National Healthcare Reform: Strategic Considerations for Large Employers

Jeffrey Chanin
FSA, EA, MAAA

BACKGROUND

In March 2010, new federal laws were enacted that will bring about significant changes to the U.S. healthcare system. The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23 and was amended by the Health Care and Education Reconciliation Act (HCERA) on March 30. Employers, individuals, health plans, and other stakeholders will be affected by these new laws. This paper focuses on the implications for large single employers.

Once the law is fully implemented, several systemic changes will impact employers, including:

- State-level insurance exchanges will be established that will offer authorized healthcare plans to individuals and small groups.
- Individuals must obtain *minimum essential coverage*[1] or pay penalties to the federal government.
- Employers must provide *minimum essential coverage* or pay penalties to the federal government.
- Certain low-income employees will be eligible to receive governmental assistance to purchase coverage.
- The Medicare Part D coverage gap (the *donut hole*) will be eliminated.
- New taxes on individuals (and possibly changes to tax withholding amounts) and taxes on certain industries will be used to finance expanded healthcare insurance coverage.

Employers will need to determine how to comply with short-term (2010 and 2011) requirements and should begin planning for medium-term implications of the new environment that is likely to emerge. Senior management will have to make benefit and compensation decisions, and should conduct financial analyses of all the implications of the coming reforms. They will also need to consider various tactical details in areas such as compliance and reporting.

Perhaps most importantly, for employer-sponsored healthcare benefit plans to remain viable, employers will need to continue to develop and implement strategies that will control healthcare costs and utilization. The new law focuses on providing insurance coverage and access to healthcare services, but includes few major cost-control mechanisms.

This paper provides a summary that is focused on key strategic PPACA provisions that impact large single employers (i.e., employers with at least 50 employees).

SHORT-TERM STRATEGIC CONSIDERATIONS

1. Active Employee Healthcare Programs

Various benefit design and administrative changes will need to be implemented for the 2011 plan year. The process to meet all requirements will typically need to begin in the second quarter of 2010.

The financial impacts of all changes will need to be determined. In addition, communicating with employees (and retirees) about the implications to them of the new law and specific employer program changes is critical.

Key changes include:

- Dependent coverage to age 26 (i.e., up to a dependent's 26th birthday). Extending coverage to adult children will increase the complexity of plan administration and increase costs for many employers. Because there is some flexibility in the implementation of the extended coverage, employers will need to decide how and when to extend the coverage to adult children.
- No lifetime maximum benefit limits and restricted annual benefit limits.
- Coverage and no member cost sharing for certain preventive services (does not apply to grandfathered plans[2])
- No reimbursement from savings accounts–flexible spending accounts (FSAs), health savings accounts (HSAs), or health reimbursement arrangements (HRAs)–of non-prescribed

[1] Minimum essential coverage is provided by healthcare insurance plans that pay at least 60% of plan costs, and for some employer-sponsored plans the employee contribution (or premium) must be no more than 9.8% of household income.

[2] A grandfathered plan is any group health plan that was in effect on March 23, 2010 (the date of PPACA enactment). Grandfathered plans are exempt from certain provisions of the healthcare reform law. Currently, it is unclear how in future years a plan can lose its grandfathered status.

prescription drugs. This may be a claim adjudication challenge, particularly for over-the-counter drugs.

- Whether or not to offer federal long-term care benefits (through the CLASS program). (See Milliman's *Adverse Selection and the CLASS Act* for a description of the CLASS program.[3])

2. **Retiree Healthcare Programs**

a. Early Retiree Reinsurance Program

Beginning June 21, 2010, the federal government will reimburse 80% of pre-65 claim amounts between $15,000 and $90,000 (a maximum of $60,000 per claim). The reimbursement program is temporary, ending once its $5 billion funding is exhausted but no later than December 31, 2013. Based on the Department of Health and Human Services (HHS) interim final rule (IFR) filed on May 3, 2010, reimbursements will be made on a first-to-apply/first-to-be-reimbursed basis. Therefore, interested employers should plan now and must act quickly to be prepared to apply for reimbursement as soon as the final application is available in late June 2010.

