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Bending the Cost Curve: Will Health Care Reform Rein in Health Care Spending?

By Mark Warshawsky

One of the main stated motivations for health care reform is "bending the cost curve" — reducing the high rate of growth of total U.S. health care spending.[1] Advocates of reform, including President Obama and top officials in his administration, cited the necessity of reducing or even eliminating the government's large projected long-run fiscal deficits, financing coverage for the uninsured, improving the efficiency and competitiveness of the American economy, raising standards of living for workers and retirees, and reducing wasteful and even harmful spending.

Many of the provisions in the Patient Protection and Affordable Care Act of 2010 (PPACA) passed in March 2010 aim to reduce future growth rates of health care spending. Most apply directly to Medicare, some to Medicaid and other federal programs, and some to employer plans, but others are even broader in scope. At the same time, the expansion of health insurance coverage — in terms of both numbers of people and benefits provided — is certain to increase spending and likely push prices upward. Opinions differ as to the net effect on the rate of health care spending, in both the near and the long term. This article reviews the range of opinion and estimates by government and academic experts. We evaluate and weigh this information and then consider the economic and political consequences of the likely outcomes.

Stated motivations for reform

In his September 9, 2009, remarks to Congress on health care, President Obama stated:

> Then there's the problem of rising cost. We spend one and a half times more per person on health care than any other country, but we aren't any healthier for it. This is one of the reasons that insurance premiums have gone up three times faster than wages. It's why so many employers — especially small businesses — are forcing their employees to pay more for insurance, or are dropping their coverage entirely. It's why so many aspiring entrepreneurs cannot afford to open a business in the first place, and why American businesses that compete internationally — like our automakers — are at a huge disadvantage. …
>
> Finally, our health care system is placing an unsustainable burden on taxpayers. When health care costs grow at the rate they have, it puts greater pressure on programs like Medicare and Medicaid. If we do nothing to slow these skyrocketing costs, we will eventually be spending more on Medicare and Medicaid than every other government program combined. Put simply, our health care problem is our deficit problem. Nothing else even comes close. Nothing else.
>
> …
>
> Second, we've estimated that most of this plan can be paid for by finding savings within the existing health care system, a system that is currently full of waste and abuse. Right now, too much of the hard-earned

[1] The cost curve as it appears on a graph of the rapid increase in spending on health care as a share of national income plotted over the past 50 or so years.

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Insider

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> savings and tax dollars we spend on health care doesn't make us any healthier. That's not my judgment — it's the judgment of professionals across this country. …

Soon after the passage of health care reform, presidential advisors Peter Orszag and Ezekiel Emanuel wrote:[2]

> The Affordable Care Act (ACA) not only will extend health care coverage to millions of Americans but also will enact many policies specifically aimed at reducing the amount we are spending on health care and, by changing the delivery system, reducing the rate of growth in health care costs over time. Indeed, one of the essential aspects of the legislation is that unlike previous efforts, it does not rely on just one policy for effective cost control. Instead, it puts into place virtually every cost-control reform proposed by physicians, economists and health policy experts and includes the means for these reforms to be assessed quickly and scaled up if they're successful. By enacting a broad portfolio of changes, the ACA provides the best assurance that effective change will occur. …

About the same time, David Cutler, academic advisor to the Obama administration on health care, wrote:[3]

> The cost of health care is a perennial policy concern. It took center stage in the divisive national debate that culminated in the enactment of the Patient Protection and Affordable Care Act of 2010. By and large, the discussion of national health reform focused on whether new revenues and spending cuts called for in the legislation would be sufficient to offset the costs of near-universal coverage in the first decade after reform.
>
> However, whether reform is successful over the long haul will be determined almost exclusively by its impact on health care spending beyond the first decade. If reform can successfully "bend the cost curve" over the longer run, coverage will be affordable and the federal budget will be close to balanced. However, if health care spending growth is not reduced, it will be very difficult for the federal government, state governments, employers and individuals to keep the spending commitments made in the health reform act.
>
> …
>
> The central question is how much savings might be realized, and whether the Patient Protection and Affordable Care Act provides the tools for realizing the savings. I believe it does. …

Taken together, these statements and writings set out the essential motivations and assertions of the proponents of the health care reform legislation on its ability to reduce the rate of growth of national health care spending and on the critical importance of doing so.

Reform provisions: cost control versus higher spending

We start by listing most of the main cost-control provisions of the health care reform legislation and indicating their focus — Medicare, employer plans, hospitals and so on. We then list the primary provisions of the reform law that increase spending on health care and may raise price pressures. The effective dates of these provisions range generally from 2010 to 2018, with a predominant implementation in 2014.

[2] Peter R. Orszag and Ezekiel J. Emanuel, "Health Care Reform and Cost Control," *New England Journal of Medicine,* 2010.

[3] David Cutler, "How Health Care Reform Must Bend the Cost Curve," *Health Affairs*, 29:6, June 2010, p. 1131.

