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Employer Costs For Health Care Reform

Employer Price Tag for the Health Care Reform is $912 Billion Over the First Ten Years

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Although the health care legislation, the Patient Protection and Affordable Care Act and the reconciliation bill are estimated to cost the federal government at least $382 billion over 10 years, the new law will actually cost employers $912 billion over ten years.[1]

A recent Towers Watson survey found that 69 percent of large employers believe health reform will increase the cost of their benefit programs,[2] and a recent HR Policy Association survey found 79 percent of large employers believe health reform will increase the cost of their company's health care costs.[3] Of those who think reform will increase costs, 41 percent say it will increase costs by 6 to 10 percent, 35 percent say it will increase costs by more than 10 percent, and 25 percent say it will increase costs by 0 to 6 percent.[4]

As employers analyze the likely impact health care legislation will have on their firms and employees, they are finding that the law will significantly increase the cost of employer provided health care for both employees and retirees.[5] These cost increases may discourage employers from hiring American workers as the economy struggles to recover, and force them to pass these cost increases on to employees and retirees or drop their health insurance benefits altogether.

Specifically, the Health Care Reform Law and Reconciliation Bill Will:

Increase the Number of Employees Covered by Existing Employer Sponsored Health Care Plans – $57.8 billion per year: The individual mandate combined with the requirement that large employers automatically enroll employees will significantly increase take-up rates and health care costs for employers.[6] According to the Congressional Budget Office (CBO), up to 7 million people will gain employment-based coverage largely because the individual mandate will increase the demand for employment-based coverage.[7] This will cost employers with existing plans $57.8 billion per year in additional health care expenses.[8]

Create an Employer Mandate – $11.0 billion per year: The reconciliation bill increases the cost of the employer mandate from $27 billion to $52 billion over 6 years, or 92.6 percent. Large employers *who do not offer coverage and* have at least one full-time employee who purchases health insurance through an exchange *and* receives a premium tax credit or cost-sharing subsidy will pay a penalty of $2,000 per full-time employee. This effectively increases employers' costs for full-time employees by an average of 5.1 percent.[9]

For large employers *who offer coverage but* have at least one full-time employee who receives a premium tax credit and purchases health insurance through an exchange because the coverage is unaffordable or has an actuarial value less than 60 percent, the penalty is the lesser of $3,000 per full-time employee receiving a premium credit, *or* $2,000 multiplied by the total number of full-time employees. This effectively increases employers' costs for these full-time employees by at least of 7.7 percent.[10]

Create New Supply-Chain Taxes –$16.3 billion per year: Most of the tax increases on health insurance companies, drug companies, and medical device companies will be passed on to employers and other health care consumers. Specifically, the reconciliation bill imposes the following taxes:

- $10.0 billion in taxes over 5 years on health insurance companies beginning in 2014.[11]
- $2.9 billion in taxes over 6 years on medical device manufacturers and importers beginning in 2013.[12]
- $3.0 billion in taxes over 9 years on branded drug manufacturers and importers beginning in 2011.[13]
- $2.6 billion in taxes over 7 years on full and self insured plans to fund comparative effectiveness research beginning in 2013.[14]

Increase Cost Shifting from Medicare and Medicaid – $20.7 billion per year: Although the CBO's assessment of the health care reform law is that it will have a "minimal effect" on private-sector premiums via cost shifting, it does recognize that some cost shifting will occur.[15] In fact, under the health care reform law $20.7 billion per year in increased cost shifting to the private sector will likely occur from the deep cuts in Medicare and expanded eligibility for Medicaid.[16] The reconciliation bill would slightly increase this amount.

Government programs like Medicare and Medicaid pay artificially low rates for health care services and providers compensate by passing on billions of dollars in under-compensated costs to employer plans. A 2008 Milliman study estimated cost shifting increases the costs for private sector payers by $88.8 billion per year, resulting in a hidden tax that accounts for more than ten percent of the cost of employer-based coverage.[17] The health care reform law would result in a net increase of $20.7 billion per year in cost-shifting from the cuts in Medicare and Medicaid spending and the expansion of Medicaid, less the reduction from the cost of uncompensated care from the uninsured.[18] Although the law would lower the government's health care costs, it would raise the cost curve for the private sector.

