The Evolution of Employer-Based Health Insurance in the Face of the Patient Protection & Affordable Care Act

Exploratory

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INTRODUCTION

Healthcare is an ever changing environment for those who work in the field and those that navigate it. As an employer, offering healthcare benefits is expected by prospective employees, particularly for large group practices. Where did this assumption come from and how does an employer continue to be attractive to potential employees in the looming face of the Patient Protection and Affordable Care Act (PPACA)? Where did the phenomenon of employer-based healthcare benefits begin and how did employers get to the challenges face today? The rise of employer-based health insurance as an expectation of employment does deserve attention. While we commonly ponder the origin of this option, the bigger question is, where is it going?

This paper will explore the evolution of the healthcare system and the introduction of employer-based health benefits. As the delivery of healthcare progresses through time, employers will be faced with the task of attempting to lower their cost. In today's environment, the introduction of the Patient Protection and Affordable Care Act will complicate this endeavor.

HISTORY

Until the 20th century, physicians made house calls to care for their patients. They made these visits to get to know where, and how, their patients lived, in order to provide them with optimal care. Medical care was rudimentary; caregivers were limited by the necessary tools to deliver the care, and by the still
evolving advancement of medical technology to treat chronic diseases. “The
evolution of the American healthcare system began in the 1920s, when choices
boiled down to which crazy cure you preferred”. (Blumberg & Davidson, 2009)

In the early days of healthcare, the cures were found in bottles. Hospitals
were places patients went to die. If a patient was infirmed, they were never to
return home, but were sent to these dark houses of death.

From the late 1800’s until the early 1920’s, medicine was evolving quickly.
Treatment was aimed at addressing the latest epidemics, in an on-going attempt
to save the afflicted. (Blumberg & Davidson, 2009) The following table provides
a short chronology of early medicine.

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Event 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1850 – 1870</td>
<td>Louis Pasteur, Joseph Lister and others develop understanding of bacteriology, antiseptics, and immunology</td>
</tr>
<tr>
<td>1870 – 1910</td>
<td>Identification of various infectious agents including spirochaeta pallida (syphilis), typhus, pneumococcus, and malaria. Diphtheria antitoxin developed. Surgery fatality rates fall.</td>
</tr>
<tr>
<td>1887</td>
<td>S.S.K. von Basch invents instrument to measure blood pressure.</td>
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<tr>
<td>1895</td>
<td>Wilhelm Roentgen develops X-rays.</td>
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<tr>
<td>1910</td>
<td>Salvarsan (for syphilis) proves to be first drug treatment that destroys disease without injuring patient.</td>
</tr>
<tr>
<td>1920-1946</td>
<td>Insulin isolated (1922), sulfa developed (1935), large-scale production of synthetic penicillin begins (1946).</td>
</tr>
<tr>
<td>1955</td>
<td>Jonas Salk announces development of vaccine for polio. (Thomasson, 2010)</td>
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During this time, medicine was evolving but healthcare was yet to be born.

“In 1900, the average American spent $5 a year on healthcare ($100 in today’s
money). No one had health insurance, because you don’t need insurance for something that cost $5 a year”. (Blumberg & Davidson, 2009) Hospitals did not have many patients. Patients went if they were really sick, but there was no system to provide preventative medicine or maintenance healthcare. On the other hand, the science of medicine was greatly improving. The creation of the Federation of State Medical Boards and their acceptance of the American Medical Association’s ratings of medical schools in the 1912 led to quality and accreditation measures for physicians. Doctors were required to be licensed, and medical record standards were created. (AMA History Timeline)

By the 1920’s, the demand for hospitalization increased as the population shifted from rural to a more urban setting. (Randolph, 2001) During this time, the demand for health care grew along with the cost to deliver that care. As Americans transitioned into smaller homes in metropolitan areas, the confined spaces left little room to care for the sick, forcing the population to turn to hospitals for treatment. (Preskitt MD, 2008)

As modern medicine advanced, hospitals were transformed from institutions for the chronically ill and indigent population, to those seeking improved medical outcomes. It was this specialized care that resulted in a need for a fluent revenue stream in order for the hospitals to sustain the level of service, thus initiating fees for care delivered. (Gorman, 2006)

In the late 1920’s Baylor University Hospital did a study and found that the average American woman spent more on a tube of lipstick than her family did on
healthcare. “The Baylor Hospital started looking for a way to get regular folks in Dallas to pay for healthcare the same way the paid for lipstick – a tiny bit each month. They offered a plan for teachers to pay 50 cents each month in exchange for Baylor picking up the tab on hospital visits”. (Blumberg & Davidson, 2009) The plan was eventually named Blue Cross and provided 21 days of hospitalization for a fixed $6.00 monthly payment. (Blumberg & Davidson, 2009) This plan created by Baylor marks the first health insurance plan offered to the American population.