Cost containment provisions

1. Create a Center for Medicare and Medicaid Innovation (CMI) to test payment and delivery models while preserving or enhancing quality of care under Medicare, Medicaid and the Children's Health Insurance Program (CHIP). The initial emphasis will be on populations with poor clinical outcomes and high spending, and on improving coordination, quality and efficiency. The secretary of Health and Human Services (HHS) can expand these demonstration projects nationwide if the Centers for Medicare and Medicaid Services (CMS) actuary determines they can reduce spending.
2. Have Medicare recognize groups of providers and suppliers who meet certain quality criteria as accountable care organizations (ACOs). ACOs can share in cost savings they achieve for Medicare, even receiving bonuses if the savings are large enough. This program will also be available to pediatric medical groups under Medicaid.
3. Test an alternative payment methodology for Medicare nationwide in a voluntary pilot program to incent providers to coordinate patient care across the continuum and to manage all care associated with a hospitalization. Similarly, create demonstration projects under Medicaid to pay bundled payments for episodes of care that include hospitalizations.
4. Establish other programs to encourage providers and plans to provide more efficient care for certain chronically ill and high-risk Medicare and Medicaid populations.
5. Establish an Independent Payment Advisory Board to submit proposals to reduce Medicare spending if projected growth rates in Medicare spending per beneficiary exceed target growth rates specified in the law. The board's proposals take effect automatically unless Congress passes an alternative that achieves the same level of savings. But proposals cannot ration care, raise taxes or Part B premiums, or change benefits, eligibility or cost-sharing standards; and generally they cannot affect inpatient hospital and hospice care or diagnostic lab tests.
6. Reduce Medicare payments to home health providers. More significantly, Medicare payments to all providers (except physicians, who are governed by different payment rules) will be adjusted by the percentage change in the 10-year moving average of annual private nonfarm business multifactor productivity. The Medicare trustees expect a 1.1% annual reduction. The phased-in adjustment varies by type of provider from 2010 through 2019, and will apply fully and equally thereafter.
7. Reduce Medicare Advantage (MA) plan benchmarks for payment to roughly the cost of fee-for-service Medicare services — more for low-cost counties and less for high-cost counties. High-quality MA plans get a bonus in their benchmark, while rebates to plans bidding less than the benchmark are generally lowered and are further modified for plan quality and certain coding practices. Plans with low medical loss ratios must remit partial payments to Medicare, and plans with consistently low ratios will be barred entirely.
8. Shorten the period for submitting Medicare claims. Physicians ordering durable medical equipment (DME) or home health services must be enrolled in Medicare, and face-to-face encounters with patients are required for such orders.
9. Adjust Medicare hospital payments based on performance under a value-based purchasing program. These incentives will be funded from the base operating diagnostic-related group payments. The law also reduces payments to acute care hospitals whose rates of hospital-acquired conditions are in the top quartile and those with high readmission rates. Disproportionate share hospital payments will be reduced significantly, although hospitals dispensing significant amounts of uncompensated care will receive bonuses.
10. Pay Medicare bonuses to physicians who report quality measures and impose penalties on those who do not.
11. Reduce Medicare payments for magnetic resonance imaging and bone density tests and expand competitive bidding for DME.
12. Create an annual wellness visit benefit for Medicare beneficiaries, and eliminate cost-sharing for certain preventive services recommended by the U.S. Preventive Services Task Force (USPSTF). The law blocks payments for preventive services discouraged by the USPSTF, however, and restricts Medicare reimbursement for certain mental health services.
13. Increase the Medicaid drug rebate (to governments from drug manufacturers) percentage for brand-name drugs.
14. Require the disclosure of financial relationships between health entities, such as physicians, hospitals, pharmacists, and manufacturers of drugs and devices.
15. Support comparative effectiveness research by establishing a nonprofit Patient-Centered

"Many of the provisions in the PPACA aim to reduce future growth rates of health care spending."

Outcomes Research Institute to compare the clinical effectiveness of medical treatments. Findings from this research, however, cannot be used to deny coverage or be construed as a guideline.

16. Award demonstration grants to states to develop alternatives to current medical tort litigation.
17. Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status, electronic fund transfers and health care payments, health claims and similar processes.
18. Increase the threshold for itemized deductions for unreimbursed medical expenses from 7.5% to 10% of adjusted gross income. Limit annual contributions to a flexible spending account for medical expenses to $2,500.
19. Structure the new health insurance exchanges established by the states for the individual and small group markets to encourage competition among health plans based on price rather than on risk selection and benefit design. This will presumably occur through standardized plans negotiating lower prices from providers, new approaches to eliminate unnecessary utilization and reductions in administrative costs. The framework here, sometimes called managed competition, assumes participants will choose low-cost plans because their government subsidy (discussed below) is fixed. It also assumes competing insurers will cut costs and therefore lower prices.
20. Impose a 40% excise tax on employer-sponsored health plans to the extent the value exceeds $10,200 for individuals and $27,500 for family coverage, as indexed, effective in 2018. The threshold amounts are somewhat higher for 55- to 64-year-old retirees, and for "high-risk" professions and firms with older workforces. The tax penalty is intended to motivate employers to encourage their employees to choose high-deductible-and-co-pay health plans, such as account-based health plans (ABHPs), perhaps with limited provider choice. These plans, in turn, will encourage participants to make more cost-effective choices of health care goods and services. Alternatively, health maintenance organizations might make a comeback.

"The expansion of health insurance coverage — in terms of both numbers of people and benefits provided — is certain to increase spending and likely push prices upward."

