Health Care Reform Cheat Sheet for Bargainers

Health care reform is set to impose changes to our health benefit plans -- including requirements of new benefits and lifted restrictions on benefits. Changes may impose new costs on plans or provide cost relief. It is important to keep track of these changes and understand their potential impact on our negotiated plans.

Overview	Date Effective	Impact on Benefits	Notes for Bargaining	Data Request
Coverage for adult dependents until age 26 Job-based plans must offer coverage to adult dependents. There is no requirement for dependents to be students, live at home, be financially dependent, or single (though spouses and children of adult dependents are not covered).	Sep 23, 2010	Additional costs to plan could result from expanded dependent coverage, though cost should be small due to low cost nature of group (estimated increase of 0.7-1%). [1]	● Employer may seek to shift new cost to workers. ● Bargainers should verify terms for this new group are identical to terms for other dependents.	Request average claims cost of employees age 21-26 to serve as proxy for new coverage group.
No Cost Sharing for Preventive Care All new and non-grandfathered health plans will be required to cover a range of preventive services (including vaccinations, screenings, and contraceptives) at no cost to patients. [2]	Sep 23, 2010 (The US Supreme Court is currently hearing arguments regarding contraceptive coverage)	Most large employer plans already cover preventive services at no cost to employees because it is generally accepted that preventive care will lower health care costs in the long run. Smaller employers may see initial increases in costs as these benefits go into effect.	● Check your Summary Plan Description (SPD) to verify that the plan covers all required preventive services free of charge.	Request total cost and employee out of pocket cost towards preventive care services in each of the past 3-5 years to estimate new costs to employer.
Eliminate Lifetime Limits on Benefits All plans must provide unlimited lifetime coverage for essential health benefits.	Jan 1, 2011	Some of our smaller negotiated plans had lifetime limits on coverage (typically $1-2 million). Most larger plans do not. Prohibiting limits will add to cost of plan.	● Review Summary Plan Description (SPD) to see if plan has lifetime limits. If yes, they must removed by employer unilaterally or through bargaining.	Request the number of individuals that exceeded the lifetime limit in each of the past 3-5 years and their total cost in excess of limit.
Phase Out Annual Limits on Benefits Annual limit cannot be less than: ● $750,000 as of 01/01/2011 ● $1.25 million as of 01/01/2012 ● $2 million as of 01/01/2013 ● Eliminated entirely 01/01/2014	Jan 1, 2011 - Jan 1, 2014	Phasing out of Annual Limits will add to plan costs.	● Review Summary Plan Description to determine if there are annual limits on benefits. These must be phased out according to schedule at left.	Request number of individuals that exceeded annual limit each of the past 3-5 years; the total cost of claims in excess of the maxiumum; and the percentage of total claims in excess of the limit.

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Limits on Health Spending Accounts The penalty on use of funds for non-medical expenses is increased from 10% to 20%.	Jan 1, 2011	These accounts are associated with high deductible health plans and the balance in the account rolls over from year to year.	● Determine if the account is an HSA. ● Request an education effort to alert employees to the change.	Request number of employees that use the accounts, number that have used funds for non-medical purposes, and how much has been used on average.
Medical Loss Ratio Minimum Large fully-insured group plans are required to spend 85% of collected premiums on medical expenses for their customers (as opposed to administration or profits). Small groups and individual insured plans are required to spend 80%. Plans are required to refund the difference if their ratio falls below these levels.	Jan 1, 2011; All rebates for 2011 paid out by Aug 2012	Group health plans are required to use any rebate attributable to contributions paid by employees to either lower contributions or write checks directly to covered employees.	● Insurance plans are required to submit medical loss ratio to the Department of Health and Human Services. [3] ● If reimbursements are required for a plan year, bargainers can negotiate the method by which the payments are made.	Medical loss ratio reports are publicly searchable. Plans are also required to notify the plan sponsor and group subscribers of a pending rebate.
Report Cost of Coverage on W-2s Employers will be required to report the cost of benefits provided to employees on their W-2s.	Required for all employers beginning 2012 (for W-2s sent to employees in early 2013)	The reporting is for informational purposes only. The cost of the benefits is not taxable for employees.	● Confirm if the employer has implemented this provision. ● Ask for an education plan to alert employees to the change and allay any fears about taxation.	
Provide Summary of Benefits and Coverage (SBC) At the beginning of annual open enrollment periods, group health plans are required provide employees with an easy-to-understand summary of available coverage options and a glossary of important insurance terms (e.g. "deductible" and "copayment") to help applicants make well informed decisions.	Sep 23, 2012	This provision is unlikely to increase costs for the employer significantly. It is an important tool to ensure that unit members are making informed decisions with regard to their coverage.	● Check with employer that they are complying with this rule. The federal government has released standardized templates for employers to use. [4] Contact the CWA Research Department if you have trouble finding a template.	

