Health Care Reform Readiness

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Health care prior to reform filled with uncertainty

- For employers
  - Constantly rising costs against economic downturn
  - Increasing federal role in health care benefit management
    - For example, mandated benefits such as Mental Health Parity, COBRA
- For individuals
  - Constantly rising costs – premiums, out-of-pocket expenses
  - Employment insecurity creating health insurance insecurity
  - Growing uninsured population across the pre-65 demographic scale
- For health care providers
  - Pressure on public and commercial payment levels
  - Increasing uncompensated care burden (uninsured/underinsured)
  - Shortages of primary care providers
- For carriers: extensive criticism on individual market practices

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Key elements of reform

- The political right is concerned that reform represents a federal takeover of health care
- The left is disappointed that reform does not represent a federal takeover of health care
- The truth may lie in the middle!
  - Retention of employment based system
    - Employer share of health care cost becomes like a hidden tax on the middle class
  - Expansion of existing federal role
    - Medicare and Medicaid
    - Premium assistance subsidies for private non-employer-based coverage
  - Retention of private insurer delivery in substantially altered market
    - Mix of for profit and not for profit entities
    - Standardized products, rating, no health status underwriting, minimum loss ratio
    - Dramatic expansion of federal regulation against normal state regulatory role
- Net effect: substantial but incremental change to the current system
  - How employers and individuals behave over time will determine ultimate shape

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Patient Protection and Affordable Care Act (PPACA)

Unprecedented scale and impact

- Effects will unfold over many years; some changes immediate; others seen over next 3 – 5+ years; system impact cannot be predicted with any certainty

Focus on workforce health and productivity

- Improving workforce health/productivity remain critically important for employer cost control

Current tactics remain attractive

- Continuing role for account-based plans, value-based strategies, quality and care delivery improvements, vendor optimization, consumer engagement, health improvement and wellness initiatives, etc.

Opportunities in retiree medical

- New opportunities for accelerating employer exit from both pre-65 and post-65 retiree medical

Assess reward and benefit strategies

- Implications for total rewards strategy and workforce health and productivity initiatives
- Exit strategies and alternative delivery options

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Employer implications

Direct	Indirect

• Increased cost for health care benefits
  • Likely higher enrollment
  • Various play and pay penalties
• Substantial increase in administration and compliance burden
  • Government assumes larger role in health care benefit design and plan management
• Health benefit vendors will be preoccupied in complying with reform requirements
  • Changes to plans, systems, rating
  • Substantial new federal requirements layered over existing state requirements
  • Potential impact on account service and employer focus
	• Likely increase in cost shifting as hospitals, physicians and other providers struggle with cuts to federal payments
	  • Already seeing difficult negotiations between hospitals and managed care vendors
	  • Some of this effect may be offset by reduced cost to providers of uncompensated care
	• Impact on participant access to care in competition with 30 million new insureds
	  • Primary care already in short supply!
	• Competition for employee attention on health care benefit issues as government launches massive communication campaign on 2014 changes

