Health Care Reform
and its Effect on Corporate America
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Executive Summary

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act, commonly known as the “Senate bill.” One week after its signing, this bill was amended by the Health Care and Education Reconciliation Act of 2010, which became law on March 30, 2010.

Now that “health care reform legislation” has passed and been signed into law, what do all those 2,000-plus pages mean for senior financial executives? How will the Nov. 2nd elections affect this legislation? How will the early October, one-year waivers given by the administration to some insurers, employers and unions on some of the rules required by the legislation effect the overall business community? How are senior financial executives supposed to plan their companies’ strategy in response to the legislation?

These are just some of the questions that executives would like to see answered.

This research report by Financial Executives Research Foundation (FERF), in collaboration with Merrill DataSite®, aims to shed some light on how companies are responding to this legislation and what financial executives should be doing in preparation for the coming changes required by the legislation.

Given the sheer volume of information contained in the health care reform bill, this report will provide a brief overview of some of the key points included in it. This overview will also provide senior financial executives with perspective on the bill, based on a 20-question survey that was completed by 200 of their peers and colleagues. Additionally, in-depth follow-up interviews were conducted with financial executives to provide “real world” examples of how companies are responding.

Some of the key survey findings:

- 83% of survey respondents believe the health care reform bill will either slightly or greatly increase their company’s insurance costs.

- More than half (64%) of respondents think that small business will be more adversely or far more adversely affected by the health care reform bill than will larger companies.

- During the recent recession, 46% of the companies surveyed increased the dollar amount employees contribute to their health care program.

- 58% of respondents believe the health care reform bill will have little to no effect on private equity transactions over the next 12 to 18 months.

While there were many interesting points that came out of the follow-up interviews, perhaps the two biggest were that due to all the uncertainty related to the legislation and its requirements, companies should not make any dramatic changes but rather, plan to the best of their abilities. However, don’t wait; prepare by planning now. In addition, it is extremely important for senior financial executives to be proactive and open with their employees and keep them informed.
Legislation Overview

After several decades and failed attempts to overhaul the U.S. health care system, President Obama assured himself a place in history by succeeding where others before him had failed. While the passage of the health care legislation was a huge success, it is by no means the end of the health care debate.

In the March 31, 2010 article, “Health Care Reform: Not Ready to be Discharged Yet,” Wharton professor of legal studies and health care management Arnold J. Rosoff said, “The fat lady hasn’t even come on stage yet.” Already more than a dozen states have filed suit in federal court to challenge the validity of some of the health care bill requirements. In its current form, the reform bill is expected to expand coverage to 32 million Americans who are presently uninsured by mandating that all U.S. citizens be covered by health insurance. For those who cannot afford it, the government plans to issue subsidies to help them pay for coverage.

The cost of the legislation is currently estimated at $940 billion over the next 10 years, and the administration said it would reduce the federal deficit by $130 billion over the first 10 years. The Congressional Budget Office (CBO) later updated that figure to $143 billion over the first 10 years, and it is estimated that the plan will reduce the deficit by $1.2 trillion over the second 10 years.

So just how does the government plan to pay for the plan?

Starting in 2012, the Medicare Payroll tax on investment income would be expanded to include unearned income. That would be a 3.8% tax on investment income for families making more than $250,000 ($200,000 for individuals). Beginning in 2018, insurance companies will pay a 40% excise tax on “Cadillac plans” worth more than $27,500 for families ($10,200 for individuals). Dental and vision plans would be exempt and not counted in the total family plan cost. A 10% excise tax will also be applied to indoor tanning services.

While technically there is no employer mandate, employers with more than 50 employees must provide health insurance for their employees or face a $2,000-per-worker fine each year if any worker receives federal subsidies to purchase health insurance.

In addition to the above, the bill also addresses Medicare and Medicaid. It closes the Medicare prescription drug “donut hole.” Seniors who reach the donut hole by 2010 will receive a rebate of $250. Beginning in 2011, seniors in the gap will receive a discount of 50% on brand-name drugs. The bill also includes $500 billion in Medicare cuts over the next 10 years. The bill expands Medicaid to include 133% (or $29,327 for a family of four) of FPL. It requires states to expand Medicaid to include childless adults starting in 2014. The Federal government will cover 100% of the costs for covering the newly eligible individuals through 2016. It also stipulates that illegal immigrants are not eligible for Medicaid and that they would not be allowed to purchase health insurance on the exchanges even if they pay with their own money.
Specific insurance reforms were included as well so that six months after enactment, insurance companies could no longer deny children coverage based on pre-existing conditions. Starting in 2014, this would be expanded so that insurance companies could no longer deny coverage to anyone with pre-existing conditions. It also requires insurance companies to allow children to stay on their parents’ insurance plan until age 26.