Provisions leading to higher total spending and price pressures

1. The law requires most U.S. residents to maintain "essential health benefits." Those who don't will be subject to a tax penalty. Employers must pay penalties for full-time employees who receive tax credits (described immediately below) for health insurance through an exchange, with exceptions for small employers. Employers with more than 200 employees must automatically enroll eligible workers in their group health plans, with an opt-out right for employees. The government will provide a tax credit to small employers with low-income workforces that provide health insurance.
2. The federal government will provide premium tax credits on a sliding scale for those with incomes below 400% of the federal poverty level (currently $22,050 for a family of four). The premium credits will be tied to the second-lowest-cost "silver" plan in the geographical area, thereby limiting premium contributions from the insured to certain percentages of income for this level of benefits. (Plans are designated bronze, silver, gold and platinum, in increasing order of generosity of benefits, lower cost-sharing and higher premium costs.) But, beginning in 2019, if aggregate premium credits and cost-sharing subsidies exceed a certain percentage of national income, the change in premium credits is limited to the change in the Consumer Price Index. An employee whose employer offers coverage is eligible for a premium tax credit through an exchange if the group health plan does not pay at least 60% of covered benefit costs or if the employee's share of the premium exceeds 9.5% of her income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the United States will be eligible for premium credits. The government will also provide cost-sharing subsidies through the exchange to eligible individuals and families with incomes below 400% of the poverty level.
3. Health care reform expands Medicaid to cover everyone under age 65 with incomes up to 138% of the poverty level.
4. Insured employer plans will become subject to nondiscrimination requirements.
5. All plans must offer coverage to adult children up to age 26, comply with restrictions on annual and lifetime benefit limits, and eliminate pre-existing condition exclusions. Waiting periods for eligibility may not exceed 90 days, and rescission of coverage is not allowed, except in cases of fraud or intentional misrepresentation.
6. All plans, except grandfathered employer-sponsored plans, must provide preventive care services without cost sharing. They must also make "effective" internal and external appeals processes available, eliminate any restrictions or limitations on emergency care, and include guarantee issue and renewability. Most plans

must also offer at least the essential benefits package and limit premium ratings.

7. Pharmaceutical, manufacturing and health insurance companies must pay substantial annual fees to the government. In a competitive market, these fees are eventually passed to buyers, according to economic models.
8. The law increases Medicaid payments for primary care physicians, at least temporarily, to Medicare levels, and Medicare will pay a 10% bonus to primary care physicians.

Official estimates, expert opinion and research results

Health care reform legislation passed in March 2010 despite solid Republican opposition. The lack of bipartisan consensus calls into question whether a future Congress will carry out the commitments made by a past Congress, including the future reductions to costs and provider incomes.

For example, under the 2003 Medicare reform law that created the prescription drug program, passed by the then-majority-Republican Congress, a "funding warning" issued by the Medicare trustees was supposed to trigger legislative action to reduce Medicare spending automatically. The trustees have issued such warnings since 2007, but in 2009, the House, having shifted to Democratic control, voted to exempt itself from this law. Similarly, under a law passed by Congress in 1997, Medicare payments to physicians are controlled by a sustainable growth rate mechanism that was supposed to have imposed significant and growing cuts. But every year since 2003, Congress — including members of both parties — has voted to override the cuts, sometimes even awarding small increases instead, responding to seniors' concerns about access to health services and increasing pressure from physician trade groups. Indeed, the CMS actuary has said that, in his professional view (but not reflected in his official scores), the productivity adjustment to Medicare payments to providers (cost containment provision 6 above) is not sustainable and will be overridden by future Congresses, because the low reimbursement rates would prompt providers to refuse to treat Medicare beneficiaries.

Similarly, events around the time the health care reform legislation was being debated demonstrate the difficulty of achieving the savings targeted by some of its provisions. For example, many experts claim that comparative effectiveness research and the recommendations of the USPSTF will help cool the ardor for new and expanded use of tests, drugs and procedures. In November 2009, the USPSTF recommended delaying routine breast cancer screenings from age 40 to 50, and reducing their frequency from annual to every other year. They based their recommendation entirely on scientific evidence, without consideration of cost. The new recommendations nevertheless set off a political firestorm, sparking protest from disease advocacy groups, medical societies and politicians. The secretary of HHS backed off from the recommendation, which was explicitly repudiated in the health care reform law.

"The CMS actuary has said the productivity adjustment to Medicare payments to providers is not sustainable and will be overridden by future Congresses."

Nonetheless, the official scorers of legislation, including the Congressional Budget Office (CBO) and the CMS actuary, are required to consider the law as written, regardless of the likelihood of its actual implementation, and to give their best judgment on its cost and economic impact. Therefore, it is significant that the CBO scoring of the health reform legislation as it wound its way through the administration and Congress gave little or no "credit" to many of the "softer" cost-containment provisions, such as demonstration projects, value-based performance programs and payment bundling, concentrating instead on the cuts in payments to providers. In turn, the lower savings scores forced the president to look beyond reducing health care waste to pay the cost of expanding coverage.

For the president to keep his pledge not to increase the deficit, other revenue sources had to be found, which eventually included the increase in the Medicare payroll tax, a surcharge tax on investment income to upper-income households, and fees on drug makers and insurers, as well as reinsurance and risk-adjustment collections. Specifically, the CBO estimated that, over 10 years, the coverage provisions would cost $1,072 billion, and would be paid for by $455 billion in cuts in provider payments and $669 billion in higher fees and taxes.[4] The CBO also estimated that the number of uninsured persons would decline by 32 million by 2019, with the insured share of the nonelderly legal population increasing from 83% in 2010 to 94% in 2019. The average exchange subsidy per enrollee would be $6,000 in 2019.

"The CBO scoring of the health reform legislation gave little or no 'credit' to many of the 'softer' cost-containment provisions."

The CBO concentrates its analyses on the impact of legislation on government finances. For our purpose, a more relevant and direct view of the impact of the

[4] See the March 20, 2010, letter from Douglas Elmendorf, Director of the CBO, to Nancy Pelosi, Speaker of the House of Representatives. We do not include premium flows to the CLASS program (voluntary federal long-term care insurance), estimated by the CBO to be $70.2 billion over 10 years, because they represent reserves for future insurance policy claims. Moreover, many analysts have raised doubts about the sustainability of CLASS and consider the CBO estimates of premium flows to be high.

legislation on total health care spending comes from the CMS actuary, who summarizes his results as follows:[5]

> … [W]e estimate that overall national health expenditures under the health reform act would increase by a total of $311 billion (0.9%) during calendar years 2010–2019, principally reflecting the net impact of (i) greater utilization of health care services by individuals becoming newly covered (or having more complete coverage), (ii) lower prices paid to health providers for the subset of those individuals who become covered by Medicaid (but with net Medicaid costs from provisions other than the coverage expansion) and (iii) lower payments and payment updates for Medicare services. Although several provisions would help to reduce health care cost growth, their impact would be more than offset through 2019 by the higher health expenditures resulting from the coverage expansions.

