Defining the Road Ahead:

Thinking Strategically in the New Era of Health Care Reform

by Edward M. Pudlowski

Understanding the implications of the new health care reform legislation, including those provisions that do not take effect for several years, will be critical in developing a successful strategic plan under the new environment of health care reform and avoiding unintended consequences of decisions made without the benefit of long-term thinking. Although this article is not a comprehensive assessment of the challenges and opportunities that exist under health care reform, nor a layout of all of the issues, it looks at some of the key areas in order to demonstrate why employers need to identify critical pathways and the associated risks and benefits of each decision. Key health care reform areas include insurance market reforms, grandfather rules, provisions that have the potential to influence the underlying cost of health care, the individual mandate, the employer mandate (including the free-choice voucher program) and the excise tax on high-cost plans.

The enactment of sweeping health care reform legislation in 2010 presents employers with many new challenges and opportunities. Historically, employers have taken a short-term strategic view to providing health care benefits. However, the long-term implications of health care reform will now require a much longer view. Companies must consider how employers may be affected and what strategies are in the best interests of the company and its employees.

In order to successfully navigate and achieve overall business and human resource goals, a company must understand the implications of health care reform now, including those provisions that do not take effect for several years. Companies also need to understand the financial, administrative and operational implications of the reform provisions in order to develop their long-term organizational strategies.

Health care reform affects each employer differently. Organizations in industries that typically rely on a young, seasonal, part-time and/or low-wage workforce to drive revenue face different issues than those of well-paid, generally older workers. Therefore, it will be critical to view the reform provisions with a strong understanding of each organization’s population.

In addition, employees will have new choices beginning in 2014 when the state insurance exchanges are available. These new options will create different behavioral patterns, which will affect employers providing health care. Choices include access to new plans outside the employer-sponsored options as well as new sources of subsidy to offset the cost of health care for some U.S. citizens. Anticipating shifts in behavior and utilizing that information will be critical in developing a long-term strategic plan under health care reform.
This article reviews several key provisions of the new law and demonstrates why employers need to think strategically about their health care offerings. This is not a comprehensive assessment of the challenges and opportunities that exist under health care reform, nor is it a layout of all of the issues. However, it is a look at some of the key areas reinforcing the need to identify critical pathways, associated risks and benefits of each decision.

Health care provisions creating new opportunities and challenges include insurance market reforms, grandfather rules, provisions that have the potential to influence the underlying cost of health care, the individual mandate, the employer mandate (including the free-choice voucher program) and the excise tax on high-cost plans.

**INSURANCE MARKET REFORMS**

Health care reform legislation includes a number of insurance reforms that apply to any group health plan offered by an employer. Failure to comply can open employers up to monetary penalties and participant suits. Many of the insurance reform mandates are effective for any plan year beginning six months after the date of enactment (plan years beginning September 23, 2010 and thereafter).

Plans in place as of the date the legislation was signed into law (March 23, 2010) enjoy grandfathered status. A number of the new mandates apply to all plans—including those with grandfathered status. Mandates applying to all plans include the following:

- **Adult child coverage.** If a plan offers any dependent coverage, it must provide an adult child with coverage through the age of 26. Before 2014, for grandfathered health plans, this rule applies only if such child is not eligible for coverage through his or her own employer. The coverage requirement does not extend to a child’s spouse or the child of a child.

- The law does not allow for the employer to charge a separate premium cost for these new dependents who are likely to come on the roster of the employer plans. One strategy being considered to address this new cost is to create more “family” tiers of coverage and charge accordingly. For example, an employer that has three tiers of coverage today (e.g., employee only, employee plus one and employee plus family) may choose to create five tiers based on family size (e.g., employee only, employee plus one, employee plus two, employee plus three and employee plus four or more). By pricing the tiers in accordance with the number of family members, the employer may better spread the risk and pick up a portion of the cost for the new dependents. However, while this strategy might reduce the cost of the new dependents required by the law, it could also create a higher cost family tier for the same benefit level, and that may mean the employer will be more likely to exceed the excise tax limits in 2018.

