LOCKTON COMPANIES, LLC TESTIMONY

HEARING ON

"BARRIER TO LOWER HEALTH CARE COSTS FOR WORKERS AND EMPLOYERS"

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS
EDUCATION AND THE WORKFORCE COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES

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Chairman Roe, Ranking Member Andrews and members of the Committee, my name is Edward Fensholt and I am a Senior Vice President of Lockton Companies, LLC. Lockton is the largest privately-held insurance brokerage and consulting firm in the world. Domestically, Lockton employs 2,300 associates in 24 offices nationwide who serve the insurance risk needs of approximately 9,000 employer clients from coast to coast. Lockton Benefit Group ("LBG") is the employee benefits consulting arm of Lockton Companies, LLC, and provides employee benefits consulting services to approximately 2,500 of those clients.

LBG provides consulting expertise related to qualified and nonqualified retirement plans, group life and disability insurance programs, voluntary supplemental benefits, dental, vision, and comprehensive group medical benefit packages. The majority of our 2,500 employee benefits clients employ us to assist in the design and administration of their group medical insurance programs.

I am the Director of LBG's Compliance Services Division, and also lead our Health Reform Advisory Practice, a multi-disciplinary team of professionals formed to steer our clients through the federal health reform initiative. On behalf of Lockton I thank you for the opportunity to appear here today to share our observations and our clients' views regarding the impact of aspects of 2010's health reform law on the group health plans sponsored by our clients.

Most LBG clients are "middle market" employers, employing between 500 and 2,000 employees. Our clients include private and governmental employers, and employers across many industry segments, including construction, healthcare, manufacturing, transportation, retail, professional services firms, and the hospitality/entertainment industry.

More than half of LBG's clients maintain self-insured group health plans. The others purchase group health insurance from licensed insurance companies.

The PPACA Imposes Additional Costs on Employment-Based Health Insurance

The Patient Protection and Affordable Care Act of 2010 ("PPACA") is a sweeping piece of legislation affecting the health insurance marketplace, the Medicaid program, the Medicare program, and health care providers from doctors to nurses to hospitals and community health clinics. It affects health insurers, group insurance plans (both insured and self-insured), the employers who offer them, and the employees and their dependents enrolled in those plans. My comments today are confined to the cost impacts on the latter, that is, the impact of the PPACA on employers who sponsor group health insurance plans, and the employees and dependents who receive coverage through those plans.

Let me say at the outset that neither Lockton nor the vast majority of its clients have any quarrel with the stated goal of the PPACA, that is, to provide health insurance

protection to millions more Americans who want or need it, but cannot afford it. We and the law's proponents may disagree on *how* that should be provided, who should bear the administrative burden, who should pay for the new entitlements and how to allocate the nation's financial resources to provide them. But we appreciate the stated goal behind the measure.

As a firm heavily engaged in analyzing the statutory and regulatory construct of the PPACA, and advising and shepherding our clients through that construct, we have respect for and appreciate the efforts of the federal administrative agencies working hard to implement the law as Congress has mandated they must. In listening to and speaking with officials from the Labor Department, the IRS and the Department of Health and Human Services, and analyzing the guidance they have issued thus far, it's clear that federal regulators are making a strong effort to listen to the employer community, to understand the concerns of employers, and to endeavor to balance the needs of employers with the needs of those individuals the PPACA was intended to benefit.

That said, there's no question the PPACA has, to this date, bent the health insurance cost curve north, not south. As additional taxes, fees and mandates on employer-based health coverage come on line, we fear the health insurance affordability forecast will continue to deteriorate. Let me mention a few examples for the Committee.

<u>2011 Coverage Mandates</u>

Health plans are already complying with the obligations to cover adult children to age 26 (even if married and non-dependent upon the employee), to waive pre-existing condition restrictions on newly enrolled children, and to eliminate lifetime and annual dollar maximums on what the PPACA terms "essential health benefits." Most plans in our book of business have lost grandfathered status under the PPACA, subjecting them to additional mandates such as the obligation to cover a wide-variety of preventive care services—including, beginning several months from now, well women care, including contraception drugs and devices—at no out-of-pocket cost to the enrollee.

The increase in health insurance costs to employers in our book of business, to implement these mandates, has been 2 – 3 percent. For some sectors the increase is more, for some it is less.

