

THE HOUSE TRI-COMMITTEE HEALTH REFORM DISCUSSION DRAFT *Small Employer Perspective: Analysis and Comment*

A New Employer Mandate

The draft legislation requires employers to choose between providing health coverage or paying an 8% excise tax on payroll. See Section 411.

The 8% tax would be applied to the employer's entire payroll, including wages paid to owner-employees and others who may be covered under the employer's group health plan.

The so-called exemption extends only to "certain small businesses" – there is not a number, threshold or information as to how that determination will be made, who will be making it or if there is an ability for the government to lower that threshold – as the government attempts to do with other thresholds including FMLA, paid sick leave, GINA, etc.

Employers who unknowingly provide benefits that do not comply with required levels of care can be levied – up to \$500,000

Employers who offer care but whose employees decline coverage will still be required to pay the 8% payroll tax.

Comment *A payroll tax is the worst tax of all because the employer pays it regardless of whether or not they make a profit. The research and data on the devastating impact of an employer mandate is clear – it is a job killer, potentially costing 1.6 million jobs-- hardly what this country needs in these challenging economic times.*

A Politically Powerful Insurance Commissioner

As outlined in the draft, a new Health Choices Commissioner will have the authority to institute rules and regulations that greatly affect small employers, including the ability to define who is and is not a full-time employee. The commissioner will also have the ability to enact a complex formula to determine and require coverage of part-time workers.

Comment *The Commissioner would be able to determine employee eligibility of full-time and part-time employees. Such authority means small business owners will be in constant fear of ever-changing thresholds that could impact compliance requirements.*

Insurance Rating Reform

The insurance rating reform section sets and enforces insurance reforms and consumer protections, facilitates enrollment, and administers affordability credits to help low- and middle-income individuals and families purchase insurance. The proposal also limits the ability of insurance companies to charge higher rates due to health status, gender, or other factors. Under the proposal, premiums can vary based only on age (no more than 2:1), geography and family size. In addition, insurers can no longer exclude coverage of treatments for pre-existing health conditions or prohibit lifetime and annual limits on benefits. Over time, the Exchange will be opened to all employers as another choice for covering their employees. States may opt to operate the exchange in lieu of the national exchange provided they follow the federal rules.

Comment *Rating reform is a little bit like the story of Goldilocks and the Three Bears. It takes a lot of work to “get it just right.” Rating reforms must make insurance available and affordable for all sectors of the population.*

A Connector-Exchange

The draft provides that the Exchange will offer health plans that comply with the minimum requirements established under the Bill. The draft also provides that if State law licensing requirements require a richer benefit than the mandatory benefit options described in the Bill, those requirements will apply to the Exchange-participating health plan only if the State reimburses the Exchange for any increase in premiums as a result of the State law requirement. See Bill Section 203(d).

Packages available in the exchange

A new Advisory Committee will recommend the levels of benefit packages allowed in the Exchange. The basic package will include preventive services with no cost-sharing, mental health services, dental and vision for children, and caps the amount of money a person or family spends on covered services in a year.

There will be 3-4 levels of policies available in the Exchange: basic, enhanced, premium, premium plus. The packages will vary on cost-sharing only. The premium plus package can have extra benefits, and the costs of those services must be transparent.

Insurance companies must offer a basic plan if they are in the exchange.

Comment *This new essential benefit package will serve as the basic benefit package for coverage in the exchange and over time will become the minimum quality standard for employer plans.*

Transition times to enter the exchange for employers (by size)

In the first year, small businesses with less than 10 employees are allowed to participate in the exchange; those with less than 20 employees are allowed the second year; and those with 20 or more the third year (phase-in). This final phase-in will occur by the decision of the commissioner so that it has sufficient numbers and insurers to offer coverage.

Comment *The draft leaves the commissioner with the power to close the door on exchange to the entire small group market (up to 50 employees), so it may or may not ever happen.*

Interaction of Benefit Package with State Regulations

States have the ability to add on top of the requirements as defined by the federal entity.

Comment *If benefit package requirements serve as the “floor” rather than the “ceiling” it leaves small employers vulnerable to the same regulatory incongruity they suffer from today.*

A “Maximum” Price Tag for a Minimum Plan

At the base level, the basic plan outlined in the Tri-Comm draft requires a 72.5% and 65% contribution for individual and family respectively.