There were two significant benchmarks that paved the way for employer-based health insurance. In 1932, President Roosevelt decided not to pursue universal health insurance. Under President Roosevelt’s direction, legislation was passed to create jobs for Americans through manufacturing plants and agricultural activities. (Blumenthan, 2006) America’s economy was healing fast, and the rapid development of the manufacturing industry left many organizations seeking enticements to attract employees. The second milestone was the series of federal statues pertaining to how employer-based insurance should be treated with respect to federal taxes and labor negotiations. (Blumenthan, 2006) “In 1943, the Internal Revenue Service ruled that employer-based healthcare should be tax free. A second law, in 1954, made the tax advantages even more attractive. By the 1960’s, 70 percent of the population was covered by some kind of private, voluntary health insurance plan”. (Blumberg & Davidson, 2009)

In 1929, Justin Ford Kimball founded the Blue Cross insurance plan. (Lichtenstein, 2012) As hospitals started to flourish under the Blue Cross plan,
physicians soon began to realize that they, too, needed to organize themselves. Physicians did not want to join with the Blue Cross plan as they wanted to allow different pricing to their patients correlating with their ability to pay. (Thomasson, 2010) Out of the physician organization, the Blue Shield insurance plan was born. This development in medical coverage resulted in the National Labor Relations Act of 1935, bringing forth commercial insurance plans, and acting as the primary catalyst of employer-based coverage. (Lichtenstein, 2012)

Demand for health insurance rose as medical technology advanced. “Perhaps the most influential aspect of government intervention that shaped the employer-based system of health insurance was the tax treatment of employer-provided contributions to employee health plans”. (Thomasson, 2010) Legislation was passed that insurance premiums would be a tax deduction if paid by the employer. Likewise, through premium conversion, those premiums paid by the employee were pre-tax. This was a benefit to both the employee and the employer as the employer did not have to pay payroll taxes on the employee paid premiums.

“In 2004, more than 159 million Americans – 62.4 percent of the nonelderly population - had health care coverage through employer-sponsored insurance plans”. (Blumenthan, 2006) However, due to the increase of health insurance premiums and the economic recession, the number of Americans covered under these plans has decreased. The drop in coverage has commonly been affiliated with the retirement of a large portion of the population.
“Between 1980 and 2000, the proportion of mid-sized and large firms offering any health care coverage for retirees dropped from 85.6 percent to 37.1 percent, and the proportion of all firms offering health benefits to Medicare-eligible retired persons fell from 20 percent in 1997 to 13 percent in 2002. Recently, a slew of large employers, including General Motors, Sears, Lucent, and several airlines, have reduced or eliminated benefits for the retired.” (Blumenthan, 2006)

**EMPLOYER REMEDIES**

With the escalation of healthcare premiums, many employers have felt forced to make adjustments. The balance between an attractable employee benefit offering, rising medical practice expenses and declining physician reimbursements has created a lot of heartburn for medical practices as employers. The old attraction of selling prospective employees on no weekends, no holidays and better hours doesn’t counteract robust salaries and health insurance benefits. As a practice administrator, creativity has played a role in attracting quality, affordable employees. It has been imperative for a larger practice to offer health benefits in order to attract ideal candidates. However, with rising cost of premiums, adding to the other financial pressures of practice management, employers have sought out ways to lower these costs, while remaining competitive with area hospitals.

According to the Bureau of Labor Statistics, by the 1990’s the cost of healthcare benefits had escalated to over 6 percent of employer wages. While
that was a large percentage at that time, it now stands at 8.4 percent. (Bureau of Labor Statistics, 2013) Business owners tried different approaches to control this now necessary expense. Monthly premiums were increasing by 25-30 percent annually which was crippling small employers. At first, many organizations attempted to reduce the cost of the premiums by altering the benefits. Deductibles were raised from rich plans that had no deductibles to $1,000 to $2,000 per individual and twice that for dependent/family coverage. (Bureau of Labor Statistics, 2013) The introduction of co-pays added to employees paying for more of their own health insurance.

