



Brought to you by the TemPositions Group of Companies - [www.tempositions.com](http://www.tempositions.com)

## **Health Care Reform: What's In the Bill and What It Means for Business**

By Anne DeAcetis  
May 17, 2010

In late March of 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA), making it the law of the land. Finally, months of passionate debate in Congress over health care reform were over.

But after such a noisy battle, filled with such contentious rhetoric, many Americans remain confused about what's in the final bill. We all know the reforms are intended to benefit patients and increase access to care, but the details can seem murky. And HR managers, unlike average Americans, must be among the first to fully understand health care reform. They're urgently asking, "What does this mean for my company and our workers? *How will this affect costs?*"

Todd Sullivan and Alan W. Wiederhold visited TemPosition's HR Roundtable Series on Thursday, April 29, 2010 to offer their insights on the changing employer-based healthcare landscape. Sullivan is a managing partner with COBECON, a premiere employee benefit management firm. And Wiederhold (a Triathlete) is VP of National Account Sales & Wellness for Principal Financial Group, which provides consulting services for wellness programs.

Sullivan and Wiederhold began by assuring attendees that their many questions are appropriate. Many details are simply unknown. Like COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), PPACA was passed to initiate broad reforms. It took time for amendments and additional legislation to clarify all of the system and processes necessary to administer COBRA; the same will be true for PPACA.

The good news is that much of PPACA can be explained today. And HR managers can do much to prepare for the future—as well as seek out cost-saving measures for their companies—by understanding the basics.

### **Timeline**

All the changes mandated by PPACA won't go into effect right away. Some reforms will apply immediately (within six months of the bill's passage), while others will go into effect after six months, in 2014 and in 2018. The staggered schedule serves two purposes: to give insurance carriers and companies time to make significant changes while fast-tracking access to care for the most at-risk Americans.

It's important to note that self-funded health insurance plans formerly fell under the jurisdiction of ERISA (the Employee Retirement Income Security Act of 1974). But now PPACA will govern both fully-insured and self-funded plans. Some plans will be grandfathered and exempt from the most immediate reforms, though compliance will eventually be necessary.

The following are all immediate reforms:

### **Lifetime maximums and annual limits**

PPACA eliminates lifetime maximums and annual limits. If a worker is covered, their benefits cannot be cut off once their claims reach a certain dollar amount. Wiederhold noted that it is very rare for a single patient to exceed their maximum benefit. But this provision prohibits such limits. It applies to all plans, including those that are grandfathered.

### **Rescissions**

Insurance companies can no longer rescind (or cancel) a patient's coverage when they become ill—unless the carrier can prove that the patient committed some act of fraud. Administrative errors and other technicalities will no longer be legitimate grounds to rescind coverage. This change also applies to grandfathered plans.

### **Preventative care**

PPACA requires all insurance plans to cover preventative care. (The goal is to encourage healthier living habits and catch illnesses in earlier stages, when they are less costly to treat.) A variety of government agencies already provide guidelines for appropriate preventative medicine. But now all health plans will be required to follow their direction, with an emphasis on covering evidence-based treatments.

The US Preventive Services Task Force rates preventative services on an alphabetical scale. Services, treatments and screenings rated "A" and "B"—deemed the most beneficial—will be covered by all insurance plans.

The Centers for Disease Control and Prevention (CDC) recommends immunizations and strategies for combating infectious disease. All CDC-recommended inoculations will be covered.

The Health Resources and Services Administration (HRSA) helps uninsured, at-risk Americans get access to health care. HRSA's recommended screenings and treatments (again, with a focus on evidence-based methods) will be covered under PPACA.

The bill focuses special attention on women's health care. Combined recommendations from HRSA and the US Preventive Services Task Force will require insurance carriers to cover mammographies, breast cancer screenings and other preventative measures.

### **Dependent coverage for adult children**

Under plans that extend coverage to dependent children, parents will now be able to insure their children up to age 26. This will apply to grandfathered plans.

Until January 1, 2014, this provision will only apply to children who are not eligible through an employer. (It's unclear whether that restriction will remain in place beyond 2014 or 2018.) And per Wiederhold, leaving a parent's plan will be considered a qualifying event to trigger COBRA.