"The CMS actuary projects that health care spending as a share of national income will increase from 17.8% in 2010 to 21% in 2019, compared with a projection of 20.8% in 2019 under prior law."

The CMS actuary projects that health care spending as a share of national income will increase from 17.8% in 2010 to 21% in 2019, compared with a projection of 20.8% in 2019 under prior law. According to his estimates, the excise tax on employer-sponsored health insurance coverage (cost containment provision 20 above) reduces total health spending by 0.1% in 2019, and its impact increases over time as it affects more plans and participants. He asserts that, because of the cost-sharing subsidies and coverage expansions, reform will reduce Americans' out-of-pocket health care spending as a share of total spending from 10.8% in 2010 to 8.6% in 2019. Finally, there is a caveat from the CMS actuary: His estimates assume that the higher demand for health care services can be met without market disruptions. He particularly notes the potential difficulty of meeting the higher volume of demand for Medicaid services because of its low provider payment rates. But the health reform law itself has anticipated some of these access problems (see higher spending provision number 8 above), so for primary care services at least, the more likely market outcome will be upward price pressures, at least in the short run.

Although the official scores are comprehensive and insightful, representing the work of literally dozens of skilled analysts using well-established models and databases, they are not infallible. Assumptions might be incorrect and important issues ignored or given the wrong emphasis. Therefore we review some differing opinions across the political spectrum and summarize a couple of relevant, more formal, academic studies.

Some advocates of health care reform claim the official scores underestimate the savings from reform. David Cutler and colleagues assert that the insurance exchanges (cost containment provision number 19 above) will significantly reduce administrative costs, specifically those for marketing, underwriting, churning, benefit complexity and brokers' fees.[6] They estimate the savings at $211 billion over 2010 to 2019. The CBO's estimate, however, is a much lower $27 billion, and indeed, the exchanges will not eliminate the costly administrative tasks of aggregating large numbers of individuals and small employers and servicing their needs. Cutler and colleagues also claim that the new efficiency incentives for providers, such as those designed by the CMI or derived by employing comparative effectiveness research, will reduce spending by $406 billion over 10 years. But the CBO scores these savings at $10 billion and the CMS actuary at only $2 billion. Indeed, Cutler himself elsewhere notes the inchoate, tentative and experimental nature of many of these cost containment reform provisions:[7]

> For reform to be successful, two things must happen. First, the administration must move forward rapidly with the design and operation of the pilot programs and demonstration projects, and with needed internal reforms. Medicare has a demonstration process, but it is slow and cumbersome. It takes five to 10 years from concept to results; this cycle must be cut to a year or less. Such streamlining is feasible, but it will require an enormous change in agency culture. …
>
> Even more important than the administration of programs within the government is getting providers to respond to the new system. … Private-sector providers and large private payers must actively participate in the change to new models of care delivery. … Payers, including insurers and businesses, need to consider piggybacking other changes

[5] Memorandum from Richard S. Foster, CMS actuary, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010.

[6] David M. Cutler, Karen Davis and Kristof Stremikis, "The Impact of Health Reform on Health System Spending," Commonwealth Fund publication 1405, Vol. 88, May 2010 Issue Brief with the Center for American Progress.

[7] Cutler, "How Health Care Reform Must Bend the Cost Curve," op. cit., pp. 1134–5.

> onto payment reforms to help speed the creation of new care models and delivery systems.

Cutler also said:[8]

> The federal government directly controls Medicare payments, so they were the obvious focus of the legislative effort. The assumption is that what happens in Medicare will spread to the private sector. ...

On the other side of the political spectrum, conservative analysts claim the costs of expanding coverage have been underestimated. They note that neither the extra administrative costs imposed on CMS and the IRS to administer and enforce the new law nor the costs in explicitly authorized health care grant programs have been budgeted.[9] And they doubt that legislated future limits on premium tax credits and cost-sharing subsidies will survive political pressures.

Another possibility is that the savings identified in official scores, which are tied mainly to Medicare and Medicaid, do not represent savings in health care spending overall, but instead will be pushed to other payers — including employer-sponsored plans — through higher provider charges to the parts of the sector not controlled directly. This is the opposite of what Cutler identifies above as the underlying assumption of health care reform legislation. There might also be upward overall price pressures, as we mentioned above. Some supporting, albeit incomplete, evidence on these effects comes from two empirical studies of past expansions of health insurance coverage.

John Cogan and his colleagues used survey data to investigate the effect of Massachusetts' health reform plan on employer-sponsored insurance premiums.[10] The Massachusetts plan served as the model for national health reform legislation in many respects, although it is neither as generous to plan participants nor as onerous to plan sponsors. Subsidies are reserved for those with incomes below 300% of the poverty level (versus 400% in the federal reform), and employers face more modest fines and plan requirements. Cogan and his colleagues tabulated premium growth for private-sector employers in Massachusetts and the United States as a whole for 2004 to 2008. They estimated the effect of the reform as the difference in premium growth between Massachusetts and the United States between 2006 and 2008 — that is, before versus after the plan — over and above the difference in premium growth for 2004 to 2006.

Health reform in Massachusetts increased single-coverage employer-sponsored insurance premiums by about 6%, according to their findings. Depending on sample definitions, premium increases for family coverage were even larger. Cogan and his colleagues mainly blame the higher demand for health services stimulated by reform, which first triggered higher prices for health care services and then higher premiums.