The deep plans where virtually everything was paid for by health insurance shifted to putting more responsibility on the employee as well as those providing the care. Employees were, in some cases, forced to choose a primary care physician who directed their care. In order for employees to see a specialist, a referral was needed from the primary care physician. It was through those channels that higher cost testing was allowed as well. There were also exclusions to services particularly if services were for conditions pre-existing to current coverage.

In addition, with the introduction of the health maintenance organizations (HMO's), resulted in limited provider networks, thereby reducing choice for employees. (Rossiter, 2009) By narrowing the choices as to where or when employees received care, premium costs were lowered to employers. Consequently, employees have tended to choose providers of their healthcare who are “in network” in order to maintain a lower out-of-pocket cost. This was
the initial shifting of payment for healthcare from insurance companies to the subscriber. (Rossiter, 2009)

As the premiums continued to rise, employers continued to seek innovative ways to lower their cost. By the millennium, businesses began to shift some of the premium cost to the employee. In an effort to lessen some of the shock, premium conversion plans were initiated. These plans were orchestrated through Section 125 cafeteria plans that allowed the premium paid by employees to be paid with pre-tax dollars. Business owners are excluded from that benefit as the deduction is taken on their personal tax returns. (Dukett, 2013)

Employers, in many cases, stopped paying for dependent/spousal coverage and allowed employees to choose to cover their families and pay for the premiums pre-tax. Most small employers don’t pay for any of the dependent/spousal coverage and have passed more and more of the employee coverage on to their staff. (Dukett, 2013) The selling point on this phenomenon is that the premium is paid by the employee with pre-tax dollars.

Still, health insurance premiums have continued to rise and employers have continued to seek ways to lower these costs. Large employers turned to partnering with health plans or self-insuring themselves. This was translated into a tangible benefit to employers, in that their premiums were fixed at a much reduced rate. A portion of their premiums paid for coverage and a portion was put in an escrow account. The employer then became responsible for paying a
threshold of claims out of the funds from the escrow account. If claims went over
the threshold, the insurance carrier paid. (Dukett, 2013)

The employer now knew their employee population’s health status and
began encouraging wellness programs. Employers began to pay more attention
to office ergonomics, job stress, and office sponsored food events. Job stress
was evaluated much closer, and working environment consisting of mothers, day
cares and fitness facilities, slowly became the norm. But even with this shift, the
cost of healthcare continued to rise thus driving up the cost of healthcare.
Hence, employers have continued to seek ways to lower this cost.

The next phase of employer-focused reduction of healthcare premiums
resulted in the use of flexible spending accounts, health reimbursement
arrangements and health savings accounts. A flexible spending account (FSA)
allows for non-owner employees to pay for out-of-pocket health care costs with
pre-tax dollars. As the health coverage is watered down, thereby shifting more
cost to employees, employers allow workers to deduct, pre-tax, a set amount that
the employer set the cap on, to be deducted from their paycheck. The employer
provides a platform for the employee to pay for these costs on a pre-tax basis.
The cost is reduced for the employer and employee alike. This has been a win-
win for employees and employers. The employee uses money they “saved” and
the employer has lowered their social security liability. However, over the years,
the Internal Revenue Service has made more and more restrictions on what
could be “run through” the plan and has recently lowered the amount of the
annual election.
The one drawback to this plan is its “use it, lose it” aspect. Any monies not used by the employee during the plan year, becomes the property of the employer. Conversely, if an employee uses the entire annual budgeted amount in the first couple of months of the plan year and leaves employment, the liability falls on the employer.

Next has been the introduction of the Health Reimbursement Arrangements (aka Health Reimbursement Accounts or HRAs). These plans allowed employers to pay for a portion of employee and their dependent’s health benefits or deductibles with the submission of an explanation of benefits from the insurance carrier. Employees could submit a bill for treatment covered under the plan. This allowed employers to continue to water down the plan benefits, banking on the inclination that a low number of employees would actually use the plan. The lower premiums far out-weigh the amount of benefits of employee-submitted bills. While this sounds like a form of self-insurance, it has been very popular for the smaller employer. (Dukett, 2013) The goal of an HRA has been to allow employers to offer higher deductible plans thus lowering the health benefit premiums.

