The Milliman Healthcare Reform Strategic Impact Study: Helping employers make sense of healthcare reform

WHY DO YOU NEED AN IMPACT STUDY?

In 2014, the Patient Protection and Affordable Care Act (PPACA) will introduce significant changes to the commercial health insurance landscape. Rather than employer-sponsored insurance (ESI) offering the sole source for guaranteed issue insurance, coverage for preexisting conditions, and generally affordable coverage, many employees may have alternative sources of coverage through expansion of Medicaid eligibility or premium subsidies through the state or federal exchanges. This paper discusses key healthcare reform questions for employers that a strategic impact study can help answer.

Employers will be required to meet minimum standards for plan actuarial value and plan affordability, or potentially incur penalties under PPACA. For many large employers, current plan design and required contributions may meet the minimum standards. However, the presence of an individual mandate, employee health plan automatic enrollment, coverage of dependents to age 26, and the potential for small employer health plan termination may result in a materially higher number of employees being covered by some large employers' health plans. Additionally, PPACA-related fees such as charges for the transitional reinsurance program, health insurer assessment, and other fees will add to the cost of your employer-sponsored health plan. Finally, the issue of future cost increases is not likely to be adequately addressed by the provisions of PPACA. *Therefore, even if your plan meets minimum requirements for plan affordability and value, the implementation of PPACA may still result in significant additional costs above normal healthcare inflation. All future plan design changes must be made in the context of PPACA cost impacts.*

The sum of the changes and forces introduced by PPACA can be overwhelming and create significant uncertainty regarding future plan costs. The Milliman Healthcare Reform (HCR) Strategic Impact Study quantifies the cost impacts by HCR provision. The cost risks assessed include the 2018 excise tax on high-cost health plans (i.e., the "Cadillac plan" tax), potential in-migration of employees and dependents who currently waive coverage, potential adverse selection as a result of both in- and out-migration of participants, possible cost shifting from Medicare, Medicaid, and other employer plans, as well as new HCR penalties, fees, benefit mandates, and administrative requirements. *The study also identifies available strategic opportunities under HCR specific to the health plan and recommends how to capitalize on them to maximize your employee benefit dollar.* This paper discusses key healthcare reform questions for employers that Milliman's strategic impact study can help answer.

UNDERSTANDING THE NEW PARADIGM

Strategic decisions regarding employer-sponsored healthcare must be made with an understanding of how employer-sponsored insurance (ESI) will interact with the Medicaid eligibility expansion and the premium subsidies available in the state or federal health insurance exchanges.

As illustrated in Figure 1 on page 2, the insurance expansions under PPACA interact with employer-sponsored health insurance based on employee household income and employee premium contributions. The table in Figure 1 assumes that the employer is offering qualified health coverage that meets the minimum standards under PPACA.

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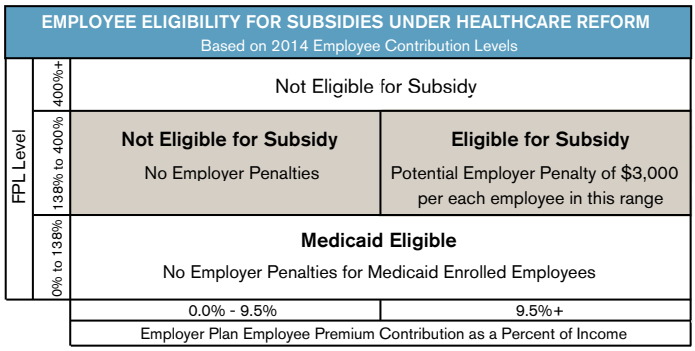
FIGURE 1: EMPLOYEE ELIGIBILITY FOR SUBSIDIES UNDER HEALTH-CARE REFORM (BASED ON 2014 EMPLOYEE CONTRIBUTION LEVELS)



Note: Based on the June 28, 2012, Supreme Court decision, states are not required to carry out the Medicaid expansion to 138% FPL. If a state did not expand Medicaid to 138% FPL, employees between 100% and 138% FPL will become eligible for premium subsidies, *where employer penalties would apply.* Milliman can help employers understand this additional exposure depending on what a given state chooses to do.

