Center for American Progress

Workers and Their Health Care Plans

The Impact of New Health Insurance Exchanges and Medicaid Expansion on Employer-Sponsored Health Care Plans

Alan Reuther September 2011

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Introduction and summary

During the long campaign to enact our nation's new health reform law, President Barack Obama and other supporters of the legislation repeatedly promised Americans that they could keep their existing health care coverage if they liked it. This commitment was intended to reassure the overwhelming majority of Americans who already have good coverage that they would not be adversely impacted as coverage was expanded to the uninsured. The Affordable Care Act, they were told, would provide new options for obtaining health insurance but would not undermine existing employer-sponsored health care plans that currently cover most Americans.[1]

Yet in the wake of the passage of the Affordable Care Act into law two years ago, speculation continues to swirl about the consequences of the law's three central health insurance vehicles on existing employer-provided health insurance coverage: the two new health insurance exchanges for small businesses and individuals due to be up and running by 2014; and the expansion of Medicaid for those who cannot afford insurance. The Office of the Actuary for the Centers for Medicare and Medicaid Services, or CMS, the federal agency that administers those two government-run health care programs, projects that there will only be a slight decline of less than 1 percent in the number of people covered under employer-sponsored health care plans by 2019.[2] Other studies reach similar conclusions.[3]

In contrast, a controversial report by the business consultancy McKinsey & Company predicts there will be a much more precipitous shift in coverage from employer-sponsored plans to the new health insurance exchanges.[4] The McKinsey survey, however, on which this report was based, faced criticism from the Obama administration, Congress, and others for relying on slanted questions and a flawed online survey methodology that did not provide employers with enough information to make fair evaluations. As a result, critics contend that the survey produced skewed results that are an outlier from most other studies.[5]

In addition, some employers may have exaggerated the negative impact of the new health reform law on their health care plans in order to try to justify changes in the plans that would otherwise be resisted strenuously by employees.[6]

The continuing debate over the impact of the new health insurance exchanges and Medicaid expansion on existing employer-sponsored health care coverage is important politically and substantively. This will have important ramifications for the implementation of the Affordable Care Act, including the costs associated with the new health insurance vehicles and whether workers and retirees will in fact be able to keep their existing employer-sponsored health care coverage if they like it.

For a number of reasons, labor unions have particular insights into the different economic and other factors that will determine whether existing employer-sponsored health care coverage will continue or will be displaced by the establishment of the health insurance exchanges and the expansion of Medicaid beginning in 2014. Today about 160 million people in the United States receive their health care coverage through work. Estimates of the number of people covered under health care plans negotiated by labor unions range as high as 50 million people, nearly one-third of the total population insured through employment-based plans.[7] Labor unions negotiate health care coverage in diverse sectors across the economy, including the industrial, construction, telecommunications, hospitality, service, and public sectors, often establishing a benchmark for compensation in these industries—benchmarks that have a much broader impact on the coverage provided to millions of nonunion employees across the country.

This paper is based on detailed discussions with health care experts at 19 major unions and their umbrella organizations covering the vast majority of organized workers who work for a cross-section of private- and public-sector employers throughout the country. It also included discussions with independent health care policy experts and officials in the Obama administration.[8] The analysis and recommendations set forth in this paper, however, are solely those of the author.

The results from these discussions

The consequences of the new health insurance exchanges and the expansion of Medicaid on existing employer-sponsored health care coverage will be greatly affected by a number of uncertain factors, including how well the exchanges function in different states, the status of the economy, and how regulations govern-

ing the exchanges from the Obama administration address various issues. Yet it also seems clear that there will not be a widespread displacement of employer-sponsored health care plans, with most of them remaining in place for employees without any significant disruptions.

This is because most middle- and upper-income workers covered under existing employer-sponsored health care plans will not be eligible for substantial subsidies in the individual exchanges or for Medicaid, and their employers will not be eligible for the small business tax credit in the so-called SHOP exchanges, the ones being set up so small businesses can more easily and more affordably offer health insurance to their workers.

The upshot: There will be little incentive for most employers to drop their existing health care coverage for these workers.

At the same time, in certain sectors of the economy, some employer-sponsored health care plans could be replaced by alternative coverage provided through the two health insurance exchanges or Medicaid. This is especially likely to happen in those industries where there are large numbers of lower-wage and part-time or seasonal employees. It is also likely that the longstanding decline in employer-sponsored coverage for retirees will accelerate due to the availability of these alternative sources of coverage.

In many cases, the shifts in coverage of these employees and retirees to the health insurance exchanges or Medicaid will be a positive development that enables them to have more secure and affordable health care coverage, and improves their standard of living. Furthermore, any adverse impacts can be avoided or minimized if the regulations implementing the new health care law adopt certain approaches, and if several improvements to the law are enacted.

This paper will explore these anticipated changes (small and large) in our nation's health insurance in 2014, focusing specifically on:

- The expansion of Medicaid
- The new SHOP exchanges
- The new individual exchanges
- Family coverage for spouses and dependents
- Part-time and seasonal workers

- Supplemental "wrap" health insurance coverage
- The treatment of tax-favored health accounts
- The treatment of retirees

This paper will explore all of these issues in detail, but briefly, let's preview the report's findings and recommendations.

The expansion of Medicaid

The expansion of Medicaid will not have any impact on the existing health care coverage for most employees. But it will help to provide stable, affordable coverage for certain very low-wage, part-time, and seasonal employees who currently have inadequate or no insurance, and potentially improve their standard of living.

The new SHOP exchanges

The new SHOP exchanges—SHOP stands for Small Business Health Options Programs (with a silent "B")—will make it easier for some small single employers to continue to provide stable, affordable health care coverage to low-wage workers and could lead to an improvement in the standard of living of these workers. These new exchanges also could have the same positive impact on health care coverage provided through so-called Taft-Hartley funds (multiemployer health care programs run by a joint labor-management board) and through regional or statewide trusts that provide health care coverage to education and local government employees who work for many different employers—but only if the regulations implementing the new health law allow these types of funds and their contributing employers to have equal access to the SHOP exchanges. Otherwise, the SHOP exchanges could undermine the existing coverage provided through these funds.

The new individual exchanges

The new individual exchanges present the most complex set of issues for employers and employees. It seems clear that the individual exchanges and premium tax credits and cost-sharing reductions that are part of the Affordable Care Act will not have an impact on most existing employer-sponsored health care coverage provided to middle- and upper-income employees in a wide range of industries.

At the same time, they likely will displace existing coverage for some lower-paid, part-time, and seasonal employees. In many cases this will be a positive development that enables these workers to have access to more stable, affordable health care coverage and to improve their standard of living.

There is a danger, however, that this could be a negative development for low-wage workers in the food service, hospitality, and other service industries, and some parts of the construction industry and local governmental units in rural areas and the South. Economic and political forces may enable employers in these sectors to use the shift in coverage to the individual exchanges as a mechanism to cut back health care benefits and reduce compensation for employees.

The regulations implementing the new health care law could adopt a number of approaches to avoid or minimize the potential adverse impacts in these sectors. Ultimately, the Affordable Care Act may need to be amended to impose an "anti-dumping" fee on large employers to discourage abuses and help offset increased costs to employees in these sectors.

Family coverage for spouses and dependents

The new law is not likely to have a significant impact on family coverage currently offered by employer-sponsored health care plans covering most middle- and upper-income employees. But there could be a more significant impact on family coverage offered by employers with lower-wage workers. Depending on how various issues are resolved in the final regulations issued by the Obama administration, employers with lower-wage workers might have an incentive to shift family coverage to the exchanges. Or many spouses and dependents could be trapped in unaffordable employer-sponsored coverage.

To avoid these dangers, the final regulations should give spouses and dependents an independent right to receive subsidized coverage through the individual exchanges when they are not offered any family coverage or when the family coverage offered to them is unaffordable, regardless of whether the employee-only coverage is affordable.

Part-time and seasonal employees

For many part-time and seasonal workers who currently are uninsured or have inadequate insurance, the availability of subsidized health care coverage through the individual exchanges will be a very positive development. But in the food service, hospitality, and service sectors where part-time and seasonal work is common, some employers may manipulate work schedules and their corporate structures to make sure most of their workers are considered part-time or seasonal, enabling them to avoid any employer-responsibility assessments and thereby increasing the likelihood that these employers will terminate their existing health care coverage for these workers and transfer them to the individual exchanges.

The regulations implementing the new health reform law should define full-time employees in a manner that reduces the opportunities for such employer manipulation. A more effective solution to prevent such abuses would be to amend the Affordable Care Act to require a proportionate employer-responsibility assessment in situations where an employee works less than 30 hours per week or 120 hours per year.

Supplemental "wrap" health insurance coverage

The regulations implementing the new health care law should allow employers to provide supplemental "wrap" coverage to employees who are enrolled in the individual exchanges and potentially receiving premium tax credits and cost-sharing reductions. This could include supplemental benefits such as dental and vision coverage, as well as coverage for copays, deductibles, and other cost sharing required by health insurance plans offered on the individual exchanges. This would help maximize health care coverage and avoid any loss of benefits due to the establishment of the individual exchanges.

The treatment of tax-favored health accounts

The new health law specifically states that employees cannot use a flexible spending account (or FSA, a tax-advantaged account that allows employees to set aside part of their earnings to pay for various benefits, including health care) to reimburse premiums they may pay for subsidized coverage through the individual

exchanges. But the Affordable Care Act and the proposed regulations issued by the Obama administration do not provide any clear guidance as to whether the same position will be applied to payments from health reimbursement accounts (or HRAs, which allow employers to set aside funds on a tax-favored basis to reimburse medical expenses for employees and retirees) and health savings accounts (or HSAs, tax-advantaged medical savings accounts available to individuals enrolled in high-deductible health care plans). It is important that the regulations implementing the health care law do not treat HSAs more favorably than HRAs. Otherwise, this could lead to an explosion in the use of HRAs by employers, which would undermine health care coverage for employees.

The treatment of retirees

The introduction of individual health insurance exchanges in 2014 will likely accelerate the longstanding decline in employer-sponsored coverage for retirees. Many employers, Taft-Hartley funds, education and local government trusts, and Voluntary Employees' Beneficiary Associations (or VEBAs, which are tax-exempt medical expense funds covering employees or retirees with a common employment-related bond) will consider the option of terminating their existing retiree health care plans and shifting the retirees to the individual exchanges.

In many cases, this may be a positive development that guarantees retirees a stable, affordable source of health care coverage. It also may help to avoid cutbacks in health care coverage for active workers, or enable resources to be used to address pension or other issues facing retirees.

