Senate health care proposal –

Employer and health insurer implications

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Senate unveils proposed health care plan

The Senate released on June 22, 2017, a discussion draft of its health care legislation, entitled the "Better Care Reconciliation Act" (the Senate proposal). The Senate proposal includes many of the provisions of the American Health Care Act (the House bill) that was passed by the House of Representatives on May 8, but makes some significant changes to that legislation. (*For a discussion of the House bill, see Tax Alert 2017-768*.) The Senate proposal and House bill would repeal and amend portions of the Patient Protection and Affordable Care Act (the Affordable Care Act); however, both the Senate proposal and the House bill retain many of the provisions enacted with the Affordable Care Act.

Here we summarize the key provisions of the Senate proposal affecting employers and health insurers and highlight where the Senate proposal differs from the Affordable Care Act and from the House bill. The side-by-side chart at the end of the Alert illustrates the differences in some of the key provisions.

What happens next?

This is merely a Senate discussion draft and could change before it comes to a vote. Receipt of the CBO estimate is a necessary step for the Senate parliamentarian to complete a review of the legislation in order for it to move forward to a vote. Questions also continue to be raised as to whether the Senate Republicans have the 51 votes (50 senators plus the vice president, if necessary, to break a tie) required to pass the bill. If the bill passes the Senate, the House would either have to pass the Senate bill without modification or the Senate and House would need to undertake a conference process to reconcile the differences in their bills.

Background

The Senate proposal continues the Affordable Care Act's Medicaid expansion provisions through 2021, but begins to phase out these Medicaid funding provisions after that date and sharply reduces Medicaid expenditures beginning in 2024. The proposal would permit low- and middle-income individuals to purchase health care coverage with the benefit of premium tax credits similar to the current-law Affordable Care Act credits, but would limit the eligibility criteria and reduce the amount of the credits. Finally, the proposal continues to require health insurers to enroll all individuals, regardless of health status or preexisting conditions.

Similar to the House bill, the Senate proposal essentially repeals the individual mandate and the employer mandate provisions by reducing to zero the taxes imposed under those provisions. It also repeals or modifies the bulk of the Affordable Care Act taxes and fees.

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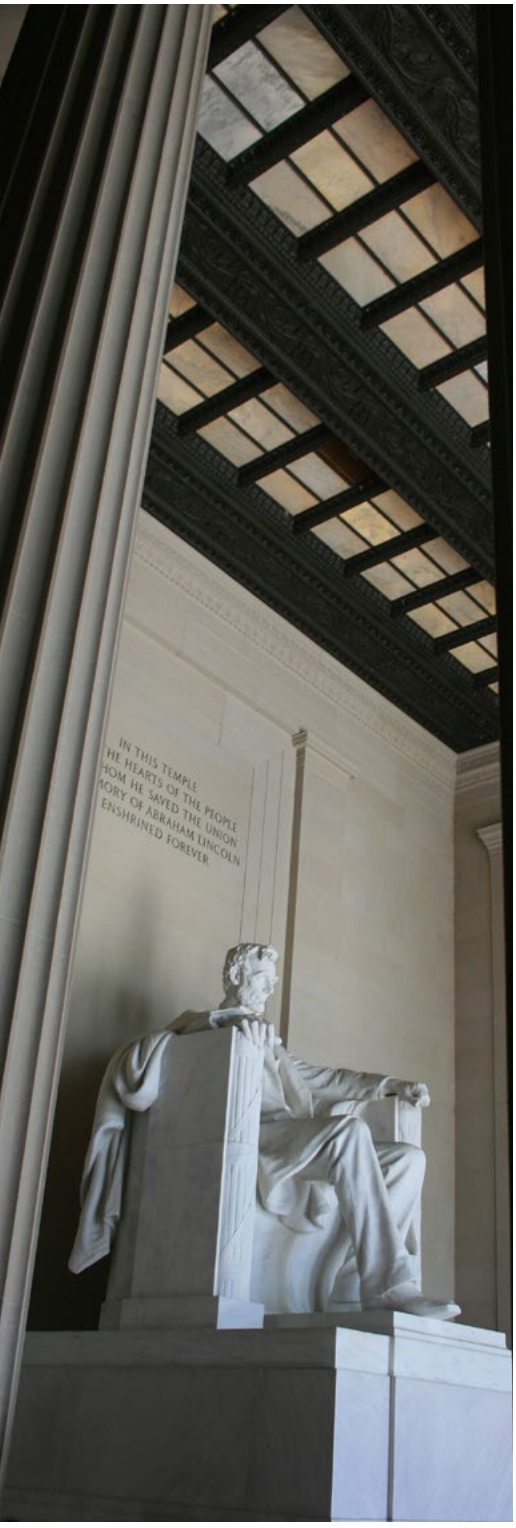