Eligibility for Medicaid and subsidized coverage through the exchanges is determined from each employee's household modified adjusted gross income (MAGI), which is converted to a federal poverty level (FPL) percentage. The FPL is adjusted by the number of individuals as follows for 2014 (estimated future income values):

- $11,500 for a single-person household
- $23,800 for a family of four

Under PPACA, there are three distinct FPL tiers, with benefits and coverage options varying greatly:

- FPL Tier I: 0%-138% (100% for states not opting to expand Medicaid)
  - Single-member household income less than or equal to $15,900
  - Four-member household income less than or equal to $32,800
- FPL Tier II: 138%-400% (100% to 400% for states not opting to expand Medicaid)
  - Single-member household income between $15,900 and $46,100
  - Four-member household income between $32,800 and $95,200
- FPL Tier III: > 400%
  - Single-member household income greater than $46,100
  - Four-member household income greater than $95,200

TIER I

Tier I provides automatic Medicaid eligibility to individuals who have an adjusted FPL of 138% or lower. Individuals newly eligible for Medicaid pay no premiums with minimal, if any, cost sharing and no qualification for further subsidies.

TIER II

Tier II is the most complicated because an individual's eligibility depends on not just household percentage of FPL (138%-400%), but also the availability of qualified employer-sponsored coverage. If an individual's employer coverage meets the following qualified coverage standards, the household is *not eligible for a premium subsidy* through the exchange:

- Employer-sponsored coverage has an actuarial value of at least 60% (i.e., 60% of the employee's healthcare cost is estimated to be paid by employer-provided benefit)
- The required *self-only*[1] employee contribution to participate in the employer plan does not exceed 9.5% of household income

If either of these qualified coverage standards are not met, or no employer coverage is offered, an individual with an adjusted FPL of greater than 138% but less than 400% is eligible for a premium subsidy through the exchange. The maximum an employee pays for a policy in the exchange ranges from 3.0% (138% FPL) to 9.5% (400% FPL) of household income, with additional healthcare cost sharing subsidies also available for households under 250% FPL.

TIER III

The third tier reflects households above 400% FPL. These individuals are not eligible for a premium subsidy through the exchange, regardless of the availability of employer-sponsored coverage.

Employer penalties

If an employer does not provide employer-sponsored coverage, it must pay a penalty of $2,000 per full-time employee (defined as greater than 30 hours per week). Employers with fewer than 50 employees are exempt from the penalty. The $2,000 penalty is not tax-deductible for the employer.

Employers that sponsor a health plan, but do not meet the definition of qualified coverage for each employee, also are subject to penalties. For each employee that purchases an exchange policy and receives a premium subsidy through the exchange, by reason of being below 400% FPL and not having qualified employer coverage, employers must pay a $3,000 penalty (not tax-deductible for the employer). If an employer has fewer than 50 employees, it is exempt from the penalty. In aggregate, premium subsidy penalties cannot exceed the penalty amount for not providing coverage.

However, employers do not have to pay penalties on behalf of eligible (Tier I) employees who enroll in Medicaid. *If a state elects not to carry out the Medicaid expansion, additional penalty exposure may be created for employees between 100% and 138% FPL, as they would be eligible for premium subsidies through the exchange, rather than Medicaid.*

1 The Department of Health and Human Services has not ruled on how premium subsidy eligibility will be determined for related individuals (i.e., spouses and children). This determination may have significant implications for employers, which can be tested using the Milliman reform model.

REEVALUTE THE VALUE OF EMPLOYER-SPONSORED HEALTHCARE

The implementation of the major insurance expansion provisions of PPACA in 2014 provides an opportunity for employers to reexamine the value of offering health insurance benefits. For some low-income employees, Medicaid or the insurance exchanges may provide cheaper and richer benefits than their current plans. For these employees, the employer-sponsored health benefits may offer limited value because a better or equivalent plan could be purchased in the insurance exchange.