- **Lifetime maximums.** The act imposes new limits on lifetime maximums and places restrictions on annual benefit limits. Plans may not impose lifetime dollar limits on essential benefits, nor may they restrict annual dollar limits on essential benefits except as permitted by the secretary of Health and Human Services (HHS). HHS regulations allow only the following dollar restrictions on essential benefits: $750,000 for plan years beginning on or after September 23, 2010; $1,250,000 for plan years beginning on or after September 23, 2011; $2 million for plan years beginning on or after September 23, 2012; and no limit for plan years beginning on or after January 1, 2014. There is no special rule for grandfathered group health plans.

- **Preexisting conditions.** Plans, including group grandfathered plans, may not impose preexisting condition exclusions on children’s coverage (under the age of 19). Starting in 2014, this prohibition is extended to coverage for all persons for all group plans.

- **Rescission.** Once a person is covered by a plan, the plan may not rescind that coverage (although this provision does not preclude an employer from eliminating all group health plan coverage). The act includes an exception for fraud or misrepresentation (but an appeal must be allowed). This provision applies to all plans, including grandfathered plans, starting with plan years beginning on or after September 23, 2010.

**GRANDFATHER RULES**

While the provisions discussed above apply to both grandfathered and nongrandfathered plans, there are a number of provisions from which grandfathered plans are exempt. Therefore, it will be important to understand the implications of maintaining grandfathered status versus relinquishing grandfathered status in exchange for the flexibility to make certain plan design changes to control costs. Grandfathered plans are exempt from the following rules:

- **Rules requiring preventive health services.** The act provides that preventive health services must be provided with no cost-sharing requirement for certain minimum defined services. These include services and screenings established by the United States Preventive Services Tax Force, immunizations listed by the Centers for Disease Control and Prevention, and
preventive care and screening for children and women encouraged by the Health Resources and Services Association. This provision applies to plan years beginning on or after September 23, 2010.

Nondiscrimination rules. Under the act, insured plans may not discriminate in favor of higher paid workers. Self-insured plans are already subject to nondiscrimination (in favor of highly compensated employees) rules under Section 105(h) of the Internal Revenue Code. This Code provision, which results in taxation of highly compensated employees, remains in place. The new nondiscrimination rule applies to fully insured plans. It is a provision of the Health Insurance Portability and Accountability Act (HIPAA) and not of the Code. Violations are subject to a penalty of $100 a day per individual failure. This new nondiscrimination rule is effective for plan years beginning on or after September 23, 2010.

The regulations take a middle ground on allowing plans to change provisions without losing grandfathered status. Generally, if the change is to the employee’s advantage or does not increase cost more than a permitted amount, changes do not cause loss of grandfather status.

Rules requiring establishment of claims appeals process. The act requires plans to establish internal and external claims processes. Group health plans and insurance issuers must provide an internal appeals process for coverage determinations and claims. Insured plans must also comply with any state external review process. If there is no state external review process or the plan is self-funded, the plan or issuer must establish external standards pursuant to regulations.

For plans wishing to maintain grandfathered status, the rules to maintain grandfathered status are complex and can be onerous. For a group health plan in existence on March 23, 2010 to be a grandfathered plan, the plan or coverage must include a statement in any materials provided to participants or beneficiaries (primary subscribers in the individual market) describing the benefits, the belief that the plan or coverage is grandfathered, and a contact for further information. Interim final regulations issued by the Departments of the Treasury, Health and Human Services, and Labor in June 2010 contain a model notice that plans may use for this purpose.

The interim regulations provide that grandfather treatment is not lost merely because some (or even all) of the participants in the plan on March 23, 2010 are no longer in the plan or coverage, as long as the plan or coverage has continuously covered someone since March 23, 2010. This determination is made separately with respect to each benefit package made available under the plan or coverage.

