Employer Based Health Insurance Items

(by Antonio Paulo Pinto – DRAFT copy updated 12 November 2020)

Overview

This article is an extension of ideas presented in an earlier article titled: Health Insurance Financial Assistance Program Modernization, Attachment A, and is specific to the Employer-based group health insurance marketplace; and the interdependent stability related to the Individual-based health insurance marketplace, inclusive of Medicare and Medicaid, PPACA Subsidies, HRAs and HSAs, Payroll Taxes, etc. I am not a CPA; however, I am a former business owner with employees, and former health insurance agent that assisted Employers with group health insurance.

Fundamentally, the idea presented here is that with a few basic changes, the health insurance marketplaces in the country can be rebalanced and made flexible for both Employers and Employees, specifically allowing for completely portable health insurance plan options for Employees and more options for Employers for offering health insurance with predictable and manageable budgets.

Overall, the ideas presented here are experience-based and focus on creating a robust health insurance marketplace that balances the employer-group, individual, Medicare, and Medicaid health insurance programs. This article does not address affordability of health insurance plans or affordable access to health care services, as those are addressed in my book and other articles. The two simplest methods for addressing those issues are: (1) Update the "per-capita" health care spend and utilization definition in PPACA to only consider "commercial" health insurance plans, not including Medicare and Medicaid spend, including updating the AV Calculator to reflect the update, effectively lowering deductibles and copayments. (2) Establish a National "Shared" High Risk Pool under HHS, operated under the TPA model, with each state operating independent TPAs that roll up to HHS; and limit Provider payments for enrolled individuals to two times the Medicare rate, with no balanced billing allowed, while allowing employers to enroll employees by paying into the system.

Recommendations

HSA Modernization – Update the tax code to allow HSAs to be utilized for paying for health insurance plans and any medical related expenses, by eliminating the requirement to be coupled with a HSA Qualified Health Plan.

PPACA Employer Penalties – Update and convert the current system to a more predictable and manageable flat rate contribution system, based on requiring a minimum employer contribution to employees for them be able to purchase health insurance plans, with one rate for FT employees, and one rate for PT employees, if offered.

Employer Medicare and Medicaid Updates – Update and convert the current system that allows and incentivizes employers to move employees onto Medicare and Medicaid programs, based on income and the requirement to offer employees over age 65 a group health insurance plan or be penalized. The employer and employee would benefit from a program that allows the employer to pay a flat rate into the Medicare or Medicaid programs, while allowing the employee to choose between the employer group health plan and Medicare or Medicaid.

PPACA Individual Subsidies – Update the program to be a fixed dollar amount that does not change below a fixed income level and allow individuals to purchase any health insurance plan without having to purchase a health insurance plan only through a government run marketplace. The fixed dollar amount should be set as a flat rate per-individual and should not penalize family members if they have a *spouse* enrolled in Medicare, Medicaid, VA, Tricare, *or any employer-based health insurance plan*, as the current system is anti-family.

Item Clarifications

HSA versus HRA

The main item that is addressed by HSAs and HRAs is that both allow for pre-taxing the cost of a health insurance plan and related medical expenses; however, HSA plans are only pre-tax if purchased through an employer-group. If the goal is to make health insurance more portable and more accessible to individuals, primarily in times of flexible employment as being experienced under COVID, and for entrepreneurs and gig economy workers, then the cost of a HSA plan health insurance plan should be allowed to be a pre-tax benefit to the individual, not just for an employer. It can either be paid through the HSA, by increasing the dollar amount tax limits of the HSA accounts or by allowing individuals to deduct 100% of the cost of an individual health insurance plan. It is important to note that under PPACA, even if the employer provides an HRA to reimburse employees for the cost of their health insurance plan, that is considered a group health insurance plan and *would most likely make the employee and their family members ineligible for Subsidies*.

PPACA Employer Penalties

Employers face a variety of penalties under PPACA, for not offering health insurance, for not having enough employees enrolled in offered health insurance, and many others. What one needs to understand is that the final result of all the penalties is that it is the employees that are penalized, from the employer having to focus on lowering employer liability, resulting in employees and their families losing access to subsidies, *family glitch*.