Legislation’s Impact on Business

While the coming changes in health care will impact both individuals and businesses, it is important to distinguish between the changes that will impact an organization’s business and the changes that will impact an organization’s employees. A timeline of changes that provides a general overview of the legislation’s provisions is provided in the Appendix of this report on page 22.

The changes that will impact businesses fall into one of two categories: direct and indirect. Given the volume and complexity of the changes required by the health care legislation, businesses must plan carefully and accordingly.

Edward Fensholt, senior vice president and director of Compliance Services with Lockton Benefit Group, provided this summary:

“Direct impact” category:

- New benefit mandates that add to plan costs, such as prohibition on lifetime dollar maximums, prohibition on annual dollar maximums, obligation to cover adult children to age 26, obligation to pay for wide variety of preventive care with no cost sharing, and others.

- Obligation to automatically enroll eligible full-time employees (effective date unclear, but probably 2014). This rule applies to employers with 200 or more full-time employees. While most employers pay the vast bulk of premium costs, it’s rare for all eligible employees to be enrolled (some employees simply decline to take insurance, some have coverage elsewhere, etc.). That means that when an employer must automatically enroll ALL its eligible employees, there will be an immediate cost impact to the employer. Some of these automatically enrolled employees will opt back out of coverage, but some will stay (just due to the law of inertia).

- The “free rider surcharge” rules in 2014 will result in some employers (those with hourly, full-time, relatively low-paid employees who are not offered coverage today) to incur significantly increased cost to either extend an offer of coverage to these employees; pay a $2,000 or $3,000 annual penalty per such employee, or make them part-time employees. Other employers will simply cancel their plans and pay the surcharge because it’ll be cheaper to do so (they may be spending $5,000 to $6,000 or more per employee now). Many of the affected employees—the ones who lose their coverage—are likely to be enrolled as dependents under the plans maintained by their spouses’ employers, impacting the cost of those plans.
- Hassle costs. The law imposes several new reporting and disclosure obligations on employers: There is an obligation to furnish new four-page plan summaries ($1,000 per violation penalty); an obligation to notify employees about the new benefit mandates and, in 2013, the coming of the insurance exchanges; an obligation to produce an annual report (beginning in 2012) on employment-based wellness programs, and an obligation to report details (beginning in 2014) on the employer’s plan offerings; who is eligible for them, the rate charged to employees, and who is enrolled.

- New nondiscrimination rules will require some employers that offer more generous benefits to executives or salaried employees to either make that more generous (and expensive) coverage available to their rank-and-file employees, or reduce the coverage for the salaried class to equal the level of coverage for the rank-and-file.

“Indirect impact” category (defined as requirements that will make the prices of insurance offered by insurance companies more expensive, in turn costing the employer a greater expense):

- Increased risk. As carriers are required to issue policies to all applicants, and cannot impose pre-existing condition restrictions upon them for those conditions, people will wait to buy insurance until they get sick (because the penalty for not buying insurance is largely unenforceable, and in any event, is far less than the cost of insurance).
  - This is akin to being able to buy a homeowner’s policy when your house is on fire. It isn’t even insurance at that point. The result will be much higher premium costs for those who actually ARE buying insurance, because they’re paying for the enhanced risk posed by those who will wait to buy insurance until they get sick, and whose claims will far and away exceed their premium payments.

- Cost shifting. Doctors and hospitals lose money today when they provide care to Medicare and Medicaid patients because the programs’ reimbursement rates are about 20% below the providers’ costs. Providers shift those losses to private insurance (which is one reason why doctor and hospital charges to those of us with insurance are so high). Health reform intends to slash $500 billion (half a trillion dollars) from Medicare reimbursement rates. Thus, providers will have to shift $500 billion in losses to those with private insurance…driving up the price of that insurance.

- Taxes. The law imposes $60 billion in taxes on insurers, just because they’re insurers. It imposes additional and similar taxes on drug manufacturers and medical device manufacturers. These entities will simply pass those costs on through to the purchasers of their products.

