An ALM Publication
CORPORATE COUNSEL

Hard Choices for Employers in Light of Health Care Reform

By Amy M. Gordon and Susan M. Nash
Corporate Counsel
February 15, 2013

Amy Gordon

Susan M. Nash

Last June, the U.S. Supreme Court upheld most provisions of the Patient Protection and Affordable Care Act, which presents employers with a multitude of crucial compliance-related choices to make regarding their employer-provided health coverage. It also provides plenty of options to employers with respect to the delivery of health benefits.

Three basic approaches will now become available. Many companies will want to continue providing employer-sponsored health insurance coverage to their employees and dependents. Others will choose to take advantage of federal or state insurance exchanges or purchase insurance on private exchanges. Other employers are likely to take a renewed look at their retiree medical coverage.

Companies that continue to provide group health coverage have a singular set of issues to consider, in light of the effects of the new law on some often highly entrenched insurance

positions. The state and federal exchanges are scheduled to go into effect in 2014. And many private exchanges offered through health plan vendors and insurance companies are already up and running as of early 2013.

Will your company be better off continuing to provide group health coverage to employees, or should you send employees to a government or private exchange? As of this writing, eight states (Colorado, Connecticut, Kentucky, New York, Massachusetts, Maryland, Oregon, and Washington) have received conditional approval to operate health insurance exchanges, as has the District of Columbia. Ten other states (California, Hawaii, Idaho, Minnesota, Mississippi, Nevada, New Mexico, Rhode Island, Utah, and Vermont) have submitted applications for approval. The exchanges provide employees an avenue to purchase individual health insurance policies, and may also provide these employees with premium subsidies from the federal government.

If your company decides to continue providing group health coverage to your employees, then you need to consider the following for 2014:

- Coverage may become more costly, given requirements under the act. For example, for nongrandfathered plans, certain preventive services and immunizations, as recommended by the U.S. Preventive Service Task Force, the Centers for Disease Control, and the Health Resources and Services Administration, must now be covered on a first-dollar basis under certain circumstances. This means a group health plan may not impose deductibles, coinsurance, or copays for these services. Effective January 1, 2014, all plans must eliminate preexisting condition exclusions. In addition, nongrandfathered group health plans will be subject to expanded claim and appeal rights. So group health plans must establish internal and external review procedures consistent with minimum standards.

  You will now need to engage independent review organizations to perform external reviews of adverse benefit determinations under your plans. These same organizations will also issue final internal adverse benefit determinations under state or federal external review procedures. And all group health plans will be required to eliminate lifetime and annual limits on essential health benefits. As a result, many employers may wish to continue to sponsor a group health benefit plan for their employees while also incorporating additional features such as wellness programs, health savings accounts, and health reimbursement arrangements.
- To avoid having to pay a nondeductible excise tax under the act, large employers (more than 50 employees) will need to provide coverage that is affordable to its employees. If the coverage is unaffordable, a nondeductible excise tax will be assessed on the employer. This will be equal to the lesser of: $3,000 per full-time employee who receives a federal subsidy under the exchanges; or $2,000 per FTE in excess of 30 employees. Coverage is deemed unaffordable if: it exceeds 9.5 percent of the individual's household income; the employee falls within 100–400 percent of the federal poverty level; *and* the plan's share of allowed costs is below 60 percent. There is a safe harbor provision that allows a company to base the 9.5 percent on an individual employee's income. Employers that want to continue to offer health insurance coverage and avoid excise taxes will need

to evaluate the plan design with an eye toward ensuring that it is both properly subsidized by the company and within the 9.5 percent range of affordable premiums based on the particular employee's W-2 income.

If your company decides to eliminate group health plan coverage in whole or in part and send employees to the state or private exchanges, you need to consider the following:

- A nondeductible excise tax will apply to large employers that provide no health coverage to their employees. A nondeductible excise tax of $2,000 per full-time employee in excess of 30 employees will be assessed if even one FTE obtains a tax credit or cost-sharing assistance from the government and buys coverage on the exchange.
- Employers may want to increase employees' compensation with the intent that additional compensation can be used to purchase coverage on the federal- or state-based exchanges. Alternatively, employers can provide employees with additional pretax flexible spending credits that can be used to pay for other health and welfare benefits.
- Sending employees to either the government-sponsored or private exchanges will now be viewed by regulators as if you were providing no health coverage to your employees, even if you provide employees with money to purchase exchange coverage.
- Employers should compare the quality of exchange coverage to its current group health plan offering, and also evaluate what peer employers are doing from an employee retention and recruiting perspective.
- Employers should weigh the fact that depending upon the demographics of its employees, a low-paid employee may be eligible for a government subsidy toward the cost of his or her coverage through the government-sponsored exchanges, making the government-sponsored exchanges a more affordable option for that employee and his or her family.
- If an employer is the only one in its peer group or geographical area not offering group health coverage, the employer will need to consider the competitive disadvantage of eliminating group health coverage. On the other hand, if the employer is the last in its field that continues to offer group health coverage to its employees, it also may be at a competitive disadvantage.

Should your company continue to offer retiree medical coverage? Both pre- and post-65 retirees are typically expensive to insure. Now that coverage will become even more expensive:

- Beginning January 1, 2013, the tax deduction for the Medicare Part D subsidy was no longer available to employers.
- If your retiree medical plan is not a stand-alone plan but a part of your active employee plan, all of the coverage mandates of the act will also apply to your retiree population. For example, there will no longer be any lifetime or annual limits on essential health benefits.
- The state and private exchanges may offer an affordable avenue for pre-65 retirees to obtain health coverage for themselves and their dependents. So this may be a good time to terminate retiree plans and send retirees to the exchange. This may also, perhaps surprisingly, result in more employees taking early retirement.
- Employers may want to provide retirees with a flat dollar amount that can be used to purchase coverage on the private or state-based exchanges.

- Collective bargaining agreements and/or retiree promises may restrict an employer's ability to change current retiree medical plan options.

Employers have always faced many crucial decisions regarding insuring the well-being and satisfaction level of their employees. Now, under the act, you need to carefully reconsider your options from a financial, a legal, and a morale standpoint.

Amy M. Gordon and Susan M. Nash, partners in the Chicago office of McDermott Will & Emery, focus their practices on the areas of health and welfare benefits.