Create an Excise Tax on High-Cost Health Care Plans – $16.0 billion per year: The health care reform law enacted a $32 billion tax on high-cost, employer-sponsored health care plans beginning in 2018.[19] Although the tax would average $16.0 billion per year from 2018 to 2019, its cost would exceed $20.0 billion per year beginning in 2020.[20]

Eliminate Employer Deduction of the Medicare Part-D Subsidy – $643 million per year: The health care reform law eliminates the ability of employers who provide qualified drug coverage to deduct the retiree drug subsidy that they receive from the government. This change in tax treatment of the subsidy increases taxes for affected employers by $4.5 billion over 7 years or an average of $643 million per year beginning in 2013.[21]

Increase Costs for Seasonal Employees: The health care reform law prohibits waiting periods longer than 90 days. However, in industries with seasonal work environments that are longer than 90 days (i.e., May to August, or November to February), employers will face increased health care, administrative, and turnover costs. It will also create a strong incentive to employ seasonal workers for only 90 days, or for less than 30 hours per week.

Require Employers to Provide Vouchers to Employees Who Opt-Out of Coverage: The health care reform law requires employers to give certain employees the option to opt out of employer sponsored coverage and receive a voucher from their employer to get coverage through an exchange.[22] The CBO estimates that 1 million employees would receive a voucher.[23] Because healthier individuals will tend to take the vouchers to seek less expensive coverage in the individual market, the net effect will be to increase the cost per worker of providing coverage to those who remain in an employer's group plan.

Increase Administrative Costs – $2.0 billion plus per year: The health care reform law creates costly new external appeals requirements for group plans, including requirements that they comply with state-specific rules, or new federal standards in states that do not meet minimum requirements.

The new law also requires substantial reporting to the IRS and full-time employees including a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan; the length of any waiting period; the months during the calendar year for which coverage under the plan was available; the monthly premium for the lowest cost option in each of the enrollment categories under the plan; the employer's share of the total allowed costs of benefits provided under the plan; the number of full-time employees for each month during the calendar year; the name, address, and Social Security number of each full-time employee during the calendar year and the months (if any) during which such employees (and any dependents) were covered under any such health benefits plans; and any other information the Treasury Secretary may require.

The CBO estimates the health care reform law will cost the IRS and Department of Health and Human Services $1.0 billion per year for administrative costs.[24] It is likely that the private-sector costs will be at least that much, and probably significantly more.

Increase Premiums for Small Employers -- $13.6 billion per year: The CBO and other studies estimate that the health care reform law will increase insurance premiums by 1 to 3 percent in the small-group market.[25] This would increase the cost of health insurance premiums on small businesses and their employees by up to $13.6 billion per year.[26]

Impose New Health Benefit Mandates on Employer-Sponsored Plans: Although the grandfathering provisions in the health care reform law are fairly broad, the reconciliation bill will impose new mandates on all employer plans that will increase health care costs. For example, all group health plans will have to cover adult dependents up to age 26, and will not be able to exclude preexisting conditions, or have annual or life-time limitations.

Increased Medicare Tax on High Income Earners -- $210.2 billion over 10 years: The health reform law will increase the payroll tax that individuals (*not employers*) pay from 1.45 percent to 2.35 percent for high-income taxpayers and adds a new 3.8 percent tax on unearned income (interest, dividends, annuities, royalties, or rents). This will raise taxes by $210.2 billion over ten years beginning in 2013.[27] It applies to individuals with incomes over $200,000 and families whose income exceeds $250,000, and significantly redistributes income from higher-income taxpayers to lower-income taxpayers. The higher taxes do not apply to income derived through the ordinary course of business that is not a passive activity, such as income from active participation in an S-corporation.

Conclusion

In addition to imposing billions of dollars in mandates and taxes on jobs, employers are concerned that the health care reform law will not significantly decrease the cost curve for employer provided health care. True reform should not inhibit the ability of companies to compete globally, drive up labor costs for employers, and potentially erode employment-based health care.

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[1] Congressional Budget Office, Letter to Speaker Nancy Pelosi, March 20, 2010, Table 2, available at: http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf. The federal government's cost does not include the $19.0 billion in savings from the student loan provisions in the reconciliation bill. The $912 billion is derived as follows: $578 billion in higher health care costs from higher take-up rates plus $52 billion in employer mandate costs plus $18.5 in higher supply-chain taxes plus $207 billion in increased cost shifting plus $32 billion for the excise tax on high-cost health insurance plans plus $4.5 billion for loss of the Medicare Part-D subsidy plus $20.0 billion in higher administrative costs.

[2] Towers Watson, 15th Annual National Business Group on Health - Towers Watson Employer Survey on Purchasing Value in Health Care, January 27, 2010, available at: http://www.towerswatson.com/press/958.