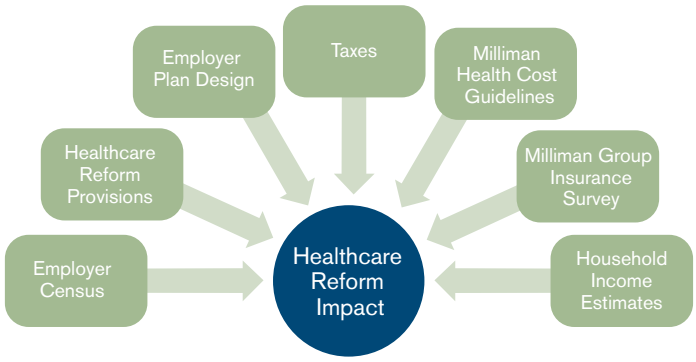
As household income rises, the premium subsidies in the exchanges are phased out. For employees qualifying for a limited or no premium subsidy, the cost of coverage in the insurance exchange may be significantly higher than the employer plan. Further, out-of-pocket premiums in the insurance exchanges cannot be paid on a pretax basis, a significant consideration for higher-income employees. For these employees, employer-sponsored insurance is likely to remain an important part of their benefit compensation.

Most employers have a mixture of low- and high-income employees. Therefore, the "value" of employer-sponsored health insurance may differ significantly within the employee population. *To optimize the value of its health insurance plan and its benefit spending, employers should consider strategies that result in covering only employees who consider employer-sponsored insurance a valuable part of their total rewards compensation. This may be achieved by educating employees on alternative sources of coverage that may be more affordable and offer richer benefit coverage and by calibrating employee health plan contibutions to optimal levels.*

MILLIMAN'S EMPLOYER HEALTHCARE REFORM MODEL

Milliman's employer healthcare reform model, as illustrated in Figure 2, has been developed from our extensive knowledge and information regarding healthcare reform from the perspectives of employers, insurance carriers, insurance exchanges, and providers. Our modeling leverages existing proprietary tools such as the Milliman Health Cost Guidelines™ to accurately model regional health insurance cost variation. It incorporates federal and state income taxes, payroll taxes, and corporate taxes in its financial projections. Our modeling provides future total *year-by-year health plan cost projections* through 2018, which reflect the future indexing of the employer penalties, premium tax credits, and individual mandate penalties.

FIGURE 2: HEALTHCARE REFORM IMPACT



KEY QUESTIONS ANSWERED

We can help employers quantify how their organizations will be impacted by PPACA and determine strategies that optimize the perceived value of their health plans in the context of the new healthcare reform environment. Key questions that will be answered include:

What is the estimated household income distribution of an employee population?

As discussed above, employee household income is fundamental in evaluating the value of offering employer-sponsored health insurance. Milliman's employer model estimates household income using a formula based on an employee's salary, gender, marital status, number of children, education level, and cost of living area. Rather than just grossing up all employee salaries by a fixed ratio, this method provides our clients with employee household income estimates that are reflective of the unique characteristics of its employee population. An illustration of how estimated employee household income is summarized into the key FPL tiers is shown in Figure 3.

FIGURE 3: COMPANY ABC EMPLOYEES BY HEALTHCARE REFORM FPL TIER, 2014 ESTIMATES

FPL TIER	EMPLOYEES ENROLLED IN COMPANY ABC'S HEALTH PLAN	EMPLOYEES CURRENTLY WAIVING COVERAGE	TOTAL ELIGIBLE EMPLOYEES	PERCENT OF ELIGIBLE EMPLOYEES
UP TO 138% OF FPL	10	15	25	2.6%
138% TO 400% OF FPL	251	100	351	36.0%
400%+ OF FPL	450	150	600	61.5%
TOTAL	711	265	976	100.0%