Another form of cost control has been the institution of Health Savings Accounts (HSAs). This option allows the employer to offer a high deductible option at a far lower premium to employees. This type plan channels insurance claims to be adjudicated utilizing the deductible first. For example, if a claim is made for a $1,000, the employee would be responsible for the entire amount. However, if the employee (or the employer) has contributed to a Health Savings
account (deducted on a pre-tax basis) the funds can be withdrawn from that account by the employee to pay the $1,000 healthcare claim. If there are no claims that year, the money just stays in the account to be used at a later (sometimes years later) date. (Health Reimbursement Arrangements 101: Zane Benefits, 2013) However, due to the timing of employer deposits into the health savings account, the employee could have to pay a substantial amount before benefits are paid under the plan. The employee would be allowed to put money in a health savings account pre-tax to save for these expenditures. More often than not, employers will entice employees to use this plan by contributing to their Health Saving accounts. This is still a savings for the employer and creates good will in employee/employer relations. In addition, the savings account is completely portable. This is different from the flexible spending plan in that an HSA can be used as another form of retirement plan if not used for health care expenditures.

As employers have sought out ways to lower their healthcare benefit expense, many have tried to band together to form alliances. This cohesion has resulted in the formation of healthcare benefit consortiums. A consortium is a group of different employers banding together to form a larger group to help to curtail the healthcare premium expense. This form alliance can only be structured with business-related companies. Hence, since many medical practices are independent of each other, this type of arrangement is not feasible. Often times, these arrangement are used by local governments joining their
school systems. (Dukett, 2013) The benefit of these consortiums have resulted in employer groups saving money by utilizing enhanced buying power.

Lastly, some employers have put together Multi-Employer Welfare Associations (MEWA). These relationships allow completely independent businesses to come together solely for the purpose to become a large group for health insurance benefits. Under a MEWA, a Board of Trustees must be nominated and the Association is required to file a charter with their respective state. (Hepler, 2013) There is a sizeable recording fee assessed by the state and the billing administration may be complex. If the MEWA can partner with a local insurance agent who can handle these issues, this form of collaboration can be economically beneficial for most medical practices. (Hepler, 2013)

Over the past decade, employers have tried to be very creative as to how they will control their healthcare costs. According to the Bureau of Labor Statistics, the cost of healthcare premiums has risen from 6 percent of wages to 8.4 percent over a 25 year period. (Blumenthan, 2006) As noted, employers have made attempts to adjustment employment benefit plans including reaching out to their fellow independent practice constituents. But, with the impending changes of the Patient Protection and Affordable Care Act (PPACA), where does this leave businesses and more importantly, independent medical practices?

PATIENT PROTECTION & AFFORDABLE CARE ACT (PPACA)

The implementation of the Affordable Care Act as it applies as part of PPACA is an ever-changing piece of legislation. The primary focus of this law is
to ensure that all Americans have health insurance benefits. (Health Reform, 2013) Over the last couple of decades, it has become surprisingly clear that many Americans do not have health benefits. In addition, those born between 1946 and 1964 (Baby Boomers) are making unsustainable demands on federal programs such as Medicare and Medicaid. “By 2035, in the absence of change, spending for Medicare alone (which is more likely to be impacted by aging Boomers) will have more than doubled to 8 percent, and by 2080 it will have grown to 15 percent”. (Gigante, 2010) This alone has the potential to cause severe economic havoc for the United States.

Furthermore, there has been a rise in the initiation of community-based free clinics. These clinics are for the working uninsured who meet a lower personal economic status. The qualifications for accessing care through a free clinic requires patients to be actively working but whose income is at or just above the federal poverty line. (Free Clinics: U.S. Department of Health and Human Services, 2013) As many smaller businesses do not offer health benefits, combined with lower wages, this has led to an increased portion of the working population unable to afford health insurance. These employees do not meet the welfare assistance criteria and end up showing up in local emergency departments unable to pay. Many providers donate their services to support these clinics. However, there are still many people who don’t qualify for free clinic care or welfare assistance and don’t have health insurance benefits. The Patient Protection and Affordable Care Act is aimed at addressing this problem. As noted earlier, one major goal of this legislation is for all Americans to have
affordable health insurance. The question remains, who is going to pay for this coverage?

