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A Mid-Market Perspective on Health Reform: Upsides, Concerns and Consequences

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Chicago



Agenda

- Looking back
 - What we needed, what we got
- Legislative update
- Financial impact on employers
- Taking action
- Looking forward
 - Changes in market dynamics
 - New sources of tension

Disclosure



Warning!!

Many requirements are poorly defined

Regulations may or may not be helpful

Provisions that are clear now may change



**Looking back: What We
Needed, What we Got**

Looking back

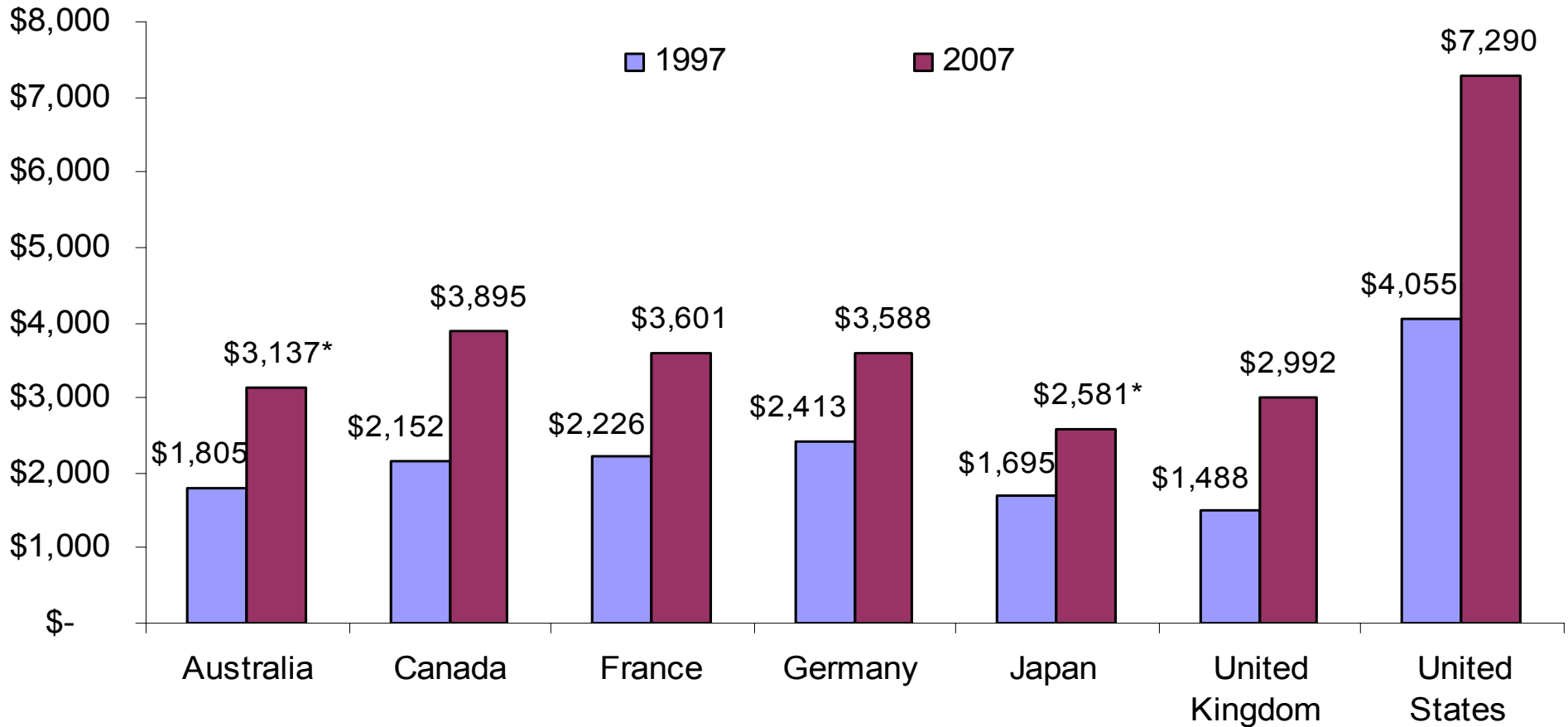
What was health reform supposed to accomplish?

- Key issues that needed to be addressed
 - Unsustainable cost and trend
 - Uneven quality and outcomes
 - Large uninsured population that cannot afford or does not qualify for coverage
 - Future cost burden driven by health risks
- Tough challenge to achieve all goals at one time
 - Politicians tend to favor the “giving” side
 - Yet, funding for reform required Congress to make and keep tough financial decisions