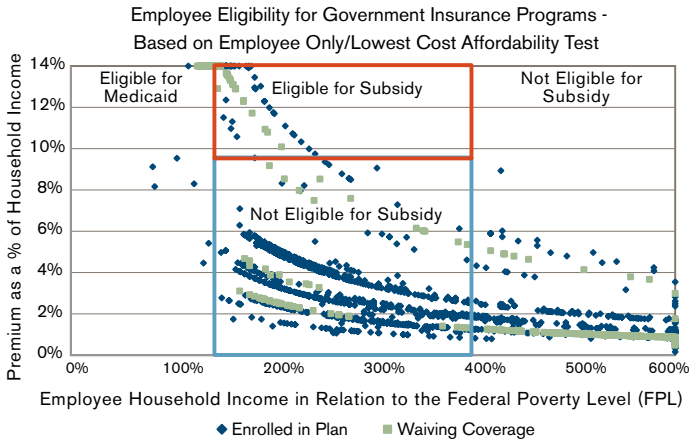
How many employees may qualify for Medicaid or significant premium subsidies in the state or federal exchange?

Based on estimated employee household income and required employee contributions for the most affordable plan offered by your organization, we can estimate the number and demographic characteristics of employees that will qualify for either Medicaid or a premium subsidy. Figure 4 on page 4 provides a sample illustration of an employer's employee household income distribution in relation to Medicaid and premium subsidy eligibility.

How many employees will elect to enroll in Medicaid or purchase an individual policy in the exchange using a premium subsidy?

Because an employee qualifies for Medicaid or a premium subsidy does not necessarily mean that that employee will opt out of an employer's plan. Our modeling considers the relative costs (including tax differences) between employer-sponsored and alternative sources of health insurance coverage. This allows an employer to observe the estimated impact of modifications to required employee contribution rates on enrollment and costs.

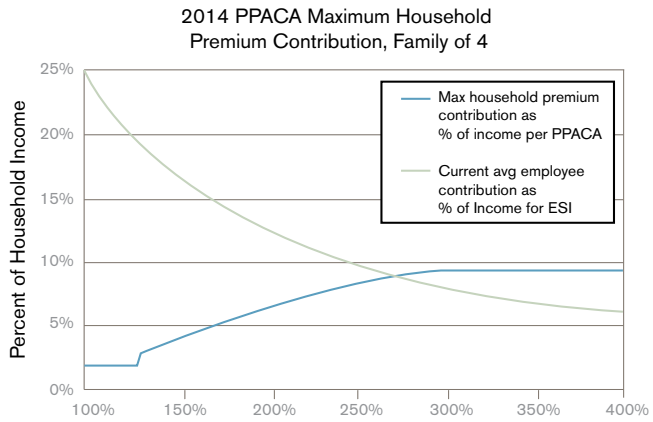
FIGURE 4: EMPLOYEE HOUSEHOLD INCOME DISTRIBUTION



Should employers incentivize or make eligible a portion of their employee populations for the premium subsidies in the state or federal insurance exchanges?

For low-income employees, many may have lower premiums and richer benefit plans in the exchange rather than on an employer's plan. The chart in Figure 5 illustrates the employee premium for family coverage in a typical employer plan relative to the required premium in the state or federal exchange. For employees with household income under 250% FPL, exchange coverage may be significantly less expensive.

FIGURE 5: 2014 PPACA MAXIMUM HOUSEHOLD PREMIUM CONTRIBUTION, FAMILY OF 4



Note: Family contribution based on 2012 Milliman Medical Index average family contribution trended to 2014 values. Maximum contributions assume that employees will be eligible for federal premium subsidies.

Will the number of employees and dependents covered under an employer's plans change significantly beginning in 2014?