A plan or coverage loses grandfather status if the employer enters into a new policy, certificate or contract of insurance after March 23, 2010. This could happen, for example, if a policy, certificate or contract is not renewed. The test is whether the policy was in effect March 23, 2010 for the specific plan. If policy X existed prior to March 23, 2010 but was not held by the existing plan A, plan A does not receive grandfather status upon switching to policy X, nor will a new plan B be given grandfather status if the employer purchases policy X. Self-insured plans, however, are permitted to change their third-party administrator.

The act allows the plan or coverage to add family members and other employees without losing grandfathered status. The regulations make clear that new employees may be added whether they are newly hired or newly enrolled. Because some existing employees who were newly enrolled may have been in other grandfathered plans with different benefits, the regulations include two antiabuse rules. A plan loses grandfather status if:

- The principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered plan (so grandfather status cannot be bought or sold as if it were a commodity); or
- (A) Employees are transferred into a previously grandfathered plan (transferee plan) from another grandfathered plan (transferor plan), (B) the benefits of the transferee plan would have caused loss of grandfather status for the transferor plan if the transferee benefits had been an amendment to the transferor plan, and (C) there was no bona-fide employment-based reason for the transfer. Changing the terms or cost of cover-
age is not a bona-fide reason. (This rule is to prevent employers from circumventing the rule on provision changes.)

The regulations take a middle ground on allowing plans to change provisions without losing grandfathered status. Generally, if the change is to the employee's advantage or does not increase cost more than a permitted amount, changes do not cause loss of grandfather status.

Other factors in determining maintenance or loss of grandfather status include:

• Changes in premiums, changes to comply with federal or state legal requirements and changes to voluntarily comply with the provisions of the act will not cause loss of grandfather status.

• The elimination of all or substantially all benefits (including loss of a critical element) to diagnose or treat a particular condition causes loss of grandfather status for the entire plan. For example, if both counseling and prescription drugs are needed to treat a mental health condition and counseling benefits were eliminated, the plan would lose grandfather status. Changes to the percentage level of participant coinsurance (e.g., from 20% to 21%) would eliminate grandfather status.

• Changes to the fixed cost-sharing amounts other than copayments (e.g., deductibles, out-of-pocket maximums, etc.) eliminate grandfather status only if they exceed the “maximum percentage increase.” The maximum percentage increase is defined as a medical inflation expressed as a percentage (compared to the March 23, 2010 index) plus 15 percentage points. Medical inflation is measured by the medical component of the Consumer Price Index for all urban consumers. The Internal Revenue Service has indicated that the additional 15-percentage-point increase is the total increase allowed while the plan is grandfathered, but a plan can increase cost sharing by the amount of inflation annually.

• Changes to the fixed amount of cost sharing for copayments (e.g., per office visit, per brand-name drug, etc.) eliminate grandfathered status only if they exceed specified limits equal to the greater of (A) $5 adjusted for medical inflation compared to March 23, 2010 or (B) the maximum percentage increase.

• Grandfathered status can also be lost if the employer reduces its contribution (or subsidy) toward the cost of any tier of coverage by more than five percentage points below the March 23, 2010 rate.

The rules regarding what does and does not apply to grandfathered plans, as well as what changes can be made to plan provisions without violating grandfathered status, are complex. Employers need to be strategic about their decisions regarding plan changes and how they affect their grandfathered status. Questions employers should ask before making design decisions include:

• What are the cost implications and other administrative requirements of losing grandfathered status?

• What are the cost implications associated with changes to manage overall costs, and do they violate the grandfather rules?

• Can the plan make the same cost-reduction target through other design changes that don’t violate the grandfather rules?

• What changes can be made incrementally over the years to manage costs and stay within the parameters of the grandfathered rules versus making a larger change today and losing grandfathered status?

• What future changes to essential health benefits, as defined annually by the secretary of Health and Human Services, would the plan be subject to in future years if grandfathered status is lost this year? (There is no definitive answer, but employers need to consider the additional risks raised by the potential loss of grandfathered status.)