Cost challenge

US pays highest per capita cost for health care

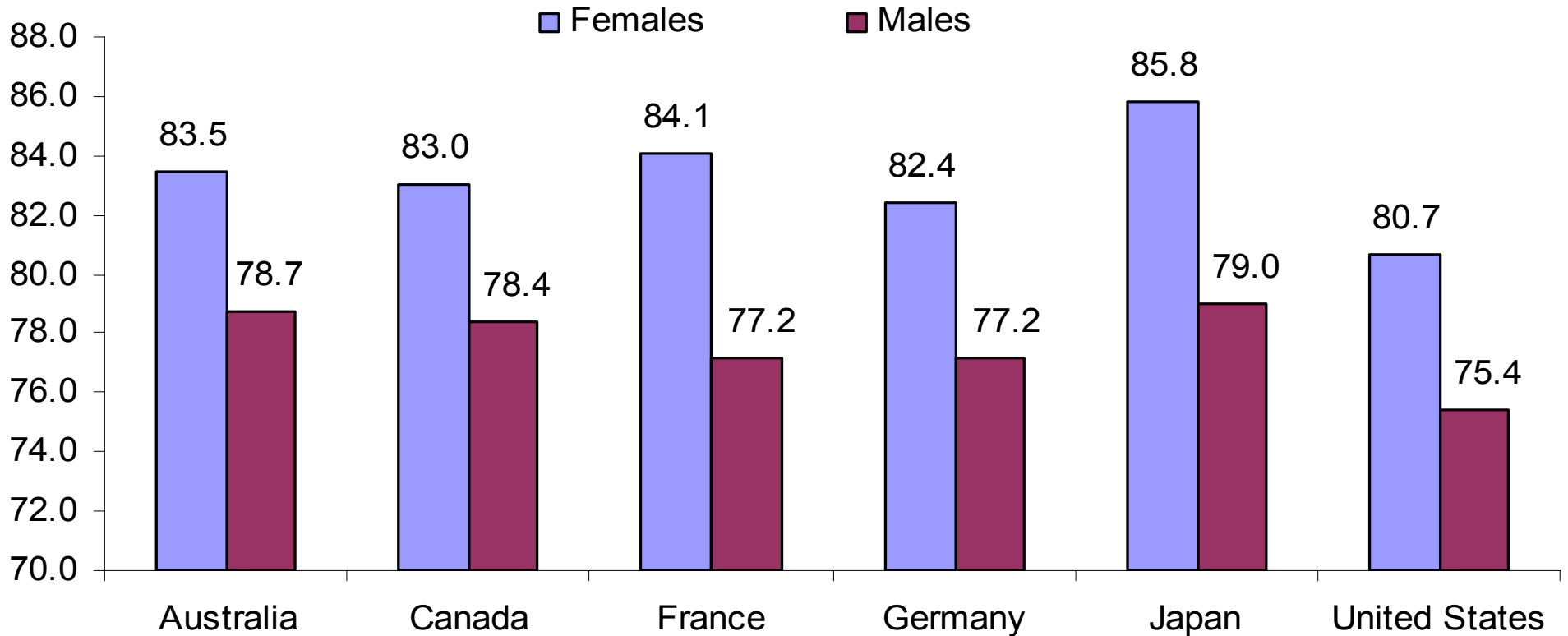


Source: US\$ purchasing power parity, Organisation for Economic Co-operation and Development (OECD) Health Data 2009, June 2009

* Japan and Australia are based on 2006 data

Cost challenge

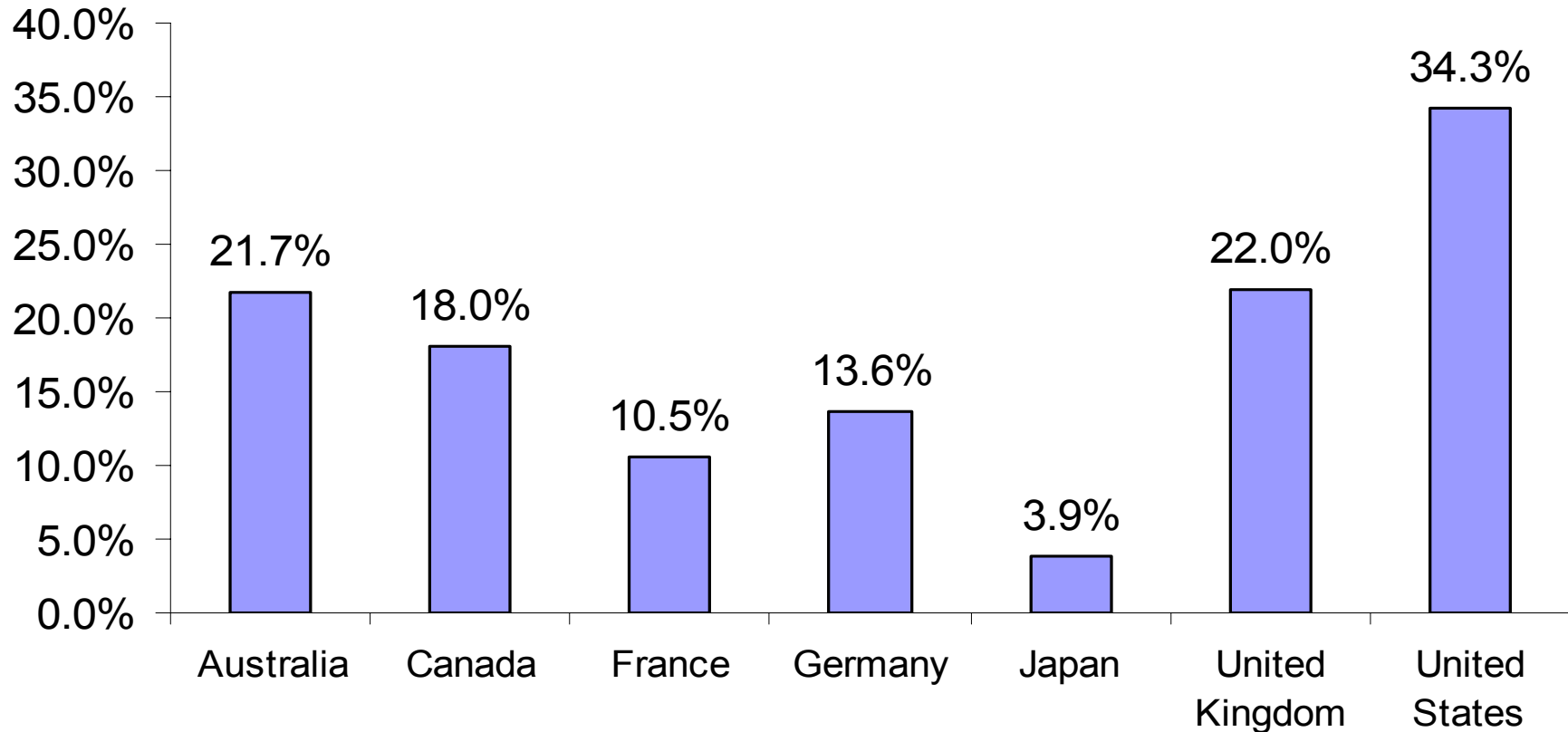
Life expectancy is lower despite higher costs



Source: 2006 life expectancy at birth, OECD Health Data 2009, June 2009

Cost challenge

Future costs and average lifespan will be impacted by obesity



Source: UK NHS, National Obesity Observatory, International Comparisons of Obesity Prevalence, June 2009
- United States (2004), United Kingdom (2007), Japan (2005), Germany (2005), France (2006), Canada (2005),
Australia (1999)