Employer Medicare and Medicaid Updates

All employers, including governmental agencies, have to comply with health insurance program rules and regulations, such as those under PPACA; and additionally, they must also comply with rules and regulations issued by other governmental agencies, related to health insurance plan offerings, anti-discriminatory, fair employment, etc. The discussion here is very limited as it is a complicated discussion. From a Medicare perspective, almost all employers are required to offer group health insurance plans to their FT employees that are age 65 and older, Medicare eligible individuals, resulting in the employees being enrolled in both programs. The idea presented is that employees should be able to opt-out of the employer group health plan while working FT and just be enrolled only in Medicare, while allowing the employee to pre-tax the cost of the Individual Medicare plan with the requirement that the employer contribute to the cost of the Medicare plan *and requiring the employer to allow the employee to keep their spouse and children on the employer group health insurance plan*. With regards to Medicaid, it should similar as to the opt-out mentioned for Medicare, a fixed rate paid into the system. In either case, the idea is that if an Employer has a FT employee that is enrolled in either program, then there should be a fixed rate paid into the system for that employee.

PPACA Individual Subsidies

The major issue with the PPACA Subsidy system is that it penalizes people a year after the fact and people could be subject to $10,000's in paybacks for "not being eligible" when they thought, and were told by marketplaces, that they were eligible, up-to a year and a half earlier. In fact, it almost exclusively falls on low- and middle-income families, everyone under 400% of the FPL. The subsidy / financial assistance program should be a fixed dollar amount, per-individual, and should not penalize family members with a *spouse* enrolled in Medicare, Medicaid, VA, Tricare, *or any employer-based health insurance plan*, as the current system is anti-family.

Attachment A - Transitioning from Employer-Group to Individual-Owned Health Insurance Plans (page 4)

In the big picture, one needs to understand that "ALL" health insurance programs are interdependent on one another at a fundamental level. The simple way to think of this is that people will always find the lowest cost way to purchase health insurance plans for themselves and their families. It may be through their employer, or it may be on their own; but the decision is based on cost, which is dependent on how the pool or group of insured individuals is spending money on health care expenses as compared to how much they are paying into the pool or group.

It is important to note that PPACA's current Medical Loss Ratio (MLR) regulations do absolutely nothing to lower health insurance plan costs or incite competition between health insurance carriers. In fact, the MLR incentivizes health insurance carriers to not compete and to sell really high cost health insurance plans, as PPACA basically guarantees them up-to a 20% share of the health insurance plan premium. Therefore, the more someone pays for a health insurance plan, means even more dollars, at 20 percent, for potential profit for the health insurance company.

One new issue that has come to light with COVID-19 is the real need for people to not have to switch health insurance plans, not have to restart health insurance plan deductibles, and not have to worry about losing access to their health care providers or prescription drug medications half way through the year, in the case of a sudden job loss or temporary unemployment. The COBRA program was never designed for a situation like the one we are facing today and is too inflexible to address our new reality.

Therefore, I am proposing an alternative Employer-based Individual-plan model for people to have health insurance coverage as an alternative to the Employer-based Group health insurance plan model. Basically, Employers should be allowed to form self-funded groups, or MEWA's, or Association Health Plans, Multi-State Plans, etc., that enroll people in Individual health insurance plans, as opposed to Group health insurance plans. This would be contingent on these organizations participating in the new national and shared risk pool and offering multiple health insurance plan options through the group to employees of the participating Employer groups. The health insurance plan costs and the administrative costs of the programs should all be treated as pre-tax dollars, meaning fully tax-deductible.

This new model should incorporate two very important criteria. (1) Employers must be required to contribute a minimum amount of funding per month of employment, or per year, to the employee health insurance plan cost and/or HSA account; or pay a comparable penalty to the national risk pool; and (2) Employers must offer these programs through an Employer-based exchange that provides advice to employees on how to pick the health insurance plan that is best for them and their families.

This employer program should require funding that is at least 50 percent higher than the newly proposed subsidy funding levels earlier in this document due to the cost shift benefit for employers!

The proposed Mandatory Employer Financial Assistance Level:

Employer Health Plan Assistance Requirement	Employer "Assistance"
Proposed Standard Minimum Assistance	$3,000/employee, $6,000/family
Proposed Maximum Assistance Level	$6,000/employee, $12,000/family

**It may be necessary to exempt Small Employers (under 50 employees) from this requirement.*