Employers and sponsors of group health plans need to understand these complex rules and make informed decisions regarding strategic plan changes for 2011 and beyond.

HEALTH CARE COST PRESSURES

The health care reform law has several provisions that may influence the underlying cost of health care. These include cuts in reimbursement rates to Medicare and Medicaid providers; fees or excise taxes on pharmaceutical companies, medical device manufacturers and health insurers; reduction of hospital bad debt; and quality initiatives.

In June 2010, the first of $455 billion in cuts in the reimbursement rates to Medicare and Medicaid providers began. Some have observed that when provider payments were cut in these two programs, affected physician and hospitals often put pressure on their private sources of reimbursement for services to increase payment rates to offset the lost revenue. Historically, the Medicare/Medicaid cost shift has been identified as a contributor to health care inflation rates (which consistently exceed general inflation rates). It is expected that the $455 bil-
The availability of more affordable options through the state insurance exchanges, could significantly reduce the number of uninsured citizens. If more people have health insurance, the amount of uninsured individuals hospitals treat should go down, resulting in a reduction in the amount of bad debt carried by health care providers, which was often offset by negotiating a higher reimbursement level on private sector business.

In addition, the health care reform law includes several quality initiatives that should help to reduce health care inflation. These initiatives include studies comparing the effectiveness of medical treatments, initiatives to reduce Medicare hospital readmission rates, and new incentives for Medicare providers that meet certain quality standards. Health plans will help pay for comparative effectiveness studies through a fee of $1 per covered life annually in 2013 and $2 per covered life in 2014 and thereafter.

The improvements in quality to the Medicare program (readmission rates, incentives, etc.) can translate into better quality outcomes for non-Medicare patients, as providers alter practice protocols and

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*Increased based on premium growth.

All numbers expressed in billions.

Source: Joint Committee on Taxation JCX-17-10, estimated revenue effects of the amendment in the nature of a substitute to H.R. 4872, the “Reconciliation Act of 2010,” as amended, in combination with the revenue effects of H.R. 3590, The “Patient Protection and Affordable Care Act (PPACA),” as passed by the senate, and scheduled for consideration by the House Committee on Rules on March 20, 2010.
procedures across their entire patient load based on findings from the Medicare initiatives. This often translates into changes in behavior for providers that do not provide services to the Medicare population as information on best practices is shared across the physician community.

While the revenue-generating provisions of the act, which were designed to offset the estimated $1 trillion in cost, are fairly well-defined in terms of the dollars generated, the expected revenue effects of the cost-reduction and quality-improvement provisions are not as clear-cut.

It is possible that the upward pressures on health care inflation from the reform law may outweigh those factors that could influence health care inflation downward. Given this, and the other upward cost pressures that existed before health care reform, there will be an even greater urgency and onus on employers to manage costs—through either benefit design changes or less intrusive measures such as wellness programs, utilization management or population management. Population management is a practice where the organization looks at its employee and dependent population to determine what programs will best benefit the group to decrease the adverse health conditions and reduce costs. The term population management is used as a catchall phrase for programs such as wellness, utilization controls and disease management but uses the best from each dependent on the specific issues inherent in the population (diabetes management, weight-loss programs, smoking cessation, etc.).

Employers will need to become even more focused on strategic opportunities to manage costs under the new era of health care reform. In fact, some cost-conscious employers have begun joining insurers in negotiating provider rates in light of these changes.

**INDIVIDUAL MANDATE**

Starting in 2014, every U.S. citizen will be required to maintain minimum essential health care coverage or pay a penalty. Certain types of plans are deemed to be minimum essential coverage. These include employer-sponsored plans, grandfathered plans, certain individual plans, plans under the state insurance exchange, Medicare, Medicaid, the Federal Employees Health Plan and other federal government programs. The penalty for failing to acquire coverage will be the greater of $95 or 1% of household income in 2014; $325 or 2% of income in 2015; and $695 or 2.5% of household income in 2016. Thereafter, the $695 is indexed for inflation. Exemptions exist for individuals who do not maintain minimum essential coverage because of religious objections or financial hardships.