Amy Finkelstein, a scholar noted for her ingenuity in capturing and using hard-to-get databases, used a similar "differences-in-differences" empirical approach to investigate the effects of the single largest change in health insurance coverage in American history: the introduction of Medicare in 1965.[11] She estimated that Medicare was associated with a 37% increase in real hospital expenditures (for all ages) between 1965 and 1970. About half of its impact on spending resulted from new hospitals to accommodate expanded demand, while the rest was due to growth in existing hospitals. She also found suggestive evidence that marketwide changes in health insurance may fundamentally alter the behavior of all consumers of health care by financing the adoption of new medical technologies.

"Health reform in Massachusetts increased single-coverage employer-sponsored insurance premiums by about 6%."

Possible outcomes and consequences

The cost-containment provisions in the health care reform law might moderate health care spending, thus fulfilling the hopes of advocates. Given the estimates, arguments and evidence, however, total health care spending could accelerate rather than slow down. Continued higher spending would increase the federal deficit and reduce the efficiency and competitiveness of the U.S. economy, thus affecting standards of living. This scenario would spark demands for further changes.

Already some analysts with doubts about the cost-containment provisions are suggesting we consider "a strong public plan that would negotiate prices more aggressively or for explicit all-payer rate regulations that would determine what private plans would pay providers."[12] Taking this approach to its

[8] Op.cit., p. 1133.

[9] Douglas Holtz-Eakin and Michael J. Ramlet, "Health Care Reform Is Likely to Widen Federal Budget Deficits, Not Reduce Them," *Health Affairs,* 29:6, June 2010, p. 1139.

[10] John F. Cogan, R. Glenn Hubbard and Daniel Kessler, "The Effect of Massachusetts' Health Reform on Employer-Sponsored Insurance Premiums," *Forum for Health Economics and Policy,* 13(2), 2010, Article 5.

[11] Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence From the Introduction of Medicare," *Quarterly Journal of Economics,* 122 (1), February 2007, pp. 1–37.

[12] Stephen Zuckerman, "What Are the Provisions in the New Law for Containing Costs and How Effective Will They Be?" Urban Institute and Robert Wood Johnson Foundation, August 2010, p. 4.

logical extreme, some might demand a single-payer health care system.

Or, moving in the opposite direction, frustration in some quarters with highly subsidized health care and the resulting redistribution of resources could lead to more cost-sharing and lower subsidies to encourage health care consumers to economize and to cut government expenditures, and reduce the crowd-out of plan-sponsor and personal spending. The direction will depend on the political environment at the time the results are in and current economic conditions, including the status of the deficit and income growth among workers.

"Employers might want to consider workforce health improvement programs, ABHPs, access to health information and a continued emphasis on promoting high-value services through preferred provider networks."

In the meantime, there are several steps employers can take now so they won't be caught off-guard later:

- Before simply passing along any higher costs to employees or eliminating retiree health programs, assess the potential effects carefully. For example, terminating a retiree medical plan might prompt employees to postpone retirement or weaken employee engagement. Shifting too much premium cost to low-income employees could drive them to seek exchange-base coverage, thereby triggering employer penalties. Employers might want to consider other cost management options, such as workforce health improvement programs, ABHPs, access to health information and a continued emphasis on promoting high-value services through preferred provider networks wherever possible.
- Keep up with interim and final regulations. The federal government will continue to issue guidance on complying with PPACA regulations. Employers can keep abreast of these releases by visiting www.towerswatson.com/united-states/research/2691 or the Department of Labor website (www.dol.gov/ebsa/healthreform/).
- Model costs under various business scenarios to project the long-term cost effects of health care reform on talent management, cost management and productivity — and model them again when regulatory agencies release critical new guidance or the company's financial situation changes significantly.
- Evaluate the company's retiree medical strategy, including anticipated costs under health care reform and the role of retiree medical in the total rewards program. For example, how highly do employees value retiree medical compared with other benefits? And for companies that offer pre-65 retiree medical benefits, the PPACA might offer a new opportunity — the legislation intends to open the individual health insurance market to retirees younger than 65 as well as to those eligible for Medicare.

Mandated Clawbacks Will Create New Tensions Between Executives and Boards

By Marshall Scott and Steve Seelig

"The new law mandates clawbacks from executive officers regardless of whether the acts that led to the restatement were within their control."

The Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 is widely viewed as the "say on pay" legislation, but its clawback requirements will likely spark contention and litigation for years to come. Under the new law, which took effect July 21, listed companies must "develop and implement a policy regarding clawbacks of erroneously awarded incentive-based compensation" paid to executive officers. These clawbacks would be triggered by an accounting restatement.

Virtually all publicly traded companies must rewrite their clawback provisions, many of which were developed in response to the Sarbanes-Oxley Act (SOX) but don't go as far as required by Dodd-Frank. Where previous law called for clawbacks after "acts of commission" by executives, the new law mandates clawbacks from executive officers regardless of whether the acts that led to the restatement were within their control.

This article examines some of the thorny definitional questions the statute raises, any of which the Securities and Exchange Commission (SEC) may resolve via regulation. More troubling, however, are the legal and practical implications, which companies need to confront quickly. Most of these are not amenable to easy resolution. What's more, Dodd-

Figure 1. Comparison of clawback rules in SOX, TARP and Dodd-Frank

	SOX	TARP	Dodd-Frank
What triggers a clawback?	Accounting restatement due to material noncompliance with securities laws as a result of misconduct	Any materially inaccurate performance metric criteria or financial statements (including statements of earnings, revenues or gains) that are later found to be materially inaccurate	Accounting restatement due to material noncompliance with any financial reporting requirement under the securities laws
What is clawed back?	Amounts received as incentive-based compensation and profits realized from stock sales	Any bonus, retention award or incentive compensation paid	Erroneously awarded incentive-based compensation (including stock options) in excess of the amount that would have been paid under the accounting restatement
Who is subject to a clawback?	CEOs and CFOs — but not other executive officers — of publicly traded companies	Senior executive officers (five most highly paid) and any of the 20 next most highly paid employees	All current and former executive officers
What time period is covered?	Applies to compensation paid within the 12-month period following the misstated financial statement Can be enforced any time after the payment	Provides that clawback rights must be exercised at any time after the material inaccuracy is discovered unless it is unreasonable to do so (e.g., if the expense involved would exceed the amount recovered)	Applies to compensation paid during the 3-year period preceding the date the company is required to prepare the accounting misstatement

Source: Towers Watson.

