

Health & Benefits Perspective

June 2010



This *Perspective* reviews some of the issues that are emerging as employers decide how to move forward with compliance.

Health care reform: Impact on employer-sponsored plans begins to emerge

The Patient Protection and Affordable Care Act (PPACA) will have a profound impact on employers and our health insurance system. While the employer community hoped that reform would place a priority on controlling cost trend and improving quality of care, the final legislation tilted disproportionately toward insurance reform and expansion of government-funded insurance coverage. The law did not create a comprehensive or certain path toward a more rational health care system, so the US will continue to operate short term with disparate and conflicting approaches to provider payment, outcomes measurement, consumer engagement and plan administration.

Health insurance reform puts the US on a path that increases consumer expectations of having comprehensive and affordable insurance coverage. Absent significant changes in health care cost, this expectation is unrealistic. And the federal subsidies that are intended to make insurance coverage more affordable simply mask the cost problem rather than correct it.



Impact on employer cost

As a result of the new insurance reforms, employers face new pressures to control costs, expand eligibility, comply with new coverage and contribution requirements, absorb new fees and, at the same time, try to avoid paying excise taxes for having a high-cost plan. Mercer assumes that in the near term employers will absorb an additional 4% to 6% increase above current health care cost trends due to new sources of cost, including:

- Expanded eligibility for groups of employees who are not currently eligible and for dependent children up to age 26
- Higher contributions for low-income employees who are currently paying more than 9.5% of income for coverage
- Expanded benefit coverage to eliminate any copayment or coinsurance on preventive care and to eliminate lifetime and annual plan maximums
- Industry fees on suppliers, manufacturers and health plans that add billions of dollars that are likely to be passed through to employers as part of the cost of materials and administrative expense
- Per-participant fees for effectiveness research

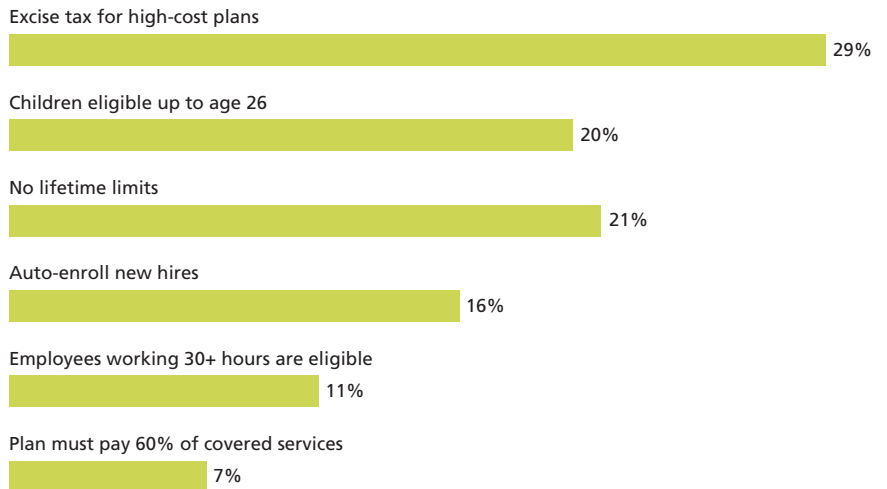
In addition to these new costs, health insurance reform did not address the inequities between provider costs paid by government-sponsored plans and those paid by employer-sponsored plans. Medicare and Medicaid have negotiated extremely favorable payment rates, leaving providers looking to the private sector to make up any insufficiencies or profitability losses. The legislation assumes that Medicare will make payment cuts in both the basic Medicare program and in Medicare Advantage. These cuts pose several risks, as follows:

- If the cuts do not materialize (as has been the case with planned cuts to Medicare physician payments), the shortfall will increase the federal deficit and potentially increase taxes and fees for employers and individuals.
- If the cuts occur, then providers will turn to employer-sponsored plans and individuals to make up the differences in their payments.
- Medicare payment reductions also increase the risk that providers will limit the number of Medicare patients they accept.

Employers face not only new sources of cost, but also the risk of continued and more intensive cost shifting from government-sponsored programs. As a result, it is highly likely that the cost trend may increase at a higher rate than expected over a 10-year period. A recent Mercer survey of 791 employers found that the excise tax was their most significant concern, followed by changes to lifetime limits and dependent eligibility.

Excise tax is the reform provision that worries employers the most

Percent of employers saying provision is a significant or very significant concern



Source: Mercer's 2010 Survey on Health Reform – Sizing Up the Challenge

Impact on the health insurance market

The new law creates some positive outcomes, some new risks, possible changes in workforce strategy, and some unintended conflicts and consequences that could profoundly reshape our health care system. Increased access to coverage, for example, creates conflicting outcomes.

