LOCKTON COMPANIES, LLC TESTIMONY

HEARING ON

"THE PRESSURES OF RISING COSTS ON EMPLOYER PROVIDED HEALTH CARE"

COMMITTEE ON EDUCATION AND THE WORKFORCE

UNITED STATES HOUSE OF REPRESENTATIVES

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Mr. Chairman, Ranking Member Miller and honored members of the Committee, my name is Michael Brewer and I am the president of Lockton Benefit Group, the employee benefits consulting division of Lockton Companies, LLC. On behalf of Lockton I thank you for the opportunity to appear here today to share our views regarding the impact of the new health reform law on the group health plans sponsored by our clients.

Lockton is the largest privately-held insurance brokerage and consulting firm in the world. Domestically, Lockton employs 2,300 employees in 24 offices nationwide who serve the insurance risk needs of approximately 9,000 employer clients from coast to coast. Lockton Benefit Group ("LBG") provides employee benefits brokerage and consulting services to approximately 2,500 of those clients. Nearly all of those clients employ us to assist in the design and administration of their group health insurance programs.

The vast majority of LBG clients are "middle market" employers, employing between 500 and 2,000 employees, although we also have some small-group and "jumbo" clients. Our clients include private and governmental employers, and employers across many industry segments, including construction, health care, 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.

Make Employer-Based Coverage Less Expensive and Burdensome

Approximately 160 million Americans receive health insurance today through an employer-sponsored group health plan. Employees of our clients enjoy and appreciate this coverage.

Our clients tell us they have no quarrel with the notion that improvements in the health insurance system are necessary, to improve access to insurance and reduce the cost of health care and, concomitantly, the cost of health insurance. However, they are frustrated that in the effort to achieve these aims the health reform law adds additional expense to their health insurance costs and imposes additional administrative burdens upon them.

In short, our clients find that the health reform law makes what is already a costly and administratively burdensome endeavor—the sponsorship of a simple group health insurance plan—even more expensive and more hassle-prone. Our clients wish that Congress would work to make an employer's provision of health insurance *easier* and *less costly*, rather than more expensive and more burdensome.

Modeling Results

We have modeled for several hundred clients the impact of the health reform law on their group health insurance programs, now and in 2014. As of the date we prepared these comments, our actuaries had aggregated the results from 136 of these modeling reports, and broke out the aggregated results by industry segment. I would like to share some of those results with you today. We will be pleased to supplement these remarks in the coming weeks and months as we continue to add additional modeling results to this aggregated analysis.

Effect of Immediate Benefit Mandates

On average, the health reform law's immediate benefit mandates (for example, the obligation to cover adult children to age 26, the elimination of lifetime dollar maximums, restrictions and ultimate elimination of annual dollar limits, etcetera) add 2.5% to our clients' health insurance costs.

Industries that currently supply more generous health insurance packages—that is, they already cover adult children to age 25, for example, and/or already apply high lifetime maximums, such as $5 million per lifetime—see the smallest increase (.5%).

Firms that supply more modest packages—such as coverage of children to age 22 and/or $1 million lifetime maximums—see the largest percentage increases (3.7%).

Standing alone, expressed as a percentage of total plan costs, these increases may not appear compelling. But the increases—particularly the larger increases—concern our clients, many of whom are already struggling with health insurance inflation well in excess of the rate of inflation generally. For example, an employer whose health insurance costs are trending at 10% without regard to the reform law finds its trend increased to 12.5% (an additional 2.5% increase, on average) on account of the reform law's mandates. If the employer has 2,000 employees and spends $16 million per year on health insurance, the additional cost of the mandates alone is $400,000.

Effect of Limited Waiting Periods (2014)

The health reform law prohibits waiting periods of more than 90 days, beginning in 2014. This mandate has little cost implication for most of our clients, because most do not currently maintain waiting periods in excess of 90 days.

For our clients that have waiting periods in excess of 90 days, the consequences can be more dramatic. For example, a construction firm client with a 6-month waiting period for health coverage experiences a 3.9% cost increase, while another construction firm with a 12-month waiting period experiences a 39.3% cost increase. Our transportation firm clients with 4-month waiting periods experience a 6.4% increase.