The individual mandate may cause employees who had previously elected not to participate in an employer-sponsored plan, and had no other source of health care coverage, to reconsider the employer’s offering. Industries that rely on a relatively young and/or low-wage employee base are likely to be heavily affected by this provision.

Additionally, starting in 2014, premium assistance tax credits will be available for individuals and families that make less than 400% of the federal poverty limit ($43,320 for an individual and $88,200 for a family of four in 2010) and that elect coverage through the state insurance exchanges. The tax credits can be as much as $3,000 per year. The availability of these credits to offset the cost of the plans available through the exchange, and the penalty for not obtaining health care coverage, will create a new set of financial decisions for employees in 2014. These provisions will make it even more important for organizations to understand their employee profile and their potential decisions as 2014 draws near.

Employers with a greater risk of new participants entering into their plan as a result of the individual mandate may want to evaluate their plan and cost structure in light of the benefits offered in the state insurance exchanges. While little is known now about the benefit levels of plans to be offered in the exchanges, the actuarial value of those plans is known. As such, organizations can begin to look at their own plans from an actuarial value perspective to get a sense for how their plan may compare in 2014.

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Additionally, understanding how employees at various age, salary and family status groupings will view their employer offerings compared to the exchanges will be critical in assessing potential employee migration. The individual mandate could push more employees who previously did not elect coverage to elect a well-established program (their employer’s) over an unproven start-up plan with no prior history of quality and service excellence (the state exchanges). Strategic design and cost planning could go a long way to reducing the risks employers may face as a result of the individual mandate provision.

**EMPLOYER MANDATE**

In 2014, employers with 50 or more employees will be required to provide coverage to *full-time workers* (defined as working at least 30 hours per week over a month) or to pay a tax penalty if even one worker who cannot afford the coverage buys coverage on the exchange and receives a subsidy.

Employers that do not offer coverage to full-time workers will pay a penalty equal to $2,000 times the total number of full-time employees (less the first 30 full-time employees) if even one employee receives the subsidy. The penalty is prorated on a monthly basis.

Even employers that provide coverage could find that they are still subject to penalty payments if their plan is deemed “unaffordable” for any employee. Affordability is determined on an employee-by-employee basis. A plan will be considered unaffordable if it is determined that the employee’s contribution to the cost of coverage exceeds 9.5% of his or her household income. If a lower income employee (those below 400% of the federal poverty limit) for whom employer coverage is unaffordable seeks a subsidy for coverage through the exchange, the employer will be subject to a penalty. In this situation, the employer will be required to pay a penalty of $3,000 times the number of employees (less 30 employees) receiving a subsidy but not more than $2,000 times the total number of employees (less 30 employees).

Finally, employers may be required to make free-choice voucher payments to employees who elect coverage through the state insurance exchanges even if the cost of the employer’s coverage is not above 9.5% of the employee’s household income (and thus the employee is not eligible for a subsidy). If an employee who meets the requirements declines employer coverage, the employer must, beginning in 2014, provide the employee with a voucher equal to the amount of the employer contribution available under its group health plan. The employee may use the voucher to purchase health care on the exchange. If the cost of the health care plan on the exchange is less than the amount of the voucher, the employee may retain the extra amount, which would constitute taxable income to the worker.

Employers have many issues to consider with respect to the employer mandate. Some employers are already beginning to reevaluate providing health care benefits to their employees, in light of the availability of the exchanges in 2014 and the comparison of the penalty payments versus the current cost of coverage. Financial considerations, however, are only part of the analysis. Employers also need to consider competitive practices, the employer’s desired relationship with its employees and reputational effects of not offering coverage.

