MILLIMAN WHITE PAPER

The American Health Care Act: Implications for self-insured employers

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On March 6, 2017, the U.S. House Energy and Commerce Committee[1] and the U.S. House Ways and Means Committee[2] released legislation that repeals portions of the Patient Protection and Affordable Care Act (ACA, also known as Obamacare). This legislation, the American Health Care Act (AHCA),[3] retains some provisions of the ACA, and eliminates or delays significant ACA tax provisions, but the legislation does not specifically repeal the entire ACA. Those legislative actions will unfold only after the House bills move to the U.S. Senate and the Congressional Budget Office (CBO) provides the tax-revenue effects with its "scoring."

Our briefing here highlights several elements of the AHCA that affect the employer-sponsored insurance (ESI) programs of large self-insured employers. The following list is not exhaustive, nor does this article fully develop each item. The intent is to inform self-insured employers of elements of the legislation that can affect their plan offerings to employees.

- The "Cadillac Tax" is further delayed until plan years starting in 2025. There was no discussion of whether the structure of the tax would change.
- Dependents to age 26 can remain on their parents' ESI plan.
- Minimum essential coverage requirements would remain.
- Wellness/preventive visit cost would remain at $0 copay.
- Women's wellness benefits will remain unchanged.
- The employer mandate penalties are reduced to $0 retroactively to 2016, effectively repealing the employer mandate. (We expect a corresponding elimination of the compliance report at another time.)
- Tax-exempt contributions to Health Savings Accounts (HSAs) are substantially increased in 2018, up to the annual limit on cost sharing for high-deductible health plans (HDHPs).
- Individual tax penalties for withdrawal of HSA funds for non-qualified expenses would be reduced from 20% to 10%.
- The health insurance tax is repealed in 2018, along with the tax on pharmaceuticals, medical devices, net investment income, and tanning beds. The health insurance tax will have more of a reduction for fully insured plans; that tax does not directly affect self-insured plans.
- For employers that provide health benefits to their retirees, the Retiree Drug Subsidy (RDS) will be exempt from taxes. Employer Group Waiver Plans (EGWP) and RDS analysis should be reconsidered if the tax treatment were to hold.
- There is a possibility that provider fees for employer-based insurance could increase. This would arise as a consequence of reduced provider compensation from other sources. Specifically, Medicaid funding and Medicaid eligibility are being reduced. This could result in a reduction to what providers are paid for Medicaid beneficiaries; it may also increase the number of uninsured and thus increase the amount of uncompensated care.
- A new "Patient and State Stability Fund" is established with federal funding of $100 billion over nine years. If States choose to participate, they will have to match a certain percent of the federal funds starting in 2020. There is nothing in the legislation that indicates how this $100 billion of federal funds or the required state contributions will be funded; if the cost is to be shared across all healthcare markets (similar to the way transitional reinsurance was funded), there could be a new cost for employer-sponsored plans.
- Conspicuous from its absence in the AHCA is any attempt to limit the tax-exempt amount of the cost of the employee's ESI (the employee paycheck premiums and the out-of-pockets costs such as coinsurance and copays).

1 U.S. House Energy and Commerce Committee. Section-by-Section Summary. Retrieved March 12, 2017, from http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/Section-by-Section%20Summary_Final_.pdf.

2 U.S. House Ways and Means Committee (March 6, 2017). Repeal and Replace of Health-Related Tax Policy. Chairman Kevin Brady. Retrieved March 12, 2017, from https://waysandmeans.house.gov/wp-content/uploads/2017/03/03.06.17-Section-by-Section.pdf.

3 The full text of the bill may be found here: https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/AmericanHealthCareAct.pdf.

Several other elements of the legislation have direct applicability to the individual and small group insured marketplace and not ESI. Some are listed below to provide context on the breadth of the changes contemplated by the legislation.

- Guaranteed coverage will remain. Preexisting conditions will not hinder members from obtaining insurance.
- Plans that provide abortion coverage will not be defined as qualified health plans, nor will plans that offer these services provide any eligibility for the proposed tax credits. However, separate abortion coverage plans are permitted.
- The individual mandate will be replaced by instituting a late enrollment penalty for those who have a gap in care to discourage anti-selection. The penalty will be a 30% addition to premiums. This is being referred to as the continuous health insurance coverage incentive.
- The actuarial value standards that create the platinum, gold, silver, and bronze metallic tier definitions for plan richness levels are repealed in 2020. This action is taken to provide more flexibility in plan design offerings.
- The "Patient and State Stability Fund," identified above, is established in 2018 to provide financial help to high-risk individuals, promote access to preventive services, replace the current cost-sharing subsidies for lower-income people, create a new reinsurance program, or other uses, as determined by the states. The focus for use of these funds is primarily on the individual and small group marketplaces.

There are many other changes concerning Medicaid, Medicare, tax credits, and payment of the tax credits that are also part of the American Health Care Act. It is important to understand that this draft bill is the beginning of the process. The final legislation will differ from what was released on March 6. Milliman will provide updates on healthcare reform legislation as Congress continues its movement to "repeal and replace" the ACA.

The comments and summaries are based on the interpretation of the AHCA by the authors. The authors are not attorneys and, therefore, cannot issue legal interpretations or opinions.

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