Healthcare Reform: At What Cost?

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The healthcare reform legislation passed in late March is a voluminous far-reaching law. At more than 2,000 pages in length, we have all been inundated with information. Now with midterm elections approaching, we will undoubtedly hear much more, with many Republicans calling for repeal and the President and many Democrats trying to ease concerns by touting the more popular outcomes of the overhaul.

Recent polls reflect Americans becoming increasingly concerned.

A poll released at the end of May by Rasmussen Reports show that 63% of those surveyed favored repeal; while only 32% oppose repeal. This is somewhat surprising considering the reform package is considered to be front-loaded with benefits, such as the closing of the so-called donut hole in Medicare Part D prescription drug coverage for seniors and several mandates improving coverage levels. The tough stuff comes later, mostly in 2014 (yes, after the next Presidential election).

So why are most employers concerned? I think much of the concern at this point has to do with the unknown. Considering that the bill refers more than 1,000 times to details that need to be decided by various federal agencies, many of these details are yet to be disclosed. Some very important questions are just starting to be answered: "What happens if we lose our plan's grandfathered status?" or, "Exactly what are essential benefits?"

But the #1 question on the minds of employers is: "What will this do to our costs?" The short answer is that they will go up. Consensus is that healthcare costs will continue to rise and that the initial changes mandated by the reform law will further increase costs. Most recent estimates are that the initial mandates, which will begin to impact plans with renewals starting October 1 of this year, will impact plan costs by 1-3%, fortunately, a much more modest impact than was initially anticipated.

Will employers decide to "pay or play"?

That will be the question come 2014 when employers with more than 50 employees must either provide health insurance coverage to their full-time employees or be fined $2,000 per active employee per year. In addition, the law requires employers to provide "affordable" coverage. Employees that are required to contribute more than 9.5% of their household income for family coverage and choose instead to get government subsidized coverage through an exchange will subject their employer to a $3,000 annual fine. Will employers decide to drop their group coverage and pay the penalty? It doesn't take an actuary to determine that a $2,000 penalty is a lot less than paying $8,000-$10,000 in annual premiums per employee. However, when considering other potential costs, including higher turnover, increased salaries to compensate for the dropped coverage and higher FICA taxes, the advantages to dropping employer-sponsored coverage are not so clear. Initial surveys indicate that most employers will continue to use their health plans as attraction and retention tools, though the results will become clear when the "pay or play" option is actually there on the table.

The Goals of Reform

You may recall that there were three stated goals for reform: 1) cover more of the uninsured; 2) bend the cost curve; 3) be deficit neutral. At this time, it appears that the regulations should reduce the number of uninsured, but it is less clear whether the other two goals will be met. Cost control provisions are surprisingly absent from this new law, and, we recently learned that the overall price tag is now expected to cost $115 billion more than estimated when the bill was signed into law (now estimated at over $1 trillion). That did not take long. Considering the strict parameters placed upon the Congressional Budget Office (CBO) when calculating the costs, many people expect the total costs to come in much higher than their projections (see the history of Medicare's costs vs. original projections) once the exchanges and subsidies are effective in 2014. If many employers decide to pay the penalties rather than continue to provide coverage to their employees then look for the total cost to the taxpayers to skyrocket.

Who pays?

What is also certain is that, contrary to President Obama saying that the costs will be born by the richest Americans, the reality is that the costs will be shared by most of us, regardless of our tax bracket. According to a recent Towers Watson survey, the higher costs anticipated from health care reform will be passed on to employees by 88% of the employers surveyed. New taxes on insurance companies and drug and medical device manufacturers will be passed onto consumers through higher premiums and prices. The elimination of reimbursements for over-the-counter drugs in HSA, FSA and HRA accounts as well as the reduction of FSA contribution limits will also be a cost shared by many. Love it or hate it, perhaps it's naïve to think that the government can create such a large, new entitlement program without the costs being shared by most of us.

Have we seen this before?

In considering the effects of the federal health care reform it is instructive to consider the reform implemented in Massachusetts in 2006. Similar to federal reform, the Massachusetts law was an attempt to expand health care coverage to almost every resident of the Commonwealth and was not an attempt to control costs. Like the federal reform law the Massachusetts law requires individuals and employers to purchase private health insurance or pay a fine. It also expands Medicaid coverage and provides subsidies to help people buy coverage. The result has been a success in that more than 97% of the state's residents now have insurance coverage. However, the challenge is that the costs have exceeded projections. As plans continue to see double-digit increases and the insurers lose money, there are real concerns with the long-term viability of the program. Tim Murphy, Secretary of Health and Human Services when the law was drafted, said that the mistake was made "… by reinforcing an idea that health insurance should be a series of expensive, government-decided, pre-paid benefits." In addition, people have quickly learned how to game the system, buying insurance when they need it and dropping it after they have received care – a problem brought on by low penalties for not having coverage.

Another consequence of the Massachusetts reform that is likely to be realized on the national level has been the stress on the delivery system. By suddenly adding a large number of previously uninsured people into the health care system, providers have become overwhelmed. ABC News reported that the average wait in Boston to see a doctor is now 50 days, nearly double the next largest wait of 27 days in Philadelphia. Following the state capping of premium increases, some insurers are threatening to cut payments to doctors and hospitals. The problem of too few providers may get worse before it gets any better, if many doctors start considering a career change.

Keep in mind, we are only at the end of the beginning. Only time will tell how all of this will play out. There are going to be reams of regulatory guidance coming out of the agencies and many implications are yet to be realized. We will continue to keep our ears and eyes open so that we can counsel you through the challenging times ahead.