend beyond 2015 the current transition relief standard that an employer must offer coverage to at least 70 percent of its full-time employees (and applicable dependents) and/or implement a glide path that gradually phases the percentage from 70 to 95 over several years.
- Provide for more workable rules (e.g., the look-back measurement method) in measuring the full-time status of variable hour employees.
- Clarify that Code Section 4980H does not apply to short-term, non-seasonal hires who are employed for such limited duration for bona fide business reasons.
- Count all wellness incentives in determining affordability and minimum value.
- Once the Code Section 4980H rules are fully in effect, provide for a correction program.

4. SIMPLIFY EMPLOYER REPORTING REQUIREMENTS

Background

PPACA added Code Sections 6055 and 6056, which established complex reporting requirements for employers regarding the health coverage they offer. Under a U.S. Department of Treasury and IRS transition rule, the reporting requirements are effective for tax year 2015 and reports to IRS and statements to employees must be provided by early 2016.

Under Code Section 6056, every applicable large employer (those with 50 or more full-time employees) that is required to meet PPACA's "shared employer responsibility" requirements must file an annual return with the IRS (and provide a statement to employees) that reports the terms and conditions of the coverage provided to full-time employees during the year. The return is also required to certify detailed information on full-time employees, including those who received the coverage and when they received it. This information will be also used to administer the premium tax credit for eligible individuals.

Under Code Section 6055, every entity that provides minimum essential coverage (including health insurance issuers and sponsors of a self-insured health plan) is required to file annual returns reporting specific information for each individual for whom minimum essential coverage is provided. The information reported under Code Section 6055 can be used by individuals and the IRS to verify the months (if any) in which they were covered by minimum essential coverage. This reporting facilitates compliance with, and administration of, PPACA provisions related to individual responsibility requirements and premium tax credits.

Issue

PPACA imposes significant new information reporting obligations on employers that require substantial time and resources to implement. The implementing regulations are complex and the final forms and instructions were not issued until February 2015. Additionally, the burden of administering new reporting requirements overlaps with the implementation of the employer shared responsibility obligations that became effective 2015 – also requiring complex tracking of employee hours and coverage.

Proposal

- Streamline the reporting processes to reduce administrative burden (for example, by allowing prospective reporting) and allow employers sufficient time to satisfy these new reporting obligations.

5. REPEAL THE AUTOMATIC ENROLLMENT REQUIREMENT

Background

PPACA added Section 18A to the Fair Labor Standards Act to require certain large employers to automatically enroll new full-time employees in one of the employer's health benefit plans (subject to any waiting period authorized by law) and continue the enrollment of current employees. PPACA does not specify an effective date for this requirement. However, the U.S. Department of Labor has stated in Frequently Asked Questions that employers are not required to comply with the automatic enrollment provisions until final regulations are issued and effective.

Issue

In enacting this provision, Congress likely recognized that automatic enrollment has increased enrollment in 401(k) plans and believed it would also increase enrollment for health plans. However, PPACA has many other provisions to ensure people obtain health coverage, including the individual mandate and subsidies to help lower income individuals pay for coverage. Unlike in the 401(k) plan context, automatic enrollment is not necessary for increasing plan participation.

Additionally, requiring automatic enrollment of full-time employees could result in adverse consequences on employees' eligibility for premium tax credits (PTCs) and cost-sharing reductions. This is because enrollment in "minimum essential coverage," regardless of affordability, renders an individual ineligible for PTCs and such cost-sharing reductions. Accordingly, requiring employers to automatically enroll employees in coverage could inadvertently disqualify employees from accessing PTCs and cost-sharing reductions.

Requiring employers to implement automatic enrollment would be very costly. Employers would be required to change payroll and IT systems. Moreover, to the extent employers are required to allow individuals to opt out of coverage on a retroactive basis, employers would face significant administrative challenges. For example, employers would need to reclassify prior amounts as taxable wages. As a result, employers would need to ensure tax reporting and withholding with respect to such reclassified wages. In many instances, such reclassified wage payments might need to be made subject to any existing cafeteria plan and/or 401(k) deferral elections.

Proposal

- Repeal the automatic enrollment requirement.

6. IMPROVE HEALTH SAVINGS ACCOUNTS

Background

A Health Savings Account (HSA) is a tax-exempt trust or custodial account that pays or reimburses certain medical expenses. To make contributions into the account, the individual must be covered by a qualified High Deductible Health Plan (HDHP). Both employers and employees may contribute to an HSA.

Issue

HSAs have been used to help make health coverage more affordable, encourage a wiser consumption of health services and allow tax-free spending on a wide range of qualified medical expenses. However, PPACA imposes many restrictions and new rules on HSAs, many of which may jeopardize the future existence of such consumer-directed health plans.

Proposals (Could Adopt One or More)

PPACA-Related Changes:

- Specify that HDHPs used with HSAs meet the minimum essential coverage requirement and satisfy the employer shared responsibility requirements for “minimum value.”
- Exclude employer and employee pre-tax contributions to HSAs (and MSAs, FSAs, and HRAs) from the calculation of “applicable employer-sponsored coverage” for purposes of the 40 percent tax on health benefits.
- Repeal the prohibition on the use of HSA (and FSA) funds for over-the-counter medications unless prescribed by a physician. This PPACA restriction creates an incentive that increases the cost of health care because consumers must schedule doctor visits to obtain a prescription for over-the-counter medications in order to be reimbursed from their health care spending accounts.
- Permit individuals and families to use HSA funds to pay for medical expenses for adult children under age 26. If an employer’s health plan offers dependent coverage, PPACA requires the employer to offer coverage to adult children up to age 26. Although IRS guidance permits health FSAs and HRAs to pay for their expenses on a tax-free basis, current law and regulations do not permit HSAs to do so.

Non-PPACA-Related Changes:

- Permit employees age 65 and over to contribute to an HSA. Active employees are only allowed to contribute to an HSA if they are not enrolled in Medicare. Employees should be allowed to continue to contribute to their HSAs until they retire, even though they are automatically enrolled in Medicare Part A at age 65.
- Permit early retirees to use HSA funds to pay for health insurance coverage. Individuals who retire before age 65 should be permitted to pay insurance premiums with HSA funds, just as retirees age 65 and older are allowed to do so.
- Permit individuals to purchase Medigap coverage with HSA funds.
- Permit an employee to contribute to an HSA, even if his/her spouse has an FSA. Allow HSA account owners to certify that he or she will not receive reimbursement for any health expenses from his or her spouse's FSA.
- Protect the value of HSAs (and other consumer-directed accounts) in bankruptcy.
- Permit individual family members to satisfy the individual deductible for HSAs' imbedded deductibles. Some employer-sponsored health plans begin providing coverage as soon as a family member meets the individual deductible for the plan rather than the full family deductible. Current HSA guidance only allows this if the individual deductible is at least the minimum deductible for family coverage.
- Clarify that certain prescription drugs are preventive care that will not be subject to an HSA-eligible plan deductible. Current law includes a safe harbor allowing HSA-eligible HDHPs to cover certain preventive services before the deductible is met. The IRS too narrowly defined prevention to consist of primary preventive services, including some prescription drugs when used in certain instances. The definition should be updated to give employers greater flexibility regarding prescription drugs that may be provided before the deductible.
- Allow employers to provide care at on-site medical clinics free of charge to employees enrolled in HSA eligible HDHPs. Currently, employees enrolled in HSA-eligible HDHPs that receive medical care at on-site medical clinics must pay for services received at the on-site clinic if they have not met their deductible.