- Increased enrollment in Medicaid, individual and employer plans will reduce the uninsured population. If that happens, then theoretically employers would benefit from not being charged the cost for uncompensated care.
- However, the cost of individual coverage is likely to increase in the short term, making it less attractive to new enrollees unless they are eligible for a significant subsidy. The average cost for individuals may be impacted by several factors:
 - New enrollees will include people who had previously been denied coverage due to pre-existing conditions. Thus, they come into coverage with health conditions that must be addressed – particularly if they have delayed care due to the lack of coverage. As a result, initial utilization for this group will be high.
 - The weak individual mandate increases the risk of adverse selection. The low penalty for not having coverage provides an incentive for individuals to opt in and out of coverage as needed. Individuals who think they have little to no risk of needing coverage may continue to go without it. Including these healthier risks would be very helpful in stabilizing cost and reducing the financial risk of adverse selection.





An example of an unintended consequence comes from the combination of two provisions in the law – the shared responsibility provision and the excise tax. Shared responsibility requires employers to offer an affordable health plan or pay a penalty. An affordable plan is one that pays 60% or more of benefits. Most employer-sponsored plans, with the exception of limited medical plans, have an actuarial value exceeding 60%. Yet, a plan valued at 60% may become a new low-cost option or the only option for employer-sponsored coverage. Employers may view this basic plan as a way to be compliant, control their cost and avoid the excise tax. It could also open up new opportunities for a direct-to-consumer market for supplemental plans.

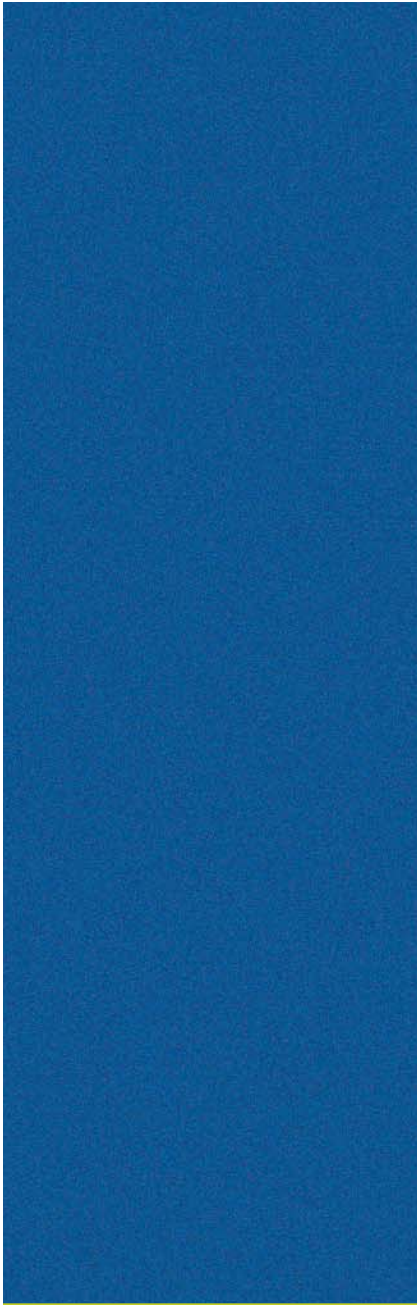
We have already seen evidence of more intense conflicts emerging between state insurance commissioners and insurers over requests to increase rates in the individual and small-group market. Insurers must present a clear and accurate rationale for rate increases. But, if regulators deny defensible rate requests, then it is likely that carriers may consider whether to exit the market. Clearly, that outcome does not provide a sustainable solution. Regulators and carriers should be working together to create alternative designs and delivery systems that could bring individual and small-group products to a more competitive price point. Those changes may require examining barriers, such as heavily mandated benefit designs, that make coverage unaffordable.

Impact on workforce strategy

All employers are asking how health care reform will affect their plans and costs. While many employers place a high value on health plans as a way to drive productivity and retain employees, that view is not universal. Some employers are looking into the option of eliminating health care benefits and giving some type of contribution to help employees buy coverage. Among the cautions to consider:

- In the near term there is not a viable individual market that would provide access to all employees without constraints.
- The “savings” to an employer are not simply the difference between current cost and the penalty. Employees will expect some compensation adjustment to help them buy coverage in the individual market, and employers must ask if they can afford the compensation boost sufficient to pay for high-cost individual marketed insurance.
- The law is not likely to result in individual market coverage that is more affordable than employer-sponsored coverage. Employers with self-insured plans, in particular, will have a more favorable cost due to lower administrative expense, less adverse selection and plan design flexibility.

Rather than encouraging employers to retain coverage, the law creates incentives for them to exit. Yet, as a result, the cost of coverage becomes more expensive.