Provisions applicable to employers and insurers

Elimination of the individual and employer mandate taxes

Like the House bill, the Senate proposal would reduce the excise taxes under Section 5000A (the individual mandate) and Section 4980H (the employer mandate) to zero retroactively to 2016. (*See discussion in Tax Alert 2017-768*).

Retention of the premium tax credit through 2019; modifications thereafter

The Senate proposal amends IRC §36B, beginning in 2020, to convert the eligibility to receive a premium tax credit to purchase health coverage into an age-and-income-based criteria, rather than an income-only criteria. In addition, the amount of the premium tax credit would be benchmarked against a much lower value health plan than under the Affordable Care Act. Prior to 2020, the current premium tax credit eligibility would remain in effect, with the exception that beginning in 2018 the credit may not be available to purchase a health care policy that includes coverage for abortions.

Under the current IRC §36B, as enacted in the Affordable Care Act, an individual with a household income of between 100% and 400% of the federal poverty level (FPL) is eligible for a premium tax credit to purchase health care coverage on the marketplace exchange, provided the individual is not eligible for government coverage (e.g., Medicaid or Medicare), employer-sponsored coverage that is affordable and meets a minimum value standard, or other types of minimum essential coverage. The amount of the credit under current law is benchmarked to a "silver plan" that is a 70% actuarial value plan (i.e., the plan generally is designed to pay 70% of the cost of medical care). Under the current provisions, an individual with household income between 100% and 133% of FPL pays no more than 2.04% of household income for a silver plan, and a person with household income between 300% and 400% of FPL pays no more than 9.69% of household income for a silver plan.

Effective in 2020, the Senate proposal would revise these provisions to limit the eligibility for the premium tax credit to individuals with household income of less than 350% of FPL, provided the individual is not eligible for minimum essential coverage, which would include any sort of employer-sponsored group health plan even if the plan is not affordable or provides limited coverage. Under the Senate proposal's amendment to Section 36B, the amount of the credit would be benchmarked to a health care policy with only a 58% actuarial value. The amount an individual must pay for the 58% actuarial value plan would depend on the age of the individual. For example, a 29-year-old individual with household income of 350% of FPL would pay 4.3% of income for a 58% actuarial value plan; a 60-year-old individual with household income of 350% of FPL would pay 16.2% of income for this type of plan.

The Senate proposal retains the existing premium tax credit provisions for 2018 and 2019. Under the existing provisions, employees who have an offer for affordable, minimum value employer-sponsored health coverage are not eligible for the credit. Beginning in 2020, the Senate proposal would prohibit an employee from receiving a premium tax credit if the employee is eligible for employer-sponsored coverage, even if that coverage is not affordable or provides only limited coverage. These provisions in the Senate proposal raise a number of questions, as discussed on the following page.

