New health care law starts to affect union health trusts

Members' children can stay covered 'til age 26, and health plans end lifetime coverage limits

By DON McINTOSH
Associate Editor

The Patient Protection and Affordable Health Care Act, signed into law March 23, 2010, by President Barack Obama, is starting to affect health insurance plans that union members and their families are enrolled in.

So far, the two biggest changes are that children will be able to stay on their parents' health plans until they turn 26; and that plans won't be allowed to impose lifetime dollar limits on claims for essential services. Those changes must take effect whenever a union health trust's "plan year" begins —and no later than Sept. 23, 2011. [For example, members of United Food and Commercial Workers Local 555 working for Portland-area grocery employers have a union-negotiated health plan whose plan year begins Jan. 1, so the changes took effect then for those members.]

If an employer-paid health plan previously covered employees' children, those children will now be able to stay enrolled until their 26th birthday — even if they're not living with their parents, are not in school, are not claimed as dependents on a tax return, and even if they are married. However, until 2013, health plans may refuse to cover children who can get health coverage through their own employer or a spouse's employer.

Gene Mechanic, a Portland attorney who is advising union health trusts about the new law, says both requirements will cost money. Plan administrators are estimating that covering kids through age 26 will increase overall costs 2 to 5 percent, and eliminating lifetime coverage limits will increase costs 0.5 to 1 percent.

The new legislation also phases out annual coverage limits over the next three years, but plans can request a waiver of that requirement; 222 plans had received waivers as of Dec. 3, Mechanic said.

Typically, union-affiliated health trusts are funded by an employer contribution that is negotiated as part of a collective bargaining agreement. So the additional expenses brought on by the new requirements could lead health plan trustees to impose a surcharge on employers, or they could dip into reserve funds to cover the added costs. One thing trustees probably won't do to make up for the extra expense is substantially reduce members' health benefits. That's because if trusts do reduce benefits, they would lose their status as "grandfathered" health plans. A grandfathered health plan is basically any employer-paid health plan that existed before the new law passed and that provides a certain minimum level of coverage.

Grandfathered health plans aren't subject to some other new insurance requirements, such as: that preventive care be provided without any co-pay or deductible; that out-of-network emergency care be charged at the same rate as in-network; and that patients have direct access to obstetric and gynecological care without referral from a primary care physician.

Union members may have heard about several other insurance regulations that are part of the new law, but those don't tend to affect union health plans directly. For example, if insurance companies sell individual policies that cover children, they may no longer exclude or deny coverage based on preexisting conditions. And insurance companies can no longer drop patients after they get sick, a practice known as rescission.

One other change may affect some union health trusts, though probably not in Oregon: As of Jan. 1, at least 85 percent of the premiums collected for large-group insurance policies have to be spent actually paying health care claims; in other words, insurance profit and administrative expenses can't be more than 15 percent. That could result in rebates to union health trusts that purchase group health policies in states where administrative costs have been over 15 percent.

"Union health plans are living with these changes, and figuring out ways to lessen the cost as much as possible," Mechanic said. "What they're more concerned about is what's going to happen down the road."

So far, the changes are small and technical; the bigger, more noticeable changes will all take place three years from now — if the law hasn't been overturned by the Supreme Court or repealed by Congress. Starting Jan. 1, 2014, everyone with earnings below the poverty level will be eligible for Medicaid. The uninsured will be required to buy health insurance through newly-established state exchanges, or else pay a tax penalty. Households up to four times the poverty line will get some amount of subsidy to purchase the insurance. Small employers will also be able to buy insurance in exchanges. Large employers will pay a penalty if they don't provide insurance. Many of the precise details will be worked out by state governments and federal agencies in the next year or two.

That means a lot of unanswered questions about how the new law will affect a complicated health care market. For example, will employers that currently provide health coverage be more likely to drop it once their employees can get affordable, government-subsidized insurance through the state exchanges? Large employers that don't provide health insurance will pay less than $2,000 a year penalty; how much will that incentivize them to provide it when employee-only insurance premiums can easily top $6,000 a year? If more people are insured, and insurance is more standardized, will health insurance premiums decrease?

"I believe that if the law is really implemented the way it was intended to be, it could provide more affordable quality health care across the board," Mechanic said. But he added it's going to require a lot of work to make sure the reform accomplishes this goal, and unions need to be in the room, and at the table.

For union health plans, the law imposes short-term costs, but also provides long-term opportunities, Mechanic says. For example, if unions are involved when states set up the exchanges, the exchanges could operate in ways that level the playing field for union employers. States are required to set up exchanges for individuals and small employers, but they could set them up for large employers (including union employers) as well.

Unions could negotiate contracts in which, instead of employers providing health care, employers could pay part or all of the premium for insurance bought though the exchange. It's even conceivable that union health plans, individually or in groups, could open themselves up to all comers, maybe becoming cooperative health insurers that sell insurance to individuals or employers on the exchanges. Unions could play a role as "navigators" helping individuals or employers choose among insurance plans offered on the exchanges.

"All unions need to realize that the act is going to greatly impact them," Mechanic said, "and they need to start thinking about how they'll be impacted and what they can do as the law is being developed."

University of Oregon's Labor Education and Research Center (LERC) will address these issues in a Feb. 17-18 training on health care bargaining, to take place in Portland.

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