Frank could have unintended consequences as companies and executives negotiate new pay programs and rework their existing programs to comply.

Background

As shown in *Figure 1*, the main thing that differentiates the Dodd-Frank clawbacks from those public companies have in place to comply with SOX or the Troubled Asset Relief Program (TARP) is that executive misconduct will no longer be the trigger.

For the first time, executives could be required to give back compensation earned due to an event for which they were not directly or even incidentally responsible.

Commonly asked questions about the Dodd-Frank clawbacks

The statute raises a host of questions, particularly given the lack of legislative history to guide regulators and courts in interpreting the clawback provisions. While many of these questions could be resolved via regulations, the SEC has no statutory deadline for rulemaking, although the agency has promised to release proposed rules between April and July 2011. The rules do not take effect until implementing guidance comes out, so companies need not have revamped clawback policies in place for the 2011 proxy. But they likely will be required to articulate their clawback policy in the Compensation Discussion and Analysis beginning with the 2012 proxy.

We expect the SEC to address the following questions during the regulatory process:

- **Who are executive officers?** Dodd-Frank says the new clawback policy applies to "executive officers," and the act appears to adopt the definition of Section 3(7) of the Securities Exchange Act. This definition includes presidents, vice presidents (division or function), others who perform similar policymaking functions and policymaking executives of subsidiaries — a much broader group than the named executive officers in the proxy. Among other grandfathering questions, the SEC needs to define an effective date to determine whether companies' clawback policies under Dodd-Frank must apply to former executive officers, including those who departed before the law's effective date (July 21, 2010).
- **What is material noncompliance?** This is a threshold question companies must answer before even attempting to nail down what constitutes incentive compensation. For example, a change in accounting standards does not seem to trigger a clawback. However, a change in how an auditor interprets accounting standards might trigger a clawback, even where the company had adequate financial controls in place. Clearly, Congress recognized that not all financial restatements would require clawbacks. The SEC might leave this determination to the company's discretion.
- **Who may or must enforce the refund obligation?** Under SOX, the SEC enforces any clawbacks for material noncompliance with securities law as a result of misconduct. Under Dodd-Frank, however, it appears that the company must enforce the clawback pursuant to its policy. The question then becomes whether responsibility

"If a committee or board fails to act or to pursue a claim vigorously, could a shareholder bring a derivative action to enforce the clawback?"

for this enforcement would fall to the board, the compensation committee or the company itself.

- **Can discretion be exercised in enforcing the clawback?** Under TARP, companies need not execute an unreasonable clawback — for example, if the expense of enforcing the clawback would exceed the recovered amount. The new law is silent on the use of discretion. The SEC might decide that, because any compensation recouped would be a corporate asset, companies should have broad discretion in seeking recovery. But granting discretion to enforce clawbacks could pose other issues. For example, if a committee or board fails to act or to pursue a claim vigorously, could a shareholder bring a derivative action to enforce the clawback? This would provide a new avenue for challenging a company's compensation practices.
- **Would existing contracts be grandfathered?** A fundamental question is when companies would have to make their new clawback policies enforceable. Would existing employment or equity award contracts be grandfathered? Would the clawback apply to compensation paid from the date the policy is made effective, regardless of contract terms? SEC guidance is needed to settle these issues.
- **What compensation is subject to being clawed back?** Under the statute, the compensation subject to recovery is measured for the three-year period before the restatement is "required," regardless of when the restatement occurs. The SEC may interpret this as requiring a restatement as of the date the financials are stated incorrectly. So if, in 2017, a company decided to restate its 2014 financials, the clawback presumably would apply to compensation paid for 2011, 2012 and 2013.

  Under this interpretation, an executive could lose out on equity gains many years later. Expanding on the example above, suppose an executive exercised stock options during 2017 that were granted during 2011 based on strong share price performance totally unrelated to the erroneous financial statement. Would those gains have to be clawed back, or will the SEC create a narrower rule tying the amount to be recovered directly to the erroneous financial statement? What's more, how would the precise clawback amount be determined? If the SEC rule bases the clawback amount on the gross (pretax) amount received by the executive, it could trigger some complex and unjust tax consequences, such as a deserved tax refund to the executive being beyond the statute of limitations.
- **How is incentive compensation defined?** Incentive compensation comes in all shapes and sizes, and is often based on a mixture of financial measures and nonfinancial or qualitative measures (e.g., customer satisfaction). Upcoming SEC regulations might permit companies to separate incentive compensation from non-incentive compensation, based on how different elements are defined by company policy. As for stock options, the SEC could define the amount subject to clawback based on the grant date being within the three-year period before the erroneous financials were issued. Alternatively, the SEC could create a mechanism to adjust the grant-date exercise price to reflect the erroneous financials.
- **Would the SEC regulate indemnity clauses?** With the advent of excise taxes on golden parachutes, many companies adopted "gross up" provisions that make executives whole for any excise tax incurred at a change in control. In its upcoming regulations, the SEC will need to address the possibility for similar "make whole" treatment. Specifically, the SEC must decide whether it has the legal authority to stop companies from making similar agreements to indemnify executives whose compensation is clawed back through no fault of their own. Even if the SEC determines that it lacks the authority to prohibit such indemnifications, companies would need to disclose these agreements in their proxy statements.
- **What about compensation in mergers and acquisitions?** Following an M&A transaction, it is common for both organizations and their auditors to hold very different ideas of proper financial statement presentation. This raises the question of whether executives of the acquired entity should have an exclusion period under the clawback rules for restatements originating before the transaction or for a limited time after.