Proceeds will not be taxable to the employer, but proceeds must be used to lower plan and participant costs, not employer costs. At the same time, the IFR requires the sponsor to maintain its level of contribution to the plan. One interpretation of these limitations precludes the reduction of plan costs below current levels. Thus, reimbursement amounts may be applied only to increases in plan costs, and any reimbursement amounts in excess of the increase in plan costs must be used to reduce member costs.

Employers will need to complete an application and have it approved by HHS before they can submit claim data for reimbursement. To be eligible for reimbursement, plans must have in place certain types of disease management programs and programs to reduce claim fraud and abuse.

Employers will need to determine if reimbursement is worth pursuing. The process will likely be similar to the Medicare Retiree Drug Subsidy process, but the actual process and resources needed to complete the process are unknown at this point in time. Also, it is not clear to what extent plan sponsors will benefit from this program.

Following are potential actions and considerations for employers that plan to apply for reimbursement:

- Monitor relevant regulations: As mentioned above, an interim final rule with comment period was filed by the HHS on May 3, 2010. We expect many public comments to be submitted, but it is unclear at this time how the program will ultimately be run.
- Determine if applying for reimbursement is worthwhile: Compare the expected value of reimbursements to the hard and soft costs of collecting them.
- Does the employer's retiree healthcare benefit program meet requirements? If not, how can it be changed to meet requirements?
- Determine how the reimbursements will be used.
- Start gathering now the information that will be needed for the application (it looks like there will be a race to the front of the line).

b. Medicare Prescription Drug Benefits

With the Medicare Retiree Drug Subsidy (RDS) becoming taxable in 2013 (and the tax accounting impact occurring in the first quarter of 2010), in many cases for larger plans, contracting with an 800-series employer group waiver plan (EGWP) would be a more cost-effective Medicare prescription drug benefit option.[4]

Even before recent national healthcare reform legislation was enacted, the RDS option typically reduced costs slightly less than did EGWPs. But the RDS seemed to be a simpler option with less disruption to retirees. However, now that RDS payments will be taxable to employers beginning in 2013, an EGWP option will likely produce lower post-tax costs than will the RDS. And even for non-taxable employers, an EGWP may be a lower-cost option than the RDS.

The 800-Series EGWP essentially functions as a typical self-funded or fully-insured plan in that the employer would contract with a plan administrator or insurance carrier. Centers for Medicare and Medicaid Services (CMS) payments to an EGWP are generally higher than RDS payments. CMS payments to an EGWP functionally reduce claim costs or lower premiums, both of which are fully tax-deductible. In addition, CMS payments to an EGWP are received sooner than RDS payments and offer a time-value advantage. And it is likely that a pharmacy benefit manager (PBM) will be able to closely match the employer's benefit design.

With the change in RDS tax status, the demand for EGWPs may increase and a buyers market may emerge as vendors compete for market share. Employers will likely continue to be able to negotiate many aspects of EGWPs.

c. Medicare Advantage Plans

Beginning in 2011, total reimbursement amounts paid by CMS to Medicare Advantage plans will be reduced and benefit restrictions will be implemented. This may result in market instability. (See Milliman's *The Impact of Healthcare Reform on the Medicare Advantage and Prescription Drug Plan Programs* for a discussion of changes to Medicare Advantage plans.[5])

[3] Schmitz, Allen (December 2009). Adverse selection and the CLASS Act. Milliman Health Reform Briefing Paper. Retrieved May 24, 2010, from http://www.milliman.com/perspective/healthreform/pdfs/adverse-selection-class-act.pdf.

[4] Anderson, Brian and Filipek, Troy (May 2010). Healthcare reform and Medicare Part D. Milliman Health Reform Briefing Paper. Retrieved June 1, 2010, from http://publications.milliman.com/publications/healthreform/pdfs/healthcare-reform-medicare-partd.pdf.

