Understanding Health Reform

FUNDAMENTALS FOR UTAH EMPLOYERS

By Robert R. Harrison

With the passage of the Patient Protection and Affordable Health Care Act of 2010, Congress enacted broad changes to the market for health insurance and created new obligations for employers. Though commonly referred to as "Health Care Reform," the legislation is primarily insurance reform; it relies on the assumption that most insurance for people not eligible for federal programs will continue to be provided by employers. There are new options for obtaining coverage; mandates for individuals to purchase coverage; and new requirements for employers to provide coverage. Understanding the changes in the health insurance market, and the new requirements imposed on employers, is essential for all Utah businesses.

NEW SOURCES FOR INSURANCE

Although employers may continue to contract directly with private insurance carriers, there are three distinct new options for individuals and employers. Health benefit exchanges create a new "virtual" market for insurance, literally existing as an internet portal where consumers may shop for plans, with standardized products and simplified application procedures. A second option allows the creation of non-profit cooperatives. The cooperatives will make their product available on the exchanges, but will operate as a non-profit alternative to the traditional private insurers. Finally, states may elect to have a "Community Health Insurance" plan, essentially a federal minimum benefit plan offered by the Department of Health and Human Services.

HEALTH BENEFIT EXCHANGES

American Health Benefit Exchanges are essentially a public internet marketplace for health insurance coverage. Starting next year, federal grants will be available to states for the development of the exchanges. By 2014, each state must have an exchange, though the state may elect not to create the exchange, deferring instead to a federal "default" exchange implemented in that state. The exchanges are initially focused on small employers, but states may allow large employers to participate starting in 2018. The exchanges will be open to all private insurance companies who are willing to offer a qualified health plan; most of the coverage available on the exchanges is expected to be offered by private carriers. The Secretary of Health and Human Services is required to implement a procedure for the certification of the plans. Although the certification process is not yet evolved, it is clear that plans will need to provide a basic package of benefits, meet market requirements in their respective states, and insure a sufficient choice of providers for individuals who enroll in the plan.

Employers are allowed to select from four levels of coverage they will make available to their employees through the exchange. These levels, identified as Bronze, Silver, Gold and Platinum, provide increasing levels of coverage. Employees are then allowed to choose any plan within the exchange offering that level of coverage chosen by their employer.

Utah is in a unique position in having an existing health insurance exchange, the Utah Health Exchange. Created in 2009, the exchange opened for small employers on August 19, 2009, and will open to large employers not later than January, 2012. As of this writing, earlier launch of a limited pilot program for large employers is being considered. The reform law allows states some flexibility, and includes a presumption that state exchanges operating before 2010, including Utah, meet the requirements for a health exchange. More information about the Utah Health Exchange is available at www.exchange.utah.gov.

The new law creates definitions for small and large employers, and for small and large group markets. The market size definitions simply follow the definitions of employer size. The large group market is the market in which plans are offered to large employers; the small group market offers coverage to small employers. For purposes of participation in health exchanges and compliance with the reform legislation, a large employer is an employer with at least 101 employees on average, on business days, in a calendar year. As a matter of general guidance, employers can expect that if they normally have more than 100 full-time employees in their company, they will be considered a large employer. Likewise, small employers are those with no more than 100 employees on an average business day.

There is an option in the legislation that will allow a state to change the definition effective January 1, 2016. After that date, states may reduce the number of employees such that a business with 51 employees on average in a calendar year is a large employer and a company with 50 or fewer employees is a small employer. The Utah Health Exchange already uses the smaller definitions; a small employer in the Utah Health Exchange has not fewer than two and not more than 50 employees.

The exchanges must initially create a small business health options program, referred to as a SHOP Exchange, intended to insure that adequate qualified health plans are available in the small group plan market, and to assist small employers in providing coverage for their employees with one of those plans. Tax credits are also available to some small businesses to offset the cost of providing coverage. Eligible businesses have 25 or fewer full-time-equivalent employees, pay annual average wages of less than $50,000, and provide at least 50 percent of the health care coverage for their employees.

Anticipating that some small employers will grow in size during a plan year, the law provides that if a small

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employer enrolls its employees in qualified health plans in an exchange, and then adds employees during the year such that it meets the definition of a large employer, that business will continue to be treated as a small employer for that year.

CONSUMER ORIENTED AND OPERATED PLANS

The new legislation requires the Secretary of Health and Human Services to establish a Consumer Operated and Oriented Plan, referred to as the CO-OP program. The CO-OP program is intended to create incentives for the development of non-profit health insurance issuers who will offer qualified health plans in both the individual and small group market in each state. CO-OP plans will be available on the exchanges alongside private carrier plans.