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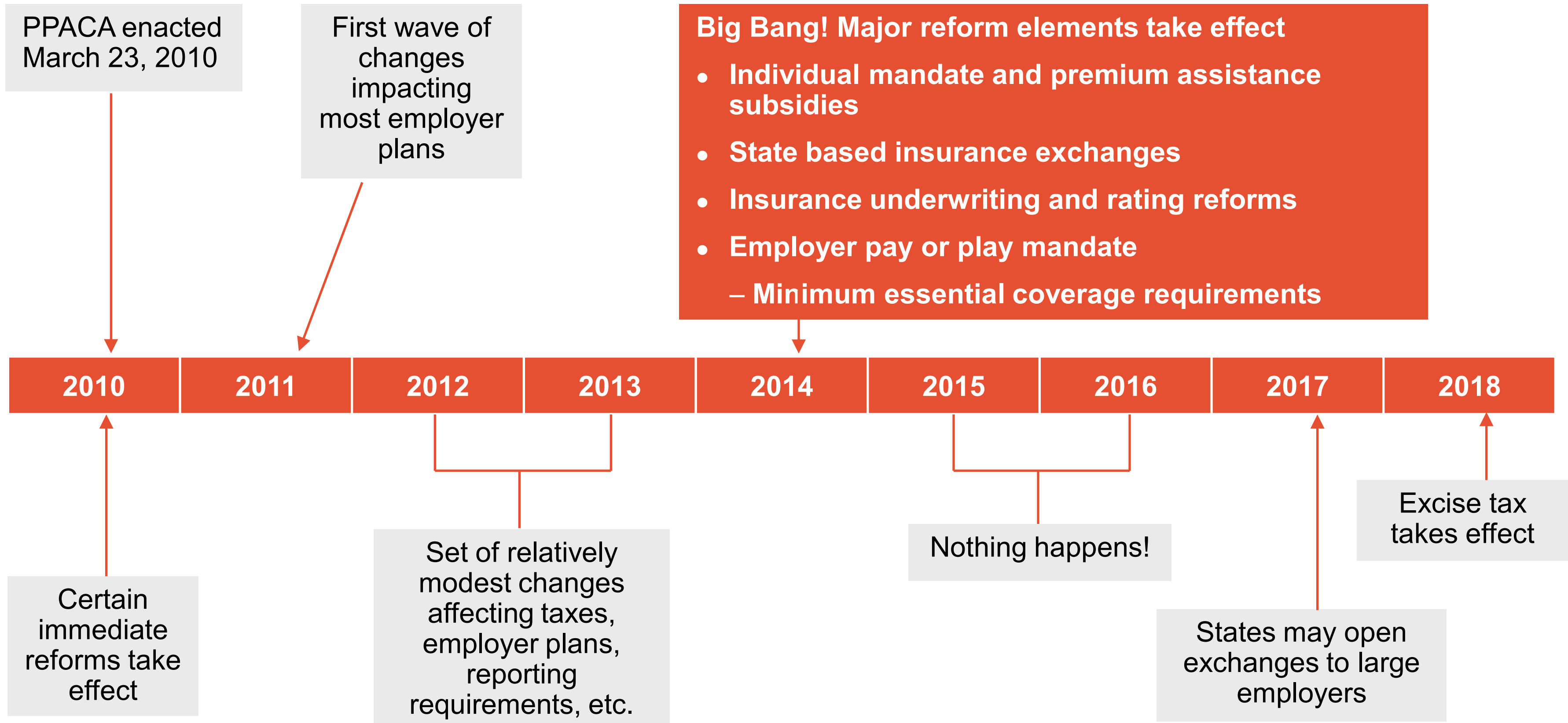
Timeline



Throughout: evolving interpretations, proposed regulations, final regulations, technical corrections, preparation for major changes, unpredictability

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Key elements

Element	Impact
Adult children to age 26	For 2011 must extend child eligibility (but not necessarily subsidy) to age 26
No maximums	For 2011 must eliminate lifetime and most annual dollar maximums
Lose RDS tax break	Immediate accounting recognition in 2010 even though not effective until 2013
Pre-65 retiree reinsurance	Opportunity for employer cost savings through reimbursement of 80% of individual claims (including retiree share) between $15k - $90k per plan year beginning in 2010
Part D enhancements	$250 rebate in 2010 for retirees reaching donut hole, followed by new brand discount program and coinsurance enhancements over next decade
CLASS Act	Voluntary program effective in 2011 providing benefits for functional impairment; employer may *choose* to support auto-enrollment and payroll deductions
No OTC HSA, FSA, HRA	Effective in 2011, cannot reimburse OTC medicines from various health accounts
W2 reporting	W-2 for 2011 must report health coverage value; deliver in January 2012
HSA non-QME	Penalty for HSA withdrawal increased from 10% to 20% in 2011 for non-medical expenses
FSAs capped	$2,500 cap effective in 2013 for flexible spending accounts
Medicare tax	Increased in 2013 for high income

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Key elements

Element	Impact
Everything changes in 2014 with employer "pay or play" mandate	• Individual mandate and federal premium assistance subsidies • State based exchanges for purchase of individual and small group plans • Insurance underwriting and rating reforms • Employer pay or play mandate • Employer play and pay mandate • Free Choice Vouchers • Auto-enrollment • Minimum essential coverage with restrictions on eligibility and design • Grandfathering ("if you like your current plan, you can keep it") • HIPAA wellness incentive threshold increases from 20% to 30% • Substantial new reporting and disclosure requirements
Excise tax	Effective in 2018

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Employer pay or play decision

Pay – offer no plan — or — **Play – offer plan**

Pay – offer no plan

- Pay non-deductible penalty of $2,000 per full-time employee in controlled group
- Possible approach for businesses with low margins and lower paid employees