In performing a literature review of the Affordable Care Act, one would think it is a good law for everyone. However, the fallout appears to be increasing the economic burden to business owners and taxpayers alike. The most fruitful approach in dissecting this legislation, is to review the requirements. Before outlining the requirements placed on employers, it is important to note which employers will be impacted by the Affordable Care Act. Any employer who employs 50 or more full-time equivalent employees will be affected by this legislation and is defined as a large employer. A large employer must offer health benefits or pay a surcharge for any employee who elects coverage through an exchange to avoid paying a penalty. A full time equivalent employee is one that works an average of 30 hours per week or 130 hours per month. These hours include actual time worked as well as time paid for vacation, holidays and paid leaves of absence (sick time). (Informed on Reform: Cigna Healthcare, 2013)

Beginning in 2013 large employers will be required to report the annual dollars paid for employer sponsored health plans on each employee’s W2. Large employers will be required to offer employee and dependent coverage to all their employees. Note, spousal coverage is not defined as a dependent coverage. (NFIB, 2012)
Spouses may be directed to their own employers or the newly forming Health Benefit Exchanges. While most employers offer employee and dependent coverage, they usually offer spousal coverage as well. In the past, some large employers have declined to offer spousal coverage or not paid any of the additional coverage to encourage spouses to seek coverage through their employers as a means of controlling the covered population. (Dukett, 2013) By reporting premium cost to the Internal Revenue Service, the federal government will be able to assess who receives their health insurance through their employer and the economic impact.

For employees earning less than $200,000 the Medicare tax will remain the same at 1.45%. However, for those employees who are earning over $200,000 the Medicare Tax will rise to 2.35% on all income after that threshold. The same thresholds apply to the new 3.8% on passive incomes such as rent income, dividends, royalties or other investment incomes. (NFIB, 2012) Most payroll systems will implement the new Medicare Tax withholdings. On the other hand, the new tax on passive income will be up to the affected employee to report on their federal tax return. (NFIB, 2012) The following chart illustrates these new tax increases.
How the new health care tax works

Some large employers have retiree health benefits included in their retirement packages. Many of these plans have rich prescription drug benefits. Beginning in 2014, the drug subsidy will be eliminated as a deductible expense which in turn raises the corporate tax liability. While this portion of the legislation does not formally occur until 2014, the liability will be required to show on the corporate books as a future liability. (Chaikind & Peterson, 2010) This will add additional cost to those employers offering bridge insurance to those retired employees who have not reached Medicare eligibility.

Another change in the employer based benefit structure for employees in 2013 is the cap on flexible spending accounts. In prior years, an employer could set the limit of how much an employee could contribute to their individual flexible spending account. While most employers set that limit to a reasonable amount
(typically no more than $3,000 per year) this amount is now capped at a mandated $2,500 per year. (NFIB, 2012) The amount was “self-regulated” as most employees set that limit to an amount that they knew they could spend due to the “use it, lose it” property of the plan. In addition, employers have been sensitive to the fact that an employee can spend the entire annual election at the beginning of the year and then sever employment, leaving the employer with the deficit. (Schaeffer, 2013)

Also on the list of changes are the new HIPAA (Health Information Privacy and Accountability Act) standards that require health plans to certify with the Secretary of Health and Human Services that they are compliant with the administrative simplification rules for electronic funds transfer, health claims status and healthcare payment. The details of this part of the Act to date has not been published, but nonetheless, health plans must file the appropriate paperwork by December 31, 2013. (Centers for Medicare & Medicaid Services, 2013)

2013 will also see the launch of Federal and state health exchanges. These exchanges (Health Insurance Marketplaces) will offer health benefits to individuals who are presently uninsured and to employees who opt out of employer-based health plans. However, not all states will implement a Health Insurance Marketplace (See chart page 25 as of 6/10/13). For those individuals who live in a nonparticipating state, their option will be deferred to the federal government. Employers will need to notify existing and new employees of their state’s Health Insurance Marketplace by the later part of 2014 (recently delayed
from 2013). Once in effect, employers will be required to enlighten employees, on their hire date, what their health benefit options will be. Included in this written overview will be eligibility requirements and their economic contribution. Employees will be directed to the applicable Federal/state Health Insurance Marketplace if the employee contribution to their own health insurance is greater than 9.5 percent of the total household income. Should an employee either voluntarily elect the Marketplace or be directed to the Marketplace due to the higher cost employer-based solution, that employer will be required to pay the Marketplace fee for that employee. (Health Care Reform: Health Insurance Marketplaces, 2013)