Milliman will estimate how the number of covered employees and dependents will change beginning in 2014. Factors that may increase enrollment include:

- Auto enrollment
- Individual mandate
- Dependent coverage to age 26

Factors that may decrease enrollment include:

- Eligibility for Medicaid
- Eligibility for premium subsidies in the state or federal exchange
- Dependent coverage to age 26

We estimate the impact of these factors based on the marital status of employees, individual mandate penalty amounts in relation to required employee contributions, Medicaid and exchange premiums and cost sharing, and employee contributions as a percentage of household income. Our modeling allows alternative contribution and benefit design scenarios to be easily tested to estimate plan enrollment impact.

Does it make sense to avoid the PPACA penalties at all costs, or are employers spending significantly more on employer-sponsored coverage than the penalty amounts?

From the employer's perspective, it needs to determine if potential PPACA penalties outweigh per-employee healthcare spending. Our modeling allows employers to see estimated costs by employee household income level to make informed decisions about benefit plans in relation to any potential PPACA penalties. The example in Figure 6 on page 5 shows an increase in per-employee annual health costs from $11,783 to $12,000. When combined with a projected increase in enrollment, this translates to a projected annual cost increase of nearly $2.1 million. *However, could a portion of this cost increase be mitigated by allowing some employees to qualify for the premium subsidy and purchase coverage in the exchange?*

What is the actuarial value of an employer's benefit plans in relation to the plans offered in the health insurance exchanges?

While the vast majority of employer-sponsored health plans are likely to meet the minimum requirements under PPACA, it is important to understand how the actuarial values of employer plans compare to the tier-level plans (platinum, gold, silver, and bronze) offered in the insurance exchanges. Employers may reevaluate why they are offering plans comparable to gold or platinum plans in the insurance exchanges, when silver-level coverage is the benchmark in the individual health insurance market. Figure 7 shows a comparison for an example employer.

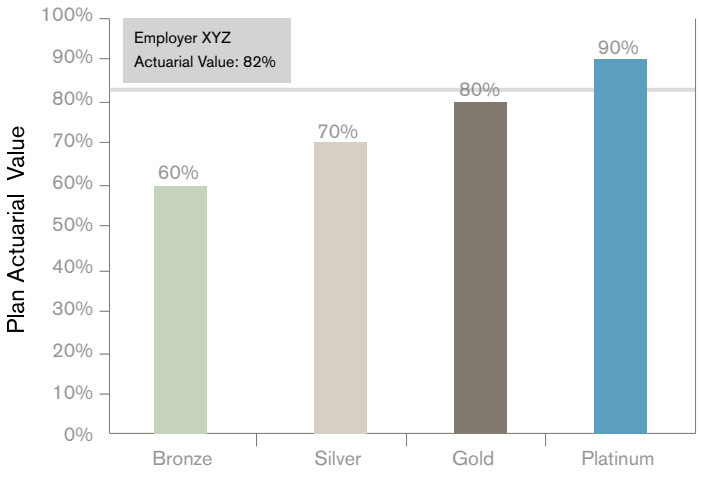
FIGURE 6: ESTIMATED COSTS BY EMPLOYEE HOUSEHOLD INCOME LEVEL

FEDERAL POVERTY LEVEL	CURRENT PARTICIPATING EMPLOYEES COUNT	CURRENT PARTICIPATING EMPLOYEES EMPLOYER PER EMPLOYEE SPEND	CURRENT NON-PARTICIPATING EMPLOYEES COUNT	POST-REFORM PARTICIPATING EMPLOYEES COUNT	POST-REFORM PARTICIPATING EMPLOYEES EMPLOYER PER EMPLOYEE SPEND
<138% (MEDICAID ELIGIBLE)	102	$9,875	52	51	$7,194
POTENTIAL SUBSIDY ELIGIBLE					
138% - 200%	225	$7,250	150	281	$8,440
200% - 250%	111	$8,375	85	168	$9,005
250% - 300%	165	$9,250	64	200	$10,410
300% - 350%	184	$14,750	52	207	$15,847
350% - 400%	200	$13,250	43	214	$13,579
SUBTOTAL 138% - 400%	885	$10,679	394	1,070	$11,359
400%+ (NOT SUBSIDY ELIGIBLE)	205	$17,500	51	222	$16,193
COMPOSITE	1,192	$11,783	497	1,343	$12,000
AGGREGATE EXPENDITURES		$14,046,000			$16,121,000
CHANGE IN EXPENDITURES					$2,075,000

How does modifying required employee contributions or benefit designs change estimated future plan costs?

