

How the Patient Protection and Affordable Care Act Will Affect Employers

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This article provides an employer's perspective on the Patient Protection and Affordable Care Act of 2010. Since this act was implemented, it has significantly impacted how employers have been planning for and providing health insurance to their employees.

The Employee Retirement Income Security Act (ERISA) was passed by Congress in 1974. ERISA was amended over time to include additional requirements, including those imposed by the Consolidated Omnibus Budget Reconciliation Act (COBRA), but the original ERISA legislation itself had far-reaching effects. Indeed, ERISA became the cornerstone on which all pension plans, 401(k) plans, and group insurance benefits are based, and this legislation affects how they have been funded, implemented, managed, and administered. Following the rules of ERISA is a formidable challenge for any company, but those rules are well understood and are considered to be a necessary evil.

As the codification of the Patient Protection and Affordable Care Act of 2010 (ACA) unfolds, it is becoming clear that the ACA will surpass ERISA in complexity, number of requirements, and overall impact. The ACA will change almost every element of the provision of group health benefits to employees, and it will change how employers strategically integrate benefits into a total compensation package. As West Virginia Senator Jay Rockefeller recently observed, "the Affordable Care Act is probably the most complex piece of legislation ever passed by the United States Congress . . . [it] is just beyond comprehension" [1].

Over the years, both large and small companies have been faced with the challenge of providing employees with affordable, high-quality health benefit plans while trying to keep the cost of those plans within the company's budget. For smaller companies that purchase health benefits through insurance company contracts, as well as for larger, self-insured companies, the cost of health benefits continues to rise, despite efforts to curtail costs through plan design, cost-sharing with employees, provider contract arrangements, and wellness programs. As we get closer to the date when health insurance marketplaces (also called health benefit exchanges) become operational—October 1, 2013—it is becoming clear that the ACA will likely add to the cost of providing health benefits. Some of these additional costs will

be the result of increased administrative requirements and plan design constraints, and other costs will be transparent, such as required plan provisions, fees, increased premiums, and penalties.

Although employers have recently been focusing on 2014 and how the health insurance marketplaces will operate, employers have been making changes to their plans and to plan administration since 2010. They have had to provide employees, within a specified time period, with summary plan information in required formats using specific wording and examples of claim payments. They have had to change payroll systems to capture the total premium cost of health insurance for W-2 reporting. And they have had to adhere to a defined plan status (grandfathered or not) to determine compliance time frames for mandated plan enhancements such as expansion of coverage to include dependent children up to age 26 years [2], the elimination of preexisting condition provisions for dependent children under the age of 19 years [3], and the elimination of health benefit plan lifetime and annual maximums [4]. Changes in administrative systems and plan design have already increased employers' costs, without factoring in the person-hours that were allocated to initial planning and to administrative requirements. It has already become more expensive to offer a health benefit plan, and doing so will not get cheaper in the future.

Although some elements of the ACA have been in effect for 3 years, the majority of the law's provisions were scheduled to take effect in 2014. However, the Obama administration unexpectedly announced on July 1, 2013, that the implementation of the employer mandate to provide medical insurance to employees would be delayed until January 1, 2015 [5]. I believe that by now most companies have decided whether to "play or pay"—that is, whether they will "play" by offering a benefit plan, or whether they will pay the penalty for not offering affordable coverage for their employees. At this point, employers also understand the effects that that decision will have on employees and on company costs. This delay now rolls this decision and analysis forward for another

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year. This is good news for some, but I believe it also adds complexity in planning benefit design and assessing costs.

Delaying the employer mandate until 2015 is good news in that companies will not yet have to monitor the employee cost of coverage to make sure that the company offers plans that are affordable, and they will not face fines for noncompliance in 2014. The delay of the employer mandate also provides temporary relief from complex reporting requirements.