Wiederhold also noted that many states currently have their own laws regarding dependent coverage. Maryland enables parents to cover their children up to age 29. Other states, like New York, consider whether or not a dependent child is a full-time student (New York enables parents to cover non-student children up to age 23). But PPACA will standardize the age limit for all 50 states, regardless of student status.

Just who will be considered a "dependent?" Again, the answer is unclear...for now. Wiederhold anticipates a new federal post—he referred to it as "Secretary of Insurance," for lack of a formal title—that will create such definitions. For now, it's safe to use the IRS (Internal Revenue Service) definition. If a child is living in a parent's home and the parent is paying 50% of the child's expenses, it's likely the child will be considered a dependent under PPACA.

### **Discrimination based on salary**

Many employers offer more comprehensive benefit plans to executives, while extending modest benefit plans to hourly workers. Under PPACA, companies with fully-insured plans will no longer be permitted to administer significantly different health care plans to different classes of employees. Congress has deemed this action discriminatory against lower wage earners.

Companies can require hourly workers to contribute more toward their premiums. But the health plans themselves cannot exhibit any bias toward higher wage employees. As Wiederhold put it, "Different contributions are OK, but vastly different benefits are not OK."

Plans that are currently in effect will be grandfathered until 2014.

### **Appeals**

Formerly, patients who filed appeals with their insurance companies followed procedures outlined by HIPAA (the Health Insurance Portability and Accountability Act of 1996). PPACA expands on the rights of appeal under HIPAA, requiring more transparency from insurers and giving patients more opportunities to play an active, ongoing role in the process.

PPACA requires that health plans explain their appeals process in a "culturally and linguistically appropriate" manner. All materials describing the process must be written in simple English, roughly at a seventh-grade reading level. This reduces the risk of patients becoming intimidated by appeals processes that seem too complicated.

While an appeal is underway, PPACA requires insurers to give patients access to their file. They can review the status of the appeal, see what information has been provided by doctors and administrators, and present more evidence and testimony along the way. Throughout the appeals process, they will continue to receive coverage.

Lastly, insurers are required to provide an external review process for appeals. This process will provide all the consumer protections outlined in the Uniform External Review Model Act, created by the National Association of Insurance Commissioners (NAIC).

Jurisdiction over appeals processes formerly fell to the states. But NAIC's definitions, mechanisms and processes will standardize the appeals process nation-wide. This will likely streamline the process for companies with employees in many different states.

### **Pre-existing conditions**

Because pre-existing conditions were cited so frequently in the health care debate, many Americans may believe that PPACA requires all health plans to cover pre-existing conditions. Not so, Wiederhold clarified. Pre-existing conditions are only covered until an enrollee reaches the age of 19.

### **Patient Protection**

PPACA's patient protection provision ensures that patients can keep their primary care physicians, even if their plan changes. It's important to note that based on an enrollee's plan, the doctor may become out-of-network. In that case, the patient may need to pay more out of pocket to see them. But unless a doctor is refusing to see new patients, they cannot discriminate against incoming patients based on their coverage, and they cannot refuse to see existing patients.

Other protections address emergency care and referrals for women's health care. If a plan covers emergency care and hospital stays, the carrier cannot require pre-authorization and must cover the care received, whether provided by in-network or out-of-network doctors. And women will no longer need a referral from a general practitioner to see an OBGYN.

### **Uniform Explanations of Coverage and Definitions**

PPACA requires insurers to simplify their explanations of coverage and definitions. They must state their offerings simply and clearly, in common (again, "culturally and linguistically" appropriate) language. Every health plan will need to generate a straightforward "benefits-at-a-glance" document that is no longer than four pages. Font size cannot be smaller than 12 points.

This provision will enable HR directors to make side-by-side comparisons of health plans much more readily. It should also reduce the burden on HR to explain benefits to employees and make repeated calls to insurers to get clarifications on coverage.

All insurers must generate their Uniform Explanations of Coverage and Definitions within one year. Companies that don't comply will face steep fines.

### **Small business tax credits**

Tax credits for health care costs will be available for small businesses for the tax years 2010-2013. Further details have not yet been announced.

### **Temporary high risk pool**

Within 90 days of PPACA's enactment, the "Secretary of Insurance" (or other federal administrator) must set up a temporary high risk pool for those Americans who cannot buy

health insurance today. This pool is largely intended to help the ill, whose pre-existing conditions make insurance either impossible or prohibitively expensive to buy.

