REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-I-14

Subject: The Future of Employer-Sponsored Insurance

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Referred to: Reference Committee J
(Melissa J. Garretson, MD, Chair)

Many provisions of the Affordable Care Act (ACA) impact employer-sponsored insurance (ESI), including the law's provisions addressing benefit standards, health insurance exchanges, employer responsibility and the excise tax. The provisions of the ACA collectively, combined with employers' desire to contain health care costs, have the real potential to impact how and to what extent employers will offer health insurance coverage to their employees. The Council notes that the direction of the employer-sponsored marketplace will impact the success of key American Medical Association (AMA) policy priorities, such as those that promote individually owned and selected health insurance coverage, portability of health insurance coverage from job to job, and maximizing patient choice of health plan.

This report, initiated by the Council, provides background on ESI; outlines ACA provisions impacting ESI; highlights the emergence of private health insurance exchanges; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

In 2012, 170.9 million individuals in the United States were covered by ESI, comprising 54.9 percent of the population. From 2000 to 2010, the percentage of Americans with ESI declined by 10 percent. In 2013, 57 percent of firms offered health insurance coverage to their workers. According to a 2013 survey of employer health benefits, 90 percent of employees worked for firms that offered health insurance coverage to at least part of their workforces. Fifty-seven percent of workers were enrolled in Preferred Provider Organization (PPO) plans, with 20 percent enrolled in a high-deductible health plan with a savings option, 14 percent enrolled in health maintenance organization (HMO) plans and 9 percent in a point of service (POS) plan.

In 2013, the average yearly premiums for ESI were $5,884 for single coverage and $16,351 for family coverage. Over the last decade, the average premium for family coverage has increased by 80 percent. For employers offering high-deductible health plans with a savings option, average annual premiums were $5,306 for single coverage and $15,227 for family coverage. On average, workers contributed 18 percent of the premium for single coverage and 29 percent of the premium for family coverage. In addition, in 2013, 78 percent of covered workers had an annual deductible for single coverage; the average deductible in 2013 was $1,135.[1]

EMPLOYER-SPONSORED COVERAGE AND THE ACA

The aim of the ACA was to build upon the foundation provided by ESI and provide low-income, non-elderly individuals without access to ESI with either Medicaid coverage or subsidized private

coverage offered through health insurance exchanges. While the ACA affords additional opportunities for employers, especially small employers, to offer coverage to their employees, many provisions contain incentives and penalties to prevent disruption to the ESI marketplace.

SHOP Exchanges and the Small-Group Marketplace

The ACA included provisions for states to establish Small Business Health Options Program (SHOP) exchanges. Seventeen states and DC have established or planned to operate their own SHOP exchanges in 2014; federally facilitated SHOP exchanges are operating in 33 states.[2] Online enrollment in the federally facilitated SHOP exchanges was delayed until November 2014, to offer coverage effective January 1, 2015. Similarly, the online enrollment in some state-operated SHOP exchanges was delayed. In the interim, employers have been able to directly enroll in a SHOP exchange plan through agents, brokers and insurance companies.

The ACA gives states the flexibility until 2016 in how they define small businesses eligible to purchase coverage through SHOP exchanges – states can limit SHOP exchange enrollment initially to small employers with 50 or fewer employees. For 2014, all states chose to limit eligibility for their SHOP marketplaces to small employers with 50 or fewer employees.[2] Starting in 2016, SHOP exchanges will be open to employers with 100 or fewer employees. States will have the option to expand SHOP exchanges to large businesses with more than 100 employees in 2017.

One of the purposes of the SHOP exchanges was to enable additional employee choice of health plan. The Centers for Medicare & Medicaid Services (CMS) delayed employee choice in federally facilitated SHOP exchanges until 2015, and gave states the option to do the same. That is, in 2014, state-operated SHOP exchanges could allow employers to select only one plan for their employees, thereby continuing the status quo. The definition of "employee choice" is, at minimum, having employers choose a metal tier level of benefits (bronze, silver, gold or platinum) and then allow employees to choose any plan within that tier. Beyond that, states have the option to provide additional employee choice: to enable employees to select plans from multiple metal tiers or from any plan offered through the SHOP exchange. In 2014, 16 states and DC had planned to offer employee choice in their state-operated SHOP exchanges. Seven states allow employers to give employees the choice of any plan on the SHOP exchange. Fourteen states and DC allow employers to set a predictable contribution toward coverage regardless of employees' choices, whereas five states allowed employers to contribute toward any plan selected by the employee.[2]

For 2015, employers purchasing coverage through federally facilitated SHOP exchanges were to be permitted to either choose a single health plan for their employees, or choose a metal tier level of benefits and then allow employees to choose any plan offered within that tier. However, CMS gave state insurance commissioners in the federal exchange states the option to request to opt out of employee choice for 2015 if they concluded that employee choice would cause adverse selection within their small group insurance markets (e.g., sicker individuals would choose more comprehensive, higher metal-tiered coverage, and healthy individuals would choose less comprehensive, but more affordable, bronze-level plans). As a result, in 2015, the federally facilitated exchanges operating in 18 states will not offer employee choice, while 14 states will offer choice.[3] At the time this report was written, employee choice is to be available in all federally facilitated SHOP exchanges in 2016.