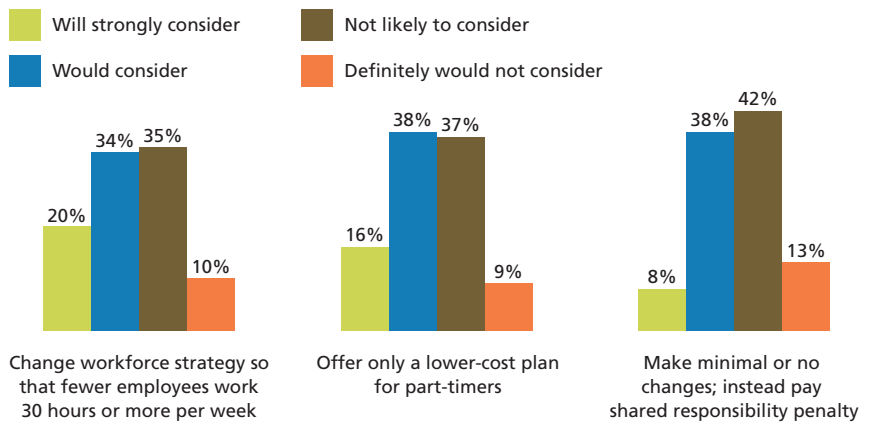


Another unintended outcome has emerged among some employers that are facing significant cost increases because of the shared responsibility requirements to cover new groups of employees. These employers have to weigh all possible alternatives – increase their cost by adding new employees, pay a penalty or evaluate ways to restructure the workforce (for example, contract arrangements, reduced work hours). Thus, rather than expanding access to coverage, the law may result in reducing the number of hours employees are eligible to work, thereby reducing employee income.

Mercer’s survey findings indicated that employers are considering changes to their workforce strategy and plan offerings as a way to deal with the shared responsibility provision.

Possible actions with regard to the requirement that all employees working 30 hours or more per week must be eligible

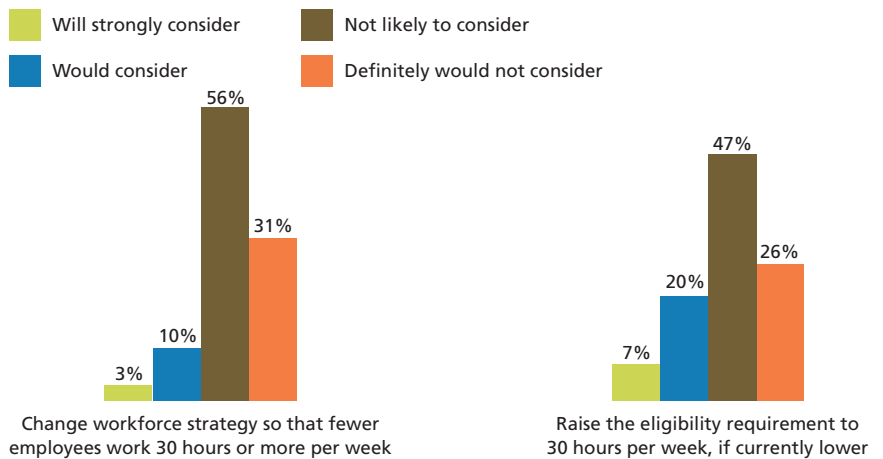
Based on employers currently not in compliance



Source: Mercer’s 2010 Survey on Health Reform – Sizing Up the Challenge

Possible actions with regard to the requirement that all employees working 30 hours or more per week must be eligible

Based on employers already in compliance



Source: Mercer’s 2010 Survey on Health Reform – Sizing Up the Challenge





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Strategic considerations

There is a new “sweet spot” or “safety zone” that is imperative for retaining health benefits that are compliant in terms of benefit design and eligibility, yet avoid the excise tax on high-cost plans. To achieve that goal means that employers must pursue some advanced health care strategies that improve quality, engage consumers and control cost trend. Key strategies include:

- Adopting plan designs that are structured to improve outcomes
- Selecting hospitals and physicians that consistently demonstrate compliance with standards of practice, optimal outcomes for their patients and cost-effective use of resources
- Adhering to medical guidelines and treatment recommendations
- Shifting to more cost-effective drug treatments
- Identifying personal health risks
- Participating in lifestyle management and care management programs
- Implementing high-quality solutions for individuals with high-cost, high-risk conditions
- Creating integrated medical systems or “medical homes” that provide comprehensive care, counseling and hands-on support for patients who have complex conditions requiring treatment by teams of specialists
- Relying on “domestic tourism,” which encourages patients to select the highest-quality providers for high-risk, high-cost surgical procedures

Employers face the challenge of keeping their plans compliant and affordable in an increasingly volatile health care market. Retaining employer-sponsored plans will require continued leadership to drive innovations in cost control, quality and consumer engagement.