The rising cost of health care

Health care and its perpetually rising costs have plagued both the public and private arenas for years, and remain on the forefront for elected officials—from the local to the national level. The Michigan Legislature is considering legislation (Senate Bill 7 and House Bill 4572) that would strip away local control over public employee health care and dictate amounts that local governments can spend on health insurance premiums. Meanwhile, provisions from the national health care reform act continue to go into effect—amidst swirling confusion and questions over compliance and applicability.

How does *health care reform impact townships? How did we get into this predicament in the first place? And what* is *an HSA anyway, and do townships need one?*

Schmitz

Murphy

To get some answers, the Michigan Township News *(*MTN*) turned to the experts. The following is a conversation between MTA and two industry leaders in Michigan who agreed to offer their insights, knowledge and expertise with* MTN *readers. Jack Schmitz, who joined Burnham & Flower Insurance Group as benefits manager five years ago, has more than two decades of experience in the insurance realm. Ed Murphy has more than 30 years of benefit consulting experience, and has served as president of Plante Moran Group Benefit Advisors, LLC since 2007.*

1 Why has health insurance become so expensive?

Jack Schmitz: There are several different factors that comprise the perfect storm of health care. First, there are the baby boomers and the aging of the population. There are more than 10,000 Americans retiring daily. As we age, our need for medical services and prescription drugs increases. There are not enough younger people paying into the system to hold costs down. So you have a large group of the mature work force leaving the system and a smaller percentage of younger employees paying into the system—this is increasing health insurance premiums.

Tied into this is an increase in utilization that is linked to chronic conditions. Prescription drug use is up quite a bit. National health care [reform] and compliance requirements are also increasing the rates as well.

Ed Murphy: At risk of sounding like an economist, which I'm not, I'd say, number one is demographics. To pick up on Jack's comments, here's a good visual: There's one person attaining the age 65 every eight seconds in the United States right now. So the demographics indicate that we've got a growing population that's utilizing the care most, so utilization is the second point. More people using more benefits is a key cost driver.

The third point is on the supply side and technology. More people are using the care more frequently because the technology is available to treat things that five, 10, 20, 50 years ago was not even on the radar screen. All combined, costs are going to continue to rise.

2 Why hasn't someone like MTA created a pool to offer lower-priced health insurance to local governments?

Schmitz: I know of several agencies that have tried to create an insurance pool, but it's never worked out because the carriers aren't that excited about the concept. A typical township employs less than 50 people. These individuals are put into a pool with all employers that have less than 50 employees in Michigan, for Blue Cross Blue Shield, for example. If you look at the average age of municipalities versus the average age of the workforce on a whole in Michigan, they are going to have a more mature age—so they are benefitting by being in a younger pool. I think it would be adverse for them to create their own pool that's based on the average age and higher utilization.

Murphy: What it comes down to is this: if you're going to be in a pool, there has got to be enough premium paid to cover claims and expenses of the entire pool. When I talk about claims, it's not only what's paid, but what's incurred, so you have appropriate reserves. The first issue is one of control. It shifts control from the employer, from that particular township, to the pool itself. Typically, that's not something that people want to deal with right off the bat.

Whenever you create a pool, you have winners and losers. You are calibrating the expense of the pool relative to your existing costs. If it's greater, you have no incentive to join the pool. By not joining, you don't create a subsidy that somebody else could use to augment their expenses or drive their expenses down. So you've got conflicting goals and objectives. Nobody wants to be the loser, but the essence of the pool is that there are some who are going to win and some who are going to come up short.

At the end of the day, establishing a pool and making it beneficial must balance governance, control over operations of the plan, winners and losers, and ensuring premiums cost plan expenses.

Schmitz: You might have 500 different townships with 500 different plans. Generally, when you have a pool, there are a certain number of plan designs. Every specific entity has its own plan design and wants to keep it that way, because of collective bargaining agreements, for example. That is another reason that it's difficult to create a pool for medical insurance.

Murphy: That really goes to the control issue. It's got to be a mutually accepted structure and manageable from an overall standpoint. You can't have 31 flavors—you might be able to have three, four or five.

3 Why is the Michigan Legislature considering to preempt local control by putting a cap on the amount that public employers can spend on health care premiums?

Murphy: Everybody understands that there is an economic crisis. There are more expenses than there are dollars, tax revenues have gone down as it relates to operating according to the status quo, and that means there either has to be improved purchasing efficiencies or cutbacks. The simple way is to slim down by saying, "Let's pass a piece of legislation that says you can't spend more than X dollars."

To a certain degree, health care reform actually has that [type of cap] built into its structure, whether people realize it or not. They have the "Cadillac tax," which will go into effect in 2018, so that's a similar type of structure that will say, "We're going to cap the total dollars that are deductible at the employee level in order to control the cost increases going forward." I think in Michigan, that is where some of this comes from. Things are perhaps tougher here, so [legislators say] let's put more economic controls and some sort of ceiling in there and then force people to redesign within that structure.

