

Implementing Health Reform: Employer & Consumer Issues



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The new Patient Protection and Affordable Care Act (PPACA, or, more concisely, ACA) contains a smorgasbord of provisions affecting how employers offer health coverage, and how consumers buy coverage. Some provisions are already up and running, such as tax credits to help small employers provide coverage, and state-based high-risk pools to offer affordable coverage to those previously considered uninsurable. Other provisions, such as health insurance exchanges, come into play in later years.

Employer-based insurance has formed the backbone of the U.S. health coverage system for decades. About 170 million Americans get their health coverage through a job. The ACA aims to preserve that structure.

In the summer of 2010, the Alliance for Health Reform, with support from the Robert Wood Johnson Foundation, began a series of Capitol Hill briefings to examine implementation of the health reform law. The third briefing in the series explored implementation issues affecting employers and consumers. Panelists were: Steve Finnan, senior director of policy at the American Cancer Society Cancer Action Network; Terry Gardiner, national policy director of Small Business Majority; Janet Trautwein, executive vice president and CEO of National Association of Health Underwriters; and Steven Wojcik, vice president of public policy at the National Business Group on Health. This issue brief builds on, and expands upon, that briefing.

Fast Facts

- Under the health reform law, employers must decide whether to keep their existing health benefits intact (“grandfather” the plan), and thus avoid some mandates of the reform law. Doing so, however, requires that the firm not significantly cut benefits or raise employee out-of-pocket costs. (They can switch insurers, however.)
- Firms offering very generous health benefits (so-called “Cadillac plans”) will face new pass-along taxes beginning in 2018, unless they scale back the plans’ premiums.
- Some small firms can decide to take a federal tax credit to defray the cost of health coverage for their workers, a benefit that is already available.
- The reform law creates a set of new consumer protections, such as forbidding insurers to drop coverage if a policyholder becomes sick, absent fraud or premium nonpayment.

As the reform law rolls out, its success will depend in part on how well it supports the current employer-based system, experts say.

Triggering job losses, the economic downturn has exacerbated some ominous insurance trends. The U.S. Census report released in mid-September found that the number of uninsured Americans rose to 50.7 million in 2009 from 46.3 million in 2008. The percentage of people covered by employment-based health insurance decreased to 55.8 percent last year from 58.5 percent in 2008. That’s the lowest figure since 1987, the first year that comparable data were collected.

Meanwhile, some provisions of health reform have already kicked in this year for employers, who are gauging the impact to their bottom line. How businesses will ultimately fare under the Affordable Care Act will depend on many factors, including their size. For instance, some small employers who have found health coverage too expensive in the past may find it affordable now, thanks to tax credits

that the reform law provides (to be discussed later).

The timetable for the reform law is spread out over the next few years, but some provisions already are forcing tough new decisions by employers on benefits changes.

The newly implemented ACA provisions include a requirement that employers offering family coverage provide insurance to cover a worker’s children until they turn 26. As long as those children don’t have coverage offered by an employer, parents can keep them on their health plan. Employers project higher costs for this change, and some are considering plan revisions that would charge a higher premium for each child covered under their health plan, says Steven Wojcik, vice president of public policy for the National Business Group on Health.

An employer survey by the Mercer consulting firm found many



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Some reform provisions in effect for new health plans beginning plan or policy year after Sept. 23, 2010:

- Provide, at a minimum, coverage without cost sharing for preventive services rated A or B by the U.S. Preventive Services Task Force; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; preventive care and screenings for infants, children and adolescents recommended by Health Resources and Services Administration (HRSA); and additional preventive care and screenings for women recommended by HRSA.
- Implement an effective process for allowing consumers to appeal health plan decisions; establish an external review process.
- No denying coverage for children because of pre-existing conditions; no excluding pre-existing conditions from children's coverage.
- No lifetime limits on the dollar value of coverage.
- No rescinding (canceling) coverage except in case of fraud or premium nonpayment.

Sources: Patient Protection and Affordable Care Act (<http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf>) and Kaiser Family Foundation, "Implementation Timeline" (<http://healthreform.kff.org/timeline.aspx>)

companies will increase the 2011 cost of dependent coverage for their workers proportionally more than they raise premiums for single coverage. Another new child-related reform feature: Insurers can no longer deny coverage for children under 19 due to a pre-existing medical condition.

Employers face a tricky decision this year on whether they will pursue "grandfathered" status for their health plans, which would allow them to avoid some cost-sharing and coverage mandates under reform. Grandfathered plans are exempt from new quality reporting requirements, government external review and internal appeals changes, and they don't have to implement some consumer protections.