- Carriers are subjected to “minimum loss ratio” rules (otherwise known as the “You Can Only Lose” rules). Carriers in the large group market must spend 85% of every premium dollar on medical care. If in a given state they have a good year, and claims run at, say, 82% or 78%, the carrier must give back the difference. But if they have a bad year, the carrier must eat the loss. Carriers must price for this enhanced risk in the build-up of their reserves.
Survey Results

To better understand how senior financial executives view this legislation, how they are interpreting it, and how they and their companies are responding to it, Financial Executives Research Foundation (FERF), in collaboration with Merrill DataSite, developed a 20-question survey that was completed by 200 senior financial executives. The charts and graphs depict the demographic information of the survey respondents.

About the Respondents

1. Current Job Title

- CEO: 2%
- CFO: 18%
- Director: 73%
- Other: 7%

2. Number of Employees in Company

- Less than 100: 22%
- 101 to 500: 36%
- 501 to 1,000: 14%
- 1,001 to 2,500: 10%
- 2,501 to 5,000: 8%
- More than 5,000: 12%

3. Company Type

- Public Company: 68%
- Private Company: 24%
- Nonprofit: 8%
Current Health Care Benefits

In order to provide a baseline for comparison, companies were asked about their existing health care benefits for full-time and part-time employees. While almost all did provide health care benefits to full-time employees, a majority of respondent companies did not provide health care benefits to their part-time employees. The graphs below show respondent's health care benefits for full-time employees and part-time employees, respectively.

4. Provide Health Care Benefits to all Full-time Employees

5. Provide Health Care Benefits to Part-time Employees
Adjustments to Benefits

With the Great Recession now “officially” over according to economists, senior financial executives were asked what changes or adjustments their companies had made to their health care benefits during the recent recession. Since respondents were able to choose up to three responses, the totals in the charts below may not add up to 100%.

More than half of survey respondents (56%) believed that the net effect of the health care legislation would be to greatly increase their companies’ insurance costs.

While one of the original stated purposes of the health care reform bill was to reduce costs, the administration quickly shifted its focus from cost savings to insurance coverage for the uninsured. Based on the survey results, it’s easy to see why.

More than half of survey respondents (56%) believed that the net effect of the health care legislation would be to greatly increase their companies’ insurance costs. The graph below shows all of the survey responses.
How Prepared is Your Company?

Although some brave senior financial executives stated that they did read the entire 2,400 pages of the health care reform legislation, due to time constraints most had to find other ways to get up to speed on the provisions of the bill. The chart here shows how executives learned about the bill.

In most companies, senior financial executives need to be aware of the legislation and its potential impact for planning purposes. However, in most cases, the hands-on implementation of the changes required by the law and the company’s response to the law will be delegated to the Human Resources department. So the survey asked, “How prepared is your company’s Human Resources department?” The chart below shows the results.
Weigh Your Options and Prepare

Since there is still quite a bit of uncertainty as it relates to the health care reform bill, many companies are still waiting and watching. Although some have chosen not to make any changes, many are at least studying their options. To that end, the survey asked the following three questions of respondents:

- Will your company grandfather-in its current health care benefits for existing employees?
- Will the recent health care reform legislation cause you to make any structural changes to your company’s health care benefits?
- Will the recent health care reform legislation change your company’s policies regarding Medicare Part D benefits?

The graphs and charts below depict the results to those questions.

Since there is still quite a bit of uncertainty as it relates to the health care reform bill, many companies are still waiting and watching.
Respondents were also asked whom they believed would most benefit from the health care legislation, or more specifically, they were asked if the bill would more adversely affect small business than larger businesses. The graph below shows the survey responses.

It was interesting to note that while the majority (65%) of respondent companies did not support a single-payer option to compete with private insurance companies, most would either drop their health care coverage or allow their employees to choose if a single-payer option was available. The following charts show these results.

Respondents were asked if the bill would more adversely affect small business than larger businesses.
When asked what effect they believed the health care reform bill would have on U.S. companies looking to sell themselves or spin off a division, most felt there would be no change (23%) or they weren’t sure what the effect would be (40%).