[3] HR Policy Association, 2010 CHRO Survey.

[4] *Id.*

[5] Deere & Co and Caterpillar Inc said they were expecting a combined $250 million in charges this year as a result of the health care reform law. See Scott Malone and Nick Zieminski, Corporate America weighs in on health law costs, Reuters, March 25, 2010, available at: http://www.reuters.com/article/idUSTRE62O3EA20100325.

[6] According to the Kaiser Family Foundation, in 2009, 82 percent of employees in large firms who were eligible to participate in their employer's plan did so. According to the CBO, this percentage will increase under health care reform.

[7] Congressional Budget Office, Letter to Speaker Nancy Pelosi, March 20, 2010.

[8] Applied Economic Strategies, using Congressional Budget Office data, Census Bureau data, and Kaiser Family Foundation data. The $57.8 billion is derived as follows: 7 million employees take-up employment-based coverage, of which 26.2 percent is individual coverage and 73.8 percent is family coverage times $4,004 (the pre-tax employer cost for individual coverage) or $9,764 (the pre-tax employer cost for family coverage), and then the increased cost of individual and family coverage is then summed.

[9] Applied Economic Strategies, (($2,000 / 52 weeks)/$748 median weekly earnings of full-time employees).

[10] Applied Economic Strategies, (($3,000 / 52 weeks)/$748 median weekly earnings of full-time employees).

[11] Joint Committee on Taxation, Estimated Revenue Effects Of The Amendment In The Nature Of A Substitute To H.R. 4872, The "Reconciliation Act Of 2010," As Amended, In Combination With The Revenue Effects Of H.R. 3590, The "Patient Protection And Affordable Care Act (PPACA)," As Passed By The Senate, And Scheduled For Consideration By The House Committee On Rules On March 20, 2010, JCX-17-10, March 20, 2010, available at: http://www.jct.gov/ publications.html?func=startdown&id=3672.

[12] *Id.*

[13] *Id.*

[14] *Id.*

[15] Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009. On page 12 and 13, the CBO states that "changes in cost shifting seems likely to be quite small" and "the total amount of cost shifting in the current health care system appears to be modest *relative to the overall cost of health insurance.*" [emphasis added] This language strongly suggests that CBO believes there will be some increase in cost shifting. On page 16, the CBO states that the "Effects Related to Cost Shifting Would Be Minimal" and that the "legislation would have opposing effects on the pressures for cost shifting." The CBO notes that "On the one hand, the legislation would reduce payments to hospitals and certain other providers under Medicare" and "significantly increase enrollment in Medicaid, which pays providers appreciably lower rates than private insurers do. Those changes could cause premiums for private coverage to increase." The CBO further notes that "On the other hand, the legislation would ultimately reduce the uninsured population by more than half, which would sharply reduce the amount of uncompensated or undercompensated care provided to people who lack health insurance" and that "The net effect of those opposing pressures would depend on their relative magnitude and also on the degree to which costs are shifted." Although CBO "expects that the magnitude of those opposing pressures would be *about* the same" [emphasis added], it concludes that "the legislation would have a *minimal effects on private-sector premiums* via cost shifting." [emphasis added] Note that the CBO did not conclude that there would be no impact or effect, only that it would be minimal on private-sector premiums. Moreover, the CBO did not present a net cost-shifting estimate as a dollar amount.