Play – offer plan

- Offer coverage to all full-time employees
  - >30 hours, max 90 day waiting period
- Minimum essential coverage standards
  - Impacts design but not subsidy
- Likely path for most larger employers

Play and pay

- Once electing to play, two pay scenarios possible for employees with family income below 4x FPL* who apply for Exchange based coverage

  (1) $3,000 penalty per full-time employee qualifying for exchange-based premium subsidies due to employer plan "unaffordability"

  (2) Employer-funded Free Choice Vouchers for *any* employee qualifying based on employer cost falling into a defined range as a % of family income (8%-9.8%)

* In 2010, 4x FPL for couple = $58,280, for family of 4 = $88,200

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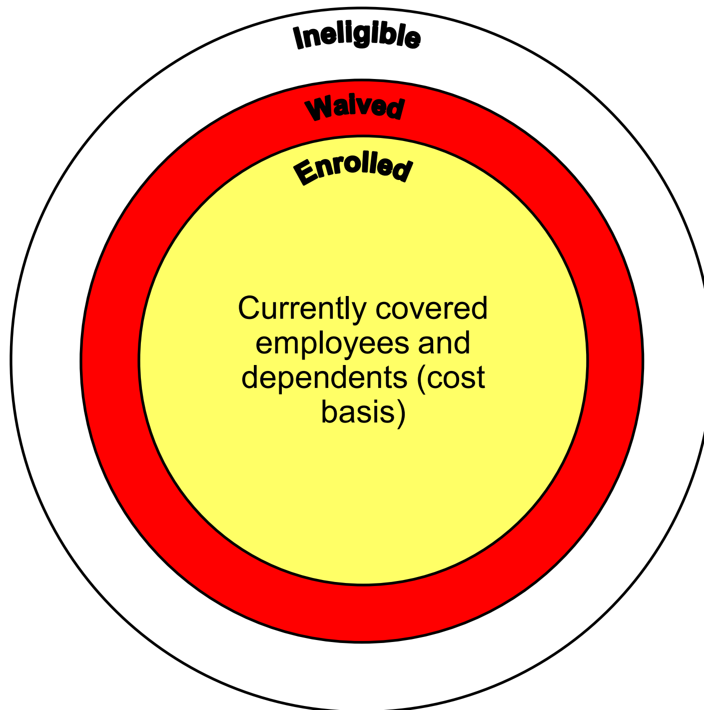
Health insurance enrollment musical chairs

Current situation



Eligible, not enrolled
Ineligible (some may become eligible under reform)

Potential enrollment shift

Change	Impact on employer enrollment
Employer adopts adult children to age 26	▲
Employer adopts FT @ >30 hours	▲
Other employers adopt adult children to age 26/FT @ >30 hours	▼
Other employer elects to offer coverage (play)	▼
Other employer elects to cease coverage (pay)	▲
Individual mandate increases enrollment	▲
Exchange based coverage with premium assistance, FCVs	▼
Net effect: difficult to predict enrollment shifts given unknowns about individual behavior, family income, other options available, etc.	