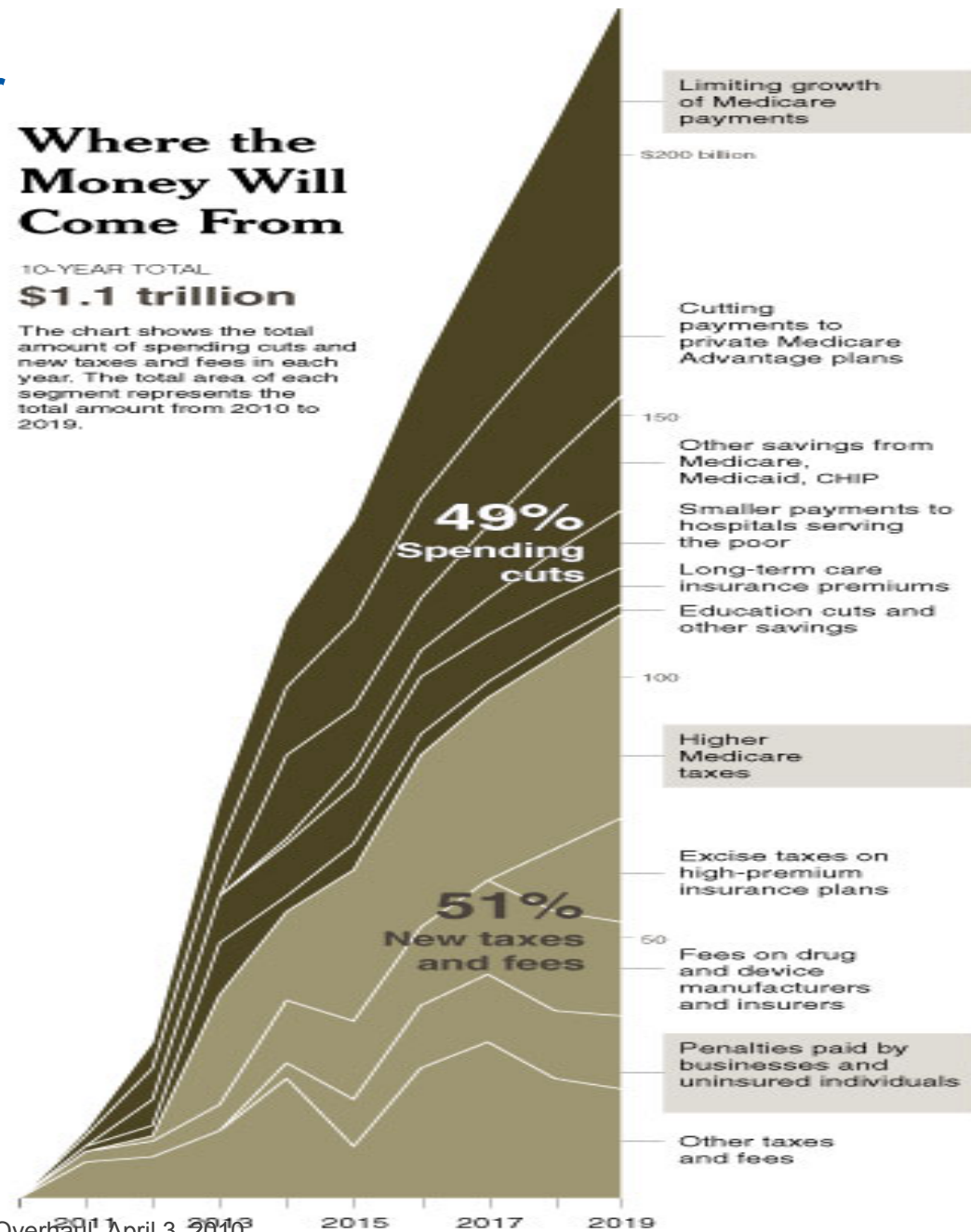
In a final effort to save reform, President Obama narrowed his message about what health reform would deliver

- Kept on point with a narrow message about goals
 - Increase access to coverage for people who are uninsured, do not qualify for coverage due to pre-existing conditions or who can't afford the premium cost
 - Make coverage easier to purchase through Exchanges
 - Encourage individuals to take care of their health through 100% preventive care coverage and premium incentives for wellness
 - Improve value by covering preventive care and eliminating limits
- Promised ***“If you like your plan, you can keep it.”***
- Created a common enemy (insurers) as a reason for change
- Eliminated some contentious elements

By opening up new vehicles for coverage, PPACA creates opportunities to think out of the box about health care as a benefit program

Revenue risks are a major concern

- Is the price tag correct?
- Is there enough new revenue?
- Will Congress follow through to on cutbacks, taxes, penalties and fees?
- If there are shortfalls, will employers be tapped to fill the gap?
- Will the penalties change behavior? If more employers drop coverage and the individual mandate is weak, will the individual market become more unstable?



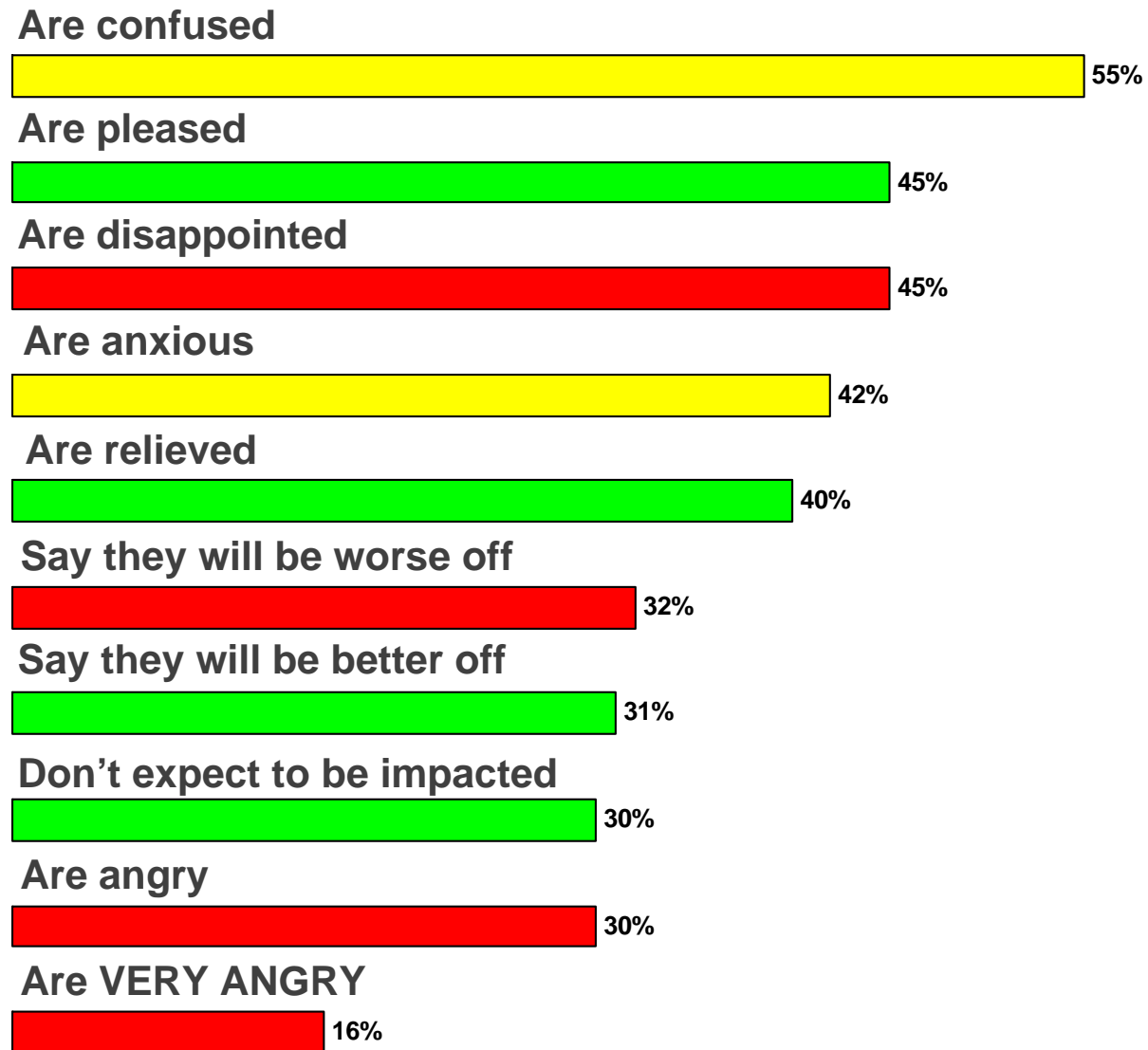
Source: *The New York Times*, Questioning the Cost of the Health Care Overhaul, April 3, 2010

