



PolicyBrief



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Health Reform Implications for Employers

More than 90% of Americans with private health insurance obtain that coverage through employer-sponsored plans. Therefore, the Affordable Care Act (health reform) targets the link between employment and health insurance. Provisions of health reform that affect employer decision making are highlighted in this policy brief.

OVERVIEW

An emphasis of health reform is to create incentives for employers to provide insurance for their employees and for employees to participate in employer-sponsored health insurance plans. The new health reform law aims to do the following:

- Provide tax credits and create exchanges (organized markets) to encourage small firms to offer coverage,
- Assess penalties to larger firms that fail to offer coverage to their full-time workers, and
- Provide options for individuals who do not have employer-sponsored coverage.

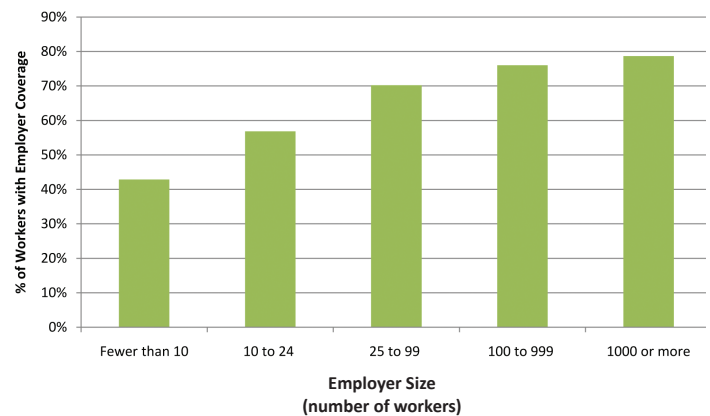
These incentives are important because in recent years the percentage of employees with employer coverage has declined as premiums have increased overall, and the employee share of those premiums has risen. Over the last decade, private insurance coverage for those whose family head works for a small firm has declined by eight percentage points.

BACKGROUND

The link between employment and health insurance has been part of the U.S. health care system since the 1930's. Workers at large businesses benefit from this relationship more than workers at small firms. Large employers are able to offer coverage with stable premiums by combining (or "pooling") the low risks of individuals who maintain coverage (but need little care) with individuals who have a high risk of needing costly care. Large employers can also consolidate administrative costs by concentrating marketing and insurance enrollment activities within human resources departments.

Small employers are less able to pool risk or lower administrative costs due to small numbers of workers. Thus, they are significantly less likely to offer coverage to their employees.

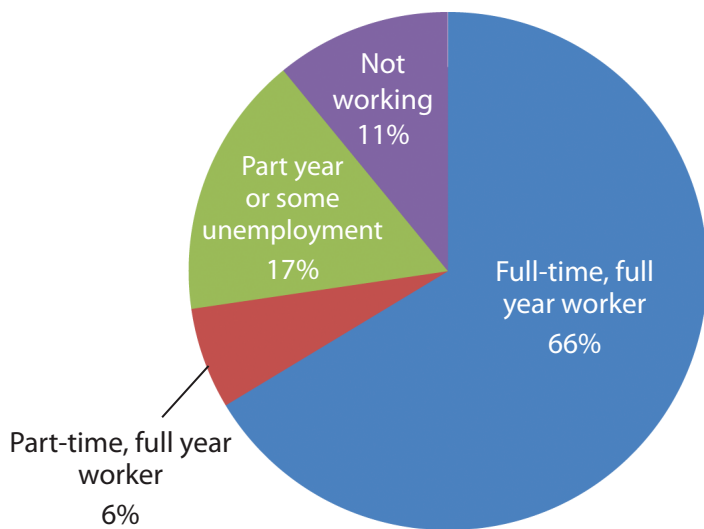
FIGURE 1: LIKELIHOOD OF WORKERS HAVING EMPLOYER-SPONSORED COVERAGE IN MISSISSIPPI, 2008



Source: Georgia State University Robinson College of Business tabulations of the March Current Population Survey

Employees benefit from the link between employment and health insurance because the employer's contribution is not recognized as income for the purpose of determining income tax liability. However, the cost of coverage has increased faster than wages over the past 20 years, so the employee share of the premium has become a larger portion of take-home pay. As a result, more workers have opted not to enroll. Therefore, many workers (especially small firm employees) do not have health insurance through their jobs.