Health Care and M&A

With the recent merger of Continental and United Airlines, as well as other M&A activity, the survey questioned whether the health care reform bill would affect the M&A and private equity markets. When asked what effect they believed the health care reform bill would have on U.S. companies looking to sell themselves or spin off a division, most felt there would be no change (23%) or they weren’t sure what the effect would be (40%). However, 17% did believe the bill would increase the urgency to complete the transaction prior to full implementation of the bill and 20% felt the bill would deter companies from selling due to lower valuations as a result of increased internal health care costs.

The overall impression of survey respondents was that while the health care reform legislation would not directly affect the M&A market, it would certainly change some of the market dynamics going forward. The chart below shows how respondents feel the health care bill will affect M&A markets.
The survey also asked who might have the “upper hand” in M&A deals as a result of the legislation. A slight majority (38%) felt the buyers would have the upper hand but a close second (30%) felt there would be no upper hand. The graph below shows the full results.

Some senior financial executives expressed that while M&A activity itself may not be greatly affected, post-merger integration could possibly take longer as a result of the bill. This seems to be a fairly commonly held belief among financial executives as the survey showed that 24% felt most definitely that post-merger integration would take longer and an additional 44% thought that it possibly could take longer. Still, 20% didn’t think it would take any longer as a result of the bill and 12% weren’t sure how the bill would affect post-merger integration.

Finally, senior financial executives were asked what they thought the private equity market would look like over the next 12 to 18 months. Below is a chart that shows the respondents’ thoughts.
Interview Results

In addition to the survey results, additional insights came from in-depth follow-up interviews that provided “real world” examples of how companies are responding to the legislation. The following individuals participated in these interviews:

- **Robert R. Scherba, senior vice president, Finance and People Development, Williams International**
  Robert Scherba is senior vice president, Finance and People Development, at Williams International. The privately held, mid-market aerospace company is the world leader in the development, manufacture and support of small gas turbine engines used in business jets, cruise missiles and ground power applications. At Williams, Scherba has responsibility for finance, human resources, information technology, security and integrated business planning. He joined Williams International in 1986 as director, Management Information Systems (MIS); was named vice president, Finance and Administration, in February 1992 and senior vice president in March 2006.

  Scherba is a graduate of the University of Michigan, where he received a degree in industrial engineering in 1970. He received an MBA in finance and accounting from the University of Chicago in 1974.

- **Paul Hennekes, vice president and CFO, Hilltop Basic Resources Inc.**
  Hennekes has more than 21 years of experience in finance and accounting. He began his career in public accounting in 1989 in the Cincinnati office of KPMG, progressing to the level of senior manager. In 1997, he joined a Fortune 500 public company and advanced to the position of director of finance and assistant corporate controller. He joined another large, publicly held corporation in 2000, where he served as vice president, Finance and Administration, for one of its operating businesses. In 2007, he joined privately held Hilltop Basic Resources Inc. as its vice president and CFO.

  Hennekes’ career includes experience with a diverse group of companies, primarily in the manufacturing, construction and service-related industries. He has significant experience in several areas, including operational finance, budgeting and forecasting, banking and treasury, SEC reporting, private equity financing, implementation of financial systems and general accounting.

- **Edward Fensholt, senior vice president, director of Compliance Services, Lockton Companies LLC**
  Fensholt has 26 years of experience as an attorney, with 20 years spent concentrating in the area of ERISA and other aspects of employee benefits law. He has extensive experience regarding compliance issues under the tax code and ERISA with respect to
The one thing that makes life extremely difficult for senior financial executives is uncertainty.

Aside from all the politics and propaganda surrounding this legislation, there is one fact that does remain; everyone is still unsure as to how this whole thing will play out in the coming months and years. That being said, the one thing that makes life extremely difficult for senior financial executives is uncertainty. At this point, many employers are still trying to figure out how the bill will affect their companies.

During the follow-up interviews, financial executives were asked if they thought that sufficient information had been made available regarding the details of the bill. Scherba, SVP at Williams International, said, “Generally, the information is out there,” adding that executives have been “…inundated with information and summaries from benefits consultants.” He said that he does think the material he has seen has been objective and shows the pros and cons of the bill.

Still others think the government could have and should have been more transparent even though the size of the bill (2,400 pages) made it difficult to get all the information out there. Some even suggested perhaps an incremental approach to releasing information about the bill would have been better. This would have allowed people time to digest some information before more information came out. Hennekes, CFO with Hilltop Basic Resources, said, “We just heard a high-level overview and didn’t hear the ‘nitty-gritty’. There wasn’t really any meat on the bones.”
In addition to this, some of the interviewees felt that there was, and still is, a fair amount of misinformation out there surrounding the bill. Fensholt, SVP and director of Compliance Services with Lockton Benefits Group commented that, “It is a very large bill and highly politicized. It’s hard to find an unbiased news outlet covering the bill. We really didn’t see neutral news reporting on health care reform.”