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Outcomes Research Fee All health insurance plans will be required to pay a fee at the end of each plan year based on the number of lives covered that will fund the Patient-Centered Outcomes Research Institute (PCORI), which will provide information to consumers and doctors to help them make better health care choices. The assessed fee will be as follows: ● Oct, 2012 - Oct, 2013: $1 per covered life ● Oct, 2013 - Oct, 2014: $2 per covered life ● Oct, 2014 - Oct, 2019: $2 x rate of inflation in national health expenditures per covered life.	Applicable from Sep 30, 2012 to Oct 1, 2019	Employers will likely seek to shift this new fee onto employees through bargaining.	● Bargainers will want to verify that the employer projections of future fees owed. Note any unusually large increases in the per person dollar rate in years 2015 - 2019. The federal government currently estimates health expenditures to rise on average 6% after 2015. [5] ● Be aware that $1-2 is a small amount per person compared to an average total cost of over $5,000 per person for single coverage in 2012. [6]	Request average covered lives for each of the past 3 plan years to estimate the size of the fee owed in years 2013 and 2014. After that the fee will be affected by the nationwide growth rate of health care spending. Request employers provide their estimate of fees owed through 2019.
Limits on Flexible Spending Accounts Pre-tax contributions limited to $2,500 per year 2013 (previously $5,000). Indexed for inflation in subsequent years.	Jan 1, 2013	These are the "use it or lose it" types of accounts. Employees make contributions which reduce their taxable incomes. Many CWA employers have these accounts, though most employees at our largest employers do not use them.	● Request an educational effort from employer to alert employees to the rules change.	Request number of employees enrolled in FSA, average contribution, and the range of contributions. Also request number of members with contributions in excess of $2.500.
Reinsurance Fee A fee will be charged to group health care plan to fund the "Transitional Reinsurance Program" which is designed to help stabilize premium rates in the new state-based health insurance exchanges. The fee will levied based on the number of covered lives within the plan. This fee has been set at $63 per covered life in 2014 and $44 in 2015. The 2016 rate is likely to be smaller due to the front-loaded structure of the program.	Jan 1, 2014 to Dec 31 2016 (Self-insured, self-administered plans exempt in 2015 and 2016)	As with the PCORI Fee, employers will likely seek to shift this new fee onto employees through increased contributions or out-of-pocket costs at the bargaining table.	● HHS is scheduled to raise $12 billion through this fee in 2014, $8 billion in 2015, and $5 billion in 2016. The per person rate charged to group plans is likely to shrink at a similar rate. ● This fee lasts only 3 years; be wary of conceding permanent changes in your plan to pay for it.	Request average covered lives to estimate size of the fee owed in 2014. Request the employer provide an estimate of what they expect to pay towards this fee in 2015 and 2016.

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Essential Health Benefits All fully-insured small group plans must cover essential health benefits defined by broad categories, including: ● emergency services, ● hospitalization, ● maternity and newborn care, ● prescription drug, ● pediatric services, ● preventive and wellness benefits, and ● chronic disease management, among others [7] Each state will designate a "benchmark" plan that will define the essential benefits package in that state.	Jan 1, 2014	Covering new benefits will increase plan costs.	● Check with state health insurance exchange or federal Health and Human Services department to determine the essential health benefits definition for your state. ● Review Summary Plan Description and ensure all essential benefits are covered.	
Rules on Minimum Waiting Periods Otherwise eligible employees cannot be forced to wait more than 90 days before being allowed to enroll in coverage. Requiring accumulation of work hours before eligibility is allowed (max 1,200) as is a 1 month max "orientation" periods.	Jan 1, 2014	Additional costs to plan could result from new employees being allowed to gain coverage more quickly.	● Check SPD to determine what eligibility rules are currently in place.	Request number of newly hired employees in each of the last 3-5 years and the enrollment rate for each plan.
Automatic Enrollment Employers with 200 or more full-time employees are required to automatically enroll new full-time workers into company offered benefit plans.	Pending final regulations from the Department of Labor.	Once final rules are released, employer will have to implement either unilaterally or through bargaining.	● Depending on the final rules, union might seek contract language determing the default plan for automatic enrollment.	Request number of newly hired employees in each of the last 3-5 years and the enrollment rate for each plan.

