

Viewpoint: Healthcare Reform

Welcome to the first edition of Equity Risk Partners' Viewpoint: Healthcare Reform, an open dialogue with our clients and partners about the federal healthcare system reform initiative. ERP's intent is to offer Viewpoint updates as frequently as unfolding events require.

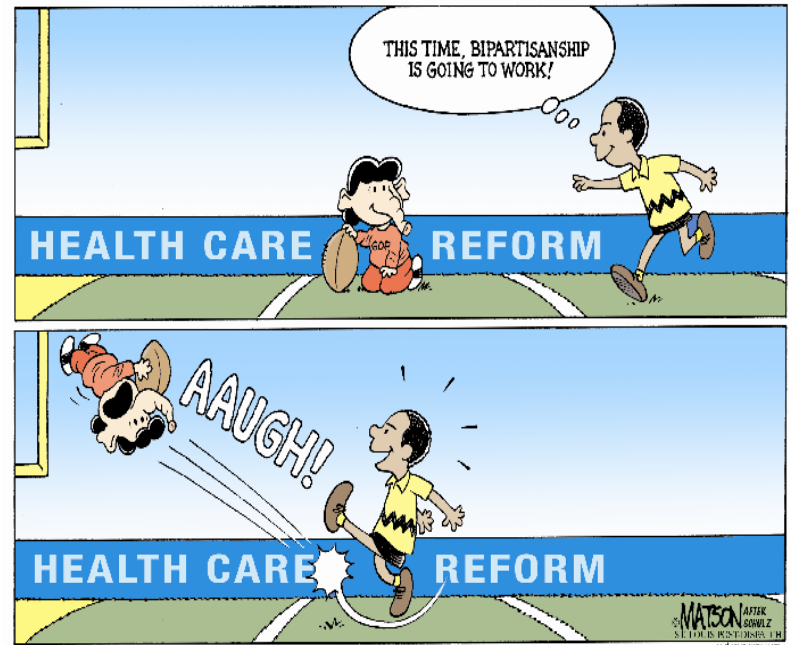
As Congress struggles to satisfy President Obama's pledge to achieve meaningful system reforms, we will focus mainly on the issues that should matter most to employers sponsoring health plans. Those persons, processes and provisions warranting attention, regardless of the political interests they represent, will be the subject of our commentary.

Our initial *Viewpoint* takes a look back at the political turmoil of recent months, leading up to the latest news in the reform bill development process; also included is a grid highlighting some of the key elements of the debate, along with ERP's perspectives on each.

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The U.S. House of Representatives passed its reform bill in November, with relatively modest drama and little fanfare. The vote held tight to party lines, with the Democratic majority's platform dominating most of the bill's key elements. Most notably, a "public option" was included, which would create a government-run competitive program to commercial health insurance. This concept is vehemently opposed by conservatives as both anti-business (suggesting it would put insurers in a severely disadvantaged competitive position) and a thinly veiled step toward single-payer, government-controlled healthcare.

Things got more interesting when the action moved to the U.S. Senate. Following weeks of rancorous debate, including Republican foot-dragging and fear-mongering, but also surprisingly ugly intra-Democratic caucus discord, the Senate version of healthcare reform was approved in an extraordinary Christmas Eve vote. The bill passed by the slimmest of margins; not a single



Republican voted for passage, resoundingly ending any bi-partisan pretense. There was one high-profile nod to pressure from Republicans (moderate Democrats, more precisely) in the final Senate bill - a public option feature similar to the House's bill did not make the cut.



Sen. Ben Nelson (D-NE) was the last Democratic holdout to be seduced so the uniformly negative Republican response could be overcome. Abortion rights provisions included in the draft bill by his more liberal Democratic colleagues prevented Sen. Nelson from signing on earlier. Movement from the left to allow more rigid abortion limitations helped bring Nelson around, but Nebraska's being exempted in perpetuity from Medicaid program expansion costs the bill requires all other states to bear – that seemed to do the trick in "enlightening" him as to the bill's overall merit.