PPACA was intended to reform health. It won't control health, but it's likely to dramatically shift the benefits landscape

- PPACA's focus
 - Improve access to coverage through Medicaid, employer-sponsored plans and exchanges
 - Make the cost of coverage more affordable
 - Increase oversight of health plans and benefit programs
- The reality is that PPACA will reshape the value proposition for employer-sponsored health and benefit programs
 - Redefines competitive practice for attracting and retaining workers
 - Provides more flexibility for employers to provide all benefits or combinations of direct and voluntary
 - Drives structural change in workforces
 - Shifts focus from health care cost to productivity



As a starting point, do your employees like it, hate it, understand it?



Source: Kaiser Health Tracking Poll, April 2010



Legislative update

Impact of health reform on employers

June 4, 2010

- Change in tax treatment for over-age dependent coverage
- Accounting impact of change in Medicare retiree drug subsidy tax treatment
- Early retiree medical reinsurance
- Medicare prescription drug “donut hole” beneficiary rebate
- Auto-enrollment of full-time employees (effective TBD)
- Break time/private room for nursing moms

- Employers must distribute uniform benefit summaries to participants
- Employers must provide 60-day advance notice of material modifications (effective TBD)
- Form W-2 reporting for 2011 health coverage
- Group health plan fees begin

- Health insurance exchanges
- Individual coverage mandate
- Financial assistance for exchange coverage of low-income individuals
- Medicaid expansion
- HIPAA wellness limit increases
- Shared responsibility penalties
- Free-choice vouchers
- Additional reporting and disclosure

- Dependent coverage to age 26 for any covered employee’s child**
- No annual dollar limits**
- No pre-existing condition limits**
- No waiting period over 90 days**
- Additional new standards for new or “non-grandfathered” health plans, including limited cost-sharing
- Health insurance industry fees begin



- Dependent coverage to 26 (grandfathered plans may limit to children without access to other employer coverage, other than parent’s coverage)*
- No lifetime dollar limits*
- Restricted annual dollar limits*
- No pre-existing condition limitations for children up to age 19*
- No rescissions*
- Additional standards for new or “non-grandfathered” health plans, including non-discrimination provisions for insured plans and mandatory preventive care with no cost-sharing

- No health FSA/HRA/HSA reimbursement for non-prescribed drugs
- Increased penalties for non-qualified HSA distributions
- Voluntary long-term care “CLASS” program slated to start
- Pharmaceutical manufacturers’ fees start
- Medicare, Medicare Advantage benefit and payment reform
- Insurers subject to medical loss ratio rules

- \$2,500 health FSA contribution cap (indexed)
- Medical device manufacturers’ fees start
- Higher Medicare payroll tax on wages exceeding \$200,000/ individual; \$250,000/couples
- New tax on net investment income for taxpayers with incomes exceeding \$200,000/ individual; \$250,000/couples
- Change in Medicare retiree drug subsidy tax treatment takes effect

- Excise tax on “high cost” or Cadillac plans

* Applies to all plans, including “grandfathered” plans, effective for plan years beginning on or after Sept. 23, 2010 (Jan. 1, 2011, for calendar year plans). Collectively bargained plans may have a delayed effective date.

** Applies to all plans, including grandfathered plans, effective for plan years beginning on or after Jan. 1, 2014.

Legislative update

New grandfathering provisions



“If you like your plan,
you can keep it.”

Let's see just how much you like that plan!

New health reform guidance – Grandfathering

- The law attempts to strike a balance between allowing people to keep coverage they had on March 23, 2010, and expanding access and coverage
- Interim final rules publicly available June 14, 2010 from the Departments of Labor, Treasury and HHS
- What is a grandfathered health plan?
 - An existing group health plan or insurance coverage in which a person was enrolled on March 23, 2010
- Who can be covered under a grandfathered plan?
 - Current enrollees can re-enroll, even if the plan or policy is renewed
 - Family members can enroll
 - Children eligible under the new extended child coverage rules can enroll
 - Newly hired and newly enrolled employees and their families

New health reform guidance – Grandfathering

- What changes can be made to a grandfathered plan that will not cause the loss of the grandfather status?
 - Voluntary increase in benefits or adoption of other consumer protections
 - Changes to conform to legal requirements
 - Changes to third party administrators
 - Some or all covered participants cease to be covered, as long as there is continuous coverage of at least one person since March 23, 2010
- What other steps must be taken to preserve grandfather status?
 - In any plan materials describing benefits, include a statement that the plan believes it is grandfathered, and contact information
 - Model statement included
 - Keep records documenting plan terms or coverage in effect March 23, 2010, and supporting documents

New health reform guidance – Grandfathering

- What changes will cause a plan to lose grandfathered status?
 - Eliminating all or substantially all benefits (or any necessary element thereof) to diagnose or treat a particular condition
 - Increasing coinsurance percentage amount
 - Increasing copayments by more than medical inflation plus 15 percentage points, or \$5 increased by medical inflation
 - Increasing other fixed cost-sharing (deductibles, OOP limits) in excess of medical inflation plus 15 percentage points
 - Decreasing employer contribution by more than 5 percentage points below March 23, 2010 rate
 - Imposing certain new overall annual limits on dollar value of benefits
 - Entering into a new policy, certificate or contract of insurance after March 23, 2010, e.g., prior policy is not being renewed (with exception for certain collectively bargained plans)
 - Violating anti-abuse rules