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Employer "Play or Pay" Mandate Large employers (with more than 50 full-time equivalent (FTE) employees) will be required to offer coverage to full-time employees (more than 30 hours per week) that's considered affordable and comprehensive. Employers that fail to offer any coverage will be subject to a penalty of $2,000 for each full-time employee (minus 30). Employers that fail to offer affordable, quality coverage (9.5% of income, 60% value) will pay $3,000 for each employee that opts out and buys subsidized coverage on the state health insurance exchanges.	Effective Jan 1, 2015 (Postponed to Jan 1, 2016 for employers with less than 100 FTEs)	Administration recently announced that it would be postponing enforcing this provision due to issues regarding data collection from employers. Standard for minimum acceptable coverage to avoid $2,000 penalty is quite lax. Affordability and minimum value standards are similarly lax - most plans likely to pass.	● Comparing contribution rates for single coverage to reported wages for lowest earners in unit will be crucial to determining if employers is vulnerable to this provision. ● Generally health plans that are not designated as high-deductible and with coinsurance below 40% will pass test for comprehensiveness. Check with employer if they have checked this with an actuary. If not, CWA research can help. ● Contract language that protects workers from being pushed into part-time status will be important. ● Workers most likely to trigger penalty also likely to be young and low cost. Their exit to exchange may increase costs of company plan.	Request W2 wages earned by all unit employees for previous years. Request any evaluation the company has done to determine the actuarial value of the plan.
Excise Tax on High Value Health Coverage Tax payable by the plan or plan sponsor. Beginning in 2018 a 40% excise is applied to the cost of a plan in excess of certain thresholds: ● $10,200 for single coverage; ● $27,500 for family coverage. Thresholds are indexed by CPI+1% in 2019 and by CPI only in each subsequent year. There are adjustments for age, gender and retirees.	Jan 1, 2018	Plans with costs that exceed the thresholds will be hit with the tax. Only the difference between the cost of the plan and the threshold will be taxable. Employers may try to begin now to shift costs to employees in anticipation of the tax. Increases in employee contributions will not affect excise tax, only changes to plan design that lower the entire cost of the plan. Union should begin now to consider alternative methods of cost control such as total health management and chronic disease management.	● Employers should be encouraged to engage in analysis of plan usage and costs to better target plan changes which will hold down costs while promoting appropriate and necessary care.	Request plan costs for single and family coverage over past 5 years and projected to 2018 and beyond. Compare historical cost increases to company's projections. Request inventory of cost containment features such as chronic disease management, health risk management, wellness programs, etc. Request an employer analysis of data relating to high costs, high utilization.

Resources on the Web:

[1] CNN, *Health insurance for the under-26 crowd*
http://money.cnn.com/2010/05/12/news/economy/health_care_dependents/

[2] Complete list of covered preventive services:
https://www.healthcare.gov/what-are-my-preventive-care-benefits#part=1

[3] Search for Medical Loss Ratio reports:
http://www.cms.gov/apps/mlr/mlr-search.aspx

[4] Template forms for Summary of Benefits and Coverage and Glossary of Insurance Terms:
http://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html

[5] Department of Health and Human Services Projection of National Health Expenditure Increases 2011-2021
http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

[6] Kaiser Family Foundation 2012 Employer Health Benefits Survey
http://kff.org/private-insurance/report/employer-health-benefits-2012-annual-survey/

[7] Healthcare.gov, *What does the Marketplace health insurance cover?*
https://www.healthcare.gov/what-does-marketplace-health-insurance-cover