But to retain this status, an employer can't significantly cut benefits or raise employee out-of-pocket costs. (They can switch insurers, however.) The Mercer survey indicated that just 52 percent of employers believe they will retain grandfathered status for all their plans between now and 2014. Other analysts believe no grandfathered plans will exist four or five

years from now. The government's rules for maintaining this status were tougher than many employers expected, Mercer says.

Other reform changes also began to take effect Sept. 23, including the elimination of lifetime caps on benefits. Health plans that are not grandfathered must cover certain preventive care benefits without deductibles or co-payments. For details, see "Recommended Preventive Services" at HealthCare.gov (here is a shortened URL for the list of services—<http://bit.ly/8XRKI5>).

Consumers in non-grandfathered plans will be guaranteed the right to appeal insurers' decisions to an independent third party. Patients will have their choice of provider within a health plan's network of doctors and won't be charged extra for out-of-network emergency care.

Another reform program aims to help employers and unions deal with the cost of health care for retirees 55 and older who are not yet eligible for Medicare (at age 65). The \$5 billion fund will provide reimbursements to

cover 80 percent of medical claims from \$15,000 to \$90,000 for retirees, their spouses and dependents. The program is intended to help employers cover retirees' health costs until 2014, when the reform law is mostly implemented. But there are questions about whether the retiree "reinsurance" program is funded sufficiently.

Small employers have much less power than larger employers in negotiating health plan designs and affordable health insurance premiums. They have to accept packaged plans offered by insurance companies. They pay on average up to 18 percent more in premiums than large companies do for similar policies, according to a Commonwealth Fund study. With the affordability of coverage the major obstacle, only about half of firms with fewer than 10 employees offer insurance.

The health reform law doesn't require employers with fewer than 50 employees to offer coverage. It does provide tax credits to give many small firms an incentive to buy or keep insurance for their workers.

The ACA this year allows small firms with fewer than 25 full-time employees who earn an average salary of below \$50,000 to qualify for a tax credit of up to 35 percent of the cost of premiums. A business must cover at least half of the insurance cost to receive the credit, which rises to 50 percent in 2014 (while remaining at 35 percent for non-profit employers).

The credit may already have helped. The percentage of businesses with three to six workers offering health coverage has increased from 46 in 2009 to 59 in 2010. But researchers say the increase could also be due in part to small firms that don't offer coverage going out of business during the recession, increasing the percentage of surviving firms offering the benefit.

Some small businesses have complained that the tax credit is too small, says Janet Trautwein, CEO of the National Association of Health

Underwriters. **The National Federation of Independent Business, a small business advocacy group, says the credit will have only a limited effect because its duration is limited and its conditions are too restrictive.**

Health reform changes will add 4 percent to 5 percent to the cost of health insurance for small businesses in 2011 alone, Trautwein says. One such cost has, on the surface, nothing to do with health care. The new reform law requires all businesses to report on an IRS 1099 form every time they spend more than \$600 per year for goods and services from a vendor. The provision is intended to increase tax collections of unreported income, with money going to a prevention and public health fund, but it's opposed by small businesses groups as an administrative burden. Attempts in Congress to soften or repeal the requirement have been unsuccessful, as of November 2010.

Reform's main implementation will come in 2014, when insurance exchanges or marketplaces debut in each state where individuals and small businesses can buy coverage. The exchanges could lower costs for small employers and offer needed choice, says the Small Business Majority's Terry Gardiner. The ACA provides funds for "navigator" programs to help reach out to uninsured consumers and small firms, assisting with enrollment.

About 60 percent of workers at firms employing 50 or fewer are offered coverage now. That share could rise to 86 percent under reform, according to a recent RAND Corp. analysis. The jump would be fueled by the 2014 requirement that individuals have health insurance, coupled with a greater availability of lower-cost options through an exchange where small firms band together for greater buying power.

That same year, larger businesses will confront a reform "stick" on coverage. Employers with 50 or more

full-time equivalent workers face penalties for not offering coverage, or for providing plans that are judged not comprehensive or affordable. Businesses that don't provide insurance or that have at least one full-time worker who receives subsidized coverage in the exchanges will have to pay a fee of up to \$2,000 per worker. The penalty doesn't apply to the firm's first 30 workers.

Some employers with at least 50 full-time equivalent employees will confront a difficult decision: cover their workers or pay a fine. That decision may depend on their size and workforce characteristics such as average wage or general workforce health. Currently, less than 3.5 percent of employers with more than 50 full-time workers do not offer health coverage.