The regulations from the Obama administration

The regulations that are in the process of being issued by the Obama administration to implement the Affordable Care Act could have a major impact on whether the new health law is successful in providing more stable and affordable coverage to millions of Americans without displacing existing employer-sponsored health care plans and making certain groups of workers and retirees worse off.[9]

In the pages that follow, this paper will explore in much greater detail the consequences of the new health care law and the regulations on existing coverage for employees and retirees in union and nonunion occupations.

In the end, it seems clear that the establishment of the exchanges and expansion of Medicaid will benefit the vast majority of employees and retirees. At the same time, the approaches adopted by the final regulations on various issues will be important in making sure that existing coverage provided by Taft-Hartley funds and education and local government trusts is not undermined by the SHOP and individual exchanges. Certain improvements to the Affordable Care Act would also be helpful in this regard.

The expansion of Medicaid

The new health law expands Medicaid to cover individuals up to 133 percent of the federal poverty line—currently $29,726 for a family of four—beginning in 2014. This is projected to cover 18 million more Americans.[10]

This expansion of Medicaid will have little impact on existing employer-sponsored health care coverage. In general, most full-time employees are likely to have incomes that make them ineligible for Medicaid, even with the expansion of coverage in the Affordable Care Act.[11] Thus, there should not be any disruption of their existing health care coverage.

Some very low-wage workers, however, especially part-time and seasonal workers or employees who are laid off for lengthy periods of time, could qualify for the expanded Medicaid program. This includes employees in home care and early child care, education support (such as cooks and bus drivers), call centers, hospitality, casinos, and some lower-skilled service and manufacturing jobs. In these cases it is likely that employers will discontinue any existing coverage and instead have the workers enroll in Medicaid.

Enrollment of these workers in the expanded Medicaid program should be a positive development. Many of these workers currently do not have any health insurance coverage. Where their employers do offer coverage, it typically is not very good and the take-up rate is not very high. Thus, despite some concerns about the availability of health care providers under Medicaid, these workers should be better off receiving their health care coverage through the expanded Medicaid program rather than relying on employer-sponsored health care coverage.

The new health law will guarantee that these workers have access to adequate health care coverage. In addition, any employer contributions that were previously paying for health care coverage may be shifted to other compensation for these workers, such as higher wages and better pension benefits, thereby improving their standard of living.

The upshot: For most employees, the expansion of Medicaid will not have any impact on their existing health care coverage. But it will help provide stable, affordable coverage for certain very low-wage, part-time, and seasonal employees, and potentially improve their standard of living.

SHOP exchanges

The new health care law requires states to establish health insurance exchanges by 2014.

The states may establish a so-called SHOP exchange for small businesses—SHOP stands for Small Business Health Options Programs (the "B" is silent)—and another exchange for individuals, or they may combine both exchanges. The exchanges are projected to provide coverage for 16 million people.[12]

Small businesses employing 100 or fewer workers will be eligible to enroll their employees in health care plans offered through the SHOP exchanges. States have the option to lower this threshold to 50 or fewer employees. Beginning in 2017, states also have the option to expand the SHOP exchanges to larger employers.

Exchange-eligible employers may pay all or part of the premiums for employees who are enrolled in SHOP exchange plans. Employers can designate a single plan for all of their employees or specify a level of coverage, leaving the employees free to shop for a specific plan. The health insurance premiums paid by employers to the SHOP exchanges are still paid on a tax-favored basis (that is, they are excluded from the employees' taxable income).

Employees are not eligible for any premium tax credits or cost-sharing reductions in the SHOP exchanges. But small employers with 25 or fewer employees who have average annual wages of less than $50,000 are eligible for a sliding-scale small business tax credit if they contribute at least 50 percent of the total premium cost of health insurance coverage for their employees. The full credit equal to 50 percent of the premiums paid by the employer for a period of up to two years will be provided to employers with 10 or fewer employees who have average annual wages of $25,000 or less. This business tax credit phases down for employers with more employees or whose employees have higher average wages.[13]

In applying the employee thresholds for determining whether a small business is eligible for the SHOP exchanges and the small business tax credit, the new health law

applies a controlled group concept that aggregates all parent and subsidiary corporations that are under common control. This will reduce the number of employers who will qualify for the SHOP exchanges and the small business tax credit.

A significant number of employers still will be eligible to enroll their employees in the SHOP exchanges. This includes many employers in the construction, hospitality, service, and mining sectors as well as some smaller manufacturing companies and local government or education employers. But a much smaller subset of these employers will be eligible for the small business tax credit. Due to the low thresholds relating to the number of employees and their average annual wages, it is likely only some employers with very low-wage workers in the construction, service, and hospitality sectors will qualify for this subsidy. This is more likely to be the case in the South and in more rural areas.

There is great uncertainty about whether the health insurance premiums charged by the plans in the SHOP exchanges will be attractive compared to the premiums in existing employer-sponsored health care plans. Some people believe the plans in these exchanges will face a serious adverse selection problem because they will attract groups of sicker, older, higher-cost individuals, resulting in their rates not being competitive with those charged by existing employer-sponsored plans.[14]

Furthermore, because the plans in the SHOP exchanges are insured, they may have higher costs than self-insured employer-sponsored plans due to the costs of insuring plus the costs associated with state mandates. To the extent some state governments are hostile to implementing the Affordable Care Act and seek to undermine its implementation, this may also translate into less-competitive premium rates for plans in their SHOP exchanges.

Other people are hopeful that various provisions in the Affordable Care Act, including pooling of risks, will enable the plans in the SHOP exchanges to attract broader and more stable groups of enrollees and avoid the feared "adverse selection" problem, resulting in premiums that are at least competitive with those charged by existing employer-sponsored plans.[15] The states can take certain steps to promote stable, competitive rates in their exchanges.[16] Furthermore, to the extent the SHOP exchanges are able to reduce administrative costs and implement other cost-containment measures, this could make the premiums charged by their plans even more attractive.

The uncertainty about the functioning of the SHOP exchanges and whether their premiums will be attractive will probably discourage any immediate, widespread shift in coverage from employer-sponsored plans to these exchanges come 2014. Many employers are likely to be cautious, waiting to see what the premiums are in the SHOP exchanges before taking any major steps with respect to their existing health care plans.

If the premiums charged by plans in the SHOP exchanges turn out not to be very attractive to employers, then there will be little displacement of existing employer-sponsored health care plans in the ensuing years. But if the premiums are competitive with or better than the premiums charged by existing employer-sponsored health care plans, then it will be important to examine more closely the impact on existing plans in various sectors.[17]

In those situations where a single company previously was providing health care coverage for its employees, the availability of the SHOP exchanges and small business tax credit should be positive developments because it has been difficult to maintain good health care coverage at small businesses with low-wage workers. To the extent the SHOP exchanges and small business tax credit reduce costs for these employers, this will make it easier for these companies to continue to provide good health care coverage to their workers. In these cases, it may also be possible to shift some of the savings into improving other types of compensation for the workers such as higher wages and pension benefits. Thus, in this context the SHOP exchanges and small business tax credit would generally appear to play a positive role.

But the consequences are less clear in those situations where many small employers previously were providing health care coverage through a Taft-Hartley fund or regional or state trusts covering education and local government employees. Unfortunately, the Affordable Care Act does not provide any guidance as to how these funds or trusts should be treated.

The proposed regulations on the functioning of the exchanges and eligibility for the SHOP exchanges do not specifically address the treatment of Taft-Hartley funds or education and local government trusts. On the surface, however, they only refer to small "employers" being allowed to enroll their employees in the SHOP exchanges, not any other entities such as Taft-Hartley funds or education and local government trusts. This issue should be revisited when the final regulations are issued.

Taft-Hartley funds historically are an important mechanism enabling many small businesses to pool their resources to provide a stable source of affordable health care coverage to employees, especially part-time, seasonal, and project-oriented workers who move from employer to employer in the construction, food service, hospitality, mining, apparel, service, and transportation sectors. If Taft-Hartley funds and their constituent small employers are not allowed equal access to the SHOP exchanges and the small business tax credit, then they could be at a serious competitive disadvantage compared to nonunion employers that are eligible for these programs.

This in turn could lead to the demise of Taft-Hartley funds if their constituent employers perceive that they can only get access to better rates in the SHOP exchanges and to the small business tax credit if they provide health care coverage on their own rather than through Taft-Hartley funds. This could result in lost contracts and jobs if the employers stick with the Taft-Hartley funds and as a result are placed at an economic disadvantage compared to nonunion competitors who are eligible for the SHOP exchanges and small business tax credit.[18]

Fortunately, all of these dangers can easily be avoided. The final regulations implementing the exchanges should allow Taft-Hartley funds to enroll the employees of their contributing employers in the SHOP exchanges. In effect, the Taft-Hartley funds would be treated simply as aggregators of the employees for their contributing small employers. The Internal Revenue Service in 2010 ruled that small employers are still eligible for the existing small business tax credit even though their health care contributions are made to a Taft-Hartley fund.[19] Since this credit will be restricted beginning in 2014 to employers that enroll their employees in the SHOP exchanges, employers that contribute to Taft-Hartley funds must be allowed to enroll their employees in the SHOP exchanges, or else the small business tax credit will become meaningless to them.

Even though many Taft-Hartley funds are composed predominantly of contributing small employers, a few of their employers may exceed the 50-employee or 100-employee thresholds for the SHOP exchanges. But as a practical matter, Taft-Hartley funds are not able to track which employees worked for which contributing employers because often the employees move from company to company. Thus, it would not be feasible for Taft-Hartley funds just to enroll in the SHOP exchanges those employees who worked for exchange-eligible small businesses.[20]

Instead, the final regulations implementing the exchanges should allow a Taft-Hartley fund to enroll all of its participants in the SHOP exchanges where the number of small employers contributing to the fund exceeds some threshold, say 75 percent of the contributing employers qualify as small businesses. Admittedly, this approach would enable a small number of larger employers that contribute to Taft-Hartley funds to gain access to the SHOP exchanges. But the costs associated with this should be outweighed by the benefits to be gained by ensuring the much larger number of small employers that contribute to Taft-Hartley funds will not be unfairly denied access to the SHOP exchanges and the small business tax credit.

This approach would not be disruptive for Taft-Hartley plans and their contributing employers, or for the existing health care coverage they currently provide to millions of employees. The employers would have equal access to the premium rates in the SHOP exchange plans and to the subsidy provided by the small business tax credit. Thus, they would not face any competitive disadvantage with nonunion employers who may take advantage of the SHOP exchanges and small business tax credit.