When the health care bill was first introduced, the administration was touting it as a cost-saver. However, the survey results found that the majority of respondents (83%) believed the health care reform bill would either slightly or greatly increase their company’s insurance costs. According to the anonymous chief portfolio strategist interviewed for the report, “The bill was sold originally as a cost-saver aimed at ‘bending the cost curve.’ However, eventually the government realized this wouldn’t happen and backed away from this goal. It was a classic bait-and-switch.”

Still others felt the bill really doesn’t address the underlying costs of health care and therefore couldn’t really produce cost savings. It mainly addresses health coverage, not that that’s necessarily a bad thing. “Expanding care to cover more people is a good idea but this will affect the supply/demand equation and could raise costs in the short run until this imbalance is corrected,” said Scherba. “I don’t believe a ‘government watchdog’ to keep costs constrained is the right approach to solve this problem.”

Many of the interviewees stated that private industry is probably better at reducing costs and that less government would help their cause. As Fensholt said, “The mantra of ‘reduce costs’ was the politicians’ …which makes it suspect. By now most employers realize they have a much wider class of people they must cover and they must supply enhanced benefits. More covered lives, enhanced benefits, increased risk—of course costs are going to go up.”

Since both practicing financial executives and benefit consultants were interviewed for this report, it became fairly obvious early on that the consultants had read the entire bill, and the practicing executives had read summary literature. This makes perfect sense given the time constraints of most senior financial executives. That said, one consultant did suggest that if the company has lawyers, those lawyers should have read the bill in its entirety. In the case of small and mid-sized companies (who may not have lawyers on staff), it is important to have someone at the company, be it an HR person or the benefits manager, who has read the entire bill and have them give training to the key employees of the company. As this consultant said, “The reality is companies would rather sit through a training session or Webinar than to actually have to read 2,000-plus pages of legislation themselves.”

Although most senior financial executives have relied on summaries, still others have members of their staff that have read the entire bill or at least most of it. For the practicing senior financial executives, consultant literature and summaries are the way to go with this legislation. As Scherba said, “There is still much ambiguity in the bill; you really need summaries to help fill in the gaps. Consultants are doing a good job in this regard and looking for that ‘ah ha!’ in new regulations as they are issued.”

Hennekes said, “I’ve read summaries and outside brokerage literature but still have more to learn.” He also brought up a very good point for all executives to keep in mind about “…trying to communicate with employees so they can make more informed medical decisions.” His point gets at the underlying issue of having enough of the correct information to make informed decisions. This seems to be the Catch-22; with all this information, it is difficult for executives and their employees to sift through it to find the truth.
One of the more interesting results of the survey was the fact that a majority (65%) responded that they do not support a single-payer public insurance option. However, if one were available, many respondents (72%) would either drop coverage for all employees or allow their employees to decide if they wanted to drop coverage. So we asked interviewees, given this scenario, why is there little support for a single-payer option?

For many it simply came down to trust (or lack thereof). One of the consultants interviewed pointed out that, “Companies use health insurance to attract and retain certain types of employees. Here again, the single-payer option would eliminate this advantage.”

Fensholt touched on a similar issue: “I think the notion of a government-run health care program for everyone frightens people who have good group insurance today. People that have good insurance already see themselves as the losers with a public option, while those that have no insurance or poor insurance see themselves as the winners.”

All the interviewees said they see private industry as the best way to promote competition and reduce costs. Scherba said, “I think this would ultimately become another entitlement program. Health care should be consumer-driven, not government-driven.” Hennekes agreed that competition is a better way to reduce costs. He said, “With a single-payer option, it puts control in the government’s hands and gives me and our employees fewer choices and less ability to choose health care as we see fit. I have no comfort that the costs would be reduced with a government option, or even with many of the other provisions of the current health care reform bill.”