There is also a new nondiscrimination rule that applies to fully insured medical coverage. Lockton has clients—such as regional and national restaurant chains, retail establishments and other employers in the hospitality industry—who currently supply typical medical coverage to corporate staff and select others (such as restaurant, store or hotel managers) but cannot afford to offer the same level of coverage, at the same rate of employer subsidies, to hourly employees. Maintaining the status quo, however, might subject these employers to excise taxes of $100 per day per hourly employee who does not receive an equivalent offer of coverage.

It is possible, depending on how federal regulators flesh out the requirements of the nondiscrimination rule, that these employers will simply have to terminate their existing group coverage. However, the nondiscrimination rule has yet to be interpreted by the regulatory agencies, and therefore our actuaries have not yet estimated the cost impact of this mandate.

2014 Coverage Mandates

Additional coverage mandates apply beginning in 2014. For example, health plans must reduce waiting periods to 90 days, and auto-enroll eligible full-time employees in available employer-based coverage.[1] Depending on the employer's industry segment, these additional expenses can be substantial. For example, our clients in the construction and transportation industries—where we find 6-month or even 12-month waiting periods—can expect to see significant cost increases. Our actuaries tell us these clients with 6-month waiting periods currently should see a cost increase of an additional 4 percent in 2014; those with a 12-month waiting period should see a cost increase of nearly 25 percent.

Our actuaries tell us that, across all industry segments other than retail and hospitality, our clients can expect to experience a 4.4 percent cost increase attributable to the automatic enrollment requirement.[2]

Taxes and Fees

To at least partially offset the cost of the health reform law, Congress (in the PPACA) levied excise taxes against the health insurance, pharmaceutical and medical device manufacturing industries, and on third-party administrators (TPAs) of medical claims. Of course, health insurers and TPAs will simply pass along these additional costs in the price of their products.

The taxes on health insurers and TPAs amount to $20 ***billion*** in 2014. Insurers we've talked to, and our own actuaries, estimate that the price of group health insurance in 2014 will rise $10-15 ***per employee***, ***per month*** (or about 2-3 percent) on account of these excise taxes alone.

Health plans are also subject to a $1 per covered life fee in 2012, increasing to $2 per covered life next year and beyond (subject to inflation-based adjustments), to pay for "comparative effectiveness research," or research into medical "best practices."

[1] Federal regulators recently deferred the compliance deadline for the automatic enrollment rules, concluding guidance regarding how to implement the requirement will not be ready by 2014.

[2] In modeling the effect of the automatic enrollment provision, our actuaries assumed that 75 percent of employees who are newly eligible for coverage but have not affirmatively enrolled, and who are automatically enrolled by the employer, will opt out of coverage.

Administrative Burdens

Of great frustration to our clients are the many additional administrative burdens, and their attendant costs, imposed by the health reform law. The majority of our clients want to continue to supply health insurance, but they struggle with the cost and the federally-imposed complexity of plan administration.

For example, under federal law and regulations today, a simple group health plan is required to supply up to more than 50 separate notices, disclosures and reports to its enrollees and the government (many of those more than once). Virtually every aspect of plan administration, from enrollment to benefit summaries to specific eligibility and benefit requirements, to claim processing times and the timing, form and cost of post-employment coverage, are now under (primarily federal) statutory or regulatory dictates.

The PPACA has added more than a dozen additional notice and disclosure obligations to health plan administration. This frustrates our clients immensely. They do not understand why, at a time when they struggle to supply this valuable fringe benefit—which is now the most expensive element of employee compensation, behind wages—Congress would make the process more expensive and more complicated, rather than less so.

A full 80 percent of our clients said, in responding to a survey we conducted last year, that they were "concerned" or "very concerned" about the additional administrative complexity created by the PPACA. They tell us the additional costs, complexity and uncertainty wrought by the PPACA affect their ability to hire additional workers, or to retain full-time employees.

Here are just some of the additional administrative obligations imposed upon health plan sponsors by the PPACA:

- Plans are (or will be) required to notify enrollees regarding the plan's retention of grandfathered status under the PPACA, the plan's obtaining a waiver from the annual dollar limit prohibitions, the right of enrollees to designate certain physicians as a child's primary care physician, the availability of health insurance exchanges, the plan's participation in the Early Retiree Reinsurance Program, and the retroactive loss of coverage due to misrepresentation or fraud.
- Employers must report the value (employer- and employee-paid) of medical plan coverage on Forms W-2, not to reflect a taxable event, but simply because Congress wanted to collect the information. Because many employees change their level of health coverage during the taxable year (due to marriage, domestic partnership, divorce, birth or emancipation of a covered child, etc.), employers must track the changes in values of the coverage, to ensure accurate reporting.
- Although the Employee Retirement Income Security Act (ERISA) already required most employers to supply health plan enrollees with a "summary plan

description" summarizing their health coverage, the PPACA imposes an additional requirement to supply a four-page (double-sided) summary of plan coverage, in hard-wired format and at specific times, to not only enrollees but also to individuals merely eligible for coverage. Health plans face fines of up to $1,000 per violation of this requirement.