It is important to note that under this approach, each small employer that contributes to a Taft-Hartley fund would still have to apply on its own for the small business tax credit. This would ensure this credit only goes to those employers that satisfy the criteria relating to number of employees and their wage levels, not to any larger employers who may contribute to the Taft-Hartley fund.[21]

Issues similar to those presented by Taft-Hartley funds may also be raised by certain regional or statewide trusts that currently provide health care coverage to education and local government employees who work for many different employers.[22] The ability of these trusts to continue providing health care coverage could be jeopardized if many of their contributing small employers, such as school districts or local governmental units, decide to opt out of the trusts and instead enroll their employees in the SHOP exchanges.

The danger of this happening may be less, however, because the public-sector employers contributing to these trusts are not eligible for the small business tax credit.[23] Thus, the only incentive for them to enroll their employees in the SHOP exchanges would be the attractiveness of the premium rates for the plans in the exchanges. It is questionable whether the difference between those premium rates and the premiums currently charged by the trusts will be large enough to raise the

threat of a mass exodus of contributing employers from the trusts. This factor may also be offset if the scope of the health care coverage offered through the SHOP exchanges is less extensive than the benefits currently provided by the trusts, or if the age banding in the premiums charged by the plans in the SHOP exchanges is problematic for many participants in the trusts. In any event, the concerns related to these education and local government trusts could be addressed if the approach suggested above for Taft-Hartley funds also was applied to these trusts.[24]

The concerns raised by Taft-Hartley funds and these education and local government trusts also could be addressed if states decide beginning in 2017 to expand their SHOP exchanges to include much larger or even all employers. This expansion of the SHOP exchanges could also be beneficial to the extent it helps them implement measures to reduce health care costs.

The upshots, then, regarding the SHOP exchanges and small business tax credit are these:

- They will make it easier for some small single employers to continue to provide stable, affordable coverage to low-wage workers, and could lead to an improvement in the standard of living of these workers.

- They could have the same positive impact on health care coverage provided through Taft-Hartley funds and education and local government trusts, but only if the final regulations implementing the exchanges allow these entities to purchase coverage on behalf of the employees of all of their contributing employers. Otherwise, there could be extensive disruption of the existing coverage provided by Taft-Hartley funds and education and local government trusts.

Individual exchanges

Beginning in 2014, the new health care law requires states to establish health insurance exchanges where individuals can obtain health insurance coverage if they do not otherwise have coverage through an employer-sponsored plan, government-sponsored programs, plans in the individual market, or other health benefits coverage such as state risk pools. Individuals will be able to choose among a range of plans offering varying levels of coverage. The so-called "individual mandate" will require all individuals to obtain health insurance coverage, or pay an assessment to the federal government if they can afford health insurance but refuse to purchase it, leaving hospitals and other health care providers to cover the cost of their care if they require emergency treatment.

Individuals with incomes below 400 percent of the federal poverty line (currently $88,200 for a family of four) will be eligible for advance refundable premium tax credits according to a sliding scale to offset the cost of premiums for the coverage available through the individual exchanges. These individuals also will be eligible for cost-sharing reductions according to a sliding scale to provide assistance with copays, deductibles, and other cost-sharing requirements, and to limit total out-of-pocket liability under the plans in the individual exchanges. But individuals are not eligible for these premium tax credits and cost-sharing reductions if they are enrolled in an eligible employer-sponsored health care plan in which the employer pays at least part of their premiums on a tax-favored basis.[25]

Employers that do not offer affordable minimum essential health insurance coverage to their full-time employees (and their dependents) must pay an "employer responsibility" assessment to the federal government if at least one of their employees enrolls in the individual exchanges and receives premium tax credits or cost-sharing reductions. For employers who do not offer any coverage to their full-time employees (and their dependents), this assessment is equal to $2,000 times the number of full-time employees minus 30. For employers who offer unaffordable coverage to their employees (and their dependents) or coverage that does not

provide minimum value—that is, where the employee is required to contribute more than 9.5 percent of their household income for self-only coverage, or the plan's share of benefits is less than 60 percent of the total allowed costs of benefits provided under the plan—the assessment is equal to $3,000 times the number of full-time employees receiving premium tax credits, up to an overall cap of $2,000 times the number of full-time employees minus 30.

Employers with 50 or fewer full-time workers, however, are exempt from this assessment. Furthermore, the assessment does not apply to part-time employees working less than 30 hours per week or seasonal employees working less than 120 hours per year. It also does not apply to retirees.

If employees enroll in the individual exchanges and receive premium tax credits and cost-sharing reductions, then they cannot have their employer pay for their health insurance premiums on a tax-preferred basis.[26] In effect, employees must choose between getting public subsidies through the individual exchanges or receiving a tax-preferred payment from their employer for their health care premiums. They cannot receive both. This tradeoff was incorporated into the Affordable Care Act to lower the overall budgetary costs of the subsidies provided through the individual exchanges, to promote a rough horizontal tax equity, and to avoid what some would consider to be "double dipping" with respect to government subsidies.

There is widespread speculation about whether many employers will calculate that it is in their economic interest to drop their existing health care coverage for employees and instead have the workers enroll in the individual exchanges and receive the premium tax credits and cost-sharing reductions for which they are eligible. Even if the employer has to pay the employer-responsibility assessment and also decides to increase the employees' compensation to offset the fact that they are now paying for their own health care premiums, this could be cheaper for the employer than maintaining its existing health care plan for employees.

Obviously, many factors will determine whether this calculation makes sense for a particular employer and group of employees. First and foremost, it will depend on the extent to which the employees would be eligible for premium tax credits and cost-sharing reductions. As a rough general rule, where the employees have lower wages and incomes below 250 percent of the federal poverty line, currently $55,875 for a family of four, it may indeed be cheaper for the company to terminate its existing health care plan and have the employees enroll in the individual exchanges.[27]

A second key factor will be whether the employer is subject to the employer-responsibility assessment, and the magnitude of that assessment. In cases where the employer is not subject to this assessment (because it employs 50 or fewer workers, or because its workers are part time or seasonal), there is a greater likelihood that the calculation will tilt in favor of eliminating the employer's existing health care plan and having the workers enroll in the individual exchanges. This may be true even where the wages and incomes of the employees are above 250 percent of the federal poverty line.

Third, as was previously discussed in connection with the SHOP exchanges, an important factor also will be whether the premiums charged by health care plans in the individual exchanges are attractive compared to the premiums under existing health care plans. This will in turn depend on a wide range of factors, including the extent of adverse selection (the number of unhealthy people purchasing coverage through the individual exchanges), whether the risk pooling and other measures are successful in counteracting any adverse selection, and the effectiveness of cost-containment measures in the individual exchanges (including administrative simplification and tighter regulation of health care plans, as well as efforts to encourage so-called medical homes, bundled payments, accountable care organizations, and other measures to improve the quality of health care at lower cost).[28] The result may vary from state to state.

Fourth, a key factor may turn out to be larger economic or political forces in particular sectors of the economy. This includes continued downward pressure by dominant employers on wages and benefits, as well as political pressure for cuts in compensation for public-sector employees. If these forces are already undermining the health care coverage and other compensation of employees in a particular sector, then the availability of the individual exchanges may help facilitate this process by providing a mechanism whereby an employer can stop paying for its workers' health care coverage without leaving them completely without access to coverage.

In addition, these economic or political forces may reduce the bargaining leverage of workers and labor unions. This could make it easier for employers to retain any savings associated with shifting their employees' health care coverage to the exchanges. Alternatively, if economic or political forces are supportive of employees' compensation and bargaining leverage due to the presence of strong labor unions or pro-worker state governments, then this may reduce the economic

advantage that employers can gain by shifting coverage to the exchanges. This would lead more employers to decide to retain their existing health care plans.

Fifth, employers are likely to pay close attention to how other employers in their sector are responding to the establishment of the individual exchanges. If leading employers in a sector continue their existing health care plans, then other employers are more likely to do the same. Competition for workers will encourage employers to continue providing good health insurance coverage to their workers. If an employer terminates its health care plan and transfers employees to the individual exchanges, the workers will have less incentive to remain with that employer and may seek employment elsewhere. But once some leading employers decide to drop their health care plans and shift employees to the exchanges, there may be a tipping point where most of the employers in the sector quickly follow suit. Competitive pressures will encourage employers to shed their health care plans in order to reduce costs and stay in line with other employers in their sector.

It seems clear that the establishment of the individual exchanges will have little impact on the existing health care plans covering most middle- and upper-income employees, especially where the plans are sponsored by large employers. This is because the workers are paid too much to qualify for significant premium tax credits and cost-sharing reductions. But they would lose the benefit of the tax exclusion for employer-provided health care coverage if their existing plans were terminated, and thus would have to pay for health care premiums with after-tax dollars.[29] Furthermore, the employers would be subject to the employer-responsibility assessment, which would reduce their incentive to shed their health care plans.

What's more, the existing health care plans sponsored by these employers are more likely to be self-insured (meaning they have enough employees to have their own pooling of risks without having to pay an insurance company for this protection, unlike the insured plans in the individual exchanges). In many cases, the existing plans sponsored by these employers also have implemented managed care and other cost-containment programs. The combination of these factors means that these plans could have lower costs than the plans in the individual exchanges.[30]

For all of these reasons, there is not likely to be significant disruption in the existing health care plans sponsored by employers in the steel, auto, aerospace, chemical, oil, paper, tire, telecommunications, airlines, rail, and mining industries, as well as the plans covering more highly skilled construction trades and public-sector workers in urban areas.

A number of factors also will militate against disruption in existing health care coverage even where the employees have lower wages, such as unskilled workers in the service and health care sectors, and thus would be eligible for significant premium tax credits and cost-sharing reductions—and even where the employers would not be subject to any employer-responsibility assessments. It will be administratively and politically difficult for any employer to make all employees whole if their existing health care plan is terminated and they instead receive their coverage through the individual exchanges. This is because the amount of premiums paid by each worker to the individual exchanges will vary based on their family income and the amount of premium tax credits and cost-sharing reductions they receive, as well as their age and whether they have a spouse or children who will be receiving coverage.

Because the employer under the new health care law is not permitted to pay workers' premiums directly to the individual exchanges on a tax-favored basis, the employer is simply left with the option of making some type of after-tax payment to employees to compensate them for the premiums they are now paying to the individual exchanges. But employers won't know the family incomes of all workers, and thus won't know the extent to which they are eligible for premium tax credits and cost-sharing reductions. And it could be difficult for employers to justify making higher payments to workers with higher incomes (because they will receive lower subsidies or none at all), to older workers, or to married workers with children.