Senate Republicans of course did their best (worst?) to stymie the Democratic majority, ultimately to no avail. Perhaps they could have swayed just one vote needed to derail the Democrats if they expended some of their energy bringing tangible, responsible counterpoints to the floor debate. Sen. Joe Lieberman (Ind-CT) was a top candidate they failed to co-opt. Instead, Republicans incessantly played the doomsday card, portraying the Democratic platform as a ticket to Socialism sure to bankrupt America, without defining a clear alternative - an approach that ultimately helped solidify the fractious Democratic caucus.

The House and Senate versions next have to be merged so a unified bill can be signed into law by President Obama. Healthcare reform is his most critical domestic priority; Mr. Obama's 2008 election campaign centered on it, and he has staked his political future, and potentially his historical legacy, on getting *something* done here where no prior administrations have succeeded.

Evidently, this will come at the expense of another Obama campaign promise – to govern in a changed, more transparent manner. Rather than running the more typical bill reconciliation process that would include conference committees from both houses and political parties publicly debating the issues, Democratic leaders from Congress are meeting as we speak behind closed doors at the White House to hammer out a final healthcare bill. Their hearts' desire is to fast track the process; stifling dissenters from impacting the final outcome and/or swaying public opinion is a mere coincidence. Driving this is the latest arbitrary target; the President's State of the Union address in February sure looks enticing as the place to announce such grand news for maximum political effect.



Sadly, but unsurprisingly, whether this landmark legislation is ultimately in our country's best interests appears to have become a secondary consideration to the associated political gains or losses to be bestowed upon those responsible.

Nonetheless, ERP will continue tackling practical implications of what spits out of the process in subsequent *Viewpoint* updates. Until then, hold out hope our elected officials will somehow find the fortitude to rise above partisan politics to make the inevitable legislation more palatable to the greatest number.

Comparison of Healthcare Reforms Bills as of January 2010

| ISSUE | HOUSE BILL | SENATE BILL | TIMELINE | ERP VIEWPOINT |
|--|---|--|--|---|
| Projected cost for first 10 years: <i>Congressional Budget Office estimate</i> | \$1.05 Trillion | \$871 Billion | 2010 - 2020 | Some funding sources kick in well before program benefits go live; deficit neutrality is easier to achieve when comparing 10 years of funding vs. 6-7 years of costs. Eventual tax increases (individual and corporate) well beyond those initially outlined should be expected. |
| Financing: <i>Funding sources identified to achieve reforms on a "deficit neutral" basis</i> | <ul style="list-style-type: none"> • Medicare program funding cuts. • High income surtax. • Tax on medical devices. • Changes in FSA and HSA tax rules. | <ul style="list-style-type: none"> • Medicare program funding cuts. • Additional Medicare tax on high income. • Industry fees on insurers, drug mfgs and medical device makers. • Changes in FSA and HSA tax rules. • Tax on Cadillac health plans. | <ul style="list-style-type: none"> 2011 House - 2011 Senate - 2013 House - 2013 Senate - 2010 for drug mfgs/2011 for insurers and medical device makers House - 2011 through 2013; Senate - 2011 House - n/a; Senate - 2013 | <ul style="list-style-type: none"> Presumed Medicare efficiency improvements needed to offset funding cuts without cutting benefits are pie-in-the-sky. Such funding cuts will be under constant political fire – expect repeal/adjustment in future Congressional actions. Limiting tax exempt status of FSA/HSA plans will stymie growth of Consumer Directed Health Plans (CDHPs). |