While the employer coverage mandate has been delayed until next year, many of the ACA's effects on employers remain unchanged. When the employer mandate is implemented, companies will have to comply with the definition of a full-time employee for benefit eligibility, which is now defined by the legislation as 30 hours per week. This may be a reduction for some employers who previously considered full-time employees to be those who work 40 hours per week. Although the federal government has created several alternative methods that employers can use to determine whether an employee is full-time, part-time, or seasonal, the rules are still complicated, particularly for new employees or those working variable hours [6]. In addition, employers will have to pay the following fees to the government: a comparative effectiveness research fee of \$1 per plan member per year, which will increase to \$2 in 2014 [7]; a transitional reinsurance fee of \$63 per covered life per year to fund reinsurance pools that will be established to help offset the costs of the insurance plans offered through the individual and small-group health insurance marketplaces [8, 9]; and a health insurers' fee equal to approximately 2.5% of total premiums [10-12]. Finally, employees will still expect their company's human resources department to explain the health insurance marketplace options available to them, and employers will need to be able to answer their questions.

While employers are happy to see the ACA rules and guidelines being issued and clarified, there are still many questions that remain unanswered. For example, employers do not know the full extent of the information they will be required to communicate to employees when open enrollment in the health insurance marketplaces begins in the fall of 2013. They do not know which employees will choose to enroll in a health insurance plan through the marketplaces rather than getting coverage through their employer, which will affect the amount the employer has to pay in plan costs. Employers do not yet know how the insurance market will be affected by the number of insurance companies participating in the health insurance marketplaces. They do not know how health care providers will respond to changes in the number of patients seeking care; changes in the provider's relationships with insurance companies, employers, and the community; changes in network arrangements; and changes in profit and loss expectations. Employers do not know how they will review plan designs without knowing the rules that may take effect in 2015, which may change the overall compliance requirements. Employers also do not know whether

plan designs will need to stay within a corridor whose top end is defined by a "Cadillac tax" (the excise tax that the ACA will impose on high-cost employer-sponsored coverage starting in 2018 [13, 14]) and whose low end is defined as the actuarial value of the plan's benefits. Employers also do not know what their health benefit plans will ultimately look like. Qualified health plans offered to small businesses and individual (nongroup) plans in the health insurance marketplaces must offer certain essential health benefits, but those same provisions do not apply to larger employers [15]. Finally, employers do not know what other changes might be made to the ACA over the next year.

Offering a health insurance benefit that employees and employers can both afford has always been a difficult task. With the increasing cost of health care, employers have had to persuade insurance companies to develop financial arrangements such as self-insurance products, and they have had to form relationships and partnerships with providers through preferred provider organizations (PPOs), health maintenance organizations (HMOs), and now the "medical home" model. All of this has changed—and continues to change—the way that employers provide health insurance benefits to employees.

Heretofore, these relationships were intertwined but seemed to move in opposite directions, with each player in the health care system seeking ways to lower costs while trying to improve the individual's access to high-quality health care. The methods that have been used have actually resulted in costs being shifted from one player to another. I believe that the ACA will put a stop to this, because each player will be operating in a box defined by rules, fixed reimbursement levels, unknown participation levels, the health status of newly insured patients, fees, fines, taxes, plan design constraints, required electronic system reporting, and added administrative burdens. The ways in which players can shift costs to one another will be limited.

Conclusion

This commentary has briefly addressed the challenges that employers are facing, but I have not gone into the challenges that confront the other players—providers and insurance companies. I believe that as we learn more about the unknowns I have listed, the challenges all of us face will become more complex. Employers, providers of health care, and insurance companies will have to work together to try to maintain the private sector health care system. This will require keeping costs affordable for employers and individuals while improving quality of care. Given how complex relationships between these groups are, this will not be easy to accomplish.

The intention of the ACA is benevolent: to provide affordable health insurance for all—to level the playing field across the health insurance industry and the health care delivery system, covering the uninsured, lowering insurance costs, improving access to providers, and requiring employers to

make sure that employees have access to affordable coverage. As we continue to see the ACA unfold through procedural rulings, guidelines, and regulations, it will be interesting to watch how this legislation transforms the entire health care delivery system. **NCMJ**

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