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Employer Sponsored Health Care:
Who is covered as well as impact of the ACA and BCRA

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Unique among the industrialized countries, American access to private health care has historically been through employer sponsored insurance plans. Prior to the ACA (Affordable Care Act), employers were able to offer any type of plan, or none at all. The desire to recruit and retain the most qualified employees was a prime motivator for offering partially paid employer sponsored health insurance. Employee health insurance costs are tax deductible for the employer and tax free for the employee. The ACA expanded employer coverage by requiring most employers to offer health insurance benefits that included, among other items, the ten essential health benefits, no lifetime or annual heath care caps, and no discrimination for preexisting conditions.

The ACA (often referred to as Obamacare) is under attack from Congress. Republicans have sponsored bills in both the House of Representatives and the Senate to dramatically change current health care legislation. The CBO's (Congressional Budget Office) independent nonpartisan review of the proposed Senate plan highlights the $321 million in deficit reduction and the increase in the number of uninsured individuals in the U.S. to 49 million by 2026.[1] Public discourse has been focused on the contraction of federally sponsored medical insurance for low income Americans and the elimination of the taxes imposed on high income Americans.

But what about employees? What impact will the legislative changes have on the majority of working Americans?

The discussion below is divided into three sections. First, we will look at who has employer sponsored health insurance today, followed by a brief review of the impact of the ACA on employer sponsored plans and then the potential impact of the Senate sponsored BCRA (Better Care Reconciliation Act). The discussion is not intended to encompass everything that impacts employee health care, but, rather, aims to highlight some of the items that I find most relevant to the conversation.

Who has employer sponsored health insurance today?

The US Department of Labor, at March 31, 2016, found that 49% of private industry workers and 73% of state and local government workers participated in employer-sponsored health care (average 52% for all civilian workers).[4]

Annually data is gathered from US employers for the National Compensation Survey conducted by the Department of Labor, Bureau of Labor Statistics. Excluded from this data are federal government workers, military, agricultural workers, private household workers and the self-employed. The 2016 survey represented 133 million workers in all industries and occupations. [2]

Employers sponsored health insurance is not the same across the United States. Coverage varies by employer size, industry, whether there is a union, and location. The selected statistics listed below are from the Department of Labor March 2016 Employee Benefits in the United States, News Release dated July 22, 2016. [2] Access to health insurance:

For all workers	70% have access, 52% participate
Full time workers	88% have access, 66% participate
Part time workers	19% have access, 12% participate

Employer sponsored Health Care by Industry Type, Employer size and how workers in the highest wage rate quartile compare to the lowest rate quartile: [2]

Workers in goods-producing industries	84% access, 66% participate
Workers in servicing providing industries	68% access, 50% participate
Union workers	94% access, 79% participate
Nonunion workers	66% access, 48% participate
Workers in the lowest 25% wage rate	36% access, 22% participate
Workers in the highest 25% wage rate	93% access, 74% participate
Employers with 500 workers or more	89% access, 71% participate
Employers with less than 50 workers	52% access, 37% participate

Who pays the premium?

Single coverage. For those employees in the lowest 25% wage level the employer pays 77% of the premium (employees pay 23%)while for the higher paid employees in the top 25% the employer pays 82% of the premium (employees pay 18%).[2]

Family coverage. For those employees in the lowest 25% wage level the employer pays 61% of the premium (employees pay 39%) while for the higher paid employees in the top 25% the employer pays 72% of the premium (employees pay 28%).[2]

For large companies employing more than 500 workers the employer pays 73% of the premium (employees pay 27%) and small companies employing less than 50 workers the employer pays 64% (employee pays 36%)[2]

What does it mean?

Health Care is not offered to all employees. The lowest paid workers are less likely to be offered access to employer offered health care insurance, less likely to participate, and will pay a larger % of the actual premium costs. For the lowest paid workers, who pay a larger % of the actual premium, it follows that employee deductions for health care are a much larger share of their compensation compared to the higher paid workers. In our society, it is expected that most skilled or professional positions have fringe benefits that include health care and larger incomes allow employees to participate.

No participation can be due to a variety of reasons: health care coverage may be obtained for the family by another employed member, coverage is through a government program such as Medicaid, or health care coverage is declined because of the cost to the employee.