Comment *Designing a benefit package requires a determination about where to start. It is critical to understand what small employers are paying today in the fully-insured marketplace. There is concern that this bill does not take those criteria into consideration. Consider the following:*

- *Small businesses, on average, pay about 18 percent more for health insurance than their larger counterparts for the same group of services.¹ Such data suggests that small employers either pay more for the same services or receive less (in terms of services) for their health insurance.*
- *The figure cited above confirms that there is a difference between the price of a plan and the value of a plan. This is particularly true in small firms where it is found that such firms have “received slightly less generous health insurance benefits, according to calculations of actuarial value.”²*
- *Actuarial costs vary according to size of firm. Actuarial value ranged from 78 percent of expected costs for firms with one to nine employees to 83 percent of expected costs for firms with 1,000 or more employees.³*

So, we must consider just what the price and value of the plan is that is attached to that contribution level.

“Keep What You Have”

Only individual policies can be treated as “acceptable coverage” for an indeterminate period of time (e.g., “grandfathered”). Sec. 102(a). Group health plans cannot be treated as “acceptable coverage” after the “grace period,” a period of time to be determined by the Commissioner. The grace period cannot extend more than five years. Sec. 102(b)(1)(A) and (2).

To be “grandfathered,” individual policies need only satisfy a handful of statutory requirements. Sec. 102(a). By contrast, Sec. 102(b)(1) could be interpreted to imply that the Commissioner can prescribe regulatory standards for a group health plan’s treatment as “acceptable coverage” during the grace period.

Comment *It is critical to insure business owners have access to a plan they and their employees want, but it must also be balanced against making sure reform does not further segment the market. This issue warrants additional discussion and special attention.*

A Government-Run Healthcare Option

The draft contains a public insurance plans alongside private coverage. The most important differences between the public option plan and private or state-run Exchange-participating health plans are:

- ✓ The public option plan has the authority to set rates that can be charged by health care providers, with limited rights to judicial review;

¹ Commonwealth Fund, Benefits and Premiums in Job-Based Insurance, May 2006.

² Chu, Rose C. and Gordon R. Trapnell, "Study of the Administrative Costs and Actuarial Values of Small Health Plans," Actuarial Research Corporation under contract no. SBAHQ-01-M-0811, January 2003.

³ Hazardous health plans. *Consumer Reports*, p. 24-29. May 2009.

- ✓ Health care providers who sign up for the public option plan are prohibited from balance billing;
- ✓ Start-up costs for establishing the public option plan will be absorbed by the Treasury from general revenues (in an amount to be decided); and
- ✓ Providers will be incentivized to participate in the public option plan during Y1-Y3 by a 5% fee premium as compared with Medicare rates.

The public option plan is not required to exceed any standard applicable to private Exchange-participating plans. However, it will have the power to set provider rates and to raise start-up capital without interest through appropriations from the federal government.

Comment *A truly competitive private insurance market is necessary to provide businesses and their employees with options to secure appropriate and affordable coverage. The twin goals of access and affordability can be achieved when proper reforms to the private market are enacted so private insurers operate in an environment that invites and produces competition that results in insurers delivering on quality and value – rather than on shedding risk, which too often is the case today.*

Tax Credit Provisions

The tax credit is available to qualifying small businesses to help cover up to 50% of qualifying health care costs. Qualifying health care costs means costs associated with a qualified plan as defined in other parts of the bill.

The full credit is available to businesses with 10 or fewer employees with an average annual employee payroll of less than \$20,000. The credit phases out at \$40,000 in average annual payroll and for businesses with 25 employees.

"High income employees" - meaning those earning more than \$125,000 - are not eligible for the credit. It is unclear but presumably ineligible employees are therefore not counted as part of the 10 employees.

A qualified employee is defined as an employee earning more than \$5,000 during the year. (Seems like a very vague definition.)

The credit is included as part of the business tax credit section, which means the credit can be carried back two years and forward 20. So, if the taxpayer has more credits than income in a particular year they can use the excess against past or future tax years.

Comment *As drafted, the credit limitations could impact of the availability of the credit and could have some adverse consequences on employee wages. Coalition member organizations may need to check with their members to identify the benefit of the credit proposed in the draft.*