Beginning in 2014 the Marketplaces will be serving individuals seeking health care coverage and employers will see the implementation of Small Business Health Option Programs (SHOP Exchanges). Initially, states may limit the use of these Marketplaces to employers of less than 50 employees for the first two years. This forces the large employers to provide adequate health insurance to their employees. The states that choose to implement their Health Insurance Marketplaces may run these organizations or choose to have a non-profit organization run them. There could be several Marketplaces in one state; however, none may overlap in their geographic presence. (NFIB, 2012)

The purpose of these Health Insurance Marketplaces is to provide affordable health insurance benefits to all Americans that is easy to purchase, maintain and afford. These Marketplaces will be set up as “one-stop shopping” approach that is easy, affordable and convenient. Individuals will be able to
compare plans, prices and benefits comparable to TV shopping at Best Buy. Americans will be able to go online and “click” to shop for their healthcare benefits at their convenience. (Health Care Reform: Health Insurance Marketplaces, 2013) All plans offered will have basic benefits known as “essential” health benefits which include outpatient services, hospitalization, emergency services, maternity and newborn care, pediatric care, mental health and substance use, lab work, prescription medications, preventative/wellness care and chronic disease management. In these essential benefit plans, the out-of-pocket expenses will be capped to mirror the high deductible (Health Savings Account) plans now in place. For 2014, these limits are $6,350 for individuals and $12,700 for family coverage plans. (Health Care Reform: Health Insurance Marketplaces, 2013)

With the delay of large employer mandates until 2015, large employers should begin investigating options as to health insurance coverage, benefit plans and operations. Smaller physician practices should take the time to educate themselves in the institution and implementation of the Health Insurance Marketplaces. As for large employers, these corporations will evaluate their current coverage, premium share programs and cost structures. Large employers will need to stay abreast of federal filings, as well educating their employees of their benefits and filing obligations.

Due to the penalties associated with not possessing health insurance coverage, it will be the responsibility of these large employers to notify their staff of the Internal Revenue Service filing obligations. Employers will need to educate
their employees of what benefits they offer, where they can get “more affordable” coverage (if the Marketplace coverage is less expensive) and their responsibility to report these premiums on their annual tax return. For employers, if an employee elects coverage outside employment with the Marketplace Insurance, the employer will be required to pay a fee to the Marketplace. This fee is only assessed if the employee enrolls in the Marketplace plan. However, if an employee waives coverage from both the Marketplace Health Benefit program and the employer sponsored plan, penalties will be assessed through annual federal income tax filings. (Health Care Reform: Health Insurance Marketplaces, 2013)

CONCLUSION

Where does the implementation of the Patient Protection and Affordable Care Act leave the average employer in the future? Any employer who has 50 or more employees will be required to do the following:

- Report health premiums on employee W2’s
- Offer health insurance benefits from a qualified health plan to their staff and dependents (not spousal) or pay the penalty for noncompliance
- Pay a fee for all employees who choose to waive health benefits and elect to buy coverage through the health marketplaces. (NFIB, 2012)

Where does that leave the health insurance system in the future? As the Marketplaces are formed by both state/Federal and private carriers, the shape of employer-based health benefits will be transformed. Employers will continue to
be faced with escalating health insurance premiums. This will, in turn, continue to cause employers to be faced with shifting more of that cost to their employees. Thus, employees will be “steered”, by price, to seek coverage from Health Marketplaces. As the employer-based health insurance benefits arena changes, employers could see changes in premiums as individual employees are rated on their lifestyle habits. Excessive negative habits such as alcohol abuse, tobacco use and obesity could lead to higher premiums. (Dukett, 2013) Employers may find it a better economic decision to promote wellness programs and lifestyle counseling.

Health insurance benefits for the American population are an ever-changing expenditure for employer-based coverage. It is suspected that this will continue to evolve for many years to come.
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Appendix 1

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