"Executives might seek enhanced compensation opportunities to offset the risk of a no-fault clawback."

Unintended consequences ahead?

Like other laws that regulate executive pay, the Dodd-Frank clawback requirement seems certain to have some unintended consequences. For example, how will the requirement for a clawback policy as an exchange listing requirement coexist with employment agreements or stock award contracts governed by state law? Unlike federal pension law, the Dodd-Frank statute does not preempt state contract law. As a practical matter, however, companies would have little choice but to impose a clawback provision or risk being delisted (or, possibly, seeking an injunction to avoid delisting).

This will put the company's interests at odds with those of the executives because few, if any, existing employment contracts, compensation plans or award agreements include a clawback provision based on a no-fault financial restatement. And, going forward, executives will endeavor to negotiate employment agreements that minimize the downside risk of potential clawbacks. It's too early to predict how this tension will play out. While executives might simply accept the clawback policy, they could also demand significant accommodations during employment contract negotiations and in the discussions around a restatement to protect their pay. Here are just some of the issues companies might confront:

- **Will executives seek a quid pro quo for existing agreements?** Companies must be prepared for objections from executives with no responsibility for preparing the financial statements. These executives might seek enhanced compensation opportunities to offset the risk of a no-fault clawback. Executives might also seek more fixed pay or to have more of their incentive compensation based on nonfinancial performance measures that would not be subject to a clawback.

  Another complication is how broadly existing agreements define "good reason" termination triggers because adopting a Dodd-Frank clawback policy could trigger a walk-away right for some executives. This would give the executive additional leverage to negotiate new compensation plan terms.
- **What might happen when a clawback provision is exercised?** Putting aside the legal question of whether a clawback can be enforced under state law, companies enforcing clawback provisions could be compelled to make retention awards, such as time-based restricted stock, to innocent executives. If the SEC prohibits such indemnities, these retention grants would likely need to be structured to be clearly attributable to future services.
- **How might incentive compensation designs change?** Once the Dodd-Frank clawback rules take effect, companies and compensation committees may come under pressure to restructure their compensation programs to minimize clawback risk. Possible changes include:
  - Skew the pay mix toward a reduced emphasis on incentive compensation (and stock options) and greater emphasis on salary, time-based restricted stock or deferred compensation.
  - Use more discretion (either implicitly or explicitly) in delivering pay (for example, issuing annual grants of time-based restricted stock at the compensation committee's discretion, which might be informed but not determined by performance. This approach might be preferred where the company is otherwise reducing the percentage of incentive compensation in its pay mix and adding a performance-based component to its restricted grant practices).
  - Base incentive compensation more on operational performance than on financial performance (one approach might be to increase levels of incentive compensation that are not financially based so as to assure a viable level of bonus income [e.g., target] based on nonfinancial operational goals or metrics).
  - Use banking bonuses that are based on financial measures so companies can hold back compensation subject to a clawback. Note, however, that "bonus banks" have been slow to catch on even in financial services, despite support for the concept from industry regulators. So companies might need to consider providing a matching contribution, perhaps subject to vesting conditions and paid in company stock, as a sweetener to executives required to defer payments.
  - Use more debt, or debt that is convertible into equity, in the compensation structure.
- **What might newly hired executives ask for?** Executives wary of the accuracy of an employer's financial statements may request more guaranteed compensation — rather than incentive compensation or stock options — before accepting a job. These executives might demand some time to get comfortable with the company's accounting practices before agreeing to traditional incentive compensation.

"Companies enforcing clawback provisions could be compelled to make retention awards, such as time-based restricted stock, to innocent executives."

News in Brief

SEC Puts Proxy Access Rule on Hold

By Russ Hall and Stephen Douglas

The Securities and Exchange Commission (SEC) has announced a temporary stay in its recently adopted rule to give certain large shareholders the right to include their own director nominees in proxy material sent to the company's shareholders. The stay is in response to litigation (in the U.S. Court of Appeals for the D.C. Circuit) over whether this new proxy access rule is illegal on constitutional and other grounds.

The proxy access rules were scheduled to take effect for most companies on November 15, 2010, but their effective date now depends on the court's decision, which is expected by late spring. If the court upholds the proxy access rule, shareholders will gain another tool that might be used to influence executive practices.

Tax Recommendations From President's Advisory Board Would Affect Retirement, Health Accounts

By Ann Marie Breheny

"The savings and retirement proposals would have significant implications for employer-sponsored programs."

A report from the President's Economic Recovery Advisory Board (PERAB) outlines tax reform options, including some with implications for retirement, health care and education savings accounts. PERAB was charged with evaluating the advantages and drawbacks of measures to simplify the tax code, increase tax compliance and reform corporate taxes. The board was told not to consider changes that would raise taxes for families earning less than $250,000 a year. On August 27, PERAB submitted its report to President Obama.

Some of the options pertain to both employer-sponsored and individual savings accounts, including defined contribution plans, individual retirement accounts (IRAs), health savings accounts (HSAs) and health flexible spending arrangements (FSAs). While some of these proposals are new, others have been discussed by lawmakers in recent years. The proposals are unlikely to receive attention or action from Congress in the near term, but the report may serve as a reference for policymakers during future tax reform or retirement security discussions.