FIGURE 2: UNINSURED MISSISSIPPIANS BY WORK STATUS OF FAMILY HEAD



Source: Georgia State University Robinson College of Business tabulations of the March Current Population Survey

In 2008, almost 90% of Mississippians without health insurance lived in a family with at least one worker, and over 70% lived in a family with a worker who was employed for the entire year.

REFORMS TO PRIVATE INSURANCE AND EMPLOYER-SPONSORED COVERAGE

Many provisions in the health reform law intended to expand private insurance coverage are scheduled to begin in 2014; however, some changes will take place before that date. Both federal and state government agencies will be issuing regulations to determine how provisions are implemented. Employers and workers should be attentive to regulations as they are issued to position themselves for future changes.

SMALL EMPLOYERS

At the core of health reform is an effort to give small businesses and individuals the same coverage opportunities enjoyed by employees of large firms. States will create Small Business Health Options Programs (SHOP) that can serve the needs of small employers interested in offering coverage. These small employer exchanges will be designed to serve firms with fewer than 100 full-time equivalent employees (FTEs), can be administered separately or jointly with the individual exchanges, and will enable small employers to pool risks and create administrative efficiencies in purchasing.

If very small employers (fewer than 25 FTEs) do offer coverage and the employer has a generally low-wage workforce (average annual wages less than \$50,000), the employer may be eligible for temporary subsidies to offset some of the costs of offering plans. Firms eligible for such subsidies can claim them through their tax returns starting in 2010. The Center for Mississippi Health Policy, the Georgia Health Policy Center, and the Florida Public Health Institute have developed an online calculator to help small employers determine if they are eligible for tax subsidies to cover part of the cost of insurance starting in 2010. Please visit www.mshealthpolicy.com to use the [50-State Health Reform Calculator for Small Businesses](#)®.

LARGE EMPLOYERS

Starting in 2014, employers over the 50 FTE threshold will be assessed a fee if any full-time employee obtains subsidized coverage through the exchange designed to serve individuals. The amount of the fee will depend on whether or not the employer offers coverage and the size of their full-time workforce.

- Employers not offering coverage will pay an annual fee of \$2,000 per full-time worker after the first 30 FTEs. For example, a firm with 60 full-time workers that does not offer health insurance would pay \$60,000 in fees starting in 2014.
- Employers offering health insurance that pays less than 60% of covered health care costs or requiring contributions for single coverage that exceed 9.5% of a worker's family income would be assessed a fee of:
 - \$3,000 per worker who obtains a subsidized plan in the exchange; or
 - \$2,000 per worker after the first 30 FTEs (as above), whichever is lower.

Employees offered employer coverage that is more generous than these guidelines are not eligible for the subsidized coverage in the individual exchange. All fees will be prorated to a monthly rate to reflect changes that occur month by month. Fees will be inflation adjusted after 2014.

Finally, for the largest employers (more than 200 FTEs) offering insurance, there will be an obligation to automatically enroll all new workers into employee-only coverage in the lowest cost plan that the employer offers. These large employers must also notify workers of all of their choices, including the right to opt-out of the plan in which they are automatically enrolled.

Note: Information shared in this brief is based on the law as it is known at this time and is our best interpretation of the data. As the law is written into rules, it will be further interpreted. Details may change during this process.

INDIVIDUALS

The health reform law recognizes that the small group market will not function as efficiently as the large group market. Therefore, even after coverage expansion provisions go into effect in 2014, there is no obligation for employers with fewer than 50 full-time employees or the *equivalent* in part-time workers (full-time equivalent or FTEs) to offer coverage.

Health reform anticipates that many workers from these firms will get coverage through the individual exchange and will be eligible for subsidized coverage. This is addressed through the creation of state-based health insurance exchanges by 2014.

Exchanges will serve as marketplaces for individuals who do not have coverage through an employment-based plan, either because they are not employed by a firm that offers coverage or because they choose not to participate in the offered plan. Individuals with family incomes below 400% of Federal Poverty Level (FPL) (\$58,280 for a family of two in 2010) may be eligible for subsidies to offset premiums or out-of-pocket spending. Subsidies will only be available to individuals who purchase coverage in the individual exchange.

KEY POINTS FOR EMPLOYERS

Employers Offering Coverage Currently:

- Employers who continue to offer the same health insurance benefits as those offered prior to the signing of the health reform law (March 2010) are considered “grandfathered in.” Those plans will be exempt from some specifications regarding essential benefits; the exemptions will be issued by 2014. Therefore, it will be important for employers to monitor regulations as they are issued and consider the impact of changes to current benefit offerings.