Schmitz: I think it's more of a political maneuver at this point rather than looking at the whole picture and looking at the total compensation.

4 How do health reimbursement accounts (HRAs), health savings accounts (HSAs) and premium conversion plans work?

Murphy: For the most, an HSA is not a plan, it's an account. An HRA, just like a premium conversion, is a plan. They look ▶

similar; they operate in similar fashions. Unless you, the plan sponsor, prescribe to a certain level of control, the HSA itself is only an account. A premium conversion plan is simply an allowance under the federal tax code, Section 125, to allow an individual to pay for the cost of health care with pre-tax dollars. Under Section 105H, the HRA is an employer-funded vehicle where the employer can put dollars into an individual's account, tax-free. By the way, they are "notional" dollars, so they are only there on demand and it's a ledger sheet accounting for it, which is why it doesn't go to a "plan" level—it's not an employee asset until used. As long as it's used for health care expenses, it's non-taxable.

Unlike an HRA, an HSA can be funded by an employer and/or employee. It is funded with real dollars into an account and is owned entirely by the individual. Unless the employer exercises a significant degree of control over those assets, it's not a plan; it's just an account. But again, it allows an individual to pay for qualified health coverages with pre-tax dollars.

While savings occur because the dollars have never been taxed, the real savings in HRAs and HSAs occur because people say, "These are my dollars. I can use them based on my discretion and I can control the spending." Studies are starting to show that where an individual has more "skin in the game," they become more informed/better purchasers. One of the issues with health care in general is that we've been very ignorant of how health care works, both from a delivery standpoint and a cost standpoint. Most of the plans that use an HRA or HSA impose higher deductibles, which gets the employee involved in the purchasing.

At the end of the day, we know more about purchasing refrigerators, microwaves or automobiles on a cost-effective basis than we do about health care. Until we get educated, we are going to spend more for health care.

Schmitz: With the health reimbursement accounts, the savings come when you go from a "Cadillac-type" plan to one with a higher deductible, so the savings is realized in the premiums. Not all employees are utilizing the plans or hitting deductibles. In townships, we're seeing about 35 percent of employees who hit their deductible. Prior to the last year and a half, carriers were giving a significant discount to go from the Cadillac plan to the higher deductible health reimbursement plans. With that discount, the employer was able to retain most of the savings because they may only need to reimburse 35 percent of the people who were paying into it, thus saving 65 percent of premiums. The carriers have since changed the pricing so it's not as attractive as it was a few years ago.

5 Is it generally better to control costs through having employees assume a greater share of the premiums, or by having employees pay higher co-pays, deductibles and eliminating optional features?

Murphy: Beauty lies in the eye of the beholder. To manage costs, there are two particular elements you need: 1) premium contributions and 2) actual costs of deductibles, co-pays, etc. I'd make that analogous to a flat-tax, which is a premium contribution. In other words, the price of admission to get in the plan is X, whether you consume one iota of health care or not. Then there's the user tax—the deductible or the co-pay—that says that now that I'm consuming health care, I have to contribute a portion of that spent—it's kind of "pay at the pump," from that standpoint. There is no silver bullet on which one is best. It depends on what your culture is, and what your entity wants to deal with from an overall standpoint.

Experts agree: the nation's aging population plays a role in the rising health care costs. Every eight seconds in the U.S., a person reaches age 65. As we age, our need for medical services and prescription drugs increases.

From an underwriting standpoint, there are different points of view of which one is more or less effective at controlling costs. My preference is to have some of both.

Schmitz: From an employer's point of view, they are obviously going to realize the largest savings if everybody is contributing to the premiums. It's important to have some skin in the game, as Ed put it, in terms of deductibles so you realize the true cost of health care—and that's just the tip of the iceberg. They both have a large part in keeping down costs.

6 Given the likelihood of increased premiums, are there programs that townships can implement that will contain costs *(e.g., wellness programs, smoking cessation programs, etc.)*?

Schmitz: It's difficult. Smaller groups' employees are pooled; no direct correlation exists if a wellness or smoking cessation program is present unless you have something like an HRA, where the employer is paying the first large deductible. You might see some savings in that instance. Statistics do show that these types of programs do reduce the amount of claims submitted. But as a smaller employer, townships are not going to see a direct reflection on their premiums.

Murphy: There's not a one-to-one relationship in the smaller-sized accounts, because you're not basing your premiums on your own claims and expense ratios. It's more of an issue of accountability, behavior change and awareness at the individual level. We've been very sheltered and insulated in the whole health care purchasing environment until relatively recently. Until we take off the insulation wrapper and expose ourselves to just how cold it is out there, it won't drive the behavior change that we need.

7 What will be the responsibilities of townships for health insurance once the new federal laws have been fully implemented? What are the timetables for these changes?

Murphy: Full implementation for health care reform, as it is currently in place, is Jan. 1, 2014. States and regions are in the process of developing exchanges where people and organizations can purchase [health care] through the exchange. In the township world, there will be a lot of townships that will be able to purchase health care through the exchange, because generally speaking, the exchanges will be available for [employers with] less than 50 employees. The exchanges have the option to say if they will go up to 100 employees.