The pool is a stop-gap measure and will come to an end on January 1, 2014.

### **Reinsurance for early retirees**

PPACA also provides a stop-gap for early retirees—workers whose coverage under COBRA will expire before they become eligible for Medicare at age 65. Workers' spouses, surviving spouses, children and dependents—anyone covered under the retiree's plan—will be included.

Like the temporary high risk pool, reinsurance for early retirees must be established within 90 days of PPACA's passage and will expire on January 1, 2014.

### **Identifying affordable coverage options**

The federal government, in collaboration with the states, must create resources for consumers (including a web site) that will help individuals find affordable health care in their own states. PPACA requires that the site be live by July 1, 2010.

### **Future reforms**

Looking forward to 2014, 2018 and beyond, Wiederhold described some of the reforms that Americans can expect over the long term: simplification of electronic record-keeping and record-sharing, individual mandates, establishment of a health insurance exchange (intended to bring down costs for individual buyers), co-ops and determinations of "essential benefits."

Attendees were particularly curious about the future of COBRA. Will eligibility periods or triggering events change? When the individual mandate goes into effect, will COBRA still be relevant? Unfortunately, PPACA does not address its interaction with COBRA, so we'll all have to wait for more legislation. Wiederhold did his best to reassure the room with humor. "We as the health plan are equally confused," he joked.

### **Enforcement**

Currently, there is no single federal body in charge of enforcing PPACA. Instructions have been issued by the IRS, the Secretary of Health and Human Services and the Secretary of the Treasury. But there's been no real announcement on who will enforce health care reform or when oversight will commence.

Wiederhold anticipates that enforcement will begin only after PPACA's generalities are wed with legislative details for its practical application. We know that companies of different sizes will need to meet different requirements, but the specifics have not been announced. And what about part-time employees—if they become eligible for coverage, will their participation be mandatory, even if pools, co-ops or an exchange are in place? Again, only time will tell.

## **Costs**

Of course, all attendees were eager to know how PPACA will affect costs. But as Wiederhold explained, we just don't know yet. Each of these reforms will result in costs...for someone. Many provisions appear to shift burdens from HR to insurers. But in the long run, he warned, insurers will likely find some way to make businesses pay.

We'll know a lot more as we reach 2014 and 2018. Wiederhold did note that as written, PPACA only requires that employers provide coverage. It does not address, or seek to limit, employee contributions.

## **What comes next?**

Rather than get bogged down in details that are all TBD, Wiederhold encouraged attendees to look at—and think about—the big picture. PPACA transforms our health care system from a sick care system to a wellness care system. The benefits encourage Americans to live healthily and take advantage of preventative medicine, rather than wait until they're sick to see a doctor.

To make the most of the new system, companies (with HR leading the way) can and should change their focus. Rather than wait for workers to take medical leaves and respond reactively, companies should proactively encourage and reward wellness in their workforce. By doing so, they can work in concert with PPACA to lower America's health care costs.

## **Taking America's pulse**

It's no secret that many Americans live unhealthy lifestyles. First Lady Michelle Obama has launched a campaign to fight childhood obesity, and popular television shows like "The Biggest Loser" and "Jamie Oliver's Food Revolution" highlight the need to exercise, eat well and prioritize personal health.

Wiederhold shared a recent article from *The Washington Post* entitled, "Heavy Losses: Military Experts Declare Obesity a National Security Threat as More and More Young People Become Too Fat to Fight." Shockingly, it stated that 27% of 17-24 year olds are too overweight to serve in the military. The government expects this number to double in the next 30 years.

Wiederhold shared other sobering statistics. Seven out of 10 deaths in America are caused by chronic disease. Approximately one in two Americans live with chronic disease, and about 25% of these sufferers experience daily limitations. In 2004, the Surgeon General stated that one out of every three children born after 2000 will suffer from diabetes. Among African-Americans and Hispanics, it's expected that one in two—half—will develop the disease.

Why is it so important to focus on chronic diseases? Because the CDC has said 80% of these conditions are preventable with a healthy lifestyle—and because we spend 75% of our health care dollars treating them. Employers must understand that 25% of their health plan members absorb 65% of resources, and that roughly 74% of plan members are at risk of becoming chronic.