- The "shared responsibility" obligations imposed on all but the smallest employers in 2014 and beyond will significantly ratchet up the administrative obligations on employers subject to those obligations.
    - Many employers will face substantial complexity in determining when their employees are considered "full-time" for PPACA purposes, triggering an obligation on the employer to offer them at least "minimum essential coverage" or risk various penalties. The challenge will be particularly acute for seasonal employers. While the administrative agencies—the IRS in particular—have done an admirable job working to strike a balance between pragmatism and the PPACA's literal requirements, we expect the process to remain significantly burdensome.
    - In order for federal authorities to coordinate employers' "shared responsibility" obligations with the availability (to the uninsured) of taxpayer subsidies in the new health insurance exchange, federal and state authorities will need employers to submit detailed reports on a regular basis, reports reflecting:
        - The employer's specific medical coverage offerings,
        - A roster of eligible and enrolled employees, and the full-time or part-time status of the employees,
        - The cost of the employer's coverage offerings, and the employer's and employees' respective shares of that cost,
        - The actuarial value, gauged against designated benchmarks, of the employer's coverage offerings, and
        - The number of months (during the year) for which an employee, and each of his enrolled dependents, were covered by a plan sponsored by the employer.

Last week came word from Washington that the IRS is re-evaluating how to assess the "affordability" of an employer's coverage offering to a full-time employee. Under the PPACA, if the employer's offer of coverage requires the employee to pay more than 9.5 percent of his or her household income for coverage, the coverage is considered "unaffordable" and the employee may qualify for taxpayer-supplied subsidies to buy insurance in a health insurance exchange. If ***that*** occurs, the employer will incur a $3,000 annual nondeductible penalty with respect to that employee.

The legislative history to the PPACA is scant, but what history exists is clear that the "affordability" test was to be applied to employee-only coverage, not *family* coverage. The IRS has initially said this is how it interpreted the statute.[3]

Now comes word that the IRS might, in fact, require that *family* coverage meet this affordability test. If federal authorities are going to require employers to heavily subsidize a full-time employee's *family* coverage, so that family coverage does not cost the employee more than 9.5 percent of his or her household income, the number of employers exiting the group insurance market, and dumping their employees into the health insurance exchanges, will be far greater than the Congressional Budget Office has estimated to date. That has profound implications for the dollars budgeted to supply taxpayer-funded subsidies in the exchanges.

The flight from the group insurance marketplace will most acute in industries where the employees tend to be modestly paid, hourly workers. Employers will opt to pay the relatively modest $2,000 per full-time employee penalty for offering no insurance, rather than pay larger subsidies for health insurance for the employees and their dependents. Congress can also expect to see many employer sectors transition full-time employees to part-time status, to take the employees out of the penalty equation.

What Employers Appreciate About the PPACA

This is not to say that employers are concerned about every aspect of the insurance reforms reflected in the PPACA. Some employers who buy group insurance (as opposed to self-insuring medical coverage) will receive refunds this August from insurers who failed to reach specific medical loss ratios in the given state.

And the PPACA supplies greater leverage to employers to encourage employees to make lifestyle changes to improve their health. The law allows employers to require unhealthy employees to pay an additional amount—up to 30 percent of the total cost the employee's coverage, up from 20 percent under pre-PPACA rules—for their health insurance, to account for the additional risks they pose to the health plan.

Conclusion

Lockton greatly appreciates the opportunity to appear before you today. In assessing the impact of the health reform legislation, we urge you to place yourselves not only in the shoes of those Americans who need access to affordable insurance, but in the shoes of the employers who supply valued coverage to 160 million of us.

Employers are burdened and frustrated by aspects of the health reform law that add costs and complexity to their health plans, and may lead some of them to eliminate group coverage and full-time jobs.

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[3] The IRS has also indicated a willingness to allow employers to utilize W-2 wages as a surrogate for "household income" in the affordability calculation.

We welcome the opportunity to work with you to mitigate these burdens on the employer community.