U.S. Department of Labor

Employee Benefits Security Administration

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The Problem Facing the US

- **Health spending in the United States averaged $7,681 per person in 2008, totaling $2.3 trillion, or 16.2% of our nation's economy, up from 7.2% of GDP in 1970 and 12.3% of GDP in 1990**

- **45 million nonelderly Americans were uninsured in 2007, and eight in ten were in families with at least one worker**

- **Employers are the principal source of health insurance in the United States, providing health benefits for about 159 million people, or about 52% of all Americans; however, the percentage of employers who offer such benefits has been falling: 69 percent offered health coverage benefits in 2000, compared to 60% in 2009**

The Problem, continued

- **The average premium for family health coverage through an employer was $13,375 in 2009, of which covered workers paid an average of $3,515**

- **Since 1999, family premiums for employer-sponsored insurance have increased 131 percent, while wages have gone up 38 percent and inflation has gone up 28 percent**

- **For the first time on record, the annual increase in the Consumer Price Index exceeds the increase in national health spending per capita, 3.8% vs. 3.5% in 2008**

History of Reform Efforts in the U.S.

- Medicare – elderly, disabled – Federal public program (1965)
  - Part A – hospitals
  - Part B – physicians
  - Part C – private managed care plans (available since 1970's; major revisions in 1997 (Medicare+Choice), 2008 (Medicare Advantage)
- Medicaid –low income – State/Federal public program partnership (1965)
- Children's Health Insurance Program – children (2006)
- Medicare Part D –prescription drugs (2003)
- Clinton Health Care Reform (1993-1994)
- Obama Health Care Reform (2009-2010) – the Affordable Care Act

Why did Obama succeed when Clinton failed?

- Economic uncertainty
  - Continued erosion of employer-sponsored health insurance
  - Rising health care costs
  - Cost-shifting
  - More than 50% of personal bankruptcies attributable to health care expenses
- No “Obama” bill
- Flexibility; pragmatism; perseverence
- Centrist philosophy
- Insurance company rate hikes
- House Speaker Nancy Pelosi

Key Elements of the Affordable Care Act

- Builds on current private/public system
- Individual responsibility
- Employer responsibility
- Changes to Government Programs
  - Expansion of Medicaid
  - Improvements and Program Reforms for Medicare
- Health Insurance Exchanges
- Health Insurance Subsidies
- Insurance reforms
- Promise of reduced costs
- Tax on high premium health plans

Continuation of Public/Private System

- “If you like the coverage you have, you can keep it” (President Obama)
  - “grandfather” for existing coverage
- Not on the table: getting to universal coverage by expanding existing public program
- Some momentum for government option as part of health insurance exchanges
- Ultimately rejected in favor of continuing reliance on private sector insurance companies and group health plans

Individual Responsibility

- Most individuals and their dependents will be required to maintain minimum essential coverage or pay a tax penalty after 2013
- Exemption for low-income individuals
  - affordability

Employer Responsibility

- Tax credit available for employers <50 employees that provide health insurance to their employees
- Employers ≥ 50 employees must offer employees opportunity to enroll in minimum essential coverage under an employer-sponsored plan or pay a tax penalty
- Employers > 200 employees offering a health benefit plan must automatically enroll new full-time employees and allow employees to opt out

Expansion of Medicaid

- Federal/state partnership
  - State programs designed within Federal parameters
  - Financed by sliding scale of Federal matches to state expenditures
  - Eligibility improvements
    - 133% of poverty as a national floor to reduce state variability
    - Coverage available for non-pregnant childless adults

Improvements and Program Reforms for Medicare

- Phased-in coverage for Part D benefit gap (so-called "doughnut hole")
- Improved coverage of prevention benefits
- Reduces payments over time to Medicare Advantage plans
- Delivery system reforms designed to improve quality and reduce the rate of cost growth

Health Insurance Exchanges

- New mechanism for purchasing coverage as of January 1, 2014
- A governmental agency or nonprofit entity established by a state – can be single exchange or separate ones for individuals and small businesses
- Open to individuals without affordable coverage and certain employers
  - Prior to 2016, states can limit to employers with <50 employees; beginning in 2017, states can allow employers with >100 employees to purchase coverage through the exchange
- Federal fallback mechanism

Health Insurance Subsidies

- **Subsidies for individuals with family income below 133% of poverty**
- **Tax credits for individuals with family incomes between 133% and 400% of poverty who purchase coverage through the exchange**
- **Amount of credit varies based on premium as a percent of income and cost of plans in the geographic area**

Key Insurance Reforms

- Prohibition on preexisting condition exclusions for individuals under age 19
- Prohibition on lifetime/restricted annual limits on dollar value of benefits
- Prohibition on rescissions
- Coverage of preventive services
- Expanded coverage of children to age 26
- Patient protections
- Improved claims and appeals rules

Special Provisions

- Immediate access to insurance for uninsured individuals with preexisting conditions (state high risk pools; federal fallback provisions)
- Temporary reinsurance program for early retirees (non-Medicare eligible individuals) to reimburse employer-sponsored plans

Promise of Reduced Costs

- Nearly universal coverage
- Comparative effectiveness research
- Electronic medical records
- Provider payment reforms
- Restructuring graduate medical education
- Emphasis on primary care, prevention, wellness, disease management

Tax on High Premium Plans

- Tax on health insurers
- Amount of premiums exempt from assessment
  - $10,200 for individuals
  - $27,500 for families
- Adjustments for firms with higher health costs because of age or gender of employees
- Exclusion of dental and vision benefits from calculation
- Effective 2018

Impact on Multiemployer Plans – Preliminary Thoughts

- Too early to tell
- Some initial cost increases will occur as new insurance reforms come into effect
- Over the long run, potential exists for reduced costs because of the reduction in cost shifting
- For plans with high cost participants, a strong incentive to encourage movement by individuals into exchanges in 2014 and beyond
- For plans with healthier workforces, a strong incentive exists to stay outside of the exchange systems

Impact, continued

- **Ultimately the impact will depend on the fiscal health of contributing employers, the strength of the sector in which plan operates, the plan's ability to predict and manage costs and reduce risk, and the overall success of ACA implementation**
- **Although organized labor strongly opposed the high cost plan tax, it may ultimately provide cover to make benefit changes that the bargaining parties would otherwise have rejected**
- **That may be good for the plan's bottom line, but not necessarily good for participants**
  - **Is the value of the benefits received greater than the tax liability incurred?**

Further Information

- www.whitehouse.gov
- www.dol.gov/ebsa
- www.hhs.gov