Effect of Automatic Enrollment Requirement (2014)

The reform law also requires employers with more than 200 full-time employees to automatically enroll in a health plan those employees who become eligible for coverage but who do not affirmatively enroll. These employees may, however, choose to affirmatively disenroll. The automatic enrollment feature adds 3.8% to our clients' health insurance costs on average, with our governmental clients seeing the smallest increase (1.4%) and our transportation industry clients seeing the largest increase (10%). For one client, a large hospital, our actuaries expect the automatic enrollment feature to add more than $1 million annually to the client's health insurance cost.[1]

Employer "Play or Pay" Mandate (2014) – Impact on Employers

Beginning in 2014, employers with at least 50 full-time equivalent employees must offer their full-time (30+ hours per week) employees "minimum essential coverage." That coverage must be "affordable" to the employee, that is, not cost him or her more than 9.5% of household income.

Where an employer fails to offer this coverage at an affordable cost and the employee instead obtains subsidized coverage in an Insurance Exchange, the employer is subject to a penalty. If the employer continues to offer coverage to *some* employees, the penalty is a nondeductible assessment of $3,000 per year ($250 per month) for every full-time employee who does not receive an offer of qualifying and affordable coverage, and who instead obtains subsidized coverage in an Insurance Exchange.

However, if the employer terminates its group plan and offers coverage to *no* employees, and at least one full-time employee obtains subsidized coverage in an Insurance Exchange, the penalty is $2,000 per year times all the employer's full-time employees.[2]

Across all industry segments in our book of business,[3] clients will have a significant financial incentive to terminate their group coverage once the Insurance Exchanges present employees with another subsidized health insurance option. The vast majority of our clients currently spend far more on health insurance, per employee, than the nondeductible penalty under the "play or pay" mandate. By 2014 this gap will be much larger still.

[1] In modeling the effect of the automatic enrollment provision, we assumed that 75% of employees who are eligible for coverage but have not affirmatively enrolled, and who are automatically enrolled by the employer, will opt out of coverage. These modeling results do not reflect the impact of the automatic enrollment feature on our retail, restaurant, hotel and entertainment industry clients. The modeling results for these clients are described separately, later in this document.

[2] The first 30 such employees are not taken into account in an employer's penalty calculation.

[3] Except retail, hospitality and entertainment employers, whose modeling results are addressed separately.

As a result, were they to terminate their group coverage they would, on average, save an amount equal to **44%** of their projected 2014 health insurance costs. For clients whose health plans tend to be more expensive, savings are larger (84% for our governmental clients, 60% for our hospital clients).

Employer "Play or Pay" Mandate (2014) – Impact on Employees

We also modeled the impact of plan termination on clients' *employees,* were they forced to seek coverage in an Insurance Exchange. On average, to purchase Exchange-based coverage equivalent to the employer's health reform-qualifying coverage, our clients' employees would pay significantly more than they pay for the employer's coverage. This is because our clients typically subsidize a larger portion of employees' health insurance costs than the Exchanges will subsidize, and employees pay their portion of employer-based coverage with pre-tax dollars. Their portion of the cost of Exchange-based coverage will be paid with after-tax dollars.

On average, our clients' employees would pay between 101% and 155% more for Exchange-based coverage (101% assuming the employee is the sole wage earner in the household, 155% assuming there is household income in addition to the employee's salary, thus reducing the size of the subsidy the employee receives in the Exchange).

The more highly paid the employer's workforce, the more significant the expense borne by the employee in the Insurance Exchange (again, because higher household income means smaller subsidies, if any, in the Exchange). For example, employees of our professional service firm clients can expect to pay, for equivalent coverage in an Exchange, 113-148% more than they would pay for employer-based coverage.

This dichotomy has triggered within some employers a conflict between the financial officers, working to hold the line on expenses and increase profitability, and the human resource officers who, as necessary, work to fashion appropriate compensation and benefit structures for employees. Next to wages, health insurance costs are the most onerous component of labor expenses for the vast majority of our clients. By 2014, when the Insurance Exchanges open and present employees with another, largely subsidized option for health insurance coverage, the burden of group health insurance costs on an employer's balance sheet will create tremendous tension within many clients. What clients do then depends on several factors.

Thus far, few clients have told us they definitely intend to terminate group coverage in 2014, when Exchange-based coverage becomes available. Similarly, few clients have told us they definitely intend to *maintain* their group coverage. The majority of our clients tell us they will wait and see. What they will do in 2014 depends on their health insurance costs and budget in 2014, and their perceived need to use a health plan to gain a competitive advantage for labor.