Some firms are considering paying the fines instead of continuing coverage, says Janet Trautwein. However, another study by the RAND Corp. projects that among firms this size, 3.2 million more workers will be offered coverage after reform is fully implemented than before. In Massachusetts, where a health insurance mandate went into effect in mid-2007, the number and percentage of people covered through employment rose in 2007 and 2008, slipping back in 2009, perhaps because of the recession.

Firms offering coverage are concerned about new ceilings on deductibles under health care reform. Many now set deductibles at much higher amounts than the maximum deductibles allowed under reform, she says.

The insurance exchanges represent an opportunity for 22 million self-employed entrepreneurs, Gardiner says, since 28 percent of this group currently lack coverage.

Although the self-employed aren't eligible for small business tax credits, they will be eligible for the same tax credits and subsidies available to other

individuals and families purchasing coverage through exchanges, Gardiner adds.

Another change for employers begins in 2018, when a tax on so-called "Cadillac" health plans will begin. Health insurers will draw a tax for employer plans that are valued at more than \$10,200 for singles and \$27,500 for families—nicknamed Cadillac plans for their rich benefits. Health plans will do "whatever they can" to avoid the tax, which almost certainly will be passed along to employers, said Steven Wojcik.

The new law is creating more protections for consumers against financial gaps and other coverage holes in health insurance policies. Yet the price of insurance remains a paramount concern for consumers, as most face a reform requirement in 2014 to purchase coverage or pay a penalty.

The Congressional Budget Office estimates that policies bought on the individual market will cost 10 to 13 percent more in 2016 as a result of the reform law, compared to the cost if the law hadn't been passed. This is primarily because the coverage will be more comprehensive than is true on the individual market today.

For consumers, the pre-reform health insurance system "has been extraordinarily unfriendly," says Stephen Finan, director of policy for the American Cancer Society's Cancer Action Network. People who have medical conditions face higher premium costs—if they can obtain a policy at all. Information about policies, procedures and the quality of medical care is often difficult to obtain and understand, and the ACA must make health care more comprehensible, Finan says.

Reform's consumer protections—some of which are in effect now, some phased in over the next few years—include:

- Barring health plans from declaring people's insurance invalid if they

get sick, unless a person intentionally puts false or incomplete information on the insurance application or fails to pay premiums on time

- No lifetime limits on benefits
- Allowing children to remain on a parent's health plan until they are 26
- Providing coverage of some preventive health services without out-of-pocket payments
- Health insurers being required to spend at least 80 percent of every premium dollar they collect on medical care for their members
- Prohibiting insurers from increasing a person's premium because of a pre-existing medical condition (beginning in 2014).

With a few exceptions, individuals will face an ACA mandate in 2014 to purchase coverage or pay a fine. But individuals and families whose incomes are up to 400 percent of the federal poverty limit (currently \$88,200 for a family of four) will qualify for subsidies to purchase coverage through the state exchanges. If there is not an individual mandate, Finan says, consumers could simply wait to seek coverage when they get sick.

Despite help paying the costs of retiree coverage, employers say reform will reinforce the existing trend of companies dropping benefits for their retirees.

A recent Towers Watson survey found 43 percent saying they are likely to reduce or eliminate retiree medical benefits as a result of reform.

And workers likely will again feel the pinch of higher costs. A National Business Group on Health survey found that about two-thirds of employers plan to increase the share of premiums that workers pay next year.

For consumers, reform's first steps have included the opening of high-risk pools for individuals with pre-existing medical conditions.

Yet an unexpectedly small number of people have signed up for the high-risk program, according to a report from Kaiser Health News. The White House in late September said there were "several thousand" people in these high-risk pools. Possible obstacles to higher enrollment are the price of the premiums, the eligibility

requirements and the lack of publicity.

As was true before the reform law was passed, the public has a mixed reaction to the law as a whole, while expressing solid support for certain provisions.

Elected officials in 20 states have filed a lawsuit challenging the constitutionality of the reform law, focusing on its requirement that individuals obtain medical insurance. Virginia's attorney general has filed a similar suit.

Proponents, on the other hand, contend that as employers and consumers experience the reform law's benefits over time, opposition will diminish, as was the case after Medicare was introduced 45 years ago. As Sen. Jay Rockefeller (D-W.Va.) has said: "It's going to take a tremendous amount of work to steer our system in the right direction." Reform implementation, he says, "will be very, very tricky."

For the sources used in writing this issue brief, email info@allhealth.org or call 202/789-2300.

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The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

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- **Small Business Majority** www.smallbusinessmajority.org

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