So how might all the potential changes on the health care horizon effect M&A and private equity activity for businesses? From the practitioners’ perspective, it won’t affect it much. They thought the legislation might have only minor effects and that perhaps there would be a modest increase in activity over the next 12 months or so. As Scherba pointed out, “When acquiring a company, you always look at health care as part of the due diligence.” Hennekes said, “Uncertainty (more so than health care) will cause M&A to remain modest in the near term. While health care won’t cause significant increases or decreases in M&A activity, I think it will be a contributing factor.” Additionally he pointed to the fact that banks and financial institutions remain cautious. However he added, “…plenty of companies are going to be well positioned (i.e. companies with excess cash or access to loans/other capital) to acquire businesses at lower or depressed prices. That being said, some companies could be forced to sell to ease the impact of rising regulatory costs mandated by the government, including increased health care burden/costs.”

The consultants all agreed with one statement: “There will be a ‘mixing of the pot’ with companies looking to sell (perhaps distressed sales) and companies looking to buy at a deep discount.”

Fensholt believes there are “significant implications. Companies must model the impact of health care reform. Are their targets still a good target?” Another consultant said that health care reform would “…serve as an impetus to squeeze the middle even more. Companies that are close to the 50-employee threshold may look to sell for economies of scale.” Scherba agreed with that point. “It does make sense that it could affect acquisitions of very small companies. Some companies could buy others out at a discount and others may sell as a result of the 50-employee threshold.”
Given all the uncertainty, what are senior financial executives doing now and what should they be doing?

According to Fensholt, “Make the immediate changes that are required by law; expanding scope of dependent coverage, for example.” He also suggests that where possible, “…shift more costs to employees. Reduce the value of the plan; increase deductibles.”

Some companies have already heeded this advice.

Hennekes said, “We have raised deductibles on our plans, increased doctor co-pays, prescription co-pays and made similar changes to our plans. However, many of these changes were implemented prior to passage of the health care reform bill.” He also said “…additional changes could happen but that really depends on how this whole thing (the health care reform bill) plays out.”

Still, some companies have not made any changes yet.

Scherba said, “In the short-term, we are not making any significant changes. We probably will need to increase premiums and possibly deductibles.” While much of the companies’ focus is on reducing costs, Fensholt said that he reminds his clients, “Continue to try to reduce the growth in health care costs with wellness programs and things of that nature. Maybe if we reduce the demand for care, we will see a decrease in costs.”

While some action is required by senior financial executives, one of the consultants pointed out, “Do not take any dramatic actions. You don’t want to lose any grandfathered status. That’s the first step.” Fensholt said, “The first thing companies must know is what the bill requires them to do now and in 2014. Don’t wait; prepare now. This could seriously affect long-term strategy and profitability.” He suggested companies “…model the bill’s implications and then put a strategy in place.” Scherba said, “A strong communication plan is key. When we moved to a consumer-driven health care plan, we thought we were very thorough but there were still some surprises. We think we understand what we need going into 2014; we have a plan with steps that allow us to change course along the way if need be.” He also thought that for senior financial executives, “The talk now is about what we should be doing and not what is in this thing, which is good.” However, Hennekes drove home the most important point. He said, “The best advice is to be proactive. Have a plan for the changes in health care. We (financial executives) must be open with our employees and get in front of them to explain things and keep them informed.”
Conclusion

Regardless of the outcome of the November 2010 mid-term elections, one thing is certain: Change has come to health care in the U.S. What that exact change will be remains to be seen. This uncertainty can wreak havoc on senior financial executives and their businesses.

According to Edward Fensholt of Lockton Companies LLC, “Concerns vary dramatically based on the size, industry and culture of the company. Some may consider dropping insurance coverage; re-configuring their workforces to hire fewer full-time and more part-time employees, and even taking business overseas as a result” of the legislation. For his clients, the issue is cost of insurance versus the cost of penalties. The results of the survey and interviews should assist senior financial executives by providing them with a barometer to gauge their organization’s response. While there are many interesting points from both the survey and interviews, the key takeaways from each are presented below.

Survey takeaways:

- 83% of survey respondents believe the health care reform bill will either slightly or greatly increase their company’s insurance costs.
- More than half (64%) believe that small business will be more adversely or far more adversely affected by the health care reform bill than will larger companies.
- During the recent recession, 46% of the companies surveyed increased the dollar amount employees contribute to their health care program.
- 58% of respondents believe the health care reform bill will have little to no effect on private equity transactions over the next 12 to 18 months.
- Almost three-quarters (72%) of respondents have read consultant’s literature to educate themselves about the provisions of the legislation.