[5] Whitney, E.L., Chamblee, M.P. & Yu, J. (April 2010). The impact of healthcare reform on the Medicare Advantage and prescription drug plan programs. Milliman Healthcare Reform Briefing Paper. Retrieved May 24, 2010, from http://www.milliman.com/perspective/healthreform/pdfs/impact-of-healthcare-reform.pdf.

d. Overall Coverage

Once the Medicare Part D *donut hole* is completely closed in 2020, Medicare will provide comprehensive coverage to eligible retirees for all major service types (inpatient, outpatient, and professional services and prescription drugs). Moreover, if a suitable individual market emerges through the American Health Benefit Exchanges (also known as "state exchanges," which begin in 2014), early retirees will have a viable option to obtain healthcare coverage from a source other than their employers.

Employers will soon need to determine whether or not to continue to offer retiree medical benefits on a defined benefit basis (i.e., directly provide health insurance coverage as is done today), provide cash, adopt a defined contribution structure for retiree medical benefits (i.e., a savings-account structure in which the employer, employees, or both contribute to a fund during active employment and the accumulated funds are used to purchase healthcare insurance during retirement), or discontinue retiree medical benefits entirely. The ultimate approach could differ for early retirees and Medicare-eligible retirees, as well as for current and future retirees.

MEDIUM-TERM STRATEGIC CONSIDERATIONS

If a suitable individual market emerges through the American Health Benefit Exchanges (beginning in 2014), employees will have an alternate source of coverage that will essentially compete with employer-sponsored plans. Employers will need to analyze the value of continuing to directly offer healthcare benefits compared to offering cash to employees to purchase coverage on their own or simply discontinuing the benefit.

This decision is similar to employer decisions to provide defined benefit plans (e.g., pensions), defined contribution plans such as a 401(k) plan, or some combination of both types of plans. However, active employee healthcare benefit programs differ in many aspects from retiree income benefit programs. The awareness and immediate use of healthcare benefits must be considered in the decision-making process. This decision could represent a fundamental change in the employer-employee relationship. Critical factors to consider include:

- The suitability of the individual markets
  - In any given market, will employees actually be able to purchase high-quality coverage at reasonable prices, regardless of health status?
  - How much stability will be provided by the plans offered in a given market?
- Will employees understand the importance of purchasing coverage? What assistance will they need from their employers?
- What is the (selection) impact on the remaining covered population of employees who elect to change coverage from their employer plans to exchange plans?
- What is the post-tax impact to employees of any change to the healthcare benefit program?
- Comparisons of the level of net dollar costs derived from:
  - Continuing to offer traditional healthcare benefits, or
  - Discontinuing employer-sponsored coverage, possibly providing employees additional cash, and paying the employer penalties
- How would discontinuing traditional defined-benefit healthcare benefits affect attraction, retention, and productivity?
- How would the employer's competitive position be affected by discontinuing traditional benefits (or by continuing to offer traditional benefits)?

The answers to many of the above questions may change over time, as the markets mature. If an employer decides to continue to provide traditional healthcare benefits, it needs to address the following issues:

- The level of benefits to offer:
  - What is the minimum level required to avoid paying the penalties?
  - How should an employer implement moderate changes in coming years to avoid the potential necessity for significant changes in 2019 when the "Cadillac" tax is implemented?
- How to control costs and manage employee health: Although there are various pilot-like cost-control and wellness programs contained in the new legislation, the new law does not focus on these issues. In addition to typical trend, the following factors may increase employer healthcare costs:
  - An increase in demand for healthcare services from the expansion of the insured population
  - Pass-through costs from the additional taxes levied within the healthcare industry
  - Higher provider reimbursement levels stemming from potential increased market clout of larger provider groups (e.g., through mergers or associations) relative to insurers and third-party administrators
- Fully insured (non-grandfathered) executive plans, which may be considered discriminatory
- Various new reporting requirements

In addition, employer plan claim costs may be significantly impacted by adverse/positive selection from lower-/higher-risk members purchasing coverage through exchanges. The availability of a catastrophic plan for individuals under 30 may result in relatively younger and lower-risk employees migrating away from an employer program. On the other hand, limitations on age-related premiums may result in a migration away from an employer program of relatively older higher-risk employees, particularly from an employer program with high employee

contributions. Significant demographic and risk-profile changes in the covered population can result in significant changes in healthcare benefit costs.