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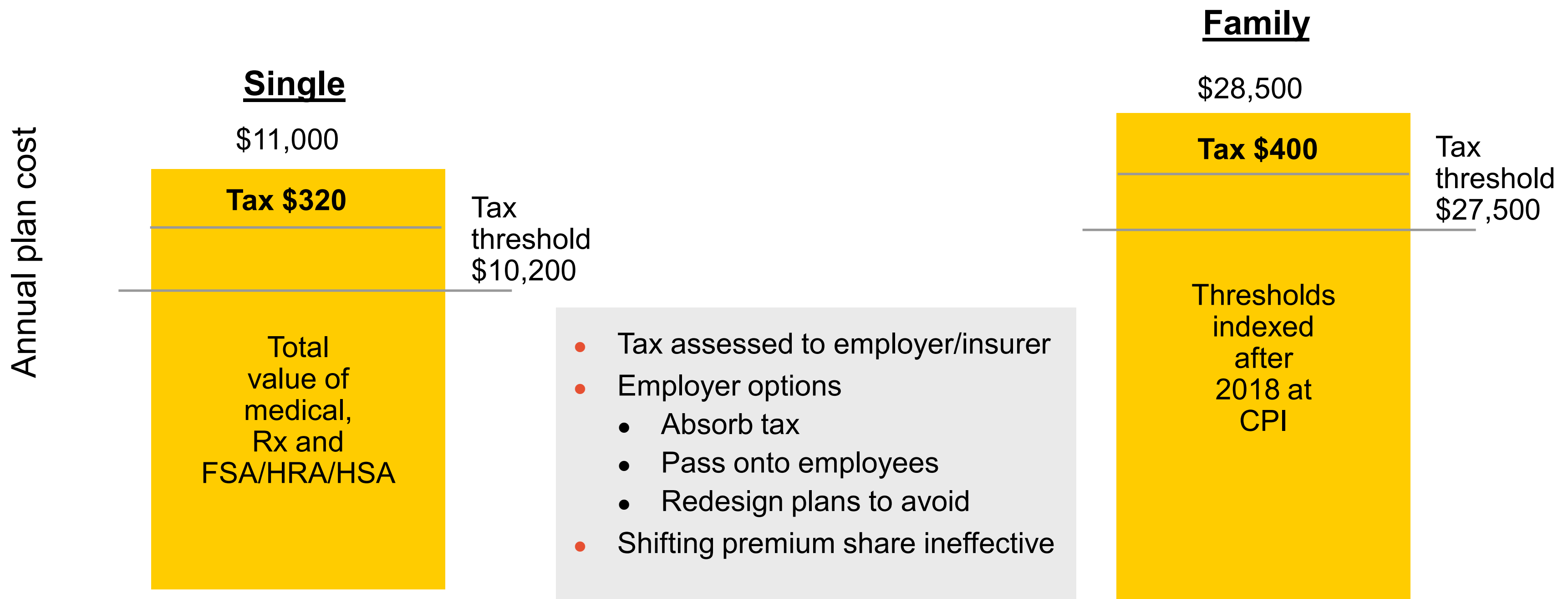
Excise tax kicked down the road to 2018

New 40% non-deductible tax on employers with "high cost" plans starting in 2018



- Thresholds may be higher in 2018 based on indexing formula (if FEHBP standard plan cost grows >55% by 2018)