With regard to this latter point, many clients have told us, "We won't be the first to drop coverage, but we won't wait to be third, either."

Our smaller clients will be the first to abandon group coverage. At a recent seminar presentation we made to approximately 200 employers ranging in size from 50 to 150 employees, half told us they intend to exit the group insurance marketplace in 2014.

To the extent the labor market continues to favor the employer in 2014, we expect some of our larger clients—particularly those employing relatively low paid, modestly-skilled hourly workers—to terminate their group health plans.

Retail, Hospitality and Similar Clients Will Eliminate Full-Time Jobs

The modeling results for our clients in the restaurant, retail, hotel and entertainment (e.g., amusement park) industries are more sobering. Most of these clients do not offer group health coverage to all their full-time employees because they cannot afford to do so. A restaurant chain, for example, will typically offer coverage to its corporate staff and restaurant managers. An amusement park will typically offer coverage to its year-round staff, but not to its extended seasonal workforce.

These employers are caught in a "damned if we do, damned if we don't" bind. On average, to comply with the "play or pay" mandate and offer qualifying and affordable coverage to *all* full-time employees, the employer's health insurance costs increase 150%.

Maintaining the status quo—offering coverage to some employees, such as corporate staff, but not rank-and-file employees—can trigger excise tax penalties under the health reform law's nondiscrimination rule, and in any event would trigger $250 per month penalties for every full-time employee not offered coverage and who instead obtains subsidies in an Exchange.

Ironically, if the employer simply terminates its group plan it still pays 56.6% more than it would pay to continue its plan. Although the employer saves a portion of its health insurance spend (it loses the tax deduction on those dollars, and the FICA/FUTA savings on employee pre-tax contributions), it pays a $2,000 per year, nondeductible penalty on *each* of its full-time employees, even those employees on whose behalf the employer is not otherwise incurring a health plan expense.

These clients, and clients like them who employ a large number of full-time, relatively low paid hourly workers who are not receiving an offer of robust health coverage today, tell us they have but one option: eliminate large numbers of full-time positions. By making full-time employees part-time, the employees are removed from the penalty equation.

Other Burdens

Federal law imposes other burdens and counter-productive barriers on group health plan sponsors, burdens that ratchet up the angst, anxiety and frustration of our clients, increase costs to their health plans, and give additional reasons for employers to escape the challenges of group health plan sponsorship the moment they think they can.

For example, under federal law alone, a simple group health plan must make up to ***46*** separate disclosures (to enrollees) and reports (to federal agencies). Nineteen of these disclosures and reports are required under the health reform law.

The disclosures often go to different individuals, at different times, via different means. Some are required annually. Some might be required even more frequently. There are requirements that some be provided in separate documents, or in specific fonts, or be "prominent," or provided in a "culturally and linguistically appropriate manner."

The myriad disclosure and reporting obligations add angst, cost and anxiety to the lives of our clients well in excess of the value that the vast majority of employees place in the bulk of the disclosures.[4]

We supply our clients with detailed "notice calendars," but employers are often compelled to pay third-party vendors to satisfy at least some of the obligations.

As they propose additional disclosure and reporting requirements, federal agencies estimate the relatively modest burden any single disclosure or report imposes on the employer. But there appears to be no effort to consider the *cumulative* burden—in time, money and effort—on the employer for supplying the currently required disclosures and reports.

Congress should endeavor to minimize the administrative burdens employers bear in order to supply group health coverage. Congress should: (1) legislatively streamline the disclosure and reporting obligations on employers, allowing them greater leeway to consolidate disclosures in single documents without existing special rules that require some notices to be more "prominent" than others; (2) synchronize due dates for various disclosures and reports, unless impracticable; (3) allow employers to consolidate multiple government reports in single filings to the extent practicable; and (4) permit employers to post many of the required disclosures in the workplace or on their intranet pages rather than deliver by hand or by mail to employees, most of whom have demonstrated little or no interest in many of the disclosures.

[4] Lockton employees have attended thousands of employee enrollment meetings, and it is not uncommon to find many of these disclosures simply littering the floor afterwards. Most employees are simply not interested. The burden on the employer, in terms of cost and effort, thus outstrips the value most employees place on many of these myriad disclosures.

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 to their health plans, and will cause some of them to eliminate group coverage and full-time jobs. They are perplexed by a federally-imposed reporting and disclosure scheme that has increased substantially under health reform and become far too cumbersome.

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