Interview takeaways:

- Companies should not make any dramatic changes but rather plan to the best of their abilities. Don’t wait; prepare now.
- It is extremely important for senior financial executives to be proactive and open with their employees and keep them informed.
- Concerns vary dramatically based on company size, industry and culture.
- Interviewees see private industry as the best way to promote competition and reduce costs.
- Companies should try to continue to reduce their employees’ demand for care, and consequently, the growth in health care costs, with wellness programs or something similar.
Appendix: Timeline of Changes

With so many changes coming over in the next year and continuing over the next eight years, senior financial executives need to not only know the changes but when these changes will go into effect. Below is a summary of the health care legislation provisions broken down by the year the provision goes into effect. This summary is for informational purposes only and does not represent a complete list of the legislation’s provisions.

Summary of 2010 – 2011 Changes

- Children under the age of 19 with pre-existing conditions cannot be denied health coverage for those conditions (effective for health plan years beginning on or after Sept. 23, 2010 for new plans and existing group plans).

- Adults who were previously denied insurance due to pre-existing conditions can no longer be denied health coverage for those conditions (effective for health plan years beginning on or after Sept. 23, 2010).

- Health plans cannot retroactively cancel coverage except in the case of fraud (effective for health plan years beginning on or after Sept. 23, 2010). In the past, insurance companies could search for an error or other technical discrepancy and use this to deny payment for services.

- Lifetime dollar maximums for coverage are eliminated on essential benefits (effective for health plan years beginning on or after Sept. 23, 2010). Lifetime caps limit how much a patient can receive for coverage during their entire life.

- Annual dollar limits are being removed on certain plans. Insurance companies’ use of annual dollar limits on the amount of insurance coverage a patient may receive will be restricted for new individual plans and all group plans (effective for health plan years beginning on or after Sept. 23, 2010).

- Consumers are now provided with a way to appeal coverage determination or claims to an independent review organization outside their insurance companies or employers (effective for new plans beginning on or after Sept. 23, 2010).

- An easy-to-use website where consumers can compare health insurance coverage options and pick the coverage that works for them will be created as a result of the bill (effective July 1, 2010).

- Up to 4 million small businesses are eligible for tax credits to help them provide health insurance benefits to their employees. The first phase of the provisions provides tax credits up to 35% of the employer’s contribution to employees’ insurance. Small nonprofit organizations can receive up to a 25% credit (effective now).

- All new plans (and other plans that lose “grandfathered” status) must cover certain preventive services such as mammograms and colonoscopies without charging co-payments, co-insurance or deductibles (effective for health plan years beginning on or after Sept. 23, 2010).

- For the estimated 4 million seniors who will reach the Medicare prescription “donut hole” this year, each senior will receive a $250 rebate (first checks mailed in June 2010, and will continue monthly throughout 2010 as seniors hit the coverage gap).
Young adults up to age 26 can stay on their parents’ existing group health plan; this right does not apply to “grandfathered” plans in 2014 if the young adult is offered insurance at work (effective for health plan years beginning on or after Sept. 23, 2010).

To preserve employer coverage for early retirees until more affordable coverage is available through the new exchanges by 2014, the legislation creates a new $5 billion program to provide needed financial help for employer-based plans to continue to provide coverage to people who retire between the ages of 55 and 65, as well as their spouses and dependents (applications for employers to participate in this program are available after June 1, 2010).

Summary of Other 2011 Changes

- Seniors who reach the coverage gap in prescription drug benefits will receive a 50% discount when buying Medicare Part D-covered brand-name prescription drugs. Over the next 10 years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed by 2020 (effective Jan. 1, 2011).

- Provide certain free preventative services, such as annual wellness visits and personalized preventative plans for seniors on Medicare (effective Jan. 1, 2011).

- To ensure premium dollars are spent primarily on health care, the bill generally requires at least 85% of all premium dollars collected by insurance companies for large employer plans to be spent on health care services and health care quality improvements. For plans sold to individuals and small employers, at least 80% of premiums must be spent on benefits and quality improvements. If these goals are not met, insurance companies must provide rebates to consumers (the rebate program will begin Jan. 1, 2011).