If a large percentage (30%) of working people don't have access to employer sponsored health insurance what do they do?

Most individuals, working or not, are required under the ACA to carry health care insurance. Family members may obtain employer sponsored health insurance through the employer of another family member. Individuals and families can buy health insurance on the ACA Exchange where they have access to income based credits to help pay for the cost of the plans. Most users of the exchange are eligible for credits to offset the cost of the insurance. Not everyone complies with the law. There are many reasons working individuals without employer sponsored health care chose not to use the ACA exchange.

Individuals may still purchase private health care insurance through brokers or directly from the insurance companies. Policies purchased privately are still subject to compliance with the ACA.

Individuals without employer sponsored health care may have to make the emergency room their primary care provider. They are subject to tax penalties. For one group the lack of insurance is due to a lack of understanding about the health insurance exchanges work and the credits available to make the insurance affordable. Another set of workers have political motivation and, in principal, refuse to participate in Obamacare.

Finally, some workers choose to purchase ACA noncompliant insurance and pay the penalty tax. For them the decision is financial and they believe they are savings thousands of dollars by purchased catastrophic insurance and paying regular medical expenses out of pocket.

The Affordable Care Act

The ACA was signed into law by President Obama in March 2010. The ACA is comprehensive health care reform legislation intended to expand coverage, control health care costs and improve access through state exchanges. [5]

Under the ACA most citizens are required to have individual health insurance or pay a penalty which ranges between $695 and $2080 and is computed based on family income. There are a few exceptions where individuals can decline coverage such as for religious reasons or when the lowest priced policy exceeds 8% of an individual's income.[5]

Employers with more than 50 employees are required to offer insurance or face a fine. Employers who offer insurance also face a penalty if they have employees who decline that insurance and purchase their own policies from the exchange and receive tax credits. Employees are eligible to decline employer coverage and use the exchange if the employee portion of the premium exceeds 9.5% of their income.[3]

Employers with more than 200 employees are required to automatically enroll employees into health insurance plans, but employees can opt out of the plan if they choose.[3]

Tax credits are available to small employers offset insurance costs and reinsurance reimbursement programs are offered to employers who offer health insurance to retirees over age 55. [3]

American Health Benefit Exchanges (for individuals and families) and SHOP (Small Business Health Options Program for employers with less than 100 people) programs were put into place. Coverage from Health insurance purchased on these exchanges is only available to US citizens or legal immigrants. States can also create a Basic Health Plan for low income individuals who would otherwise be eligible to receive premium subsidies. [3]

Age ratings for individual coverage is limited to 3:1 for age and 1.5:1 for tobacco use. The base age is 21, therefore, the highest policy price for older individuals is 3x the amount charged for the 21-year-old.

For employees, the HSA (Health Savings Accounts, pretax employee wages set aside to pay for qualified medical expenses not reimbursed by insurance) annual contribution is limited to $2500 per year, and the threshold for itemized deductions of unreimbursed medical expenses increases from 7.5% to 10% of adjusted gross income and the tax on distribution of HSAs not used for medical expenses increases to 20%.[3]

For employers who offer "Cadillac plans" there is an additional excise tax for policies that exceed target threshold value. [5] Cadillac plans annual premiums exceed $10,880 for an individual or $29,500 for a family. The excise tax is scheduled to start in 2020.

The ACA created an "essential benefits package"; ten benefits that must be covered. These benefits include: outpatient care, hospitalization, emergency services, maternity, mental health, prescription drugs, rehabilitation services, laboratory services, preventive services, and pediatric services.

Health insurance companies are required to rebate to their customers the excess of premiums over reimbursed costs when reimbursed costs are less than 80 -85% of the premium paid. The reimbursement percentage is based on company size. [3]

No lifetime limits or pre-existing condition exclusions are allowed, dependent coverage is extended to age 26, waiting periods are limited to 90 days and a website was established to help individuals compare different policy options. [3]

The Medicare payroll tax deduction increases from 1.45% to 2.35% for those employees with earnings over $200,000 and $250,000 for married couples filing jointly. The ACA also imposes a 3.8% tax on unearned income for higher income taxpayers. [3]

Proposed Changes to the ACA by the Senate's (BCRA) Better Care Reconciliation Act (as of July 11, 2017) that will have a direct impact on employers and employees

The BCRA will repeal the ACA compliant health insurance mandate (and the tax penalty) for citizens and legal immigrants.