Most chronic diseases are caused by familiar unhealthy behaviors: smoking, high cholesterol, high blood pressure, being obese or overweight, inactivity (getting less than 30 minutes of

exercise per day) and not eating five servings of fruits and vegetables daily. Only *three percent* of Americans currently meet all the recommendations for healthy living.

Within Wiederhold's practice, he witnesses that 40-50% of workers are "borderline chronic." If left untreated, they are likely to develop chronic conditions.

Considering these numbers, it's no surprise that health care costs in America are high. But changing behaviors can give us more control over these costs as a culture. As Wiederhold explained, we're all in this together. Americans can begin by making healthier personal choices, being smarter consumers of health care (taking full advantage of preventative screening and wellness plans) and reducing their own risk of disease.

Objectively, we know that costs follow risks. If companies—in partnership with their HR teams—work with their employees to identify and reduce risks, they have the power to reduce everyone's health care costs.

### **Fully-insured vs. partially self-funded plans**

Typically, HR managers buy their company's health care plan every year in the exact same way. They engage a broker, who gathers details on plans from the largest providers: Oxford, Aetna, Blue Cross, United Healthcare and CIGNA. They choose the best fully-funded plan they can find that meets their budget—and wait to do the same thing next year.

Self-funded plans are no silver bullet. But both Wiederhold and Sullivan urged attendees to take a look at their health plan options to determine whether a partially self-funded plan might make more financial sense for their companies.

Partially self-funded plans give companies more freedom to choose benefits "a la carte." They can select a good prescription drug plan, pair it with health care coverage, add a wellness program, etc. Third-party administrators actually run self-funded plans, so HR doesn't take on additional responsibility. The difference is that the company pays out for actual claims vs. estimated claims, as they would to a fully-funded provider.

Wiederhold carefully explained how fully-funded health plans come up with that magic number, the premium. Claims processing, PPO access processes, risk premiums and review processes all make up only 20% of a premium. 80% is anticipated paid claims. These paid claims include all that the insurer thinks they will pay plus a profit margin of roughly 25%.

Under a partially self-funded plan, companies hold onto more of their own money—until claims come in that need to be paid. As Wiederhold put it, "In fully-insured plans, they decide how much fluff they want. In a partially self-funded plan, you keep your fluff until you need to give it away." Companies with partially self-funded plans see their actual costs. And if their workforce stays healthy, they can see significant savings.

Why aren't more companies establishing self-funded plans? There are many reasons. Large health insurance companies with solid reputations are reassuring for workers, and there's less legwork for HR. Self-funded plans often won't result in savings for companies with an older workforce, or those with more than 350-400 workers.

For companies that could benefit, brokers sometimes pose an obstacle. They may not be adequately educated, or they may not have enough financial incentive to do the additional research. If you don't think you're being presented with all the options, Wiederhold said, talk to other brokers.

If you do go with a partially self-funded plan, meet with your administrator quarterly to discuss actual numbers. You'll soon come to greater understanding of where your company's health care dollars really go.

### **The value of wellness programs**

As a Triathlete who formerly lived an unhealthy lifestyle, Wiederhold relishes his work as a wellness program consultant. Under PPACA, he explained, companies can help drive down costs if they focus on developing a healthier workforce. But how can companies incorporate what used to be a private matter—personal health—into good business?

Wiederhold foresees the need for American businesses to make three significant changes: transforming the roles of employees, transforming the priorities of health care plans, and transforming expectations of what health care plans should do. Today, Americans feel entitled to immediate health care when they get sick (leading to expensive, and avoidable, urgent care visits). Businesses must encourage their workers to think every day of staying well.

Like any internal initiative, wellness programs need to provide employees with the information and support they need to participate fully. They have to be simple—easy to explain not only to workers, but to CEOs and CFOs who have to green light the effort. They have to be affordable, and of course, they have to succeed in making a positive change. Participation must be voluntary, so employees need to be inspired.

Wiederhold warned that most executives will immediately ask for the “ROI” on wellness programs. He acknowledged that his own company, Principal Wellness, did calculate a \$2.61 return for every dollar spent on wellness (a figure determined in partnership with independent research group Milliman Inc.). But he encouraged attendees to focus instead on the value of the investment, rather than the return.