The ACA gives states the option to combine the management of their SHOP and individual exchanges, while keeping the risk pools of the individual and small group markets separate. States have for the most part kept the administration of these marketplaces separate, because small businesses have different health plan administrative needs than individuals. Importantly, states also

have the option to merge the individual and small group risk pools, thereby operating a single exchange of health plans in their state comprised of one large risk pool. Initially, most states opted not to merge the risk pools of their individual and small-group markets due to the uncertainty of the health profiles of the respective markets; only two states (Vermont and Massachusetts) and DC merged the risk pools.[4] The Council notes, however, that merging individual and small-group markets is one of the primary options that would promote true health plan portability and eliminate job lock associated with health plan enrollment. Another option, allowing employers to purchase coverage for their employees on individual exchanges, would necessitate a change in law or a state waiver.

ACA Provisions Impacting Employer Health Plan Offerings

Since 2010, firms with fewer than 25 employees and average annual wages of less than $50,000 have been eligible for tax credits if they subsidize at least half of the cost of health insurance for their employees. The maximum credit for the smallest, low-wage firms is 50 percent of the employer's contribution for tax years 2014 and 2015.

To incentivize employers to continue to offer coverage, the ACA contained an employer "shared responsibility" provision, also called the "employer mandate," which is applicable to employers with 50 or more full-time employees. In addition to impacting the number of employers that offer coverage, the mandate is expected to raise roughly $139 billion in revenue over 10 years.[5] Under the provision, employers face two potential penalties:

- If an employer does not offer coverage meeting ACA standards to their full-time employees and dependents, and any one employee receives a premium tax credit for coverage offered through the health insurance exchange, the employer faces a penalty of $2,000 for every full-time employee over the first 30.

- If an employer offers coverage but an employee obtains a premium tax credit for coverage offered through the health insurance exchange due to the employer's coverage not being "affordable" (costing more than 9.5 percent of the employee's income) or "adequate" (not having an actuarial value of at least 60 percent), the employer must pay a $3,000 penalty for that employee.

The employer responsibility provision has been delayed. In 2015, firms with 100 or more full-time employees must offer coverage to 70 percent of their full-time employees. In 2016, these firms will have to offer coverage to 95 percent of their employees. Also in 2016, firms with between 50 and 99 full-time employees will be required to offer coverage to 95 percent of their employees.

The ACA also included standards for health plans to meet, many of which are applicable to employer-sponsored plans. There are differences in requirements for grandfathered employer plans, new employer plans and self-insured plans. ACA provisions that can impact some or all employer-sponsored plans and future decisions regarding plan design include but are not limited to: prohibiting lifetime and annual limits on the dollar value of coverage; requiring the extension of dependent coverage up to age 26; requiring first-dollar coverage of certain preventive services; requiring out-of-pocket maximums; and meeting essential health benefit standards.

Also impacting employer plan selection is an excise tax on insurers and plan administrators of employer-sponsored plans, beginning in 2018, applicable to the cost of coverage that exceeds outlined annual caps (initially $10,200 for single coverage and $27,500 for family coverage). The tax is equal to 40 percent of any dollar amount that exceeds the threshold amounts. The annual

thresholds for the excise tax will be indexed to the consumer price index for urban consumers for years beginning in 2020.

THE RISE OF PRIVATE EXCHANGES

Private exchanges are also becoming an option for employers to use in offering health benefits to their employees. These exchanges, offered by brokers, consulting firms, health plans and other stakeholders, have the potential to increase employee choice of health plan, cut employer health insurance costs and reduce the administrative burdens associated with offering ESI. However, the Council notes that private exchanges may perpetuate job lock, as health insurance will continue to be perceived by employees as being tied to their jobs. More than three million individuals enrolled in coverage offered through private exchanges during the 2014 plan year. The enrollment level of private exchanges is projected to be on par with that of public exchanges by 2017,[6] with as many as 40 million individuals enrolled in private exchanges by 2018.[7] In addition, according to a survey of 723 employers from 34 different industries, 45 percent of employers have implemented or plan to consider utilizing a private exchange for their full-time active employees before 2018. Likewise, another study showed that one-fourth of US employers are considering switching to a private exchange in just two years, while 45 percent would consider moving to an exchange in five years.[8] If employers are permitted to contribute toward employee coverage on the public exchanges in 2017 or 2018 (which for larger employers would be at state option), 58 percent would consider doing so.

With most private exchanges being newly launched, concerns have arisen regarding the immaturity of the private exchange marketplace, the impact of the private exchange on the stability of their health care costs, and the receptiveness of their employees to the concept, all of which could dramatically alter how their health benefits are offered and financed.[9] The increased choice of health plans offered on private exchanges will necessitate additional employee education and assistance to ensure that employees select the health plan that meets their health care needs as well of those of their families, and reflects budgetary realities. Another hesitation of employers is the possibility that private exchanges would not meet their risk pool targets, which would cause the employers to have to drop out of the exchange and switch health plans.

