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Increased Employer Costs For Health Care Reform Are No Surprise

Private Sector Price Tag for the Health Care Reform is $490 Billion Over the First Ten Years

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Although some members of Congress and the Administration are questioning the validity of recent Securities and Exchange Committee (SEC) filings on the employer cost for one provision in the Patient Protection and Affordable Care Act (PPACA), the filings should come as no surprise. Congress and the Administration had plenty of warnings about the measurable costs on employers in the law well before it was enacted and chose to disregard them. In fact, the $2.9 billion in costs related to the Medicare Part D subsidy provision that companies have reported to date are just the tip of the iceberg.[1] According to the Joint Committee on Taxation (JCT) and the Congressional Budget Office (CBO), the new law will increase taxes by $490 billion over ten years.[2]

Although the one study estimated the PPACA would save $683 billion over ten years,[3] most of the savings under the Act comes from reductions in Medicare provider payments, *something that Congress has not followed through on in the past.* Should the cuts in provider payments be reversed, and the House has already passed legislation to do so (H.R. 3961), additional tax revenue will have to be raised.

Moreover, the Medicare savings will have little impact on health care spending or premiums for people under the age of 65. While there may be some savings from increased competition in the exchanges and other provisions to increase access to coverage and thereby decrease uncompensated costs from the uninsured, most of these savings will be more than offset by higher taxes, insurance mandates, and increased utilization of health care services by the newly insured.[4]

A recent Commonwealth Fund survey found that just 35 percent of health care opinion leaders believe that the PPACA will successfully control rising health care costs.[5] Another survey by Towers Watson found that 69 percent of large employers believe health reform will increase the cost of their benefit programs,[6] 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.[7] Of those HR Policy members 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.[8]

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.[9] 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 PPACA:

Changes the Tax Treatment of the Medicare Part D Employer Subsidy – $643 million per year: Notwithstanding the rhetoric surrounding this issue, companies are required by Statement of Financial Accounting Standards No. 109 (now Accounting Standards Topic 740) to adjust deferred tax assets and reduce net income from continuing operations in the period in which PPACA was enacted to reflect the change for *all future years*. To date, companies have publicly reported over $2.9 billion in charges to their bottom lines. The JCT estimated this change will increases taxes for affected employers by $4.5 billion over 7 years or an average of $643 million per year beginning in 2013.[10]

The Congress and the Administration had plenty of warnings about the cost of this provision before it was enacted and chose to ignore them.

- On December 8, 2009, the Financial Executives International sent a letter to Congress warning of the substantial impact the provision would have on reported earnings and impact it will have on companies that continue to cover their retirees instead of shifting the responsibility to the federal government.[11]
- On December 10, 2009, the American Benefits Council and the AFL-CIO sent a joint letter to Senator Harry Reid warning Congress about the immediate impact the provision would have on employer's financial statements and that "it will be highly destabilizing for retirees."[12]
- On December 11, 2009, ten companies sent a joint letter to Congress and the Administration warning that the provision would negatively impact both retirees and companies and could reduce employer-sponsored retiree prescription drug coverage.[13]
- On December 15, two unions and two companies sent a joint letter to Senator Harry Reid warning Congress that warning the provision would have significant implications for both retirees and employers, and that many employers will see the need to drop or revamp their programs.[14]
- On December 19, 2009, the JCT published their cost estimate of the provision at $5.4 billion over ten years.[15] On March 20, 2010, the JCT updated their estimate to $4.5 billion over 7 years.[16]
- On January 14, 2010, the American Benefits Council published an analysis of the JCT and CBO "scoring" that estimated the provision could cause 1/3 of participants to be moved out of employer-sponsored prescription drug plans and into publicly-financed Medicare Part D.[17]

- On March 12, 2010, a Towers Watson analysis found the provision would cost employers $233 per year for each post-65 retiree and spouse and an immediate reduction to earnings reported in 2010 of $2,800 per retiree drug subsidy recipient. The national total was estimated to be $14 billion.[18]

Accounting rules have credibility because they require companies to report material items that will impact a company's financial statements, like changes to tax law. It would be inappropriate for companies to account for the indirect reduction in future health costs that are a matter of debate. Although the CBO estimates that the PPACA would reduce the present value of premiums by an average of just $6.6 billion per year,[19] other studies show that little of these premium reductions can be attributed to actual reductions in the cost of services or increased efficiency.[20] According to the Center for Medicare and Medicaid Services, Office of Actuary, there is little consensus in the literature or among experts that many of the cost control provisions in the PPACA will lower costs.[21]

In fact, most of the cost savings in the PPACA are related to federal programs like Medicare and Medicaid, not the private sector. Moreover, the outdated CBO estimates on premiums were made before the final bill imposed benefit mandates on a greater number of existing health plans, including employer-provided plans (see below).[22]

Whether one calls this closing a loophole or fixing a double-dipping corporate subsidy, the bottom-line is employer taxes are going up and as a consequence employers are reviewing their options for retiree care. In fact, John Grosso, a principal and actuary at Hewitt Associates recently noted that employers are likely to pursue a number of different options that are the most cost-effective to them including "send[ing] retirees to the individual Part D market and provid[ing] a tax-free subsidy."[23]

Creates 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 in the form of higher prices. Specifically, the PPACA imposes the following taxes:

- $10.0 billion in taxes over 5 years on health insurance companies beginning in 2014.[24]
- $2.9 billion in taxes over 6 years on medical device manufacturers and importers beginning in 2013.[25]
- $3.0 billion in taxes over 9 years on branded drug manufacturers and importers beginning in 2011.[26]
- $2.6 billion in taxes over 7 years on full and self insured plans to fund comparative effectiveness research beginning in 2013.[27]

Increases 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.[28] 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.[29]

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.[30] The PPACA 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.[31] Although the law would lower the government's health care costs, it would raise the cost curve for the private sector.