- Higher thresholds for certain jobs, early retirees (single + $1,650, family + $3,450)
- Employer can aggregate pre-65 and post-65 retirees, mitigating tax impact substantially for this group

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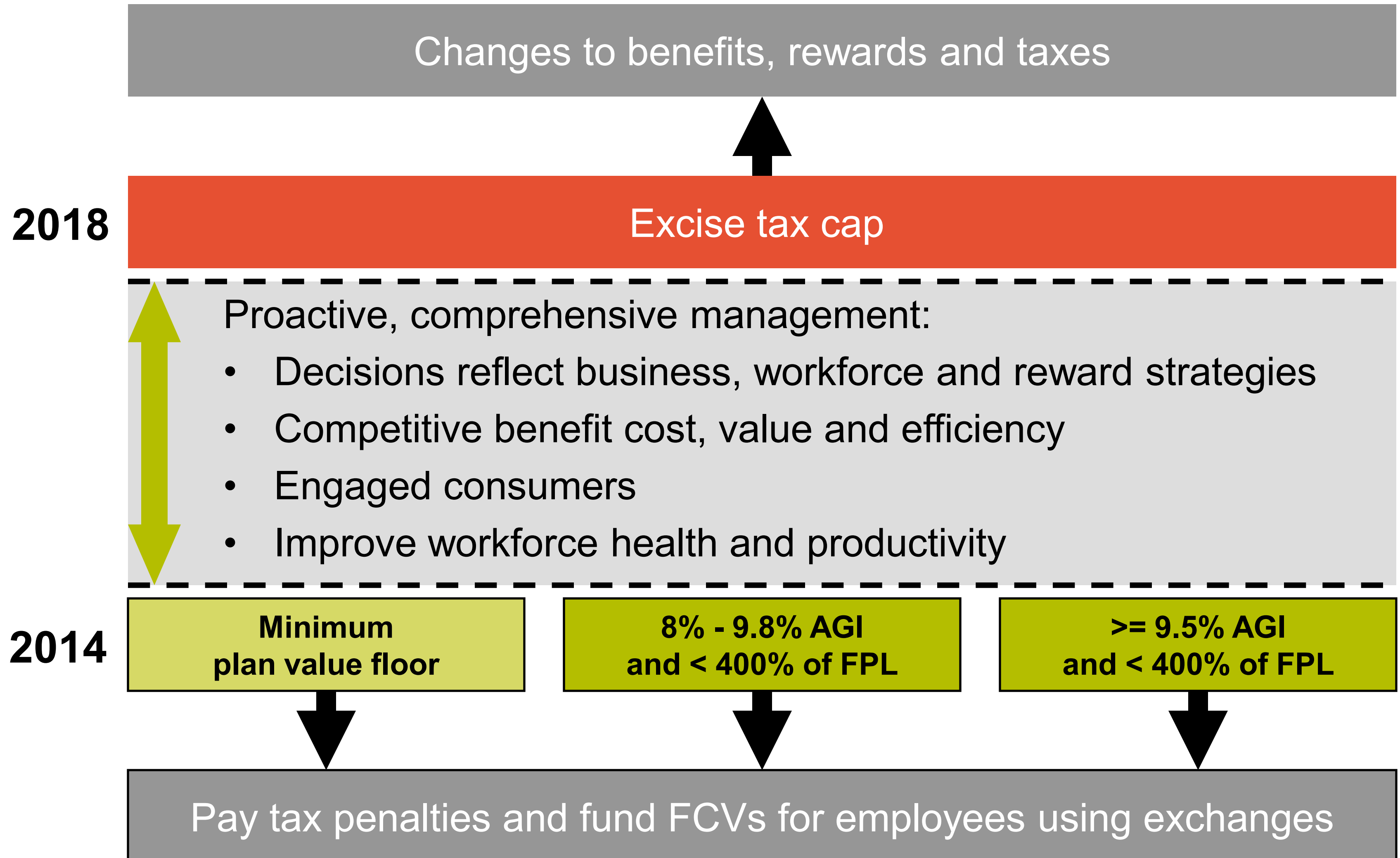
Managing active health benefits in play scenario 2014-2018+