Grandfathered plans – special rules for collectively bargained plans

- Collectively bargained plans will be treated like all other plans for purposes of new health plan standards
 - Some take effect for plan years starting on or after September 23, 2010
- Self-insured collectively bargained plans in effect on March 23, 2010 will be treated like all other grandfathered plans for purposes of determining when and how grandfather status is lost, and will become subject to health plan rules accordingly
- Insured collectively bargained plans are treated as grandfathered plans until the end of the last bargaining agreement under which coverage was provided on March 23, 2010
 - Change in issuer does not cause loss of grandfather status during period of the agreement

Impact of grandfather status (or lack of grandfather status)

- Some new health plan standards taking effect soon apply only to new or non-grandfathered plans, including
 - Cover certain preventive services with no cost-sharing
 - Insured plans subject to nondiscrimination rules
 - Dependent child extended coverage cannot be limited to children without access to other employer-sponsored coverage
 - New internal and external appeals rights
 - Emergency services access, including same cost-sharing in and out-of network
 - Participant flexibility to choose providers in plans assigning or designating primary care physicians
- Health plan standards taking effect in 2014 for new or non-grandfathered plans
- Individuals can satisfy 2014 mandate for “minimum essential coverage” with grandfathered coverage

Other important guidance

- Rules apply separately to each benefit package offered under a group health plan
- Plans exempt from health plan standards include
 - Dental only
 - Vision only
 - Retiree only
 - Nonfederal governmental retiree-only plans also exempt
 - “Excepted benefits” including Medigap, most FSAs, and Accidental Death and Dismemberment
- Very small plans (less than two participants who are current employees) will be exempt from new health plan standards

Important to know

- Government estimate of percentage of employers who will retain grandfathered status

Type of Employer	Enrollees	Plans Remaining Grandfathered 2011	Plans Remaining Grandfathered 2013
Large	133 million	71% - 87%	36% - 66%
Small	43 million	58% - 80%	20% - 51%



Financial impact

Direct financial impact

- Employer costs will increase 4-6% in the short-term due to expanded eligibility, plan design provisions and contributions
 - Plan design changes to bring plans into compliance
 - 60% Actuarial value
 - No cost sharing for preventive care
 - No lifetime maximums, no annual maximums (per guidelines)
 - No exclusions
 - Premium cost to cover all eligible employees
 - Employees working over 30 hours
 - Newly eligible dependents
 - Participants who have declined coverage
 - Limiting the waiting period to 90 days
 - Cost to make coverage affordable for low wage workers
- Longer term: Probability of paying an excise tax for high cost plan

Indirect financial impact

- Possible offsets
 - Number of low-paid workers who may be eligible for Medicaid
 - Cost of penalty vs. compliance
 - Savings opportunities by changing current eligibility, design or contribution provisions to align with the new requirements
 - More aggressive health management programs
- Additional sources of cost impact
 - Cost shifting from government programs
 - Continued cost shifting from uncompensated care until individual market is stabilized
 - Actions by insurance regulators to control rate increases for individual and small group coverage
 - Risk of more mandates, earlier implementation dates
 - Fees charged to insurers, suppliers and drug manufacturers that will be passed to employer plans as added cost



Employer reactions

- “Sizing up the Challenge” survey was fielded between April 27 and May 7 to employers registered for Mercer’s webinars on health reform
- 791 employers participated, with a good distribution by industry and employer size
 - Fewer than 500 employees: 236 respondents
 - 500-4,999 employees: 354 respondents
 - 5,000+ employees: 196 respondents
- Designed to gauge employers’ *potential* actions in response to specific reform provisions, focusing on those effective in 2011. Employers were told “Gut reactions are allowed.”

Excise tax is the reform provision that worries employers the most

Percent of employers saying provision is a significant or very significant concern