In addition, there may be considerable resistance among employees against replacing their employer-sponsored health care coverage with coverage through the individual exchanges if this results in a reduction in the benefits received by the workers. This could well be the case if the workers are enrolled in the so-called silver coverage level in the exchanges—the level on which the subsidies are based—rather than the gold and platinum levels with higher benefits.

It seems likely, however, that these factors will not be sufficient to stop some employers with lower-wage workers from dropping their existing health care plans and enrolling workers in the individual exchanges. If employers calculate that this approach would be in their financial interest, they can simply make projections about average family income, age, and marital status, and then try to achieve rough justice by providing an average payment to workers to compensate them for the health care premiums they now have to pay to the plans in the individual exchanges.

This means there will be winners and losers among the workforce. But this may not dissuade some employers with lower-wage workers from shifting coverage to the individual exchanges. These employers also may not be dissuaded from pursuing this approach by any diminution in health care coverage because many companies already are pushing to cut back the scope of health care benefits.

But even if some employers with lower-wage workers do drop their existing health care plans and enroll workers in the individual exchanges, this may still be a positive development. Many lower-wage workers do not receive any health care coverage from their employer. For those that do have such coverage, often it is substandard with a low take-up rate by employees. Where employers or Taft-Hartley funds are providing decent health care coverage to lower-wage workers, they typically are struggling to do so. Thus, shifting coverage for lower-wage workers to the individual exchanges may provide a less costly and more stable source of coverage for these employees.

To the extent a portion of the cost of the coverage through the individual exchanges is now being paid by federal subsidies, this may free up money that can be used to provide higher wages or other benefits to the workers. If the workers or their union have sufficient bargaining leverage to prevent the employer from simply pocketing any savings, the workers could wind up better off economically. Based on this scenario, the availability of the individual exchanges as an alternative source of health care coverage could be a positive development for some lower-wage workers, especially those in small manufacturing and construction firms.

At the same time, however, economic or political factors may undermine the bargaining leverage of lower-wage workers in certain sectors, making it possible for employers to use the shift from employer-sponsored health care coverage to coverage through the individual exchanges as a mechanism to significantly reduce the compensation of employees. In effect, the shift to the individual exchanges could become a means both to cut back health care benefits and to shift the cost of paying for that coverage from the employer to the workers. The net result could be a substantial diminution in the standard of living of the workers, and a windfall for the employer.

Indeed, employers in these sectors may not even try to make employees whole for the premiums they now have to pay to the individual exchanges. Instead, the employers may simply pocket any savings that result from the shift in health care coverage to the individual exchanges.

This depressing scenario could play out in sectors that are characterized by low-skilled, lower-wage employees or those with many part-time or seasonal employees. This includes the food service, hospitality, and other service industries, and some parts of the construction industry in rural areas and the South. In these sectors, the workers are likely to be eligible for significant premium tax credits and cost-sharing reductions, and the employers may not be liable for any employer-responsibility assessments. This may be especially true if companies manipulate the hours worked by their employees or their corporate structures to keep workers below the 30-hour-per-week threshold for full-time employees. Thus, there may be a significant economic incentive for the employers to shift coverage to the individual exchanges.

At the same time, nonunion employers such as Walmart Stores Inc., Target Corp., and Perdue are already exerting downward pressure on wages and benefits in these industries. This suggests that workers and their unions may have less bargaining leverage to prevent employers from using the shift in coverage to the individual exchanges as a means of gaining a windfall at the expense of a reduction in the workers' compensation and standard of living.

A similar negative scenario could occur with respect to some public-sector employees. Especially in smaller local government units in more rural areas and the South, some public-sector workers have lower wages and may be eligible for a meaningful amount of premium tax credits and cost-sharing reductions. The smaller local governmental units also will not be liable for any employer-responsibility assessments. That means there will be the same type of economic incentive to shift health care coverage to the individual exchanges.

In addition, because of budgetary pressures and political motivations, many state and local governments are already advancing proposals for cuts in health care benefits and other compensation for their public employees. These public employers may view shifting health care coverage to the individual exchanges as a means to accomplish this objective and to address their budgetary problems. They may also justify this shift as a way to ensure the new health insurance exchanges have stable groups of enrollees and can avoid the adverse selection problem, or they may hope to win political points by showing that government workers are receiving the same type of health care as the general public.[31] Significantly, in states where public-sector workers have no collective bargaining rights, the shift to the individual exchanges could be imposed unilaterally.

It would be unfair to blame the establishment of the individual exchanges as being the sole cause of cutbacks in health care coverage and the lowering of compensation for some lower-wage workers in the food service, hospitality, and other service industries and some parts of the construction industry and local governmental units, especially in rural areas and the South. Instead, the larger economic and political pressures in these sectors would appear to be a major culprit. In some cases, reductions in health care benefits and overall compensation were occurring prior to the establishment of the exchanges, and may have continued to some extent even without the exchanges.

Nevertheless, the regulations that are in the process of being issued by the Obama administration to implement the new health care law could seek to avoid the adverse consequences in these sectors by adopting several approaches. Some persons have suggested that Taft-Hartley funds and education and local government trusts should be allowed to pay for the premiums on behalf of employees enrolled in the individual exchanges on a tax-favored basis, without disqualifying employees from being eligible for the premium tax credits and cost-sharing reductions. This would enable these existing health care plans to continue while still allowing the employees to gain the benefit of the subsidies offered through the individual exchanges.

This position is based on the argument that Taft-Hartley funds and education and local government trusts are distinct legal entities for the employers who have contributed to these funds and thus should not be considered "employer-sponsored" coverage that would disqualify individuals from being able to enroll in the individual exchanges and receive the premium tax credits and cost-sharing reductions. Adopting this position would be consistent with the central objectives of the new health law to maximize health care coverage while allowing individuals to keep their existing health care coverage if they like it and ensuring they are not made worse off because of health care reform.

The proposed regulations that have been issued by the Obama administration relating to the premium tax credits and cost-sharing reductions do not directly discuss Taft-Hartley funds or education and local government trusts. It appears that no decision has yet been made on this issue.

Because the money that is contributed to Taft-Hartley funds and education and local government trusts comes from employers, however, allowing it to be used to pay for premiums on behalf of employees enrolled in the individual exchanges,

without disqualifying the employees from being eligible for subsidies, would raise certain concerns. This would be contrary to so-called horizontal tax equity principles, which stipulate that individuals with similar incomes should pay the same amount of taxes and receive similar tax preferences. What's more, such an approach could be criticized as allowing "double dipping" with respect to government subsidies because employees could receive tax-favored employer contributions for their health care and also receive tax-supported subsidies available through the individual exchanges. Finally, this approach would increase the number of employees qualifying for the premium tax credits and cost-sharing reductions in the individual exchanges, and thus would raise the budgetary costs of these subsidies.

This approach also would create a number of tensions in the application of the new health care law. It would create a distinction between employers who provide health care directly to their employees versus those that do so through a Taft-Hartley fund or an education or local government trust. Furthermore, even though these entities rather than their contributing employers would be deemed to be providing the minimum essential coverage to employees, advocates for this position would still argue that the contributing employers should be exempt from the employer-responsibility assessments. They also would argue these employers still should be eligible for the small business tax credit, and that these funds should be treated simply as an aggregator of the employees of their contributing employers for purposes of the SHOP exchanges.

Another option that could be adopted by the Obama administration to avoid the potential adverse consequences for low-wage employees in certain sectors would be to allow Taft-Hartley funds and education and local government trusts to operate within the individual exchanges as a qualified health care plan or as a consumer operated and oriented plan (or CO-OP program, which are nonprofit, member-run health insurance issuers that the states are supposed to encourage under the new health law). The proposed regulations on the functioning of the exchanges specifically ask for comments on this issue.

This approach could be analogized to the longstanding practice of some unions sponsoring health care plans in the Federal Employees Health Benefit Program, which provides the federal workforce with the option of enrolling in a wide range of health care plans. Moreover, this approach could be justified on the grounds that these types of funds are nonprofit, patient-centered health care plans that historically perform many of the pooling functions similar to what will happen

under the individual exchanges. If this approach is allowed, then the regulations would still have to decide the distinct question as to whether the Taft-Hartley funds and education and local government trusts could pay premiums on behalf of the employees of their contributing employers, without this disqualifying the employees from being eligible for the subsidies in the individual exchanges.[32]

There also appear to be a number of barriers to this approach. First, it is unclear whether the plans offered by these kinds of funds would have to be open to any individual seeking health insurance on the exchanges, which could be problematic for legal and economic reasons, or whether they could be limited to union members.[33] Furthermore, the plans might have to satisfy state insurance requirements, including regulations relating to reserves, and they also might have to satisfy Affordable Care Act requirements relating to choice of health care providers, essential community providers, quality standards, and other matters. Additional exploration needs to be undertaken to determine whether it is feasible to pursue this approach in light of these issues.

The regulations that are in the process of being issued by the Obama administration could take a number of other steps to reduce the potential adverse consequences—cutbacks in health care coverage and lowering of overall compensation—for some low-wage workers in certain sectors. For example, it would be helpful if employers, Taft-Hartley funds, education and local government trusts, and Voluntary Employees' Beneficiary Associations (or VEBAs, which are tax-exempt medical expense funds covering employees or retirees with a common employment-related bond) could use so-called health reimbursement accounts to pay all or part of the premiums on behalf of individuals enrolled in the individual exchanges, without disqualifying them from receiving the premium tax credits/cost-sharing reductions. Health reimbursement accounts, or HRAs, are currently allowed by the IRS as a mechanism for employers to set aside funds on a tax-favored basis to reimburse medical expenses for employees and retirees. The proposed regulations recently released by the administration do not appear to decide this issue. The ramifications for this health insurance vehicle under the new health law are explored in more detail on page 36.

It would be especially important for the forthcoming rules from the Obama administration to allow employers and these various types of funds to provide supplemental "wrap" coverage, including dental or vision care or filling in deductibles, copayments, or other cost sharing not covered by the plans in the health

insurance exchanges, even if the employees receive their core health care benefits through the exchanges and are eligible for the premium tax credits and cost-sharing reductions. This could help prevent reductions in health care coverage for employees. This option is discussed on page 3 of this report.

Administrative and legislative steps to prevent employers from manipulating work schedules or corporate structures to avoid responsibility for part-time and seasonal employees also would be helpful. This issue is reviewed on page 41 of this report.