Milliman's reform model is set up to provide employers with flexibility in evaluating the impact of plan design changes. The financial impact resulting from changes in required employee contributions and plan actuarial values can be done in a matter of minutes. This gives employers the flexibility to test a number of different plan design options in a quick and cost-efficient manner.

FIGURE 7: TIER-LEVEL EXCHANGE HEALTH PLANS



How will employer penalties, affordability requirements, individual mandate penalties, and premium tax credit percentages change over time?

Milliman's reform model estimates how these key measures will be indexed beyond 2014 for future premium growth and inflation as defined in the PPACA legislation. These estimates reflect government economic and healthcare forecasts through 2018. For example, the employer penalty for not offering health insurance coverage is estimated to increase from $2,000 in 2014 to approximately $2,500 by 2018.

FIGURE 8: PROJECTED 2018 "CADILLAC PLAN" EXCISE TAX, CURRENT PLAN DESIGN

HEALTH PLAN	COVERAGE TYPE	AVERAGE PLAN COST	PROJECTED EXCISE TAX
BASE	SINGLE	$13,800	$138,700
	FAMILY	$30,100	$154,200
BUY-UP	SINGLE	$15,400	$100,300
	FAMILY	$32,700	$50,400
TOTAL ESTIMATED EXCISE TAX			$443,600

Will any of an employer's plans be subject to the excise tax on high cost health plans beginning in 2018?

While the excise tax is not implemented until 2018, employers setting long-term benefits strategies should not ignore its impact.

Our modeling estimates whether each plan will be impacted by the excise tax in 2018, with adjustments to the excise tax thresholds for employee demographics, early retirees, and multi-employer plans as allowed under PPACA. Figure 8 shows the projected 2018 excise tax for an example employer. The excise tax is derived from the excess of average plan cost over defined thresholds that grow with inflation.

What steps can an employer take to minimize the financial impact of healthcare reform?

Our healthcare reform modeling provides detailed annual cost estimates of healthcare reform's impact from 2014 through 2018. As illustrated in Figure 9, these detailed cost estimates give employers the ability to quantify the cost impact of healthcare reform and make informed decisions on plan modifications.

Our model can quantify the impact of contribution changes, benefit modifications, employer penalty increases, healthcare trend, and other scenarios at this detailed level.

How will an employer be impacted if its state does not carry out the Medicaid expansion?

The PPACA Supreme Court ruling indicated that states can retain existing Medicaid funding even if they do not expand Medicaid eligibility to 138% FPL in 2014. For employers, this may have a potential cost impact as employees that may have been Medicaid-eligible may now be eligible for the premium subsidy tax credit, which may result in higher penalties for employers. The Milliman employer reform model has the flexibility to model the cost impact of a state not implementing the Medicaid expansion.