The program is open to any insurance issuer in the state who wants to structure a qualified non-profit program, but if the insurance companies already existing within a state do not apply to function as a CO-OP, the Secretary of Health and Human Services has grant money available for establishing a non-profit health insurance issuer within that state for the specific purpose of operating a CO-OP. The CO-OPs will be governed by an advisory board of 15 members appointed by the Comptroller General of the United States, and must comply with the insurance laws of the states in which they operate. The Internal Revenue Code has been amended to add CO-OPs to the list of exempt organizations under Section 501(c).

COMMUNITY HEALTH INSURANCE PROGRAM

The community health insurance option allows the Secretary of Health and Human Services to establish and offer, through the exchanges, a health care coverage program. Health insurance coverage offered under the community health

insurance option must comply with requirements of qualified health plan; it must have a sufficient choice of providers and must focus on certain indicators for high quality care, high value and essential health benefits. Unlike the private plans offered through exchanges and the CO-OP plans, the community health insurance option is designed to provide only the essential health benefits package.

States have the option to make additional benefits available through the community health insurance option, but states choosing to do so must assume the full cost of those additional benefits. An interesting provision of the law allows states to prohibit the exchange in their state from offering the community health insurance option if that state passes a law allowing that prohibition.

CHANGES IN PLAN BENEFITS

Health plan benefits will become more standardized as issuers and employers adapt to the new rules. While the specifics are not yet fully determined, there is substantial information on how the process will work and what changes will be needed. Employers will continue to offer, at their discretion, insured plans and self-funded plans. Most of the benefit changes in the new law apply equally whether an employer self-funds or uses an insurance company product.

Of particular importance are prohibitions on cancellation of coverage for employees who become seriously ill; guaranteed issue and renewal of coverage; the elimination of exclusions for pre-existing conditions; and the elimination of annual or lifetime limits on coverage. Immediate impacts include a requirement that employer plans now provide coverage for adult children of employees to age 26, regardless of the employment status of the child, and the elimination of any waiting period greater than 90 days.

All plans offered through the exchanges will have to be "qualified" plans; they must include at least a package of minimum essential benefits. The ultimate scope of essential benefits has yet to be determined. The law requires the Secretary of Health and Human Services to ensure that the scope of those benefits is equal to the benefits provided under a typical plan offered by an employer, and requires the Secretary of Labor to do a study of insurance coverage offered by employers in order to assist in making those determinations.

There are also specific services which must be covered by plans, including ambulatory care; emergency services; paternity and newborn care; prescription drugs; laboratory services; hospital care, mental health services; rehabilitation; and preventive medicine. Particular emphasis is expected on chronic disease management.

NEW OBLIGATIONS FOR EMPLOYERS

There are several categories of new obligations imposed on employers. The most compelling is the imposition of coverage mandates and the associated fines and penalties. Beginning January 1, 2014, employers with more than 50 average employees in the preceding calendar year must provide coverage or pay substantial fines and penalties. The rules for calculating average employees are very specific, employers need to be sure they understand the rules and their application in each business. Employers who fail to provide the essential package of benefits to all employees may be fined $2,000 per employee, and $3,000 for each employee who uses subsidies to purchase individual coverage because the employer did not provide coverage.

Employers also face significant obligations in the design and administration of health benefit plans. Some of the obligations include automatic enrollment for companies with more than 200 employees; the need to revise plan documents; new and expanded rights of employees to an appeal process; and a requirement for providing employees with 60-day advance notice of any plan changes. The IRS will require that forms W-2 be amended to reflect reporting of the value of insurance benefits provided to employees, and "cafeteria plans" must be revised to reflect new limits on coverage. Employers will also need careful planning to avoid incurring the 40 percent excise tax on "Cadillac" benefit plans when that provision takes effect in 2018.

THE IMPACT OF REFORM ON UTAH BUSINESSES

Although the new law is not likely to reduce the cost that employers pay for health insurance, there are provisions which are intended to control the increase in cost. Insurance companies will be required to provide information on the percentage of their collective premiums not paid out in benefits, and will be subject to limitations on cost increases they may impose. Other provisions of the bill may tend to increase costs, however; increasing the services provided likely will increase the total overall expenditure of funds.

A recent study by Mercer indicates that employers expect cost increases of 2 to 3 percent next year, above and beyond anticipated inflation in the cost of health insurance. Cost increases for subsequent years may be greater as eligibility for additional benefits expands. Absorbing the additional costs will require careful management and thoughtful strategies by Utah businesses. **UB**

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