Finally, it may be worthwhile to consider amending the Affordable Care Act to ensure employers do not receive a windfall, and employees are not made worse off as a result of health care coverage being shifted to the individual exchanges. This could be accomplished by imposing an "antidumping" fee to discourage large employers from terminating existing health care coverage and shifting their employees to the individual exchanges, and by using the proceeds from the fee to offset increased costs to employees where such shifts in coverage occur.

These are all complicated steps for the Obama administration to consider, whichever direction they choose. The upshots regarding the individual exchanges, though, can be summed up in four overarching points. First, the individual exchanges will not have an impact on the existing employer-sponsored health care coverage provided to most middle- and upper-income employees in a wide range of industries. Their existing coverage should continue without any disruptions.

Second, the individual exchanges likely will displace existing coverage for some lower-paid, part-time, and seasonal employees. In many cases this may be a positive development that enables these workers to have access to more stable, affordable health care coverage and to improve their standard of living.

Third, this could be a negative development for some low-wage workers in the food service, hospitality, and other service industries, and some parts of the construction industry and local governmental units in rural areas and the South. Economic and political forces may enable employers in these sectors to use the shift in coverage to the individual exchanges as a mechanism to cut back health care benefits and reduce compensation for employees.

Fourth, the regulations that are in the process of being issued by the Obama administration to implement the new health reform law could adopt a number of approaches to avoid or reduce these dangers. Ultimately, however, it may be necessary to amend the Affordable Care Act to impose an "antidumping" penalty on large employers to discourage them from terminating existing health care coverage and shifting employees to the individual exchanges, and to help offset increased costs to employees where such shifts in coverage occur.

Family coverage

The new health care law is ambiguous about whether a spouse and dependents may enroll in the individual exchanges and be eligible for the premium tax credits and cost-sharing reductions if the employee has affordable employer-sponsored coverage, but the spouse and dependents either have no coverage or have coverage that is unaffordable. The proposed regulations recently released by the Obama administration provide that if the employee-only coverage offered under an employer-sponsored plan is affordable, then it does not matter whether the family coverage offered to spouses and dependents is unaffordable. Spouses and dependents still will not be eligible for premium tax credits and cost-sharing reductions.[34] The wording of this proposed regulation, however, implies that spouses and dependents would be eligible for the subsidies in the individual exchange if they are not offered any coverage under an employer-sponsored plan.

The position adopted by these proposed regulations would probably reduce the cost of the subsidies in the individual exchanges because it would preclude some spouses and dependents with unaffordable family coverage from being eligible for these subsidies. But it also might create an incentive for employers to eliminate entirely any family coverage, especially where this coverage was substandard and unaffordable, in order to make spouses and dependents eligible for subsidized coverage through the individual exchanges.

Regulations have not yet been issued on the employer-responsibility assessment, "minimum essential coverage," and "minimum value." As a result, it is not clear whether an employer will be considered a "non-offering" employer and thus subject to an employer-responsibility assessment if it does not offer any coverage to spouses and dependents. Similarly, it is not clear whether an employer might flunk the "minimum value" test and be subject to an employer-responsibility assessment if it simply makes family coverage available but does not contribute anything to pay for this coverage. Resolution of these issues could have a major impact on whether the Affordable Care Act causes some employers with lower-wage workers to drop family coverage in order to make spouses and dependents eligible for subsidized coverage through the individual exchanges.

Existing employer-sponsored health care plans covering most middle- and upper-income employees are not likely to be impacted by this issue. This is because these plans often provide good family coverage, and because spouses and dependents would not be eligible for substantial subsidies through the individual exchanges.

But there could be a much more significant impact on existing employer-sponsored health care plans covering lower-wage employees. Typically, it has been difficult to establish and maintain good family coverage for lower-wage employees, such as employees at small manufacturing firms and local governmental units, as well as some construction workers in rural areas and the South. In these situations, spouses and dependents are more likely to be eligible for premium tax credits and cost-sharing reductions. Thus, if the final regulations indicate that employer-responsibility assessments would not be triggered, many employers with lower-wage employees may seriously consider terminating family coverage entirely in order to make the spouses and dependents eligible for subsidized coverage through the individual exchanges.

In contrast, if the final regulations indicate that employer-responsibility assessments would be triggered, this could discourage many employers with lower-wage employees from completely terminating family coverage. But the net result may be that many spouses and dependents of lower-wage workers could be trapped in situations where they have no alternative to substandard, unaffordable family coverage offered by these employers, because the employee-only coverage is affordable and they are therefore rendered ineligible for subsidized coverage through the individual exchanges.

To avoid this danger, it might make more sense to allow coverage for the spouses and dependents of lower-wage workers to be shifted to the individual exchanges in these circumstances. This could be a positive development that helps provide a more stable, affordable source of coverage for the families of these lower-wage workers. Furthermore, the availability of the public subsidies could free up money that could be used to help maintain good employer-sponsored health care coverage for the workers, or to improve other parts of the workers' compensation package.

Accordingly, in lieu of the approach adopted by the proposed regulations, it might be preferable simply to give spouses and dependents an independent right to receive subsidies for coverage through the individual exchanges whenever the coverage offered to them by an employer is unaffordable, regardless of whether the

employee-only coverage is affordable, as well as when the spouses and dependents are not offered any coverage at all. This would avoid creating an incentive for employers to drop family coverage entirely and would thereby help maximize the amount of employer contributions for health care coverage. At the same time, it would ensure all spouses and dependents have access to affordable health care coverage. This would be more consistent with the overriding objective of the Affordable Care Act.

Part-time and seasonal employees

Part-time and seasonal employees who are not covered under affordable employer-sponsored health care coverage can enroll in plans in the individual exchanges and are eligible to receive premium tax credits and cost-sharing reductions based on their family income. But the new health law only imposes an employer-responsibility assessment on employers if they fail to provide affordable health care coverage for full-time employees who work 30 or more hours per week. There is no assessment if employers fail to provide coverage for part-time employees who work less than 30 hours per week or for seasonal employees who work less than 120 hours per year, or 15 eight-hour days.

For many part-time and seasonal workers, the availability of subsidized health care coverage through the individual exchanges will be a very positive development. Currently, these employees often lack any health care coverage or else have coverage that is not very good. For these workers, the individual exchanges could provide a stable, affordable source of adequate health care coverage. Some of these workers could also be better off economically if this enables their employers to shift money to other parts of their compensation package, particularly wages.

But in several sectors where part-time and seasonal work is common, especially the food service, hospitality, and other service sectors, many of the workers currently receive good health care coverage that is provided through Taft-Hartley funds. In these sectors, there is a danger that employers will manipulate work schedules and their corporate structures to make sure most of their workers are considered part time or seasonal, enabling them to avoid any employer-responsibility assessments if they fail to provide any health care coverage to these employees.

To the extent employers can successfully engage in such manipulations, this would increase the financial advantage they can obtain by terminating existing health care plans and transferring employees to the individual exchanges. This would make it more likely that the existing health care coverage for these workers will be disrupted, with the attendant negative consequences for the employees.

There are a number of steps that could be taken to reduce these dangers. In issuing regulations to implement the employer-responsibility assessments, the Obama administration could define full-time employees in a manner that will reduce the opportunities for employer manipulation. This includes using lengthy "look-back" periods for measuring the number of hours worked.[35] But regulations are unlikely to solve the entire problem. A better solution would be to amend the Affordable Care Act to eliminate the 30-hour-per-week limit contained in the law for determining whether an employee will be counted for purposes of calculating the employer-responsibility assessment.

Instead, the new rules should adopt a pro-rata rule that requires a proportionate assessment in situations where the employee works less than 30 hours per week.[36] This would not affect the exclusion for small employers with 50 or fewer full-time employees. Rather, it would simply ensure very large corporations such as Walmart, Target, and Perdue are required to pay a pro-rata assessment if they fail to provide coverage for their part-time employees. A similar pro-rata rule could also be adopted in place of the 120-hour-per-year limit for seasonal employees. These approaches would guard against the worst types of abuses with respect to part-time and seasonal employees.

These approaches would not interfere with the increasingly prevalent use of part-time and seasonal employees by many businesses. Employers would still be free to work employees as much or as little as their business requires. A pro-rata assessment would simply ensure decisions by employers on how many hours to work employees are based on the needs of their businesses, and that health care assessments and costs will be a neutral factor in these decisions. Although a pro-rata assessment would mean slightly higher costs for employers with more than 50 employees that fail to provide coverage to their part-time and seasonal employees, these costs would be directly proportional to the hours worked by the employees. Moreover, the overall magnitude of the costs would not be that large given the low level of the employer-responsibility assessment for full-time employees.[37]

These approaches also should not interfere with the decision by employers about whether to provide health insurance to their employees. The pro-rata assessments would only be triggered if a company is not providing any affordable minimum health care coverage to its part-time or seasonal workers. Employers that are currently providing adequate coverage to these workers would not be required to change their practices.

Furthermore, employers still could have the flexibility just to provide coverage to their full-time employees while shifting the part-time and seasonal employees to the individual exchanges. Indeed, in some cases this might make it easier for employers to continue good health care coverage for their full-time employees while at the same time providing a more affordable source of coverage for the part-time and seasonal workers. To make such splitting of the workforce feasible, the pro-rata assessments would have to be calculated based on the number of noncovered part-time and seasonal employees—not on any full-time employees who are covered under an affordable employer-sponsored health care plan. Otherwise, employers would be forced to cover all part-time employees in order to avoid having to pay the employer-responsibility assessments based on their entire workforce.

The bottom line on part-time and seasonal workers under the new health law: The regulations implementing the employer-responsibility assessment should adopt lengthy "look-back" periods to reduce potential abuses of the rules defining part-time and seasonal employees. But to truly prevent abuses, the Affordable Care Act should be amended to establish a pro-rata rule requiring a proportionate employer-responsibility assessment in situations where employees work fewer hours than the thresholds for a full-time employee.

Supplemental "wrap" coverage

The new health care law is unclear about whether an employer can provide supplemental "wrap" coverage to its employees if they are enrolled in the individual exchanges and potentially receiving premium tax credits and cost-sharing reductions, or whether this type of coverage would disqualify the employees from eligibility for the subsidies in the individual exchanges. Wrap coverage could include supplemental benefits such as dental and vision care, as well as coverage for copays, deductibles, and other cost-sharing requirements in health insurance plans offered on the individual exchanges. This issue is likely to be addressed in forthcoming regulations defining "minimum essential coverage."