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Federal premium subsidies create competition for corporate dollars

- New federal premium assistance subsidies to offset cost of Exchange based plans
  - Eligibility based on
    - Family "modified adjusted gross income" under 4x federal poverty level
    - And not electing employer minimum essential coverage due to "unaffordable" contributions (exceeding 9.5% of family income)
  - Additional benefit enhancements also apply if income < 4x FPL
- Key question for employers considering "pay" alternative: what level of benefit might employees gain by obtaining federal subsidies instead of employer subsidies?
  - Employers with many lower wage workers may consider terminating coverage so that employees can derive greater advantage from federal premium assistance
    - Potential savings for employer and employees
    - But huge unknowns: family income, individual behavior with new choices, behavior of competitors
    - And what level of compensation adjustment would be required for employees losing employer subsidized health care coverage?

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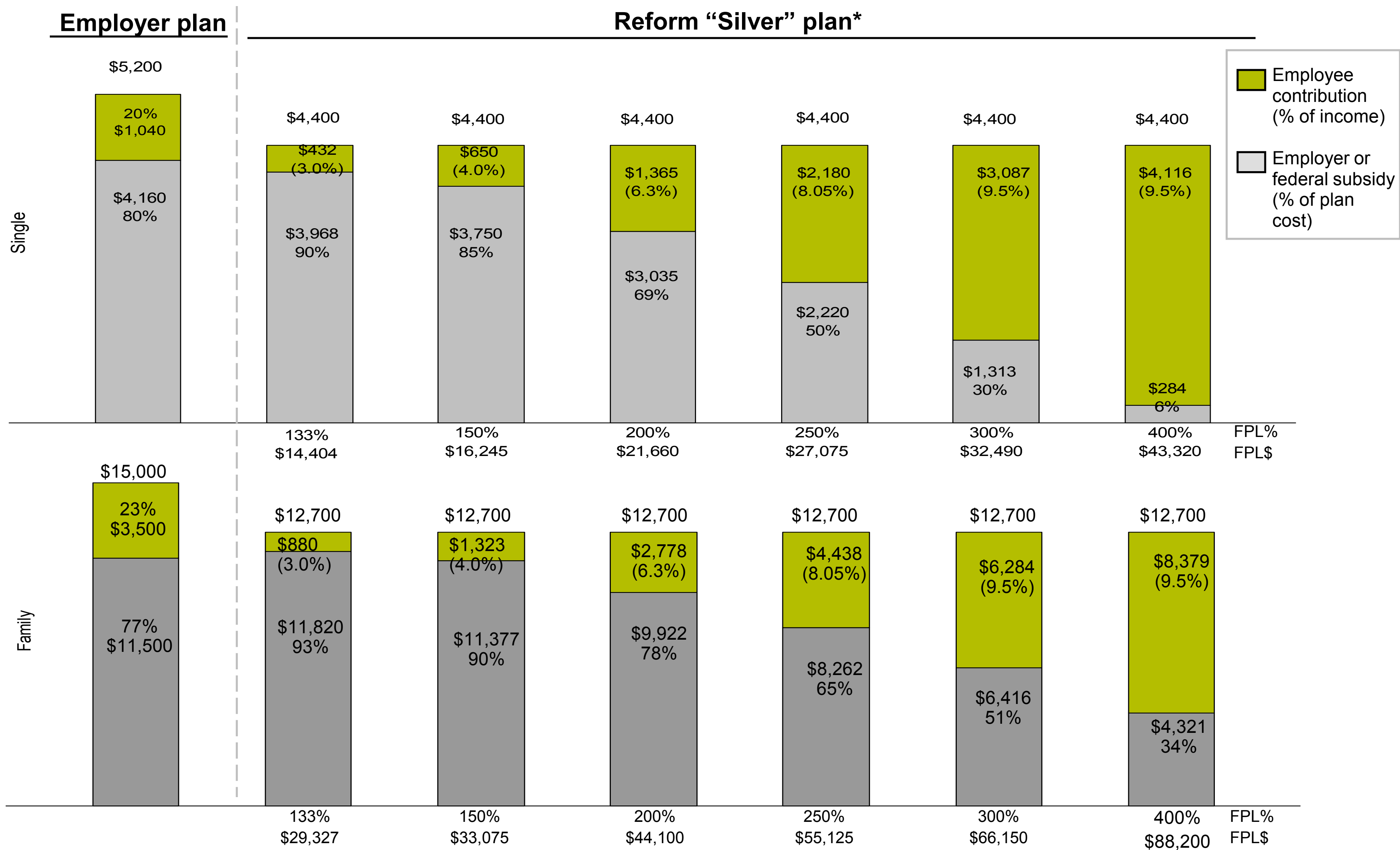
Illustration: premium assistance vs. employer subsidy (2010 cost)



* 2010 cost estimated as ratio of average employer plan relative value (83%) to Silver plan relative value 70%

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What's the total employer cost under the pay scenario?

- Not simply $2,000 per full time employee working 30 hours or more!
- True total cost includes
  - Penalty $2,000 per full timer
    - plus
  - Impact of tax non-deductibility on penalty
    - plus
  - Cost to compensate employees for loss of employer health care subsidy
    - plus
  - Cost to cover taxes (gross up) for additional employee taxable compensation
- How would this total cost compare to the total cost of health care today when considering all of these factors?
  - And what other factors will influence an employer's decision on whether to play or pay?
    - Watch for developments on competitive practices!

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Possible employer responses to reform

Employer characteristic	Active health care	Retiree health care
• Higher pay/margin • Mostly full time • Higher % of employees eligible and participating in health care	• Likelier to retain health care benefits (play) • Minimal penalties for employees obtaining Exchange coverage	• Likelier to offer retiree medical today • Most employers already exiting over time • Reform will accelerate exit for pre-65 and post-65 retirees

• Lower pay/margin
• Many part timers
• Lower % of employees eligible and participating in health care
	• Many employers will consider exiting health care in order to
	  ◦ Enable employees to obtain federal subsidies
	  ◦ Reduce company cost
		• Less likely to offer retiree medical today
		• Little or no impact under reform

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Retiree medical impact and opportunities

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Major provisions impacting retiree medical

Provision	Effective Date
Pre-65 retiree reinsurance	2010
RDS payments lose tax-favored status to employer	2013
Part D: filling the donut hole	2011 – 2020
Medicare Advantage funding cuts	2011-2013
Part D premiums based on income	2011
Medicare tax surcharge on high income	2013
Exchanges, insurance reform and premium assistance subsidies (up to 4x FPL)	2014
Employer pay or play mandate	Not applicable
Excise tax on high-cost plans (higher thresholds for retirees)	2018

Likely impact

- Post-65: Part D enhancements and RDS tax cut will accelerate current trend toward employer exit
- Pre-65: new reformed insurance market with federal subsidies reduces or eliminates rationale for employer role and creates effective exit option starting in 2014