Implications for employer-sponsored health care coverage

- **What type of coverage would large employers offer their employees once the employer mandate is terminated? Would employers continue to offer affordable coverage that meets a minimum value standard?** The employer mandate enacted with the Affordable Care Act was designed to provide large employers with the incentive to offer full-time employees affordable, minimum value coverage to avoid the assessment of an excise tax if the employee purchased coverage on the marketplace with the benefit of a premium tax credit. The repeal of the employer mandate would eliminate the concern about excise taxes and could affect the types of plans offered by employers in the future; however, it may be expected that many large employers would continue to view affordable coverage as an important part of their compensation programs. The lack of an individual mandate could also affect the take-up rate experienced by employers that offer coverage and that have a workforce including younger employees, who may not place as high a value on coverage.

- **Would employers continue to have an obligation to provide employees with a Form 1095-C and file the Form 1094-C with the IRS reporting on the offer of coverage made to the employees?** The Senate proposal does not repeal IRC §6055 and IRC §6056 reporting requirements. The IRS may continue to need information to assess whether an individual is eligible for the premium tax credit or is prohibited from receiving the tax credit because the individual has an offer in 2018 and 2019 of affordable, minimum value employer-sponsored coverage. In 2020 and thereafter, the IRS would need information to determine whether an individual has any offer of any employer-sponsored coverage to determine eligibility for the premium tax credits. The IRS would need to determine the extent to which the existing Affordable Care Act information reporting system would continue.

Small business health plans

The Senate proposal would amend the Employee Retirement Income Security Act (ERISA) to add a Part 8, which would permit small businesses to establish a single fully insured group health plan that would be subject to the group health plan requirements applicable to large group market plans. This type of association health plan is designed to improve health care pricing and coverage for small employers.

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Repeal or delay of Affordable Care Act taxes and fees

The Senate proposal "repeals" (reduces penalties to zero) or delays the Affordable Care Act taxes and fees in the same manner as the House bill with only limited modifications to effective dates. (*See discussion of these changes in Tax Alert 2017-768*).

Following is a chart showing the effective date of the changes to the applicable provisions:

Health care bill comparison of tax provision effective dates		
Affected tax or fee	House bill effective dates	Senate proposal draft June 22, 2017, effective dates
Changes IRC §5000A individual mandate penalty to $0.	Retroactive to months after December 31, 2015	Retroactive to months after December 31, 2015
Changes IRC §4980H employer mandate to $0.	Retroactive to months after December 31, 2015	Retroactive to months after December 31, 2015
Repeals limit on executive compensation deduction to covered health insurance providers	Tax years beginning after December 31, 2016	Tax years beginning after December 31, 2016
Repeals tanning tax	Services performed after June 30, 2017	Services performed after September 30, 2017
Repeals branded prescription drug tax	2017	2018
Repeals health insurance provider tax	2017	2017 (Effective date coordinates with 2016 legislation imposing a 2017 moratorium on the tax.)
Repeals medical device tax	2017	2018
Repeals 3.8% net investment income tax	Tax years beginning after December 31, 2016	Tax years beginning after December 31, 2016
Repeals exclusion of over-the-counter medication as a qualified medical expense	Tax years beginning after December 31, 2016	Tax years beginning after December 31, 2016
Repeals increase of tax on distributions from health savings accounts	Distributions after December 31, 2016	Distributions after December 31, 2016
Repeals employee annual contribution limit on health flexible spending accounts	Tax years beginning after December 31, 2016	Plan years beginning after December 31, 2017
Permits spousal catch-up contribution to joint health savings account	Tax years beginning after December 31, 2017	Tax years beginning after December 31, 2017
Permits eligible expenses 60 days prior to health savings account establishment	Tax years beginning after December 31, 2017	Tax years beginning after December 31, 2017
Repeals elimination of the deduction for expenses allocable to Medicare Part D subsidy	Tax years beginning after December 31, 2016	Tax years beginning after December 31, 2016
Decreases income threshold for medical expense itemized deduction	Tax years beginning after December 31, 2016 (5.8%)	Tax years beginning after December 31, 2016 (7.5%)
Repeals additional Medicare 0.9% tax	Tax years beginning after December 31, 2022	Tax years beginning after December 31, 2022
Repeals small business health care tax credit	Tax years beginning after December 31, 2019	Tax years beginning after December 31, 2019
Delays tax on higher cost health plans (i.e., Cadillac tax)	Shall not apply before January 2026	Delayed until years beginning after December 31, 2025