Assuming the employer decides to maintain a sponsored plan for employees, strategic opportunities exist to mitigate potential penalty or voucher payments. Assessing employee contributions against potential household income levels will help the employer understand its potential risks and develop an appropriate strategy. Implementing salary-based health plan contributions so employees below 400% of the federal poverty limit do not experience a contribution that exceeds 8% of their income is one such strategy.

**HIGH-COST PLAN EXCISE TAX**

Beginning in 2018, the act imposes a new 40% excise tax on the value of health plan coverage that exceeds certain dollar thresholds. This provision was referred to generically during the legislative process as the *Cadillac plan tax*.

The dollar thresholds are $10,200 for individual coverage and $27,500 for family coverage, beginning in 2018, subject to certain increased thresholds for retirees and employees in designated high-risk occupations. The act also provides for potential adjustments to the thresholds that will apply to the extent that health care inflation does not meet current projections.

To calculate a plan’s exposure to the tax, the total value of an employer’s health plan offering is compared to the set thresholds. To the extent the cost exceeds the thresholds, a 40% excise tax applies on the amounts in excess of the limits. While the tax is paid by the insurance company or third-party claim administrator (in the case of a self-insured plan), these taxes are likely to be passed back to the employer.

The value of health plan coverage includes the...
gross value (i.e., not reduced by the amount the employee pays) of all employer-provided health plans (medical and prescription drug); employee contributions into a health flexible spending account (FSA) or health savings account (HSA); and employer contributions into an FSA, HSA or health reimbursement arrangement (HRA). The act excludes vision, dental and other supplementary health coverage from the valuation. The act provides that the valuation is made in accordance with the rules for determining premiums for purposes of the Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage.

If the annual aggregate value of coverage exceeds the dollar thresholds, the amount of the excess must be reported by the employer to the insurer, or if the plan is self-insured, to the plan administrator. To the extent that the benefits are provided by multiple entities, a pro-rata share in the excess coverage must be reported to each entity.

Insurers or plan administrators are then responsible for paying a 40% excise tax on the excess amount. The insurer or administrator subject to the tax may not deduct the tax for federal income tax purposes. The employer has residual liability to the extent that the tax is not paid because the employer has not reasonably reported the value of the coverage. After 2018, the excess benefit thresholds will be increased annually by an amount indexed to the Consumer Price Index plus one.

Understanding how this tax will be passed back to the employer will be critical. If the cost is passed back through as an additional administrative charge, the regulations could imply that the additional cost associated with the excise tax creates an even greater cost to the employer and thus an increase in the amount of the excise tax (essentially paying an excise tax on the excise tax). Consequently, employers will need to be cognizant of how the costs are passed through. A direct pass-through of the costs versus an additional load to the administrative costs could avoid the inclusion of the pass-through in the taxed amount.

Additionally, employers will want to scrutinize how their COBRA rates are developed. In health care reform, COBRA rates are becoming more important because the rates are expected to be used to determine what gets reported on an employee’s form W-2 as well as to determine the amount of the high-cost plan excise tax. Employers may want to examine the actuarial calculations behind their rates, and note that the IRS is expected to provide additional guidance on COBRA rates.

CONCLUSION

Health care reform presents a myriad of new challenges and opportunities for employers. Understanding the impact of health care reform across the implementation timeline will be critical in developing a successful strategic plan, helping to avoid unintended consequences and managing costs in this new environment.

Author’s note: The views expressed herein are those of the author and do not necessarily reflect the views of Ernst & Young LLP.

Endnotes

1. Health care reform legislation as the term is used in this article refers to the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by Title X of such act and by the Health Care and Education Reconciliation Act (P.L. 111-52). Collectively, this legislation is also referred to as the act for purposes of this article.

2. An employee may qualify for a voucher if (1) an employer pays any part of the premium for employees who purchase the employer-offered coverage, (2) the employee chooses to purchase coverage through an exchange rather than participate in an employer group health plan, (3) the employee would have been eligible for a subsidy by virtue of his or her household income, and (4) the employee would have had to pay between 8% and 9.8% of his or her household income for the coverage.