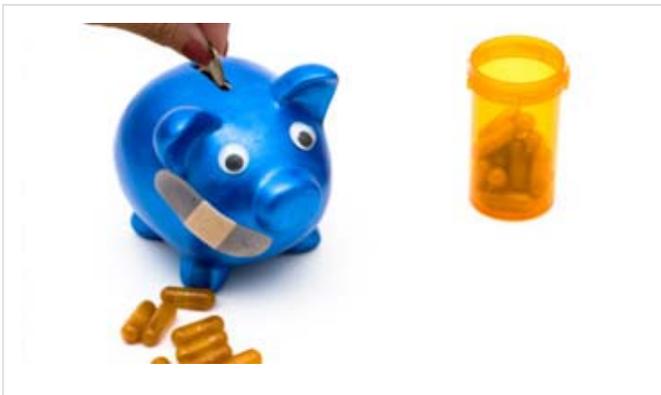


Benefits

CANADA

Will “Obamacare” affect Canadian plan sponsors?

Mike Sullivan | August 02, 2012



Do you think the U.S. healthcare reforms will have an impact on the Canadian healthcare system? [Take our poll.](#)

In late June 2012, the U.S. Supreme Court upheld the constitutionality of much of *The Patient Protection and Affordable Care Act* (PPACA), commonly referred to as “Obamacare.”

The PPACA is the most significant overhaul of the American healthcare system since Medicare and Medicaid were introduced nearly 50 years ago. The legislation is incredibly complicated and highly

politically divisive and will be phased in over many years. But an important question for Canadian plan sponsors to ask is whether or not they are likely to see any impact of PPACA north of the 49th parallel.

The goals of PPACA are noble and hard to argue with; the system overhaul seeks to decrease the number of uninsured Americans and the overall cost of healthcare in the U.S., which spends more on healthcare on a per-capita basis than any other country.

However, where this becomes challenging and complex is that American employers subsidize a significant proportion of healthcare spending in the U.S. This model is unlike what is seen in Canada and a majority of other developed countries, where socialized medicine is at the heart of the healthcare system. A recent *Forbes* magazine article estimated that as much as 60% of American healthcare spending goes through employer-sponsored plans. Therefore, an overhaul as significant as PPACA is going to have major implications for American employers.

There are a handful of aspects to the legislation that will have obvious impacts to the employer stakeholder group in the U.S., including (but not limited to) the following:

For employers with 50 or more employees, all employees must be covered under an employer-sponsored plan. Employers that fail to meet this requirement will be fined \$2,000 per employee. This provision is scheduled to be implemented in January 2014.

Individual employees will also be required to have some form of healthcare insurance or face as much as a \$695 penalty annually. This provision is also scheduled to be implemented in January 2014.

Employers that offer “Cadillac” health plans will face a new 40% excise tax on these plans as of January 2018.

Dependents are allowed to stay covered under their parents’ employer plan until their 26th birthday. This provision is already in place.

Common criticism

The most common criticisms from opponents to the legislation, as it relates to the impact on employers, are that employers may stop providing coverage altogether or that they will make material changes to their existing programs that force the sickest members out of the plan and into newly created health insurance exchanges.

Some have argued that if an employer pays the \$2,000 per employee penalty and assists employees in covering their individual mandate to own insurance (the penalty for employees not owning insurance can reach \$695) that employers would actually be much further ahead financially than they would be continuing to offer healthcare insurance themselves.

As well, employers could make changes to the level of coverage provided and scale back certain components and/or increase out-of-pocket costs to members, which could force high-cost claimants to leave the plan and look for guaranteed coverage through a health insurance exchange.

Finally, as in Canada where we see varying extended health benefits costs from one region to another, employers could end up scaling back healthcare coverage in regions of the U.S. where costs are traditionally much higher (e.g., in the northeast).

Given that some of the key employer-specific provisions are not in force until early 2014, there are a number of things that could happen between now and then to change the unintended consequences, which could include repealing the legislation if Obama is not re-elected. However, one thing is absolutely clear: the cost burden of healthcare to employers in the U.S. is not sustainable, and these costs will be under even greater scrutiny in the coming years.

Possible impacts for Canadian plan sponsors

Given the significant structural differences between the American healthcare system and our socialized healthcare system in Canada, the introduction of all of the elements of PPACA legislation is not likely to have a material impact on a majority of Canadian employers, with the distinct exception of the Canadian subsidiaries or divisions of American parent companies. It would be very difficult to envision an environment whereby American companies would contemplate reducing or eliminating healthcare benefits for employees in the U.S. while they leave generous Canadian benefits plans untouched.

In addition, the evolution of PPACA in the U.S. would likely lead to more significant and rigorous managed care initiatives, especially within the realm of prescription drugs. Employer-sponsored prescription drug plan benefits in the U.S. are dominated by vertically integrated pharmacy benefit managers, which, for years, have overseen managed care initiatives such as tiered formularies, preferred provider networks and chronic disease management programs.

However, it is realistic to think even greater cost-containment initiatives are coming. There has been more focus on the "value" concept in the American healthcare environment in recent years, but there could be even greater pressure now to contain costs, possibly at the expense of value-based plan designs. That focus on even more rigorous cost containment could spill over to Canadian divisions of American parent companies.

Considerations for Canadian employers

It will be important for Canadian employers that could be impacted by U.S. parent companies or American-based strategic partners to focus on quantifying the return on their investment in extended healthcare benefits. There will undoubtedly be more scrutiny on their healthcare spending in Canada than ever before. To the extent this spending is seen solely as an *expense*, steps will be taken that focus almost uniquely on containing costs. If, on the other hand, this spending is seen as an *investment* with quantifiable returns, there is less likelihood that Canadian plans will be adversely impacted.

Some suggestions for measuring returns include the following:

Using transactional-level drug claims data to engineer comprehensive employee health and disease state profiles and baseline numbers, and assess recent trends within that profile measured against the baseline.

Assessing the saturation rate of age-related chronic conditions and future exposure to specialty drug growth as a means of predicting plan cost increases over the next 36 months, preparing the plan for expected organic growth and assessing the effectiveness of current risk management and plan design provisions.

Integrating disability and absence data (where available) with transactional-level drug claims data and adherence scores to calculate baseline measures, assess leading indicators for absence and disability, and measure the returns of improved health outcomes on overall plan costs.

Quantifying the current effectiveness of the existing plan design and what modifications can be made to allow for cost-neutral reinvestment in the plan with enhanced, and measurable, outcomes that do not erode employee benefits.

Clearly, these are opportunities that any employer can take advantage of to improve its plan's performance, assess opportunities to increase value for the money invested in health benefits, and measure the impact of improved returns on the business to secure continued investment. Should PPACA continue to evolve in the U.S., there may be greater pressure of Canadian companies to demonstrate the returns they are seeing from investments in this area in order to ensure the sustainability of their plans.

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