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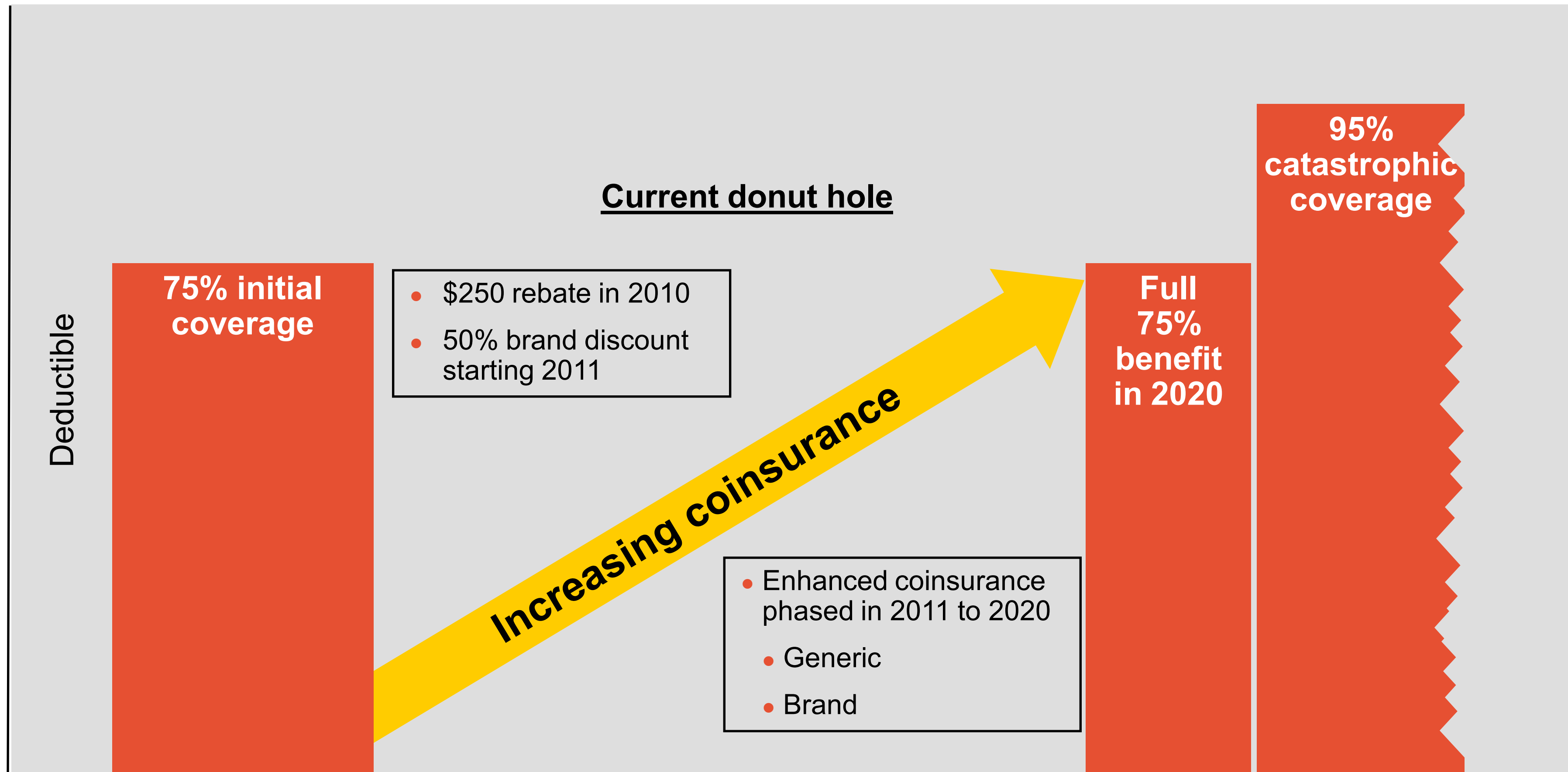
Filling the Part D donut hole