Once it comes into play, as currently written, I don't think the employer is going to be able to wash their hands of the whole issue. They still have the issue of does the employer township *want* to be a provider of benefits? Should they? If so, what does the plan look like? Is it going to meet the minimum essential coverage requirements? If it doesn't, there is a higher penalty associated with that, and they have to deal with the penalties.

They can forego the cost of the plan, but they pay a penalty. They are also dealing with, "Where do my employees buy their benefits as cost-effectively as they used to?" So the issue of the total compensation comes back into play. There are a lot of responsibilities that they are going to maintain.

8 What is your interpretation of who will be counted in total full-time employees (FTE) for purposes of health care reform?

Schmitz: Full-time employees are added up by the hours. If you have, for simple math, 40 hours and you have two 20-hour part-time employees, they are averaged to be one full-time employee, similar to how COBRA is doing it. [Burnham & Flower's] interpretation for how paid, on-call firefighters, for example, would work is that they are eligible for benefits if they are scheduled to work 20 hours a week. If they do not work those 20 hours, they still count because they are *eligible* to be called. It's really determined by if they receive a W-2 form. A lot of things are subject to change, but our interpretation is based on the *eligibility*—a full-time employee is expected to work 40 hours, but he/she might not work 40 hours that week.

Murphy: Under health care reform, for purposes of determining your FTE count, it's a reflection of your employees. If an employee is paid by a 1099 form, I can argue that they are not included in the hours at all. If they are paid by a W-2 form, whether they work two hours or 40 hours, those hours do roll up.

Remember, there is still no requirement in health care reform that an employer offer or provide the coverage—it's an option. However, if coverage is not offered, penalties apply. Or if an employer offers coverage and the plan meets the minimum standards, and an employee buys through an exchange anyway, there is a different, more expensive penalty. So, all of a sudden, the issues start getting much more complex and blurred from an overall management standpoint.

According to the law, it clearly refers to "employees," and I could make an argument that a board member is not an employee. So how do you count those folks? At the end of the day, we're going to need some clarity. There are issues that can have a negative impact from an operations standpoint. I don't think that was contemplated during the writing of the reform act. There are a lot of gray areas.

Schmitz: For board members, our interpretation is the same as for the paid, on-call. There's more clarification that still needs to come out. For board members, we make the argument with carriers every day that they are employees. We've made the argument for years that townships need to get their board members on insurance. You can make the argument either way, and more clarification needs to happen.

9 Effective January 2012, will townships no longer be able to classify employees for purposes of offering health benefits?

Schmitz: This was very common in the private sector when I worked in that sector. Let's say, managers have no deductibles, mid-managers had a $250 deductible and everyone else has a $500 deductible, or the same correlation for premium payments.

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Murphy: It comes down to this: health care reform included, for the first time, non-discrimination requirements as applied to insured programs. Under IRS Bulletin 2011-1, they basically suspended that. So right now, that whole non-discrimination issue is in limbo. That's where you get into the ability of an employer to categorize; this groups gets "A," this group gets "B," this group gets "C." And that's in a fully insured environment.

Self-insured benefit plans have always been subject to non-discrimination testing. There are two basic tests—a benefits eligibility test and a benefit test itself—which are fairly complex. But that's all existing, and it still does not preclude you from setting up groups where there is a discernible difference in benefits, especially when you get into collective bargaining. Collective bargaining supersedes an employer's inability to establish different requirements for different groups. How it's going to shake out in a fully insured world—we'll see when they lift that suspension of IRS 2011-1. Stay tuned.

10 Do you see specific elements of the new federal law that will dramatically impact townships?

Schmitz: The biggest impact is on the different plan designs and a tax on the richer plans, and how that plays out. We're starting to see changes in that. A likely trend moving forward is a move from a defined benefit [plan] to a defined contribution [plan]. I've probably had five or six conversations with different clients about this in the past few months.

Murphy: The employer is viewed as the epicenter of the delivery system for health care. Under health care reform, there's no provision for an individual to buy health care services at the individual level on a pre-tax basis. Given that such a provision doesn't exist, it means that if you want to buy as cost-effectively as you do today, you need to use the employer-based system. So, it stills comes down to if the employer is likely to be driving the benefit plan strategy of "Do I or don't I offer a benefits plan?" If I do, what's the level of coverage? What's my cost-sharing in terms of premium contributions? What is my structure in terms of benefits? How do I educate people to be educated buyers so we don't have double-digit inflation?

At the end of the day, health care is about one-sixth or one-seventh of the [U.S. gross domestic product] and it's headed toward 25 percent of GDP. That's unsustainable. Which road aren't we going to build, which school aren't we going to build, what other government services are no longer going to be provided because those dollars are going toward health care? We've got to get control over [the expense]. ■

—Recorded May 5, 2011, at the MTA office