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# ACA Employer Mandate Requires Decisions Regarding Health Insurance Offerings

The first two parts of this four-part Health Capital Topics series on Health Insurance Exchanges discussed issues for beneficiaries and insurers with the opening of the Marketplace in 2014, as well as *Consumer Operated and Oriented Plans* (CO-OPs). This third part will address *Employer Insurance Plans*, which for decades have been the primary delivery method for health insurance, and a critical component to benefits packages used by employers to attract and retain talent.[1] With the implementation of the *Patient Protection and Affordable Care Act* (ACA), employers now have the opportunity to re-evaluate how they will offer health benefits to their employees, while curbing the rising cost of healthcare within their own payroll.[2]

As a result of various ACA provisions, many employers must decide how to handle the "*employer mandate*," also known as the "*pay or play mandate*."[3] This will likely involve the decision between:

(1) Continuing to offer insurance plans to employees, and likely having to modify or upgrade these plans to meet ACA standards; or,

(2) Paying individuals (vouchers) to utilize the state and federal health insurance exchanges.[4]

In a study conducted by Mercer in 2010, only 6% of employers with more than 500 employees planned to drop their insurance plans, while only 3% of those employers with more than 10,000 employees planned to drop their insurance plans.[5] Tracy Watts, a partner at Mercer, explained:

> "*Employers are reluctant to lose control over a key employee benefit. But beyond that, once you consider the penalty, the loss of tax savings, and grossing up employee income so they can purchase comparable coverage through an exchange, for many employers dropping coverage may not equate to savings.*"[6]

In examining the differences between the health insurance plans offered on the Marketplace, and those offered by employers, it appears that the plans offered by exchanges are comparable, and, in some cases, lower in cost to, similar plans offered by employers.[7] Of note, since the exchange plans are tiered – *bronze* through *platinum* – exchange plan prices and actuarial value can vary significantly, while, in contrast, the actuarial value of an employer plan usually falls somewhere between the gold and platinum plans. The "*metal levels*" specify the "*average share of total health spending on essential benefits paid for by the plan*,"[8] with coverage levels of:

(1) *Bronze*: 60% of the actuarial value with respect to essential benefits;

(2) *Silver*: 70% of the actuarial value with respect to essential benefits;

(3) *Gold*: 80% of the actuarial value with respect to essential benefits; and,

(4) *Platinum*: 90% of the actuarial value with respect to essential benefits.[9]

The biggest difference between the health insurance plans on the Marketplace and those offered by employers may be that the Marketplace may contain more choices for the consumer, by offering a wider variety of options with the ability to choose from different types of plans and providers.[10]

When deciding whether to offer health insurance to its employees, an employer has many financial risks and concerns to consider, particularly with the rising costs of healthcare, which is why there is a positive correlation between larger companies and health insurance offerings.[11] A larger-sized company is able to negotiate better prices for plans; experience less risk (e.g., 50 employees being diagnosed with cancer at a company with 500 employees is less likely, and, relatively, less costly than 1 employee being diagnosed with cancer at a company with 10 employees); and, have the available capital to pay at least minimum wage while offering health insurance plans.[12] Additionally, small businesses typically pay 18% more for health coverage than large businesses, which prompted the implementation of tax credits for those businesses with less than 50 full-time employees.[13]

Other methods utilized by businesses to control health insurance costs include offering health and wellness benefits, such as contraception, mental health services, and wellness programs.[14] Contraception and mental health services are increasingly being provided as options, in part as a solution to reducing unnecessary


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medical spending. These wellness programs may assist employers in cutting medical expenditures, through programs like a medical self-care program, which educates employees on how to treat and monitor symptoms at home, which may assist employees in avoiding an unnecessary trip to the emergency room (ER); or, through regular treatment for mental health disorders, which could reduce the likelihood of a costly ER or urgent care visit.[15]

The ACA "*expands employers' ability to reward employees who meet health status goals by participating in wellness programs—and, in effect, to require employees who don't meet these goals to pay more for their employer-sponsored health coverage*."[16]

Many employers apply these rewards, through lower premiums, to incentivize employee participation in the wellness program, particularly since most studies find that behavior modifications (e.g. weight loss, smoking cessation) result in decreased employer health insurance expenditures, which can be attributed to wellness programs.[17]

Ultimately, there are advantages and disadvantages to both employer sponsored insurance plans and plans purchased on the Health Insurance Exchange. It will be up to individual consumers to determine whether they want to purchase insurance in the marketplace, in contrast to utilizing an employer-based plan.

Subsidies are a component of the ACA which "*helps low and moderate income Americans afford coverage*."[18] An employee is eligible for subsidies when their employer has not offered a plan that meets the requirements of the ACA. The ACA requires that any employer based plan must be considered *adequate* and *affordable* (i.e., the cost is less than 9.5% of household income for an individual policy and the plan pays for at least 60% of covered medical expenses).[19] It should be noted that in July of 2014, two separate rulings arose from the U.S. Court of Appeals for the D.C. Circuit and the Fourth Circuit regarding whether the *Internal Revenue Service* (IRS) has the statutory authority to provide the subsidies for eligible individuals pursuant to the ACA.[20] The U.S. Supreme Court will likely review these conflicting rulings, but for those consumers who recently purchased insurance plans on the exchange, "*The Obama administration…stressed that the healthcare subsidies would continue to be distributed in the federal exchange despite the court ruling*."[21]

Employer-based insurance plans have been a cornerstone in the U.S. healthcare system for many years, and while there may be difficulties to overcome with the implementation of the ACA, it is yet to be seen whether these challenges, such as the rising costs of premiums, challenges in the legal system, and the comparability of insurance plans on the Health Insurance Exchange will significantly alter the number of employers willing to offer insurance plans to their employees.

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