FIGURE 9: EXPECTED EMPLOYER COSTS

EMPLOYER XYZ, ESTIMATED EMPLOYER COSTS
PROJECTION PERIOD: JANUARY 1, 2014 - DECEMBER 31, 2014

	OPTIMISTIC SCENARIO		MOST LIKELY SCENARIO		PESSIMISTIC SCENARIO	
	EMPLOYER COST	CHANGE IN COST	EMPLOYER COST	CHANGE IN COST	EMPLOYER COST	CHANGE IN COST
CURRENT YEAR PREMIUM	$465,700		$465,700		$465,700	
2014 PRE-REFORM PREMIUM	$523,300	12.4%	$543,200	16.6%	$563,500	21.0%
2014 PRE-REFORM PREMIUM	$523,300		$543,200		$563,500	
BENEFIT MANDATES	1,200	0.2%	1,200	0.2%	1,300	0.2%
PROVIDER COST SHIFTING	0	0.0%	8,100	1.5%	16,900	3.0%
PLAN MIGRATION	-76,800	-14.7%	35,400	6.5%	194,100	34.4%
2014 POST-REFORM PREMIUM	$447,700	-14.4%	$587,900	8.2%	$775,800	37.7%
COST/(SAVINGS) DUE TO ADVERSE SELECTION	22,200	4.2%	50,400	9.3%	80,700	14.3%
CHANGE IN CORPORATE & PAYROLL TAXES	32,100	6.1%	-43,100	-7.9%	-145,000	-25.7%
ADDITIONAL EMPLOYER ASSESSMENTS AND TAXES PASSED ON TO EMPLOYERS						
TAX PASS THROUGHS	2,400	0.5%	2,500	0.5%	2,600	0.5%
PENALTY FOR EMPLOYEES RECEIVING SUBSIDY	$57,000	10.9%	$57,000	10.5%	$72,000	12.8%
EMPLOYER PPACA FEES	11,300	2.2%	14,500	2.7%	18,800	3.3%
EXCISE "CADILLAC" TAX (2018 ONLY)	NA	NA	NA	NA	NA	NA
TOTAL ASSESSMENTS	$70,700	13.5%	$74,000	13.6%	$93,400	16.6%
TOTAL EMPLOYER COST	$572,700		$669,200		$804,900	
TOTAL EMPLOYER COSTS		CHANGE FROM CURRENT YEAR		CHANGE FROM CURRENT YEAR		CHANGE FROM CURRENT YEAR
CURRENT YEAR	$465,700		$465,700		$465,700	
2014 PRE-REFORM COST	$523,300	12.4%	$543,200	16.6%	$563,500	21.0%
2014 POST-REFORM COST	$572,700	23.0%	$669,200	43.7%	$804,900	72.8%
CHANGE IN COST DUE TO HEALTHCARE REFORM	49,400	9.4%	126,000	23.2%	241,400	42.8%

Are there other nonfinancial considerations related to an employer's health plan that make it a valuable employee retention tool?

Often individuals or groups are resistant to changing historical patterns or policies, even if a new policy is in their best interest. For many employers and employees, employer-sponsored coverage is ingrained as a fundamental value provided to employees. Therefore, even if an exchange plan was a better value to an employee, the employee may maintain their employer coverage. Likewise, employers may be reluctant to drop their employer-sponsored coverage, viewing it as an important component of the compensation program and/or a competative advantage.

What additional considerations are there for small employers?

PPACA defines the small group insurance market as employers up to 100 employees. However, a state has the option of limiting the small group market to employers up to 50 employees in 2014 and 2015. Although small employers (50 or fewer employees only) are exempted from the employer play-or-pay provisions, there are additional impacts affecting only small employers, including:

- Maximum deductible of $2,000 (single coverage) and $4,000 (family coverage) in 2014
- Adjusted community rating (elimination of health status, gender, industry, and group size ratings; age rating limited to a 3:1 age ratio; 1.5:1 rate adjustment allowed for tobacco usage)
- The availability of coverage through a state or federal Small Business Health Options Program (SHOP) exchange
- Small employer tax credit available to employers meeting certain income requirements

Small employers may be significantly impacted by the adjusted community rating requirement, resulting in significant premium increases or decreases to certain groups. Milliman can help small employers assess the impact of community rating requirements, and facilitate discussion of alternative contribution or funding strategies.

Does healthcare reform provide an opportunity to revisit the value and funding of a pre-Medicare retiree health plan?

In 2014, the individual market policies in all states will be guaranteed issue, cover preexisting conditions, and not vary rates by health status. Additionally, 3:1 age rating limitations will result in retirees not yet eligible for Medicare being subsidized by younger individuals in the risk pool. Finally, the PPACA employer mandate does not apply to post-employment healthcare plans.

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in healthcare, property & casualty insurance, life insurance and financial services, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe. For further information, visit milliman.com.

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