Savings and retirement options

The savings and retirement proposals would have significant implications for employer-sponsored programs. The report notes that the array of retirement saving accounts — and the differing rules for all of them — creates confusion and might discourage participation and plan sponsorship.

PERAB lists eight general options — and some alternatives — aimed at simplifying savings and retirement incentives, some of which have been floated over recent years. For example, President George W. Bush's administration proposed consolidating all employer-sponsored retirement accounts into a single vehicle called an Employer Retirement Savings Account and consolidating all non-retirement savings into another single vehicle called a Lifetime Savings Account (LSA). Converting the saver's credit[1] to a match and encouraging automatic enrollment have featured in legislative discussions and been proposed in various bills during recent years.

The options for simplifying saving and retirement incentives include:

- Harmonize eligibility, contribution and administrative rules for 401(k), 403(b) and 457 plans. Alternatively, consolidate these plans into a 401(k)-like plan available to both private- and public-sector employers. Despite certain advantages, the report acknowledges that such consolidation could increase the administrative burden on small businesses and result in a large loss of tax revenue.
- Integrate IRA and 401(k)-type contributions and disallow nondeductible contributions. Allow all workers — regardless of income — to contribute to both a workplace retirement savings program and an IRA. The accounts would retain their separate contribution limits, but combined contributions for a taxpayer would be limited to the 401(k) annual limit. Allowing all workers to make deductible IRA contributions would eliminate nondeductible contributions. This would reduce the number of IRA vehicles, simplify recordkeeping for participating taxpayers and eliminate the qualification and phase-out calculations some taxpayers must perform to determine whether they can make deductible IRA contributions. However, the proposal would reduce tax revenue. Furthermore, imposing separate and combined contribution limits could result in continued confusion and complexity.
- Consolidate and segregate non-retirement savings by combining all non-retirement accounts into a single savings vehicle. Alternatively, convert all education savings into a single education account and all health care savings into a single health care account. Similar to the proposal for LSAs put forward by the Bush administration, the proposal would eliminate or consolidate separate health and education savings accounts, such as HSAs, health FSAs, Coverdell education savings accounts and section 529 plans. PERAB says the option would simplify the rules for both retirement and non-retirement savings, lighten administrative burdens

[1] The saver's credit is available to filers who make voluntary contributions to an employer-sponsored retirement plan or to an individual retirement arrangement and meet other requirements.

and reduce leakage from retirement accounts. However, PERAB acknowledges that prohibiting non-retirement uses of IRAs could discourage participation. The proposal could also reduce tax revenue and create significant winners and losers. PERAB notes that HSAs are integrated with specific health insurance plans, so it would not make sense to combine HSA money with money intended for other purposes.

- Clarify and strengthen savings incentives by encouraging automatic enrollment and improving the saver's tax credit. The report also mentions other automatic features, such as default investment into life-cycle funds, automatic contribution increases and automatic annuitization. PERAB proposes converting the saver's credit into a match and adjusting eligibility thresholds so they phase down, thus removing the eligibility cliffs under the current structure. It notes that administrative issues — such as accomplishing direct deposit — would have to be addressed.
- Reduce retirement account leakage by prohibiting the cash-out of small account balances and limiting tax-free and penalty-free distributions. Employers would have to maintain former employees' account balances or transfer them to IRAs or plans maintained by other employers. Tax-free distributions could occur only after age 59½, in the event of death or disability, or for hardship purposes (using a standard definition of hardship). Early distributions for education, home purchases and medical expenses would be eliminated.
- Streamline the rules for plan sponsors by simplifying nondiscrimination testing or repealing the nondiscrimination rules (including cross-testing and Social Security integration) and requiring all plans to meet a safe harbor.
- Eliminate minimum required distributions (MRDs) for individuals with account assets below a threshold. This would simplify the rules for those retirees but retain the MRD rules for those with higher balances.
- Simplify the taxation of Social Security benefits by re-establishing the pre-1993 tax structure or by eliminating Social Security benefits from the calculation of modified adjusted gross income (MAGI) and including a percentage for Social Security benefits in gross income for taxpayers who exceed a specified MAGI threshold.

Tax expenditure proposals also included in report

The report's corporate tax reform section discusses tax expenditures and a proposal to eliminate some tax breaks that would affect a relatively small number of businesses.

According to the report, the more favorable tax treatment afforded employee stock ownership plans over other employer-sponsored plans discourages diversification of savings, which can result in outsized losses to retirement wealth.

Some other tax expenditure targets include:

- Exclusion of interest on life insurance savings
- Special Blue Cross/Blue Shield deduction
- Deductibility of charitable contributions
- Deduction for U.S. production/manufacturing activities

Next steps

Congress is unlikely to delve too deeply into the proposals because legislative time is running out. Tax legislation will move up the congressional agenda during the last few months of the legislative session, as Congress seeks to extend some or all of the expiring 2001 and 2003 tax cuts and possibly other expiring tax provisions. But Congress will be discussing such tax extensions at the 11th hour, so these proposals aren't likely to receive much attention. Furthermore, revenue-losing proposals are unlikely to gain traction in the current legislative environment, where concerns about the deficit and tax revenue have thwarted action on tax extenders and other bills.

Some key lawmakers are interested in broader tax reform and might use the report as a source for legislative proposals if that debate gains momentum. Some of the options — such as those to encourage automatic enrollment in retirement savings programs, reform the saver's tax credit and consolidate savings vehicles — already have supporters from earlier discussions. The report may attract additional support and renew the focus on those if lawmakers discuss retirement savings and income security during the 2011–2012 legislative term.

"Some key lawmakers are interested in broader tax reform and might use the report as a source for legislative proposals if that debate gains momentum."