Many view the trend toward private exchanges as indicative of employers wanting to transition from paying a set percentage of the premium cost of each employee toward an approach that relies on a defined employer contribution. One employer survey showed that 13 percent of employers have already adopted or are very likely to adopt a defined contribution approach in the next two years, whereas 39 percent were somewhat or very unlikely to adopt a defined contribution approach.[8] Another survey showed that as many as 28 percent of employers may switch to a defined contribution approach in the next two to five years.[10]

AMA POLICY

Policy H-165.920 supports and advocates a system where individually owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it. Policies H-165.920 and H-165.865 advocate for the replacement of the existing employee income tax exclusion for employer-sponsored coverage with individual tax credits for health insurance that are refundable, inversely related to income, and applicable to coverage of the recipient's choice. Policy H-165.851 supports incremental steps toward financing individual health insurance tax credits, including capping the tax exclusion for employment-based health insurance.

Policy H-165.843 encourages employers to promote greater individual choice and ownership of plans, enhance employee education regarding how to choose health plans that meet their needs and offer information and decision-making tools to assist employees in developing and managing their individual health care choices. Likewise, Policy H-165.846 supports mechanisms being in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits, and lifetime benefit caps, and excluded services. Policy H-165.881 advocates for equal-dollar contributions by employers irrespective of an employee's health plan choice. Policy H-165.839 states that exchanges should maximize health plan choice for individuals and families purchasing coverage in exchanges. Health plans participating in the exchange should provide an array of choices, with respect to terms of benefits covered, cost-sharing levels, and other features.

Concerning employer decisions to self-insure, AMA policy has consistently advocated for the elimination of the ERISA preemption of self-insured health plans from state insurance laws, and for additional patient protections for those covered by self-insured plans (Policy H-285.915). With respect to physician protections, Policy D-383.984 states that our AMA will actively support federal legislation clarifying that ERISA preemption does not apply to physician/insurer contracting issues. Policy D-285.965 encourages states to monitor the rate at which small employers self-insure, and the impact of such self-insurance on the viability and purchasing power of SHOP exchanges.

DISCUSSION

While the Council is cognizant that the implementation of SHOP exchanges is in its infancy, and improvements to exchange functionality are ongoing, one of the key promises of establishing SHOP exchanges was to allow for and improve employee choice of health plans. While "employee choice" has been defined by some as allowing employees to choose from a plan on a designated metal tier, thereby only allowing a choice of plans with similar benefit and cost-sharing structures, the Council supports employees having the ability to choose from all plans offered on SHOP exchanges, across all metal tiers.

The Council remains concerned with the long-term viability and development of the SHOP exchanges, especially in light of the growth of private exchanges. While the Council is supportive of the choice of health plans most private exchanges provide, private exchanges have the potential to impact the size and the demographics of the population that enrolls in coverage offered through SHOP exchanges. Notably, employers have some perceived flexibility to provide different coverage to different segments of their employees, with some analysts expecting some employers to effectively maneuver higher-risk employees to SHOP exchanges to obtain health insurance coverage. In addition, private exchanges may also perpetuate job lock, as health insurance will continue to be perceived by employees as being tied to their jobs.

The Council notes that additional steps can be taken in the construct of the ACA to move more toward a system of individually selected and owned health insurance coverage that allows for health plan portability and eliminates job lock. While the ACA currently provides states with the option of merging their individual and SHOP exchanges, as well as the individual and small-group risk pools, the uncertainty of the risk profiles of the individual and small-group markets has been a barrier to states doing so. As the individual markets in states stabilize, the Council believes that merging individual and small-group exchanges and risk pools could promote true health plan portability, increase the size of the risk pool, and potentially result in lower premiums for all stakeholders.

In the interim, the Council believes that state experimentation, through waivers, could enable future transformations in how health coverage is provided to employees. As a step in support of health plan portability and increased employee choice of health plan, waivers could be used to allow employees to be given a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges. In this and other scenarios, to maintain budget neutrality, employers could also be given the ability to purchase or subsidize coverage for their employees on the individual exchanges. Such flexibility has the potential to particularly benefit small businesses, many of which are seeking additional options to provide affordable, meaningful coverage to their employees.

ESI is undergoing notable trends toward additional employee choice of health plan and more defined employer contribution. These trends, collectively, can result in employees being responsible for a greater percentage of their health care premiums and overall costs. In light of this development, when employees will be choosing between high-deductible health plans and plans that offer more comprehensive coverage, the Council believes that there is a need to educate employees and assist them in making choices during their health plan selection, as outlined in Policy H-165.846, which highlights the need for transparency regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. With such transparency, employees will have the ability to select a plan that better meets their health care needs and is affordable.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-165.846, which stresses the importance of health plan transparency and patient education and assistance in health plan selection. (Reaffirm HOD Policy)

2. That our AMA support requiring state and federally facilitated Small Business Health Options Program (SHOP) exchanges to maximize employee choice of health plan and allow employees to enroll in any plan offered through the SHOP. (New HOD Policy)

3. That our AMA encourage the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges. (New HOD Policy)

Fiscal note: Less than $500.

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