Dental and vision coverage are not specifically enumerated in the list of benefits included by the new law under minimum essential health coverage. Thus, an argument can be made that the provision of these benefits by an employer should not be considered an "eligible employer-sponsored plan" that would disqualify employees from the subsidies in the individual exchanges. Furthermore, it would be relatively easy for employers to administer these types of supplemental benefits.

In contrast, wrap coverage that simply fills in copays, deductibles, and other cost-sharing requirements in the plans in the individual exchanges would be more difficult to distinguish from minimum essential coverage. Also, it is questionable whether this type of wrap coverage would be administratively feasible since the amount of cost sharing for any employee would vary according to family income, age, and marital status as well as the particular plan the employee chooses in the individual exchange.

Some people believe that allowing this latter type of wrap coverage to be provided by employers could increase utilization of health care benefits by employees and thus could increase the overall cost of coverage through the individual exchanges, thereby increasing the budgetary costs of the premium tax credits and cost-sharing reductions.[38] This view is strenuously disputed by other people, however, who argue that requiring more cost sharing by workers and retirees will simply lead

them to postpone needed care, ultimately resulting in higher costs. Regardless of which view is correct, the possibility of increased utilization would be less likely to occur if employers were simply allowed to provide supplemental benefits such as dental and vision coverage.

Importantly, though, allowing employers to provide either type of supplemental "wrap" coverage could make it easier for more employers to shift their employees to the individual exchanges for their core benefits. In effect, the employees could get access to the public subsidies in the individual exchanges without having to sacrifice benefits previously provided under their employer-sponsored health care plans. To the extent this facilitates the shift of more employees to the individual exchanges, this may increase the overall budgetary costs of the premium tax credits and cost-sharing reductions.

Still, there is a strong policy argument that employers should be allowed to offer both types of supplemental wrap coverage without disqualifying their employees from receiving the subsidies in the individual exchanges. Why? Because this will further the overriding goal of maximizing health care coverage for employees and making sure that health care reform does not result in the loss of benefits for working families. If employers are not allowed to provide wrap coverage, there is a danger that the shifts in coverage from employer-sponsored plans to the plans in the individual exchanges will result in reduced health care benefits for employees in certain sectors, especially in the food service, hospitality, and service industries.

It is also important to note that if employers were allowed to offer supplemental wrap coverage without disqualifying their employees from receiving the subsidies in the individual exchanges, this means these employers would still be liable for the employer-responsibility assessments. This is because they would not be deemed to be offering minimum essential coverage to their employees.

Allowing employers to provide supplemental wrap coverage would also help preserve an important role for unions, Taft-Hartley funds, education and local government trusts, and VEBAs. An analogy can be drawn to Canada where unions and these types of funds have continued to play an important role in providing supplemental coverage for employees, even though core benefits are provided through a national health care plan.

The upshot: Employers should be allowed to provide supplemental wrap coverage to employees because this will maximize health care benefits for employees, help avoid any loss of benefits due to the establishment of the individual exchanges, and help preserve an important role for labor unions, Taft-Hartley funds, education and local government trusts, and VEBAs.

Tax-favored accounts

The new health law specifically states that employees cannot use a flexible spending account, or FSA, to reimburse premiums they pay to the individual exchanges. FSAs are tax-advantaged accounts that enable employees to set aside part of their earnings to pay for various benefits, including health care. This exclusion was included to further a fundamental policy objective of the new law—that employees must choose between receiving the premium tax credit and cost-sharing reductions offered through the individual exchanges or instead receiving a tax-preferred contribution from their employer for health care coverage. They cannot receive both because this would be considered "double dipping" with respect to public subsidies. It also would increase the overall cost of the public subsidies under the individual exchanges.

The Affordable Care Act does not specifically discuss the treatment of health reimbursement accounts, which enable employers to set aside funds on a tax-favored basis to reimburse medical expenses for employees and retirees. And the proposed regulations issued by the Obama administration do not provide any clear guidance on HRAs.

Allowing employers to use HRAs to reimburse all or part of the health insurance premiums that employees or retirees pay to the individual exchanges, without this disqualifying the workers and retirees from being eligible for the premium tax credits and cost-sharing reductions, could be an important means of keeping employer contributions for health care coverage to the maximum extent feasible and avoiding the negative consequences for workers and retirees if employers decide to shift their coverage to the individual exchanges.

The same policy arguments applicable to FSAs, however, would appear to preclude employees and retirees enrolled in the individual exchanges from being eligible for subsidies if they are reimbursed for their premiums through HRAs. The HRAs are simply a back-door means by which the employer can make

a tax-preferred contribution for employee or retiree health care coverage. Furthermore, HRAs are considered an employer-sponsored health care plan because the funds are maintained and owned by the employer. Most importantly, allowing employers to use HRAs to reimburse premiums paid by employees and retirees to the individual exchanges would likely increase the shift of employees and retirees to these exchanges, thereby increasing the cost of the public subsidies in the exchanges.[39]

The new health care law also does not discuss the treatment of health savings accounts, or HSAs, which are tax-advantaged medical savings accounts established for individuals who are enrolled in high-deductible health care plans. The proposed regulations issued by the Obama administration do not provide any guidance about these accounts either. It is unclear whether HSAs would be considered an employer-sponsored health care plan or an individual account. Nevertheless, the same tax policy arguments and budgetary considerations that apply to FSAs and HRAs would appear to apply equally to HSAs. Although any money placed in an HSA generally is used only for out-of-pocket costs, not health care premiums, this should not justify different treatment for HSAs. The large out-of-pocket costs required under high-deductible health care plans simply represent a form of self-insurance for the employees.

If HSAs were to be treated differently than FSAs and HRAs, then this could lead to an explosion in the use of HSAs by employers. In effect, HSAs could become the vehicle for allowing employees to get the benefit of the public subsidies in the individual exchanges and also receive tax-preferred employer contributions for their health care coverage.[40]

A major expansion of HSAs would significantly reduce the health care benefits available to many workers and thus would be contrary to the central objective of the Affordable Care Act. In particular, it would force many employees to enroll in high-deductible health care plans, which require very large upfront costs to be paid by the employees. It also would encourage healthy, well-compensated individuals to abandon traditional job-based health care coverage and thus could destabilize employer-sponsored health care coverage, especially in the small group market.[41]

Fortunately, the negative ramifications associated with an expansion of HSAs can easily be avoided simply by ensuring the final regulations implementing the exchanges do not treat HSAs more favorably than HRAs.

Retirees

For a number of reasons, the introduction of individual health insurance exchanges in 2014 could have profound consequences for employer-sponsored coverage for retirees. Under the new health care law, there is no assessment on employers if they drop coverage for retirees. Because retirees tend to have lower incomes, they would be more likely to qualify for the premium tax credits and cost-sharing reductions in the individual exchanges. And because retirees tend to have higher health care costs due to their age, the limits on age-related variations in health care premiums that can be charged by plans in the individual exchanges could make these premiums more attractive to retirees.

Prior to the new health law, there had already been a dramatic erosion of employer-sponsored health care for retirees over the past several decades.[42] Employers increasingly are curtailing or dropping retiree health care coverage because of changing U.S. accounting requirements, which have required private- and public-sector employers to show retiree health care liabilities on their financial statements. In addition, employers also want to drop retiree coverage due to cost and competitive concerns. Recently, state and local government budget problems also triggered calls for cuts in health care coverage for public-sector retirees.

For all of these reasons, the establishment of the individual exchanges is likely to accelerate the demise of employer-sponsored coverage for retirees.[43] Many employers, Taft-Hartley funds, education and local government trusts, and VEBAs are likely to seriously consider the option of terminating their existing retiree health care plans and shifting the retirees to the individual exchanges.[44] Where they do decide to pursue this option, in some cases they may provide additional after-tax compensation to the retirees to offset any health insurance premiums they will have to pay to the exchanges.

This shift in coverage for retirees was contemplated in the Affordable Care Act. The Early Retiree Reinsurance Program established by the new health law was intended to serve as a bridge to encourage employers to continue coverage for

retirees until 2014. But this program was expressly designed as a temporary measure that would terminate when the exchanges were established in 2014. That's because the exchanges will assure that retirees have access to affordable health care coverage because of reforms such as:

- Guaranteed issuance of coverage
- The prohibition on rescissions to cancel coverage
- The prohibition on denials of health insurance coverage due to pre-existing conditions
- No lifetime or annual limits on the amount of health insurance coverage available to enrollees
- Defined limits on variations in health insurance premiums based on age—a maximum variation of 3-to-1 in the ratio of premiums for oldest and youngest individuals
- Subsidies for persons with lower incomes

Independent studies indicate that early retirees will especially benefit both from the individual exchanges and from the expansion of Medicaid under the new health law.[45]

The shift in coverage for retirees from employer-sponsored plans to the individual exchanges is potentially a positive development. Although this might result in lower benefits or more cost sharing for some retirees, this was already happening without the exchanges. Indeed, many observers view the demise of employer-sponsored coverage for retirees as inevitable. Faced with the enormous cost and other pressures associated with trying to maintain retiree coverage, the individual exchanges could offer employers, Taft-Hartley funds, education and local government trusts, and VEBAs a viable alternative for providing cheaper and more stable coverage for retirees, ensuring they at least would have access to basic health insurance coverage.

This shift in coverage for retirees also might make it easier to avoid cutbacks in health care coverage for active workers. Or it could make it possible to shift resources to address other issues facing retirees, such as shoring up benefits and funding in their pension plans.[46]

There are a few situations, however, where retirees are unlikely to be shifted to the individual exchanges. These include cases where private- or public-sector retirees are currently covered by the same health care plan as active workers and thus receive a heavily subsidized rate for their coverage. In these cases, the rates in the individual exchanges may not be attractive for these retirees.

There also may be a few cases where the existing retiree health care plans are very large and are able to use their purchasing power to reduce costs and obtain better rates for the retirees.

Finally, in some sectors such as the mining or auto industries, existing retiree health care plans may have special statutory protections or may offer substantially better coverage than the benefits that will be provided through the plans in the individual exchanges. Where retirees are a powerful political force, they may strongly resist any shift in coverage to the individual exchanges if it would result in a reduction in their benefits and the transfer of responsibility for the premiums to the retirees. Because of the difficulties in making all retirees whole for any premiums they would have to pay to the individual exchanges, the political opposition to any shift in coverage may be particularly intense in these cases.