Increases Premiums on 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.[32] This would increase the cost of health insurance premiums on small businesses and their employees by up to $13.6 billion per year.[33] Moreover, the CBO estimate on premiums for large employers was made before the final bill weakened exemptions for "grandfathered" plans by imposing benefit mandates on existing health plans (see below). Those estimates are now outdated and very likely underestimated.[34]

Imposes New Health Benefit Mandates on Employer-Sponsored Plans: The grandfathering provisions in the Senate passed health care reform bill were significantly changed by the reconciliation bill that was enacted a week later. The final PPACA imposes new mandates on all employer plans that will increase health care costs. For example, all group health plans that provide dependent coverage 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.

Increases the Costs for Seasonal Employees: The PPACA 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.

Increases Administrative Costs – $2.0 billion plus per year: The PPACA 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.[35] It is likely that the private-sector costs will be at least that much, and probably significantly more.

Conclusion

Increased employer costs for health care reform should come as no surprise. In addition to imposing billions of dollars in mandates and taxes on jobs, employers and health care experts are concerned that the PPACA will not significantly decrease the cost curve for employer provided health care. Although there may be some savings when the exchanges are set up in 2014, most of the savings will be more than offset by higher taxes. Moreover, there is little consensus on how effective the other cost saving provisions in the Act will be, or how quickly the provisions that apply to federal programs will be adopted by the private sector and how they will be received by the public. Instead of blaming employers for simply following the accounting rules, members of Congress may want to rethink what they have just enacted.

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[1] As of April, 7, 2010, more than 20 companies have reported a cost associated with this provision. Various media sources including: http://www.reuters.com/article/idUSN0518161220100405?type=marketsNews.

[2] 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. 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..

[3] David Cutler, Why Health Care Reform Will Bend the Cost Curve, The Commonwealth Fund, December 7, 2009, available at: http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/Dec/Why-Health-Reform-Will-Bend-the-Cost-Curve.aspx.

[4] John Sheils, Will Health Reform Slow Cost Growth? The Lewin Group, March 26, 2010, available at: http://www.lewin.com/content/publications/Will_Health_Reform_Slow_Cost_Growth.pdf.

[5] Kristof Stremikis, Karen Davis, and Rachel Nuzum, Health Care Opinion Leaders' Views on Health Reform, Implementation, and Post-Reform Priorities, The Commonwealth Fund, April 5, 2010, available at: http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2010/Apr/1387_Stremikis_HCOL_postreform_priorities_data_brief.pdf.

[6] 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.

[7] HR Policy Association, 2010 CHRO Survey.

[8] *Id.*

[9] 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.

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

[11] Financial Executives International, Letter to Senator Harry Reid, December 8, 2009, available at: http://www.financialexecutives.org/eweb/upload/FEI/Medicare%20Part%20D%20Subsidy%20Letter.pdf.

[12] American Benefits Council and the AFL-CIO, Letter to Senator Harry Reid, December 10, 2009, available at: http://www.americanbenefitscouncil.org/documents/afl-cio-letter12-10-09.pdf.

[13] Various companies, Letter to Senator Harry Reid and Speaker Nancy Pelosi, December 11, 2009, available at: http://www.americanbenefitscouncil.org/documents/hcr_drugsub_cfo-letter121109.pdf.

[14] Letter from Verizon, at&t, the Communications Workers of America, and the International Brotherhood of Electrical Workers to Senator Harry Reid, December 15, 2009, available upon request.

[15] Joint Committee on Taxation, Estimated Revenue Effects of the Manager's Amendment to the Revenue Provisions Contained in the "Patient Protection and Affordable Care Act," JCX-61-09, available at: http://www.jct.gov/publications.html?func=select&id=17.
[16] Joint Committee on Taxation, JCX-17-10, March 20, 2010.
[17] American Benefits Council, Proposed Tax on Retiree Drug Subsidies: How Much is it Really Worth? January 14, 2010, available at: http://www.americanbenefitscouncil.org/documents/hcr_drugsub-worth011410.pdf.
[18] Bridge Years Health Coalition, The Unintended Consequences of Eliminating the Tax Exclusion for the Medicare retiree Drug Subsidy, March 12, 2010, available at: http://www.americanbenefitscouncil.org/documents/hcr_bridgeyears-towerswatson_rds-study_031610.pdf.
[19] Gary Locke, Don't Believe the Writedown Hype, Wall Street Journal, April 1, 2010, available at: http://online.wsj.com/article/SB10001424052702304252704575155712878109470.html?mod=rss_Today's_Most_Popular.
[20] John Sheils, Will Health Reform Slow Cost Growth? The Lewin Group, March 26, 2010.
[21] Office of Actuary, Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Passed by the Senate on December 24, 2009, Centers for Medicare and Medicaid Services, January 8, 2010, available at: http://www.cms.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf.
[22] Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009, available at: http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.
[23] Joanne Wojcik, Employers reviewing options on retiree care, April 4, 2010, available at: http://www.businessinsurance.com/article/20100404/ISSUE01/304049957.
[24] Joint Committee on Taxation, JCX-17-10, March 20, 2010.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] 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.
[29] 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.

[30] 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.

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

[32] 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.

[33] 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.

[34] Congressional Budget Office, Letter to Senator Evan Bayh, November 30, 2009.

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