Health Care Reform and Cities

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Last month the President signed into law a bill that will fundamentally change health care delivery in the United States. While there are many outstanding issues and questions regarding the law, the purpose of this brief is to provide a summary of the law by highlighting key provisions that will impact local governments as employers.

In general, while local governments will need to review their health plans to determine if they comply with the new law and may have to modify their plans to meet new requirements, two fundamental and basic aspects of the way in which cities and towns provide health insurance will be retained: local governments will be able to continue to self-insure and to participate in statewide risk pools through which they can provide health insurance.

Federal agencies will publish administrative regulations interpreting many of these statutory changes in the coming months.

New Requirements for Employers

The new law is not without its controversial requirements, including employer mandates to provide and individual mandates to purchase health insurance; minimum coverage standards that apply to all health plans; public statewide health insurance exchanges, where health insurance will be sold to individuals and small businesses of 100 or fewer employees; and a 40 percent excise tax on "Cadillac" health care plans that exceed a certain dollar level of benefits beginning in 2018.

Despite any controversy over these requirements and other provisions called for in the law, such as achieving near-universal coverage and expanding Medicaid, nothing in the law appears likely to force cities and towns to dramatically change the ways in which they currently provide health insurance to their employees.

This does not mean that cities and towns will be able to avoid making any changes to their health care benefits packages. New requirements on employers include the following:

- Local governments that self-insure must, after two years, demonstrate to the Secretary of Health and Human Services that their self-insurance plans are sufficiently funded or capitalized to cover all likely medical claims.

- Local governments, like all employers, that already offer insurance to some workers must provide insurance to all workers—both full- and part-time. This insurance will have to meet certain minimum cost, coverage and reimbursement requirements that are prescribed by the law and the Department of Health and Human Services.

- All plans must include an "essential health benefits package" that would provide a comprehensive set of services that covers no less than 60 percent of the cost of the covered benefit. The "essential health benefits package" components will be defined and annually updated by the Secretary of Health and Human Services, but will have to include hospitalization and general health care by primary and specialty physicians.

- The health care insurance that local governments, like all employers, provide to their employees must meet coverage minimums.

- Under the law, out-of-pocket expenses for any plan are limited to no more than $6,000 for individuals and $12,000 for families, and all plans must reduce out-of-pocket expenses for lower-income individuals and households by nearly 40 percent, without increasing overall costs.

- Public sector employers, like all employers, may opt out of providing employees with health benefits, but if they do they must either provide subsidies for the purchase of insurance or may face penalties as high as $3,000 per full-time worker depending on the nature of non-compliance.

- A 40 percent excise tax applies to employment-based health plans with premiums exceeding $10,200 for single coverage, $27,500 for a family plan, $11,850 for retirees, and $30,950 for employees in high-risk professions, such as police officers and firefighters. These amounts will be adjusted for health care inflation, and they do not take effect until 2018.

Immediate Changes in Health Insurance

Several key provisions of the law take effect immediately (for a new federal law this means within six months) and will require changes in health insurance plans and documents. The law:

- Prohibits pre-existing condition exclusions for children in all new plans;

- Provides immediate access to insurance for Americans who are uninsured because of a pre-existing condition through a temporary high-risk pool;

- Prohibits dropping people from coverage when they get sick;

- Lowers seniors' prescription drug prices by beginning to close the reimbursement "donut hole" gap and provides a $250 rebate to Medicare beneficiaries who hit the "donut hole" in 2010;

- Offers tax credits to small businesses to purchase coverage;

- Eliminates lifetime limits and restrictive annual limits on benefits in all plans;

- Requires plans to cover enrollees' dependent children until age 26;

- Requires new plans to cover preventive services and immunizations without cost-sharing;

- Ensures consumers have access to an effective internal and external appeals process to appeal new insurance plan decisions; and

- Requires premium rebates to enrollees from insurers with high administrative expenditures and requires public disclosure of the percent of premiums applied to overhead costs.

What's Next?

There has been much debate as to whether the cost of health insurance premiums will go up, down or remain the same as a result of the new law. While there is no consensus as to the law's ultimate impact on the cost of specific health insurance plans, most economists agree that insurance costs for current coverage will go down.

The immediate implementation burden falls on insurance companies to comply with the new law and soon to be released regulations. Over the next several months, the Department of Health and Human Services, the Department of Labor and the Internal Revenue Service will publish interim and final regulations governing the implementation of the health care reform law. KLC will keep members posted throughout this process.

The KLC research team has information about what types of health insurance plans are provided in cities, what health insurance accounts are available to city employees, what the median monthly premiums paid by cities are and what share cities pay for their employee health insurance. If you are interested in any of this information, contact Joseph Coleman at 1-800-876-4552 or jcoleman@klc.org.

Most of the information in this report was provided by the Neil Bomberg, program director for human development and public safety, Center on Federal Relations, National League of Cities.

Questions? Contact the KLC research team at 1-800-876-4552.