Then there are the issues discussed earlier in the report with respect to active employees—family coverage, supplemental wrap coverage, and health reimbursement accounts—that are also relevant for retirees. In particular, it would be especially important to allow employers to provide supplemental wrap coverage for retirees if they are shifted to the individual exchanges for their core benefits, without disqualifying the retirees from receiving the subsidies available through the exchanges. Although this may facilitate the shift in core coverage to the exchanges, this would still be desirable to help preserve health care benefits for retirees.

Conclusion

The establishment of the exchanges and expansion of Medicaid are not likely to result in any immediate widespread disruption in existing employer-sponsored health care coverage. Most existing plans that provide coverage for middle- and upper-income workers and their families will not be impacted by these provisions of the new health care law. In situations where existing health care plans cover low-wage workers, especially part-time and seasonal employees, employers are much more likely to shift these workers and their families to individual health exchanges. It is also likely that the exchanges will accelerate the demise of employer-sponsored coverage for retirees.

In many cases these shifts in coverage may be positive developments. The SHOP exchanges and individual exchanges and their accompanying subsidies, and the expanded Medicaid program, will help provide more stable, secure, and affordable coverage to many lower-income workers and their families, in contrast to the employer-provided health care system which has always struggled in these areas. The same is true for retirees. In addition, the exchanges and expanded Medicaid program provide an opportunity to replace employer payments for health care coverage with public dollars. This could free up employer contributions to improve other aspects of compensation for these workers and retirees.

To maximize health care coverage, the final regulations issued by the Obama administration on the exchanges should give spouses and dependents an independent right to receive premium tax credits and cost-sharing reductions whenever the family coverage offered to them by an employer is unaffordable or it is not offered to them at all. For the same reason, the regulations should ensure employer contributions to health savings accounts are not treated more favorably than employer contributions to health retirement accounts in terms of their impact on the eligibility of employees and retirees for subsidies in the individual exchanges.

Furthermore, it is very important that the final regulations issued by the administration allow Taft-Hartley funds and education and local government trusts to

have equal access to the SHOP exchanges. Otherwise, the SHOP exchanges and small business tax credit could undermine existing coverage provided by these three types of health care funds, leaving employees worse off.

In addition, the administration needs to ensure the establishment of the individual exchanges is not used by some employers as a way to cut back coverage for workers and depress their overall compensation. This could happen in several key sectors of our economy, including the food service, hospitality, and other service industries, as well as the construction industry and local government units in rural areas and the South. In these sectors, existing health care plans provide good health care coverage for some workers. But economic pressures from certain leading employers such as Walmart, Target, and Perdue and political pressures in some states and localities to curtail health care benefits for public-sector employees are already exerting tremendous downward pressure on health care coverage and compensation generally. Thus, there is a significant danger in these sectors that the exchanges could be used to facilitate the diminution in health care coverage and compensation for workers.

The regulations that are in the process of being issued by the Obama administration could adopt a number of approaches to avoid or reduce these dangers. Ultimately, though, it may be necessary to amend the new health law to impose an "antidumping" fee on large employers to discourage them from trying to get a windfall by terminating existing health care plans and shifting employees to the individual exchanges, and to help offset any increased costs to their workers where such shifts in coverage occur.

The regulations issued by the Obama administration also should try to prevent manipulation of the 30-hour-per-week and 120-hour-per-year rules for part-time and seasonal employees. A better solution to this problem would be to amend the Affordable Care Act to require employers to be responsible for a pro-rata share of the costs for part-time and seasonal employees.

Finally, the new rules governing the exchanges should allow employers, Taft-Hartley funds, education and local government trusts, and VEBAs to continue to provide supplemental wrap coverage to employees and retirees who enroll in the individual exchanges, without disqualifying them for the premium tax credits and cost-sharing reductions. This would be especially important to maximize health care benefits and ensure the establishment of the individual exchanges does not result in the loss of health care benefits for some workers and retirees.

About the author

Alan Reuther graduated magna cum laude from Michigan Law School in 1977. He began work as an attorney for the United Auto Workers Union in Detroit later that year. In 1982 he transferred to the UAW Washington office to handle legislative matters. He served as legislative director and head of the UAW Washington office from 1991 to 2010, when he retired from the UAW. He currently works as an independent consultant.

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Endnotes

1 In this paper, term "employer-sponsored health care plans" includes plans sponsored by Taft-Hartley funds, education and local government trusts, and Voluntary Employees' Beneficiary Associations as well as those sponsored by private and public employers.

2 Office of the Actuary, Centers for Medicare and Medicaid Services, Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended (Department of Health and Human Services, 2010). The Chief Actuary projected that there would be gains and losses in employer-sponsored health care coverage, with a net decrease of about 1 million people covered under employer-sponsored plans.

3 Gary D. Ahlquist, Paolo F. Borromeo, and Sanjay B. Saxena, "The Future of Health Insurance: Demise of Employer-Sponsored Coverage Greatly Exaggerated" (New York: Booz & Co., 2011); Bowen Garrett and Mathew Buettgens, "Employer-Sponsored Insurance Under Health Reform: Reports of Its Demise Are Premature" (Washington and Princeton, NJ: Urban Institute and Robert Wood Johnson Foundation, 2011); Mercer, "Few Employers Planning to Drop Health Plans After Reform Is In Place, Survey Finds," Press release, November 9, 2010.

4 Shubham Singhal, Jeris Stueland, and Drew Ungerman, "How US health care reform will affect employee benefits," McKinsey Quarterly (June 2011). The report predicts that 30 percent of companies will definitely or probably drop health care coverage for their employees.

5 Milt Freudenheim, "Health Law in a Swirl of Forecasts," The Washington Post, June 21, 2011, available at http://www.nytimes.com/2011/06/21/business/21insure.html.

6 A number of unions report that some employers have made wildly exaggerated and inaccurate claims about the requirements under the Affordable Care Act in order to justify employer proposals for negative changes to existing health care plans. Interestingly, a similar phenomenon occurred with respect to employer-sponsored pension plans after the Employee Retirement Income Security Act began to be implemented in 1976.

7 Alliance for Health Reform, "Employer Sponsored Coverage: Shape It Up? Ship It Out?" (2008), available at http://www.allhealth.org/Publications/Private_health_insurance/Employer-Sponsored_Coverage_83.pdf; Gerald M. Shea, "The Tri-Committee Draft Proposal for Health Care Reform," Testimony before the House Committee on Education and Labor, June 23, 2009, available at http://democrats.edworkforce.house.gov/documents/111/pdf/testimony/20090623GeraldSheaTestimony.pdf.

8 All interviews for this paper were conducted on a confidential basis.

9 In particular, the Obama administration has issued proposed regulations relating to the functioning of the exchanges, eligibility for the premium tax credit and cost-sharing reductions, and eligibility for the SHOP and individual exchanges. Subsequent regulations will provide guidance on the employer responsibility assessments, minimum essential coverage, and minimum value. During the coming months the administration will be considering comments submitted on all proposed regulations before issuing the final regulations governing these areas.

10 Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended. There is a 5 percent income disregard, effectively bringing the Medicaid threshold up to 138 percent of the federal poverty line.

11 Prior to the Affordable Care Act, most states did not provide any Medicaid coverage to childless adults, regardless of their income. For adults with children, the income limits varied by state, being tied to the income limits formerly required under the state's welfare program.

12 Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended.

13 During 2010-2013, prior to the establishment of the SHOP exchanges, small employers are eligible for a small business tax credit for up to 35 percent of their contributions for employees' health insurance premiums.

14 Adverse selection may occur if Individuals with higher health care costs gravitate toward the more comprehensive plans in an exchange. In addition, even in plans within the same level of insurance, insurance carriers may be able to use benefit design and other practices to attract lower-cost individuals. These problems may be exacerbated depending on what approaches employers decide to use in paying for employees' premiums in the SHOP exchanges, and how they respond to differences in premiums related to age and other factors.

15 A number of provisions in the new health law will mitigate against any adverse selection, including risk adjustment, essential benefits, and pooling of risks being required for all plans offered inside and outside an exchange, and premium tax credits/cost-sharing subsidies only being offered to individuals who enroll in plans in the exchanges.

16 Sarah Lueck, "States Should Structure Insurance Exchanges to Minimize Adverse Selection" (Washington: Center on Budget and Policy Priorities, 2010).

17 In the long run, several factors may militate in favor of a gradual shift in coverage from employer-sponsored plans to the SHOP and individual exchanges. New companies may be less inclined to establish their own health care plans. In addition, the excise tax on high-cost health care plans may lead to cuts in the benefits offered under employer-sponsored plans. To the extent employer-provided health care benefits are reduced and more closely resemble the coverage offered through the exchanges, this could lead more employers to discontinue their own plans and simply shift coverage to the exchanges. But these factors could be offset to the extent the new health law is successful in lowering health care costs by reducing uncompensated care and by reforming the delivery of care.

18 The extent of the competitive disadvantage that might be faced by employers participating in Taft-Hartley funds may vary. If their competitors currently do not provide any health care coverage to their workers, the health care cost differential might actually be lowered if the competitors start enrolling their workers in the SHOP exchanges, receive the small business tax credit, and are required to pay for at least half of the health care premiums for their employees. Yet it is more likely these competitors would simply leave their employees to enroll in the individual exchanges, and thus would still maintain their health care cost differential (especially if they escape liability for any employer responsibility penalty because they have fewer than 50 full-time employees). In contrast, if the competitors currently are providing some health care coverage to their workers, then the availability of the SHOP exchanges and the small business tax credit should reduce their costs, thereby magnifying the health care cost differential. To avoid this problem, it is important that Taft-Hartley funds and their contributing small employers be given the same access to the SOP exchanges and small business tax credit as other small businesses.

19 IRS Notice 2010-82.

20 This would also create an anomalous situation in which the Taft-Hartley fund would be offering different levels of health insurance coverage from different sources to participants who worked for different employers.

21 Each employer that contributes to a Taft-Hartley fund will have records on how many workers it employed and what their wages were. So it would be feasible for each employer to apply separately for the small business tax credit.

22 In addition, similar issues would be raised by multiple employer welfare associations, or MEWAs, which are largely regulated by the states. Although the approach suggested above for Taft-Hartley funds and education and local government trusts could also be applied to MEWAs, the less-stringent regulation of these plans has resulted in fewer consumer protections and greater financial instability. These factors militate against applying the same approach to MEWAs, or at the very least suggest that this approach should be limited to MEWAs that meet certain consumer protection and/or solvency standards.

23 The small business tax credit is only available to tax-exempt employers that are listed in section 501(c), not to education and local governmental units. IRS Notice 2010-44.