Excise tax for high-cost plans



No lifetime limits



Children eligible up to age 26



Auto-enroll new hires



Employees working 30+ hours are eligible

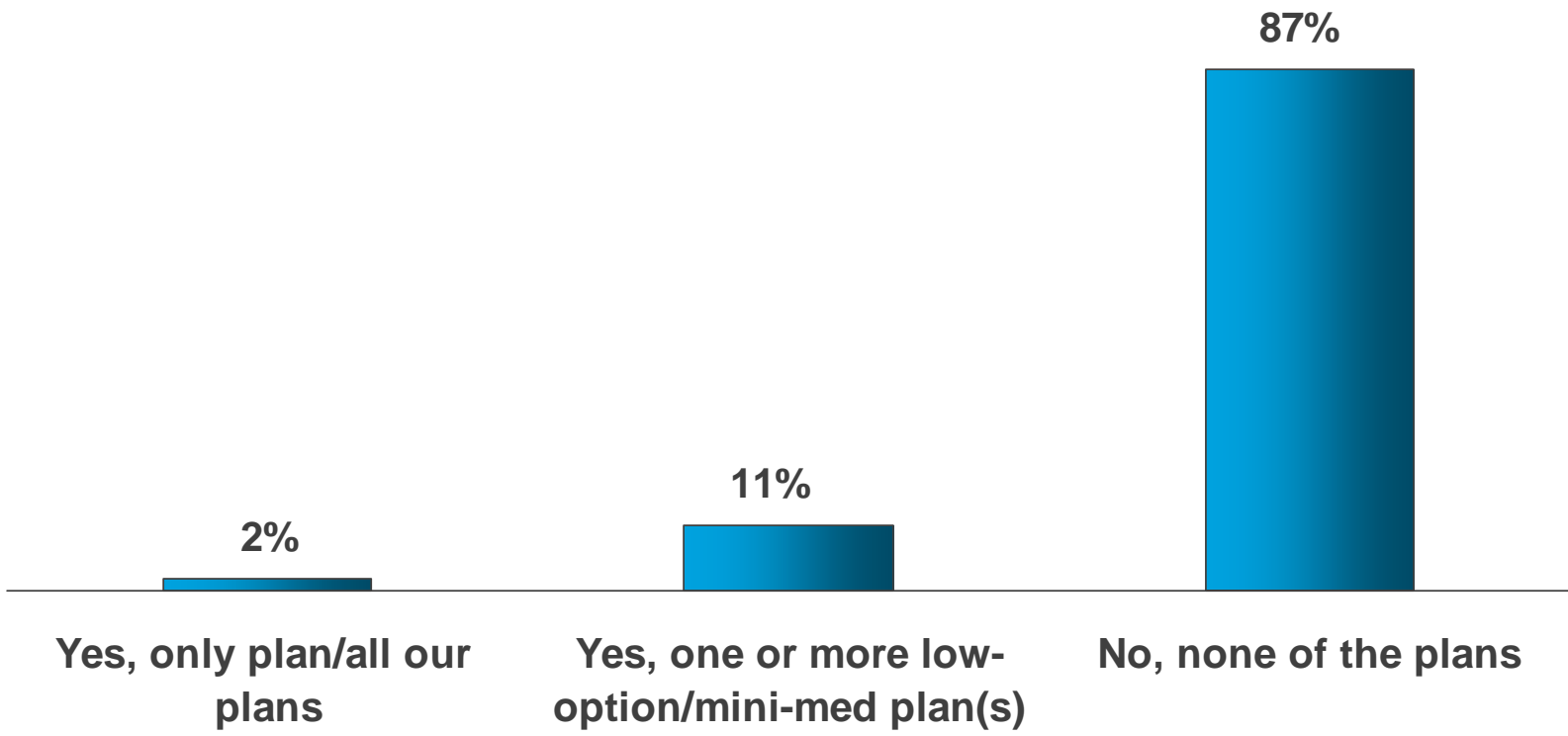


Plan must pay 60% of covered services



Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge

Most employers believe that their plans meet the requirement that plans must pay at least 60% of covered services

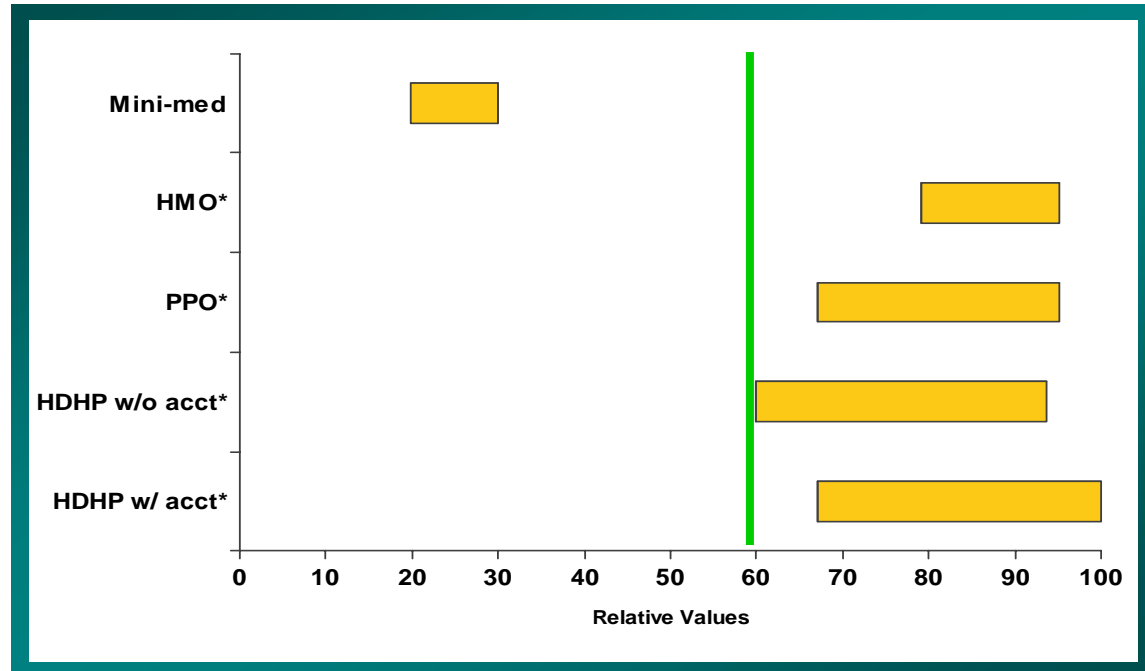


Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge

Limited medical plans are the major source of problem for failing plan designs

Percent of employers offering a limited medical plan

- 1% with <500 employees
- 5% with 500 – 999 employees
- 8% with 1,000 – 4,999 employees
- 17% Retail



Source: Mercer's National Survey of Employer Sponsored Plans, 2009

Most employers will need to remove lifetime benefit maximums

PPO/POS Plans

	Percent of plan sponsors with lifetime benefit maximums	Median lifetime limit
Small employers (10-499 employees)	61%	\$2,500,000
Large employers (500 or more employees)	71%	\$2,000,000

HMO Plans

	Percent of plan sponsors with lifetime benefit maximums	Median lifetime limit
Small employers (10-499 employees)	25%	\$2,000,000
Large employers (500 or more employees)	22%	\$2,000,000

Source: Mercer's National Survey of Employer Sponsored Plans, 2009

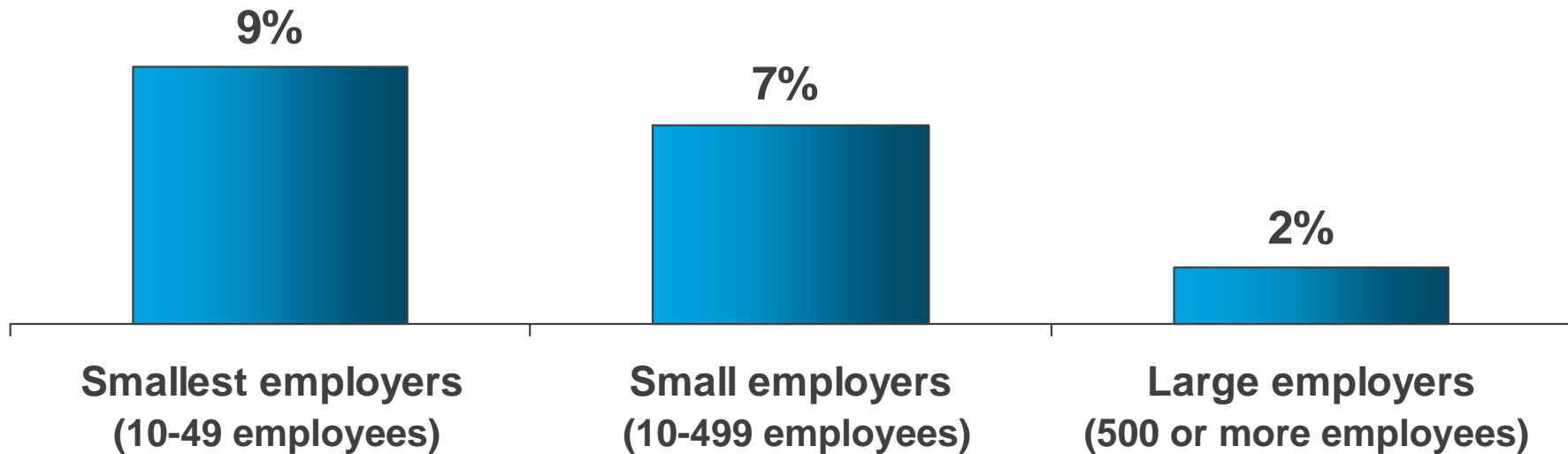
Most employers will need to lower flexible spending account caps, but few employees will notice