All Plans, including Grandfathered Plans, Starting in the Plan Year that Begins after September 23, 2010:

- Employers offering dependent coverage will be required to permit young adults up to age 26 who do not have access to their own plan to remain on a parent’s plan, regardless of whether or not that dependent is enrolled as a full-time student.
- If existing plans impose annual dollar limits on essential health benefits, these limits will be phased out.

- Health plans may no longer impose lifetime limits, and any plan member who was dropped from a plan due to reaching a lifetime limit must be notified of their right to re-enroll at the same contribution rate as all other plan members.
- Plans may not impose pre-existing conditions exclusions on coverage for children.
- Starting in 2011, employers will be required to report the full value of health insurance benefits paid on workers’ behalf on their W-2 forms. It is important to note that this change is informational only and will not alter the employees’ taxable income.

Employers Offering Plans in the Future:

- Starting in 2014, any employer offering health benefits for which the required contribution for single coverage is between 8% and 9.8% of the worker’s income will be expected to comply with the free choice voucher provisions. These employers will be expected to offer workers (who opt-out of coverage and who have family incomes below 400% FPL) a voucher to purchase private coverage in the individual exchange.
- Also starting in 2014, employers with more than 200 FTEs who offer coverage will be expected to automatically enroll their new employees into the health plan. Employees will still have the option to elect coverage elsewhere.
- Starting in 2018, “Cadillac” plans with premiums in excess of \$10,200 for single and \$27,500 for family coverage will be faced with a new excise tax of 40% of the premium value.

Other Opportunities and Challenges for Employers:

- Beginning in 2011, small businesses (fewer than 100 employees) that establish employee wellness programs may be eligible for grants.
- Any employer with more than 50 FTEs must provide nursing mothers with unpaid break time and an appropriate private location (other than the restroom) for lactation.
- In 2012, all employers will face new reporting requirements with respect to the Internal Revenue Service (IRS). The current requirement to report all payments in excess of \$600 made to individuals for the provision of *services* via IRS form 1099, will be expanded to include payments made to individuals or corporations for *goods* and

services. Employers will need to ensure that their information systems are able to collect and report these transactions.

Note: As of this date, there are bills in both the Senate and the House to change this provision but it is uncertain what the change will be. Employers need to stay informed and ensure that they are fulfilling their reporting obligations.

CLASS Act:






- Employers must choose whether to participate in the new, voluntary long-term care insurance program (CLASS Act). Workers must be automatically enrolled in long-term care insurance by participating employers unless they actively opt-out of coverage. Employees of non-participating employers can still elect to enroll in the program. This portion of the law expands access to home and community-based services that are sometimes necessary for the elderly and those with disabilities to stay in their homes.
- Regardless of employer choice to participate, it will be very important for employees to be informed regarding the procedures for enrolling or disenrolling from the program and to understand the implications of their choices, both now and in the future.

KEY POINTS FOR INDIVIDUALS

FSA and HSA Plans:

- Starting in 2011, it will no longer be permissible to use the money in Flexible Spending Accounts (FSA) or Health Savings Accounts (HSA) to pay for over-the-counter drugs unless prescribed by a physician.
- Employees with FSA or HSA accounts who withdraw the money for use other than to pay for qualified medical expenses will be subject to a 20% penalty, up from 10% in prior years.
- In 2013, contributions to FSAs will be limited to \$2,500 per family unless such accounts are coupled with a high-deductible insurance plan.

FIGURE 3: HEALTH REFORM IMPLICATIONS BY FIRM SIZE

FIRM SIZE	CONSIDERATIONS
 LESS THAN 25 FTES	POTENTIALLY ELIGIBLE FOR TAX CREDITS – FULL TAX CREDITS FOR LOW WAGE FIRMS UNDER 10 FTES
 25-49 FTES	NO TAX CREDITS, NO PENALTIES FOR NOT OFFERING
 50+ FTES	POTENTIAL PENALTIES FOR NOT OFFERING IF ANY WORKER OBTAINS A TAX CREDIT
 LESS THAN 100 FTES	ELIGIBLE FOR SMALL BUSINESS EXCHANGE (STATE HAS THE OPTION OF ALLOWING LARGER EMPLOYERS ACCESS)
 MORE THAN 200 FTES	REQUIRED TO AUTO-ENROLL ALL WORKERS IN EMPLOYEE-ONLY COVERAGE AND NOTIFY EMPLOYEES OF ALL OTHER CHOICES AVAILABLE TO THEM