24 Unlike the situation with Taft-Hartley funds, the education and local government trusts would be able to determine which of their participants worked for exchange-eligible small employers. This is because these employees generally work for one employer, rather than shifting between many companies. Thus, it would be possible to allow these trusts to enroll in the SHOP exchanges only those employees who actually worked for small employers. But this could create difficulties for the trusts because their participants would be receiving different levels of health care coverage from different sources. Hence, a better approach would be to allow these trusts to enroll all of their participants in the SHOP exchanges if the percentage of their contributing employers who are exchange-eligible exceeds some threshold, say, 75 percent. This approach would ensure the mostly small employers that contribute to these trusts have equal access to the SHOP exchanges. And it would ensure the ability of the trusts to continue providing health care coverage is not undermined.

25 If an employer-sponsored health care plan is unaffordable or does not provide minimum value, then the employee may decline that coverage and instead enroll in the individual exchange and be eligible for premium tax credits and cost-sharing reductions. But if the employee still decides to enroll in an employer-sponsored plan that is unaffordable or lacks minimum value, then this will disqualify the employee from eligibility for the premium tax credits and cost-sharing reductions.

26 In the proposed regulations issued by the Obama administration, eligibility for the individual exchanges is treated separately from eligibility for the premium tax credits and cost-sharing reductions. Thus, there does not appear to be anything that would prevent employers from paying or reimbursing premiums to enroll their employees in the individual exchanges; this would just preclude these employees from being eligible for any premium tax credits and cost-sharing reductions. Ironically, this would seem to run contrary to the thrust of the SHOP exchanges, which establish limited circumstances in which employers can pay premiums to enroll their employees in an exchange. In any event, allowing employers to pay or reimburse premiums to enroll their employees in the individual exchanges would only be advantageous if the rates in the plans in the individual exchanges were more attractive than the rates in existing employer-sponsored plans. Without the availability of the subsidies provided by the premium tax credits and cost-sharing reductions, it seems likely that many fewer employers would be attracted to the option of paying or reimbursing premiums to enroll their employees in the individual exchanges.

27 UC Berkeley Center for Labor Research and Education, "The Affordable Care Act and Collective Bargaining" (2010). The value of the subsidies provided to individuals through the exchanges is not likely to keep pace with health care inflation. Thus, even though wages may also lag health care inflation, over time the attractiveness of the subsidies and coverage through the individual exchanges may be diminished.

28 For more details on the Affordable Care Act's measures to improve the quality of care at lower cost, see: Nicole Cafarella, "Quality Health Care Delivered Effectively and Efficiently: The Affordable Care Act Supports Cost-Containment Initiatives Now Across Our Country" (Washington: Center for American Progress, 2011), available at http://www.americanprogress.org/issues/2011/04/cost_containment.html; Harriet L. Komisar, Judy Feder, and Paul B. Ginsburg, "'Bundling' Payment for Episodes of Hospital Care: Issues and Recommendations for the New Pilot Program in Medicare" (Washington: Center for American Progress, 2011), available at http://www.americanprogress.org/issues/2011/07/medicare_bundling.html.

29 If the tax exclusion for employer-provided health care benefits were curtailed or eliminated, this could significantly alter the calculation made by employers and employees on whether to drop their existing employer-sponsored health care coverage and shift coverage to the individual exchanges, potentially undermining the entire system of employer-sponsored health care coverage.

30 However, if an employer's workforce has a disproportionate number of individuals with higher health care costs—for example, more older workers or more women—then the rates offered by plans in the individual exchanges might still be attractive.

31 By way of comparison, for political reasons the Affordable Care Act requires members of Congress to receive their health care coverage through the individual exchanges. For similar reasons, state and local public officials might perceive it to be in their political interests to force all state and local public workers to receive their health care coverage through the individual exchanges.

32 Even if the final regulations do not permit Taft-Hartley funds and education and local government trusts to pay premiums on behalf of the employees of their contributing employers, without this disqualifying the employees from being eligible for premium tax credits and cost sharing reductions, labor unions might still be interested in having these funds and trusts participate as qualified health care plans or CO-OP programs in the individual exchanges. This approach might provide labor unions with certain financial or organizing advantages.

33 ERISA limits the percentage of participants in a Taft-Hartley plan who can be from nonparticipating employers. This would seem to prevent these plans from being able to accept any person in the individual exchanges. It is also questionable whether these plans would have the resources to make themselves available to anyone participating in the individual exchanges. Although the new health care law appears to require qualified plans in the exchanges to be open to all comers, an argument can be made that eligibility for a plan can be limited based on membership in a union or other organization, so long as this does not take into account health-related factors or other prohibited criteria. Section 1312(a)(2) of the Affordable Care Act specifically states that a "qualified individual may enroll in any qualified health plan available to such individual *and for which such individual is eligible*" (emphasis added).

34 In this situation, the spouses and dependents could decline the unaffordable employer-sponsored coverage that was offered to them, and then enroll in the individual exchanges. They just would not be eligible for any subsidies. This strategy would only be advantageous for the spouses and dependents if the premiums offered by the plans in the individual exchange were more attractive than the unaffordable premiums for family coverage charged by the employer-sponsored plan.

35 The IRS request for comments on implementation of the employer responsibility penalty outlines a possible look back approach. IRS Notice 2011-36.

36 It might be reasonable to still apply some thresholds. The pro-rata penalty, for example, might apply only where an employee works 10 to 30 hours per week. Below a certain level, the employee's connection to the employer becomes too attenuated to warrant the imposition of any penalty.

37 The imposition of pro-rata assessments for part-time and seasonal employees would likely be considered as a cost when employers determine the compensation for the workers. But this does not provide a persuasive reason for not applying pro-rata assessments. After all, the same argument could be made with respect to the assessments for full-time employees. It also could be made with respect to any fines or penalties that are imposed on employers that fail to abide by workplace regulations. In any event, the benefits for employees who receive subsidized health care coverage through the individual exchanges should far outweigh any diminution in their compensation package due to the employer responsibility assessments.

38 By way of analogy, the Congressional Budget Office and the Physician Payment Review Commission have found that the existence of Medigap coverage or employer-sponsored wrap coverage significantly increases utilization and costs under the Medicare program. National Bipartisan Commission on the Future of Medicare, "Private Supplemental Coverage Summary," available at http://thomas.loc.gov/medicare/K-P-1499.html.

39 An argument could be made that HRA reimbursements to retirees should be distinguished from reimbursements to employees. There is no ongoing employment relationship with retirees. And the Affordable Care Act does not impose any employer responsibility assessment on employers that fail to offer coverage to retirees. Most importantly, allowing employers to use HRAs to reimburse retirees for premiums that they pay to the individual exchanges, without disqualifying retirees from receiving the premium tax credits and cost-sharing reductions, would help to keep some employer contributions for retiree coverage.

40 Of course, even if HSAs are treated the same as HRAs and FSAs, employers could always increase the wages that they pay to employees, and then have the workers make their own tax-preferred salary reduction contributions to the HSAs. Clearly, these individual contributions from employees would not disqualify them from being eligible for the subsidies in the individual exchanges. But it is less likely that all employees would use the extra wages in this fashion. Thus, this tactic would not make HSAs as attractive and give them the same boost as would be the case if employers were allowed to make tax preferred contributions to HSAs, without disqualifying the employees from being eligible for the subsidies in the individual exchanges.

41 Sherry Glied and Dahlia Remler, "The Effect of Health Savings Accounts on Health Insurance Coverage" (New York: The Commonwealth Fund, 2005).

42 In 2010 only 28 percent of large employers offered health insurance coverage to new retirees, compared to 66 percent in 1988. Kaiser Family Foundation and Health Research & Education Trust, "Employer Health Benefits 2010 Annual Survey" (2010), available at http://ehbs.kff.org/.

43 This is particularly true for employer-sponsored coverage for retirees who are not yet 65, as well as certain state and local government retirees who are older than 65 but who were never covered under Medicare. In addition, a number of changes in the new health care law relating to the Medicare Part D prescription drug program may also have a major impact on employer-sponsored prescription drug programs for post-65 retirees. The Affordable Care Act improves the prescription drug benefits offered under the Medicare Part D program by gradually filling in the so-called donut hole, which currently requires seniors to pay a larger portion of their prescription drug costs after reaching a certain threshold, but before hitting the annual out-of-pocket limit in the Part D program. At the same time, it reduces the incentive for employers to continue their own prescription drug programs for retirees by eliminating the tax exclusion for the payments they receive from the Retiree Drug Subsidy program, which provides a subsidy to employers who continue to cover retirees under their own prescription drug program, rather than having them enroll in the Part D program. The combination of these factors makes it likely that more employers will drop their own prescription drug programs for post-65 retirees, instead pursuing various options that are available for taking advantage of the Medicare Part D program. This includes direct-contract employer group waiver plans, or EGWPs, in which the employer contracts directly with Medicare to receive payments for providing prescription drug benefits to retirees, 800-series EGWPs, in which the employer purchases the EGWP from a third-party source, or simply having retirees enroll in the Medicare Part D program with or without an employer "wrap" plan. Prior to the enactment of the new health care law, employers were increasingly moving away from the Retirement Drug Subsidy program in favor of these other alternatives. The changes in the new health law will likely accelerate this shift.

44 Smaller employers (and possibly Taft-Hartley funds and education and local government trusts) might also have the option to pay premiums to enroll their retirees in the SHOP exchanges. Yet smaller employers are less likely to provide retiree health care coverage. Moreover, this approach might be less advantageous because the small business tax credit would not appear to apply to payments made on behalf of retirees. Also, there are no premium tax credits and cost-sharing reductions available through the SHOP exchanges. Thus, the only incentives to pursue this approach would be the relative attractiveness of the premium rates in the SHOP exchanges and the ability to treat employees and retirees in a similar manner, rather than having them be split into distinct plans.

45 Ha T. Tu and Allison B. Liebhaber, "Rough Passage: Affordable Health Coverage for Near-Elderly Americans" (Washington: Center for Studying Health System Change, 2009).

46 Many state and local public-sector employers face enormous unfunded liabilities for pension and retiree health care benefits. Although there are serious legal obstacles to cutting back pension benefits for current government employees, retiree health care benefits are much easier to modify. Iris J. Lav and Elizabeth McNichol, "Misunderstandings Regarding State Debt, Pensions and Retiree Health Costs Create Unnecessary Alarm" . (Washington: Center on Budget and Policy Priorities, 2011). This suggests that state and local governments could look at shifting retiree health care coverage to the individual exchanges as a means of freeing up resources to help reduce their unfunded pension liabilities.

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