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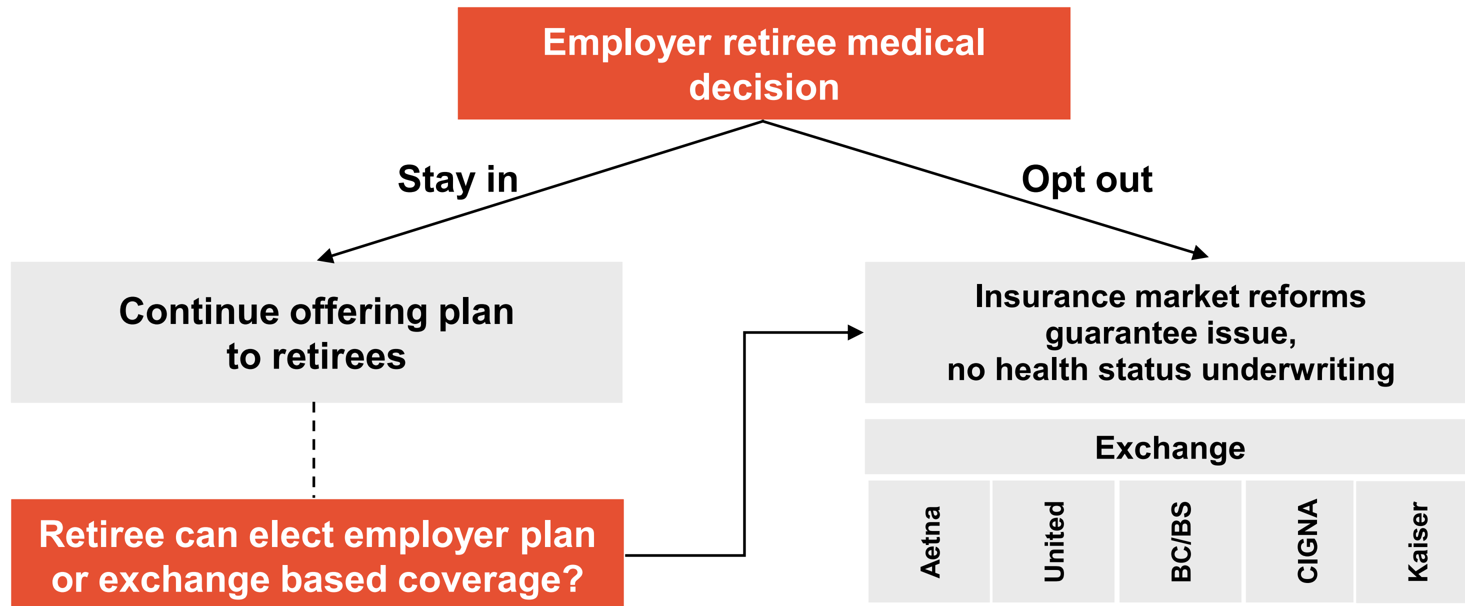
Guaranteed access to insurance for pre-65 retirees – negates employer role?

- Pay or play mandate only applies to active employees (no employer penalty for pre-65 waivers)
- Pre-65 retirees eligible for exchange plans and premium assistance same as other individuals
- Will "dual choice" (employer plan or Exchange plan) be allowable under the law?



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Summary of retiree medical opportunities

	Future Retirees	Capped/Access Only	Legacy/Grandfathered
Characteristics	**Rights reserved** **Capped subsidy or access only** **Employee has time to save!** **Intent: move toward exit for sponsorship/subsidization**	**Rights reserved** **Capped subsidy (with eroding value) or access only (with negative retiree value)** **Intent: move toward exit for sponsorship/subsidization**	**Commitment to provide benefits** **Uncapped/noncontributory** **Mostly post-65** **High average age (often 85+)** **Intent: minimize disruption**

Opportunities	• Terminate all group plan offerings
	• At retirement purchase individual coverage via Exchange (pre-65) and via Medicare Coordinator (post-65)
	• Revisit whether employer subsidies are appropriate
	• Promote tax favored personal savings (e.g., HSA)
		• Terminate group post-65 plans; offer access to individual market via Medicare Coordinator
		• Terminate group pre-65 plans in 2014 (or later) enabling retiree access to Exchange-based plans (and subsidies)
		• Continue employer subsidy via premium reimbursement for individual coverage
			• Convert RDS Rx to Part D Employer Group Waiver Plan
			  ◦ Higher federal funding reduces employer cost
			  ◦ Mimic current design
			  ◦ Retain group enrollment linked with medical
			• Retain current medical benefits

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Implementation and communication

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Near-term communication and change activities

- Engage leaders and key influencers
- Understand desired outcomes
  - Calm the waters or take a stand?
  - Signal potential change or wait and see?
  - Restate benefit or rewards philosophy
- Develop an initial communication plan
- Begin open dialog with employees, retirees and other stakeholders
- Communicate 2010/2011 program changes and reiterate key messages

**Employers can choose to be silent,
but the conversation will go on without them!**

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