- Currently Medicare pays Medicare Advantage insurance companies on average more than $1,000 more per person than is spent per person in traditional Medicare. The result is increased premiums for all Medicare beneficiaries, including the 77% of beneficiaries who are not currently enrolled in a Medicare Advantage plan. For those people enrolled in a Medicare Advantage plan, they will still receive all guaranteed Medicare benefits, and the bill provides bonus payments to Medicare Advantage plans that provide high quality care (effective Jan. 1, 2011).

Summary of Other 2011 Changes

- The legislation establishes a Value-Based Purchasing program (VBP) for hospitals in traditional Medicare. This program offers financial incentives to hospitals to improve the quality of care. Beginning with measures relating to heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients’ perception of care, hospitals will be required to publicly report performance (effective for payments for discharges occurring on or after Oct. 1, 2012).

- Provides incentives for physicians to join together and form Accountable Care Organizations (ACOs). These groups allow doctors to better coordinate patient care and improve its quality; help prevent disease and illness, and reduce unnecessary hospital admissions. If ACOs provide high quality care and reduce costs to the health care system, they can keep some of the money that they have helped save (effective Jan. 1, 2012).
The legislation will help to institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and most importantly, improve the quality of care (effective Oct. 1, 2012).

To better understand and reduce persistent health disparities, the bill requires any ongoing or new Federal health programs to collect and report racial, ethnic and language data. The Secretary of Health and Human Services will use this data to help identify and reduce disparities (effective March 2012).

Summary of 2013 Changes

- To expand the number of Americans receiving preventive care, the bill provides new funding for state Medicaid programs that choose to cover preventive services for patients at little or no cost (effective Jan. 1, 2013).

- The law creates a national pilot program to encourage hospitals, doctors and other providers to work together to improve the coordination and quality of patient care. Under payment “bundling,” hospitals, doctors and providers are paid a flat rate for an episode of care rather than the current fragmented system where each service or test or bundles of items or services are billed separately to Medicare. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program (effective no later than Jan. 1, 2013).

- As Medicaid programs and providers prepare to cover more patients in 2014, the legislation requires states to pay primary care physicians no less than 100% of Medicare payment rates in 2013 and 2014 for primary care services. This increase will be fully funded by the federal government (effective Jan. 1, 2013).

- Under the new law, states will receive two more years of funding to continue coverage for children not eligible for Medicaid (effective Oct. 1, 2013).

Summary of 2014 Changes

- The bill implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because of an individual’s pre-existing conditions. Also, in the individual and small group market, the law eliminates the ability of insurance companies to charge higher rates due to gender or health status (effective Jan. 1, 2014).

- Prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may receive (effective Jan. 1, 2014).

- Insurers are prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial. This applies to all clinical trials that treat cancer or other life-threatening diseases (effective Jan. 1, 2014).

- Tax credits to make it easier for the middle class to afford insurance will become available for people with incomes above 133% and below 400% of the FPL ($43,000 for an individual or $88,000 for a family of four in 2010) who are not eligible for or offered other affordable coverage. These individuals may also qualify for reduced co-payments, co-insurance or deductibles (effective Jan. 1, 2014).
Starting in 2014, if an employer does not offer insurance, employees will be able to buy insurance directly in an exchange—a new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges will offer individuals a choice of health plans that meet certain benefits and cost standards (effective Jan. 1, 2014).

In the second phase of the small business tax credit for qualified small businesses and small nonprofit organizations, the credit is up to 50% of the employer’s contribution to provide health insurance for employees. There is also up to a 35% credit for small nonprofit organizations (effective Jan. 1, 2014).

Americans who earn less than 133% of the FPL (approximately $14,000 for an individual and $29,000 for a family of four) will be eligible to enroll in Medicaid. States will receive 100% federal funding for the first three years to support this expanded coverage, phasing to 90% federal funding in subsequent years (effective Jan. 1, 2014).

Most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption (effective Jan. 1, 2014).

Employees meeting certain requirements who cannot afford the coverage provided by their employer may take whatever funds their employer might have contributed to their insurance and use these resources to help purchase a more affordable plan in the new health insurance exchanges (effective Jan. 1, 2014).

Summary of 2015 Changes

- A new provision will link physician payments to the quality of care they provide. Payments to physicians will be modified so that those who provide higher value care will receive higher payments than those who provide lower quality care (effective Jan. 1, 2015).

Summary of 2018 Changes

- All plans must provide preventative care without co-payments, co-insurance or deductibles.

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Health Care Reform
and its Effect on Corporate America

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