Following are other PPACA provisions that may impact employer costs (these provisions are first effective on various dates):

- Minimum loss ratio requirements (for insured plans)

Loss ratio is simply defined as:

Claim Costs / Premium

where Premium equals Claim Costs plus administrative expenses plus profit.

Thus, a loss ratio of 85% indicates that 85 cents of each premium dollar was paid as claims (i.e., for healthcare services) and the remaining 15 cents was paid for the expenses associated with claims and insurer profit. The higher the loss ratio, the higher the portion of premium revenue used for claim costs and the lower portion used for expenses and insurer profit.

Although the formula of a loss ratio is simple, the definitions of the multitude of cost items that need to be defined as either claims or expenses/profit are subtly complicated. A common example is the assignment of expenses for disease management programs: Should these expenses be considered a cost to provide healthcare services or insurer expenses?

One approach an insurer can use to meet minimum loss ratio requirements is to increase claim costs, or reimbursement levels to providers. Such an increase, with no corresponding change to expenses or profit, would increase the resulting loss ratio. And the increase would likely be applied to all provider contracts, including those used by self-funded employer-sponsored plans. Of course, this would increase claim costs and associated premium and premium-equivalent rates, and could put a given health plan that increases provider reimbursements at a competitive disadvantage. Therefore, this type of approach is unlikely to be used by an insurer.

- Increased prescription drug costs stemming from 12-year patent protection of (emerging) biologics: Biologics represent an emerging area of treatment and are expected to improve treatments at a relatively high cost. Similar to common brand-name and generic prescription drugs, costs for biologics are expected to be high while there is no generic competition.

- Corporate deductibility of compensation for certain employees will be limited to $500,000: An increase in taxes paid by insurers may be passed through to employers and individuals.

- States will review individual and small group insured premium increases: As a consequence, insured premiums may be lower in some instances than they would be without such reviews. However, if premiums are limited, insurers may attempt to negotiate relatively larger administrative and other fee increases for self-insured plans in attempts to recoup revenue.

- Medicare will ban new physician-owned hospitals and limit the growth of certain grandfathered ones: This restriction may reduce the level of unnecessary care prescribed and provided, and lower employer costs.

- Medicaid family practice and internal medicine physician fee-for-service reimbursement levels will be set to Medicare levels: This increase in Medicaid provider reimbursement may decrease cost shifting to employer-sponsored plans.

- Various wellness, provider reimbursement, cost controls, and quality-of-care initiatives: If proven successful, such programs may be widely adopted throughout the healthcare system and result in more efficient care, higher-quality care, and lower costs. However, the various initiatives may be ineffective and result in higher total costs. For example, a program may have little to no impact on healthcare service utilization and associated claim costs, but will insert additional costs to run the program into the healthcare system.

CONCLUSION

The new national healthcare reform legislation will bring significant changes to the U.S. healthcare system. The focus of the legislation is to significantly increase the number of Americans with health insurance. However, the extent of efforts to control healthcare costs, particularly employer costs, is limited.

Employer sponsors of healthcare benefit programs will need to change some aspects of their programs in the short term. But in the medium term (2014 and the subsequent few years), employers will need to make fundamental decisions about their role in providing healthcare benefits to their employees.

If employers continue to offer group benefits, they will need to develop and implement effective cost-control strategies while meeting new legal requirements. However, it is possible that, if state exchanges function properly, an employer's role could be reduced or even eliminated altogether. In any case, employers will need to continually assess their competitive position relative to not only their healthcare programs, but also their total compensation and benefit packages.

Jeffrey Chanin is a consulting actuary with the New York office of Milliman. Contact Jeff at jeffrey.chanin@milliman.com or at 646.473.3000.

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