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| Coverage Mandate: Cost and Coverage requirements for Individuals and Employers associated with obligatory health plan participation | <ul style="list-style-type: none"> Individual – those electing no coverage pay 2.5% of income tax/penalty. | <ul style="list-style-type: none"> Individual – those electing no coverage pay greater of 2% of income or \$95 (2014), \$495 (2015), \$750 (2016). | House - 2013; Senate - 2014 through 2016 | Lengthy phase-in at nominal tax penalties expose commercial health plans to adverse risk selection; rates will likely be increased in anticipation given <i>Insurance Market Reforms</i> (see below) restrict insurer ability to otherwise protect rating pools. <i>Note: Constitutionality of requiring citizens to buy health coverage being questioned by AGs of several states.</i> |
| | <ul style="list-style-type: none"> Employer- 8% payroll tax for all employees (FT, PT, temporary) if no coverage is offered; if plan(s) offered, employee contributions can't exceed 27.5% single/ 35% family (pro-rata for non-FT). | <ul style="list-style-type: none"> Employer - \$750 per FT employee fee if no coverage is offered (PT, temporary not included); if plan(s) offered, penalty of \$3K per employee opting out for Exchange plan (to max of \$750/FTE). | House – 2013; Senate - 2014 | |

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| Insurance Market Reforms: <ul style="list-style-type: none"> Require "Guaranteed Issue" coverage Prohibit "Pre-existing Condition" limitations Establish minimum "Medical Cost Ratios" Repeal health insurers' anti-trust exemption | <ul style="list-style-type: none"> Included; phased in. | <ul style="list-style-type: none"> Included; phased in. | House - 2010 to 2013; Senate –2010 to 2014 | This category represents the primary trade-offs Insurance industry made to secure coverage mandate addressed above, which would add millions of insurable lives to market. However, significant premium increases may result in near term (next 6 – 18 months) since the mandate has been watered down and delayed... insurers will try to protect risk pools preemptively from adverse selection likelihood. |
| | <ul style="list-style-type: none"> Included; phased in. | <ul style="list-style-type: none"> Included; phased in. | House - 2010 to 2013; Senate –2010 to 2014 | |
| | <ul style="list-style-type: none"> Included; target 85% loss ratio for health plans (max 15% for overhead balance for health claims). | <ul style="list-style-type: none"> Included; target 85% loss ratio (80% for Individual/Small Group plans). | House – 2010 Senate - 2011 | |
| | <ul style="list-style-type: none"> Included. | <ul style="list-style-type: none"> Not included. | House – 2010 Senate – n/a | |

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| Public Option: <i>US government-run plan to compete with commercial insurers</i> | Included; structured like Federal Employees Health Benefit Program. | Not included. | House – 1/1/2013 Senate – n/a | House Democrats have all but conceded this is dead. Instead, they are trying to secure 2 trade-offs from Senate counterparts/the White House: <ul style="list-style-type: none"> • <i>federally run "Exchange" vs. State level as possible basis for eventual Public Option (see below)</i> • <i>Anti-trust exemption repeal (see above)</i> |
| Insurance "Exchanges": <i>Regulated marketplaces for delivery of individual and small group health plans</i> | Federally administered initially; States could subsequently apply for local control. | State or regionally administered. | House – 1/1/2013 Senate – 1/1/2014 | While targeted initially to facilitate coverage for individuals and small employers, could become "default Public Option" if employers increasingly opt to cease sponsoring plans and pay penalties/fees for Exchange. |
| Benefit Plan Designs: Mandated levels of "actuarial coverage value" | Plans must deliver minimum actuarial value of 70% (coverage of anticipated health expenses). Current employer plans with <70% value can be grandfathered through 1/1/2018. | Plans must deliver minimum actuarial value of 60% (coverage of anticipated health expenses); <i>exception – catastrophic ("Young Invincibles") plan for those under age 30.</i> Current employer plans with <60% value permanently grandfathered. | 2010 | Combined with less favorable tax treatment of CDHPs noted above, this provision could cause their eventual death as a viable employer-sponsored plan alternative ("high deductible health plans", key components of CDHPs, are inherently more likely to have lesser actuarial value). |



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