Provisions applicable to health insurers

The Senate proposal includes a number of provisions of particular interest to health insurers as follows:

- Appropriates the federal funding of the cost-sharing reduction (CSR) subsidies through 2019 and eliminates the CSR subsidies in 2020 (The CSR subsidies are used to prevent lower-income individuals from bearing certain out-of-pocket costs.)
- Maintains the Affordable Care Act preexisting condition and guaranteed issue requirements
- Allows insurers to employ a 5:1 age rating pricing for individual health care policies
- Eliminates the Medical Loss Ratio (MLR) established by the Affordable Care Act for individual, small group and large group plans in 2019; requires states to establish their own MLR requirements beginning in 2020
- Expands the scope of Affordable Care Act IRC §1332 waivers to allow states to waive requirements, including the waiver of essential health benefits (EHBs) and a waiver to permit premium tax credits to be used for insurance coverage offered outside of the health care exchanges
- Establishes a short-term and long-term market stabilization program. The short-term ($50 billion) program would be run by the Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS) and would be designed to address disruptions in coverage and access and to respond to urgent health care needs within states. The $62 billion, 8-year, Long-Term State Stability and Innovation Program would fund state proposals to address high out-of-pocket costs, lower premiums or otherwise stabilize state marketplaces.

Side-by-side changes to certain key health care provisions applicable to employers and health insurers

Affordable Care Act	House bill	Senate proposal
Individual mandate penalty imposed under IRC §5000A.	Reduces the IRC §5000A penalty to zero. However, insurers would be allowed to impose a 30% premium surcharge on enrollees who fail to retain coverage for 63 days in a 12-month period.	Reduces IRC §5000A penalty to zero. Nothing in the bill would replace the individual mandate to encourage individuals to obtain health insurance coverage.
Employer mandate penalty requiring large employers to offer coverage to full-time employees under IRC §4980H	Reduces the IRC §4980H excise tax to zero.	Reduces the IRC §4980H excise tax to zero.
Premium tax credits under IRC §36B based on income between 100% and 400% of FPL; sets a fixed amount that lower- and middle-income individuals must pay	Tax credit primarily based on age; credit is fixed and would not increase with premium increase in higher-cost areas.	Tax credit based on age and income up to 350% of FPL; credit amount benchmarked against lower value plan.
Cost sharing reduction (CSR) subsidies available to individuals below 250% of FPL	CSR subsidies end in 2020; subject to administration's discretion to terminate earlier	CSR subsidies end in 2020; subject to administration's discretion to terminate earlier
No preexisting condition health care pricing	States have option to permit insurer to increase premiums based on preexisting conditions if individual failed to maintain continuous coverage; must establish high-risk pools	No preexisting condition health care pricing
3:1 age rating health care pricing	5:1 age rating pricing; state option to change the age rating under the waiver provision	5:1 age rating pricing
Health savings account contributions up to $3,400 for individuals and $6,750 for families	Effective 2018, health savings account contributions for individuals up to $6,550 and $13,100 for families	Effective 2018, increased health savings account contributions
Insurers required to cover the 10 essential health benefits (EHBs)	States would be permitted to define what qualifies as an EHB.	States would be permitted to define what qualifies as an EHB.

For additional information about the health care bill and its implications please contact:

Ernst & Young LLP – Workforce Advisory Services – Affordable Care Act Services

Leigh G. Messina
+1 214 756 1032
leigh.messina@ey.com

Ali Master
+1 214 756 1031
ali.master@ey.com

Ernst & Young LLP – Compensation and Benefits Group

Helen Morrison
+1 202 327 7016

Bing Luke
+1 212 773 5790

Catherine Creech
+1 202 327 8047

Andrew Leeds
+1 202 327 7054

Rachael Walker
+1 212 773 9180

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