[16] Applied Economic Strategies estimate based on CBO data, Lewin research, and Milliman research. Although on page 17 of the Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009, CBO's assessment of "the evidence is that a small amount of cost shifting occurs but that it is not as widespread or extensive as is commonly assumed", other research has found that a substantial amount of cost shifting occurs. See: Will Fox and John Pickering, Hospital & Physician Cost Shift, *Payment Level Comparison of Medicare, Medicaid, and Commercial Payers,* Milliman, December 2008; Michael Davis, 2009 Vermont Health Care Cost Shift Analysis, State of Vermont, Department of Banking, Insurance, Securities, and Health Care Administration, February 20, 2009; Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs,* Health Affairs, Web Exclusive, August 25, 2008; Allen Dobson, Joan DaVanzo, Namrata Sen, *The Cost-Shift Payment 'Hydraulic': Foundation, History, And Implications,* Health Affairs, January/February 2006; Michael A. Morrisey, Cost Shifting: New Myths, Old Confusion, And Enduring Reality, Health Affairs, October 8, 2003; Jack A. Meyer and William R. Johnson, *Cost Shifting In Health Care: An Economic Analysis,* Health Affairs, 1983; and John Sheils, *The Cost and Coverage Impacts of a Public Plan, Testimony before the Ways and Means Committee,* The Lewin Group, April 29, 2009. In fact, Sheils stated in his testimony that "the literature indicates that only about 40 percent of uncompensated care and payment shortfalls are passed-on as higher prices for the privately insured. The remainder (60 percent) appears to be absorbed through reductions in costs and net income. Similar effects also have been observed for physician care." The reason CBO believes that $20.7 billion in cost-shifting will have a minimal effect on insurance premiums is because it represents just 1.7 percent of the projected total private insurance expenditures in 2016. The AES estimate was derived as follows: $491 billion in Medicare and Medicaid cuts (CBO) times .40 (the Lewin cost shift estimate) equals $196.4 billion over ten years, or $19.6 billion per year; plus the average annual increase in the number Medicaid participants, or 6.8 million people (CBO) times the current cost shift estimate per Medicaid participant of $481 per year (per capita cost estimate developed from data in Will Fox and John Pickering, *Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid, and Commercial Payers,* Milliman, December 2008, adjusted for medical cost inflation, $19.0 billion / 39.5 million beneficiaries = $481) equals $3.3 billion per year in additional cost shifting; minus the average annual decrease in the number uninsured, or 16.1 million people (CBO) times the current cost shift estimate per uninsured person of $138 per year (per capita cost estimate developed from data in Will Fox and John Pickering, *Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid, and Commercial Payers,* Milliman, December 2008, adjusted for medical cost inflation, $6.3 billion / 45.6 million people = $138) equals $2.2 billion per year in reduced cost shifting; for a net increase of $20.7 billion per year. Note that the cost shift increase associated with the expansion of Medicaid ($3.3 billion) is largely offset by the reduction in cost shifting associated with fewer uninsured ($2.2 billion). However, the significant cuts in Medicare and Medicaid provider reimbursements increase the net cost shifting estimate. It should also be noted that the House has passed H.R. 3961 that would significantly offset the Medicare cuts to providers.

[17] Will Fox and John Pickering, *Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid, and Commercial Payers,* Milliman, December 2008, available at: http://www.milliman.com/expertise/ healthcare/ publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf. During the past 20 years, documentation has accumulated in the health service research literature of hospital cost shifting to private payers due to uncompensated care

for the uninsured and Medicare and Medicaid reimbursement levels that do not cover the cost of providing those services. See footnote 9.

[18] Applied Economic Strategies estimate based on CBO data, Lewin data, and Milliman data. See footnote 9.

[19] Joint Committee on Taxation, JCX-17-10, March 20, 2010.

[20] Applied Economic Strategies, based on Joint Committee on Taxation, JCX-17-10.

[21] Joint Committee on Taxation, JCX-17-10, March 20, 2010.

[22] Under the health care reform law if an employee's household income is less than 400 percent of the poverty line, and the cost of the employer's plan exceeds 8 percent of an employee's household income, but does not exceed 9.8 percent, then the employee can opt-out and receive a voucher from their employer.

[23] Congressional Budget Office, Letter to Speaker Nancy Pelosi, March 20, 2010.

[24] Congressional Budget Office, Letter to Speaker Nancy Pelosi, March 20, 2010.

[25] Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009; and Oliver Wyman, *Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability,* October 14, 2009, available at: http://online.wsj.com/public/resources/documents/OliverWymanFinalReport101409.pdf. Although the Wyman study analyzed the Senate Finance Committee bill, similar benefit mandates are in the Patient Protection and Affordable Care Act.

[26] Applied Economic Strategies estimate based on Wyman data, CBO data, Census data, and Kaiser Family Foundation data. According to Census data for the Small Business Administration there are 42.7 million employees in firms with less than 100 employees, and according to the Kaiser Family Foundation 2009 Annual Survey, Exhibit 3.2, 64%, or 27.3 million employees, in small firms are covered by employer-provided health insurance. Further, Census data shows that 76.4%, or 20.9 million employees, in small firms with employer coverage are in families, and 24.6%, or 6.4 million, are single individuals. Therefore, 20.9 million times ($19,000 times .03) = $12.1 billion, and 6.4 million times ($7800 times .03) = $1.5 billion, for a total of $13.6 billion. Although this increase in premium costs may be partially offset by federal subsidies to small businesses, the subsidies are available for only two years for each firm.

[27] Joint Committee on Taxation, JCX-17-10, March 20, 2010.