The Medicare payroll tax deduction increase for high earners and the tax imposed on pharmaceutical and the health insurance companies will be repealed. It will also repeal the Cadillac tax [4]

Waiting periods will increase to 6 months for those individuals who haven't had continual coverage. Short term nonrenewable policies, which can be priced based on health status, can be sold to cover this period. [4]

The CBCRA allows for a new small business health plan where the essential health benefit requirement is not applicable. [4]

The plan retains the 10 essential health benefits requirements, but makes it easier for state to waive those requirements. [4]

The limits on consumer HSA accounts are increased and the tax penalty for non-medical expense reimbursement withdrawal is decreased to 10%. [4]

Maximum out of pocket limits remain but states can apply for waivers to increase those amounts. The same waiver process applies to lifetime limits. [4]

Change the maximum age rating limit from 3:1 to 5:1. This potentially increases the premiums for older individuals not yet eligible for Medicare by 67%.[4]

The ACA income based tax credits will remain in place through 2019. Beginning in 2020 the credits will be reduced and the tax credits are disallowed for anyone who is offered an employer sponsored health plan (whether they can afford the plan or not). In addition, the eligibility for credits contracts from "individuals in the US legally" to "qualified aliens" only. This will exclude worker visas and student visas.

In summary

Most Americans access health care through employer sponsored health insurance. We are the sole remaining industrialized nation that doesn't guarantee health care for the majority of their citizens. Several proposals over the decades have tried to move the US closer to a national health care system; none were successful.

The ACA was signed into law March 23, 2010 in an attempt to make good health care insurance affordable and available to all US citizens and legal residents. Millions more Americans now have access to affordable health care. But medical costs have continued to rise and the ACA has not been popular with large swaths of the American population. One of the campaign promises made by President Trump was to repeal and replace the ACA; replace it with something that offered better care at less cost.

The BCRA of 2017 is the current Senate proposal. The bill promises large tax cuts and decreased government spending. I hope that I have been able to demonstrate how the proposed BRCA could negatively impact the average employed American whether they have employer sponsored health care insurance or they purchase individual insurance policies through the exchanges.

Missing from the public dialog is discussion of the impact the proposed changes could have on working middle class families. Proposed changes that include no longer requiring employers to offer health insurance, increased premiums for older Americans, and the individual state option to request waivers of the essential benefits, out of pocket limits, or the lifetime exclusion.

And finally, although the majority of individuals received their health care insurance via employer sponsored plans there are still millions of people who do not have access to employer provided health care. Access to good health care should be available to all Americans.

References

(1) CBO*, Congressional Budget Office Cost Estimate, H.R. 1628 Better Care Reconciliation Act of 2017,* CBO, Washington D.C. released June 26, 2017, accessed through CBO.gov. Last accessed 7/10/17

(2) Bureau of Labor Statistics, U.S. Department of Labor*, Employment Benefits in the United States – March 2016, USDL-16-1493; News Release*, Washington D.C., July 22, 2016. Accessed through the Social Security website www.ssa.gov

(3) The Henry J. Kaiser Family Foundation, *Focus on Health Care Reform, Summary of the Affordable Care Act*, Palo Alto, CA, modified April 23, 2015. Last accessed through the Kaiser Family Foundation website on June 27, 2016

(4) The Henry J. Kaiser Family Foundation, *Compare Proposals to Replace the Affordable Care Act*, Palo Alto, CA. Last accessed through the Kaiser Family Foundation website on July 10, 2017

Field MJ, Shapiro HT, editors, Institute of Medicine (US) Committee on Employment Based Health Benefits, Employment *and Health Benefits: A connection at Risk. Chapter 2. Origins and Evolution of Employment Based Health Benefits*, Washington DC: National Academies Press (US); 1993. Accessed through the www.ssa.gov website)

Reed LS, *Private Health Insurance in the United States: An Overview, December 1965*; Washington DC; 1965. Accessed through www.ssa.gov/policy/docs/ssb/v28n12p3.pdf