After all, wellness programs are relatively new, and they take a long-range view of improving workers' health to reduce costs. This, combined with the many financial unknowns within health care reform itself, make it difficult for anyone to decisively say how much instituting wellness programs will bring down health care costs.

To institute such a program at your own company, Wiederhold recommended getting support from the highest levels with a focus on value, not dollar signs. The company must have a 3-5 year strategy with specific goals to be met along the way. The program can't succeed if employees aren't properly incentivized, so design some rewards. And communication is critical. Every worker must know why the program has been instituted and how they will benefit.

First make sure your health plan will provide you with broad, anonymous data on the general health of the company's population. This enables leadership to see where health care dollars are being spent without violating HIPAA's privacy rules.

With this knowledge, your company can set wise goals for its wellness plan. How many workers need chronic illness management services? How many can transition from being at-risk to being healthy by receiving regular wellness coaching? And how many workers are currently healthy, and just need regular preventative screenings?

By establishing a wellness program that's customized to your workforce, HR can integrate wellness into an organization's culture. Each month, a new wellness initiative can roll out—continually educating workers about wellness and challenging them to meet new benchmarks and earn new rewards.

Wiederhold urged attendees to look for a full-service, turnkey partner. A good wellness partner will create a full suite of educational materials (electronic and hard copy). They'll provide health coaching and arrange for biometric tests and other screenings, both for on-site and off-site workers (and covered family members).

The best wellness programs balance the obligations of individuals and the organization. You'll want employees to take part in preventative screenings, receive health coaching, review wellness assessments and attend seminars. The organization supports workers' participation by instituting challenges like exercise goals, campaigns for healthy eating, and by getting involved in local events like cancer walks. An employee-led wellness committee also strengthens the program.

Wiederhold encouraged companies to embrace—and get creative with—incentives. Every worker will attend a free “one and done” health screening. But to get workers to the gym, offer to pay more of their premium if they can prove they've worked out a certain number of times. One company achieved 95% participation by offering a car. Incentives should be objectively desirable. But companies can also reinforce their core values by making them on-brand.

Wiederhold recommended breaking incentives down into tiers. All employees, with minimal effort, should be able to receive some reward. As participation deepens, incentives should become more and more valuable. As Wiederhold put it, “match value with effort.”

Change is hard, so set goals that are attainable, even if they're quite modest. Wiederhold explained the Prochaska Lifestyle Behavior Model, which maps out the five stages of making a lifestyle change. Individuals have to be nurtured through these stages rather than pressured, so it's important to understand the architecture of personal change as it intersects with health.

Individuals begin in “Pre-contemplation,” where change is not even on their minds. Then they move to “Contemplation,” thinking about making a change within six months. “Preparation” follows; at this point, they're getting ready to change within the next 30 days. Next comes “Action,” making the change. And finally, they reach “Maintenance”—sticking to the new lifestyle for more than six months.

As programs complete their first year (and move into years two, three and beyond), executive summary reports will reveal employees' level of engagement. Review those HIPAA-compliant summary reports of your company's health. Are workers attending screenings? Are they reaching out to health care coaches? Are they earning incentives across all available tiers? Based on this tracking, businesses can make smart decisions about how to retool their wellness plans.

## **Working with PPACA**

The changes coming under PPACA may seem daunting, and missing details cause understandable frustration. But at base, we know that health care reform will transform our relationships with medicine to focus on our wellness. Businesses that are concerned about costs can look closely at what PPACA encourages and rewards—and institute wellness programs that encourage and reward the same behaviors.

Again, Wiederhold urged everyone to focus on value. We all want to save money on our health care. But perhaps because of PPACA and wellness programs, more Americans will learn about how to stay healthy, get the support they need to maintain good habits and live healthier lives free of chronic disease. Now that would be a welcome change.

*Anne DeAcetis is a freelance writer based in New York. Reach her at [anne.deacetis@gmail.com](mailto:anne.deacetis@gmail.com).*

*The HR Roundtable is a breakfast forum for human resources professionals in New York City sponsored by The TemPositions Group of Companies. TemPositions, one of the largest staffing companies in the New York tri-state area with operations in California, has been helping businesses with their short- and long-term staffing needs since 1962. Visit them online at [www.tempositions.com](http://www.tempositions.com) or email them at [info@tempositions.com](mailto:info@tempositions.com).*