- PPACA places a cap on health care spending accounts
 - Viewed as a way to increase taxable compensation and raise revenue
- Availability of accounts varies by employer size
 - 85% of large employers (>500 employees)
 - 26% of small employers (10-499)
- 98% cap the employee contribution amount*
 - Median annual cap is \$4,500*
 - PPACA cap is \$2,500
 - Average annual employee contribution in 2009: \$1,535

*Data from Mercer's National Survey of Employer-Sponsored Health Plans 2008

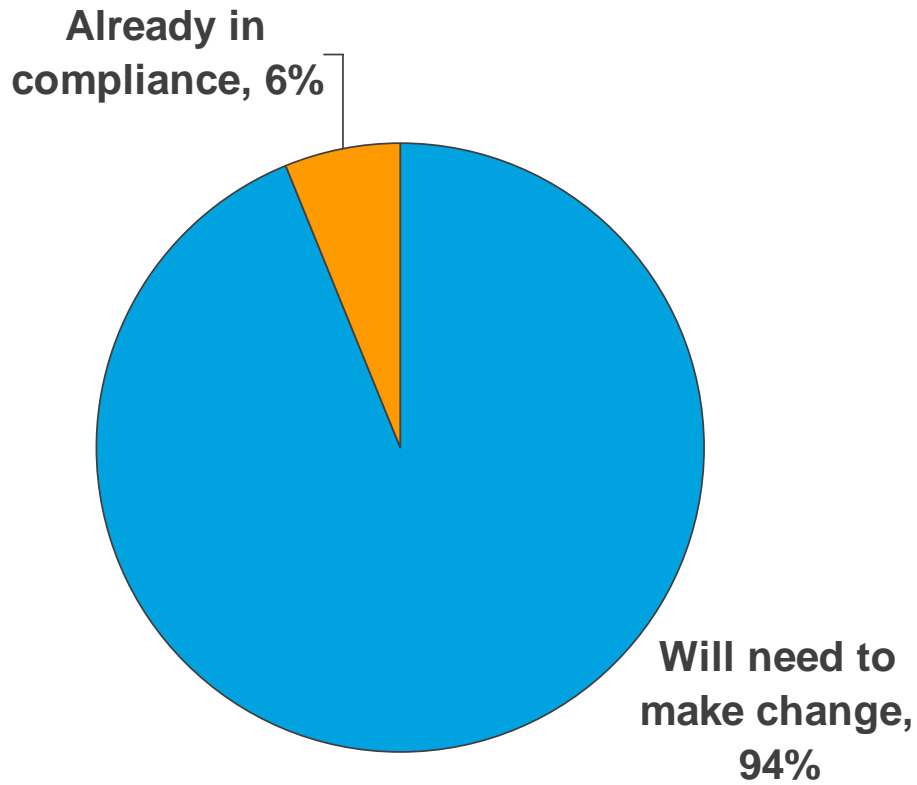
Most employers already meet 90 day waiting period

Percentage of employers with a waiting period of more than 90 days



Source: Mercer's National Survey of Employer Sponsored Plans, 2009

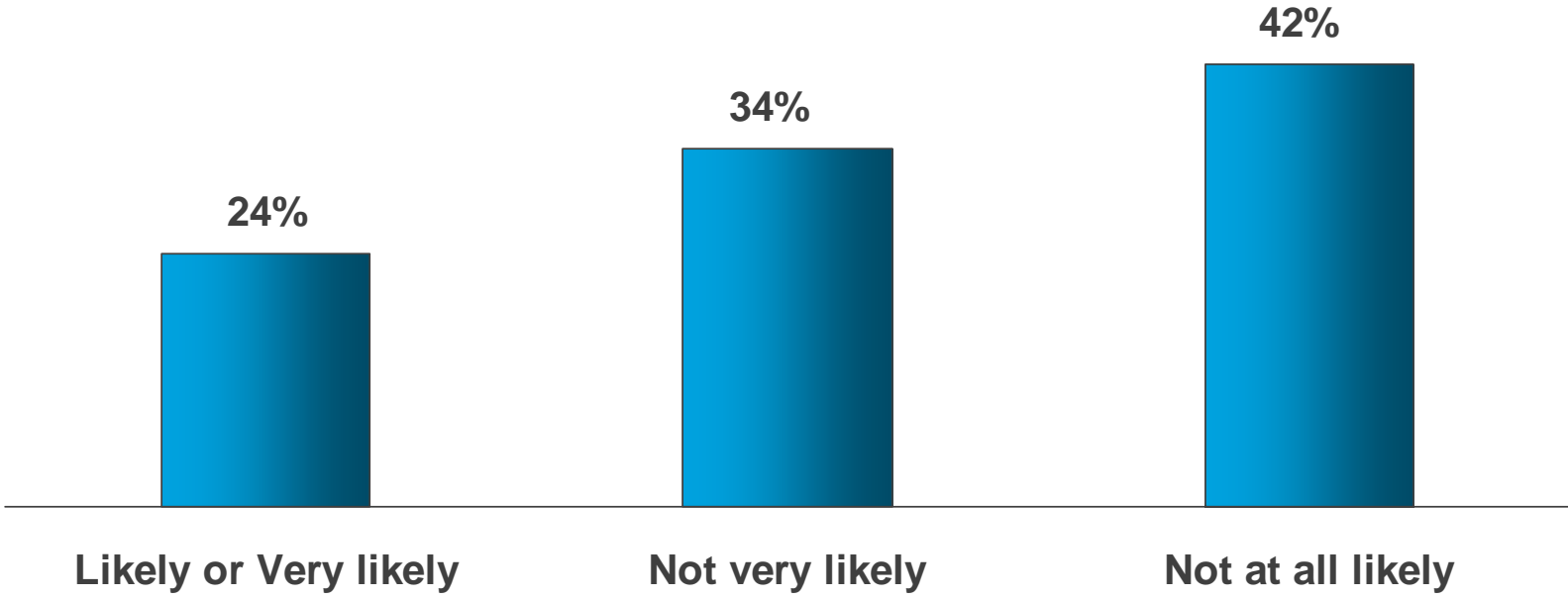
Most employers need to change their dependent eligibility rules to comply with the PPACA requirement that children up to age 26 be eligible for coverage



Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge

Likelihood that employer will extend coverage eligibility to children up to age 26 before the PPACA effective date

Based on employers that will need to change dependent eligibility rules



Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge



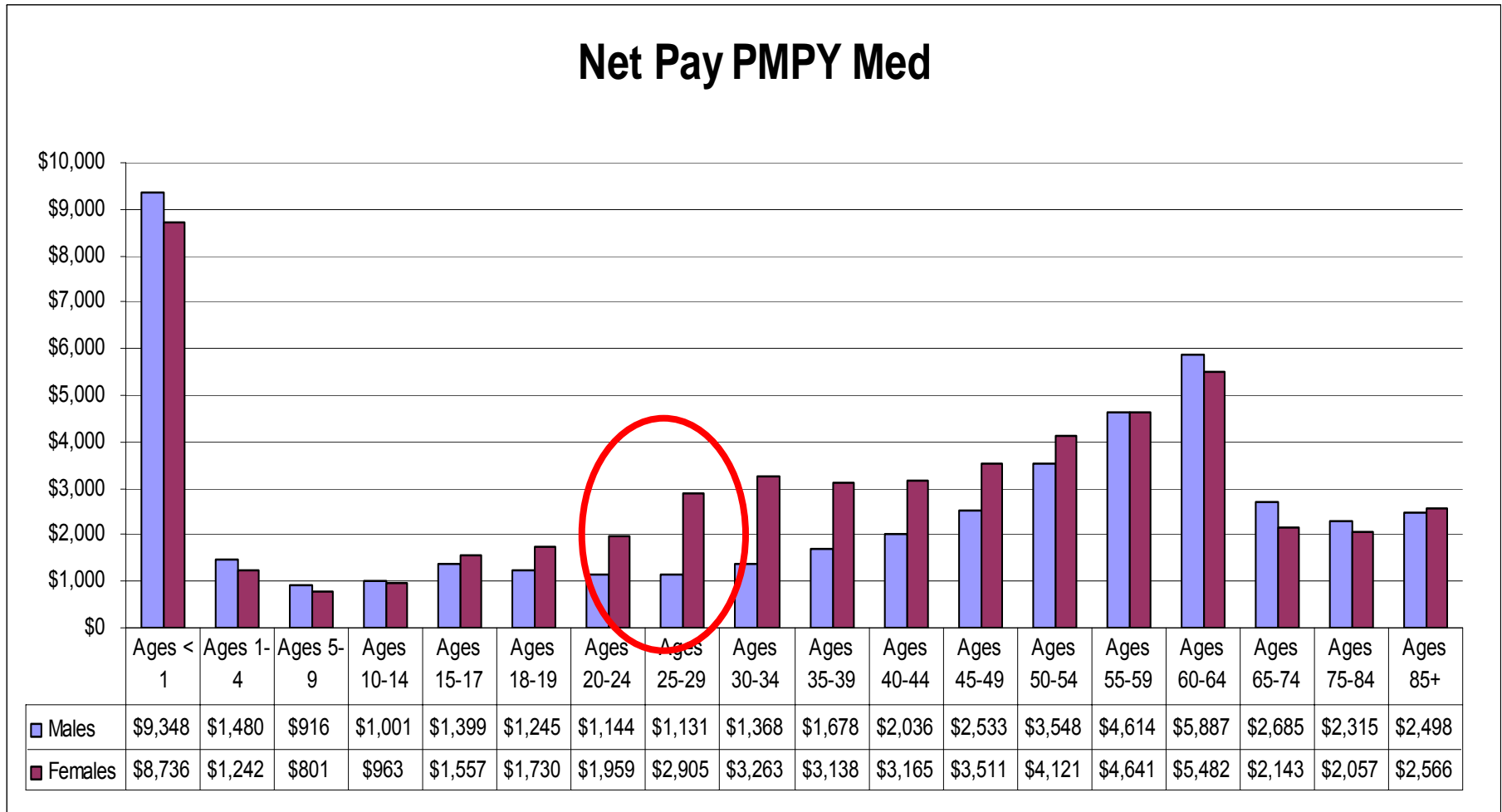
Cost considerations

Expanding eligibility to older dependents

- Cost for dependent children is highest when children are infants
- Older dependents are more costly than younger children, but less costly than the average adult plan participant – absent adverse selection
 - \$2,000-\$2,500 PMPY cost based on MHO data
 - In the 19 – 26 age range, females are more costly than males due to maternity expense
- Employers will have to offer enrollment to all eligible dependents, including those who had been removed from coverage
 - But, a dependent's spouse or child is not required to be covered

Cost considerations

Average annual cost for older dependents

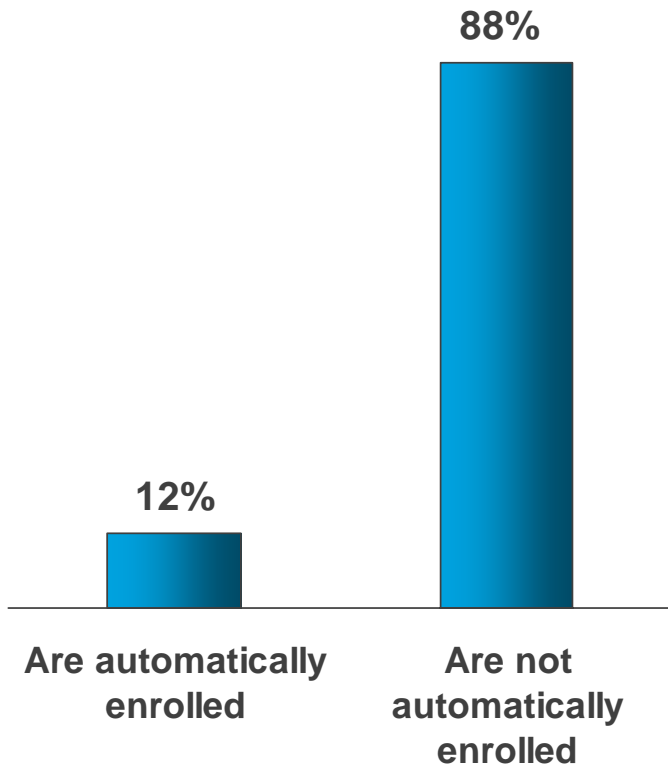


Source: Thompson-Reuters Market Scan Q12009 data

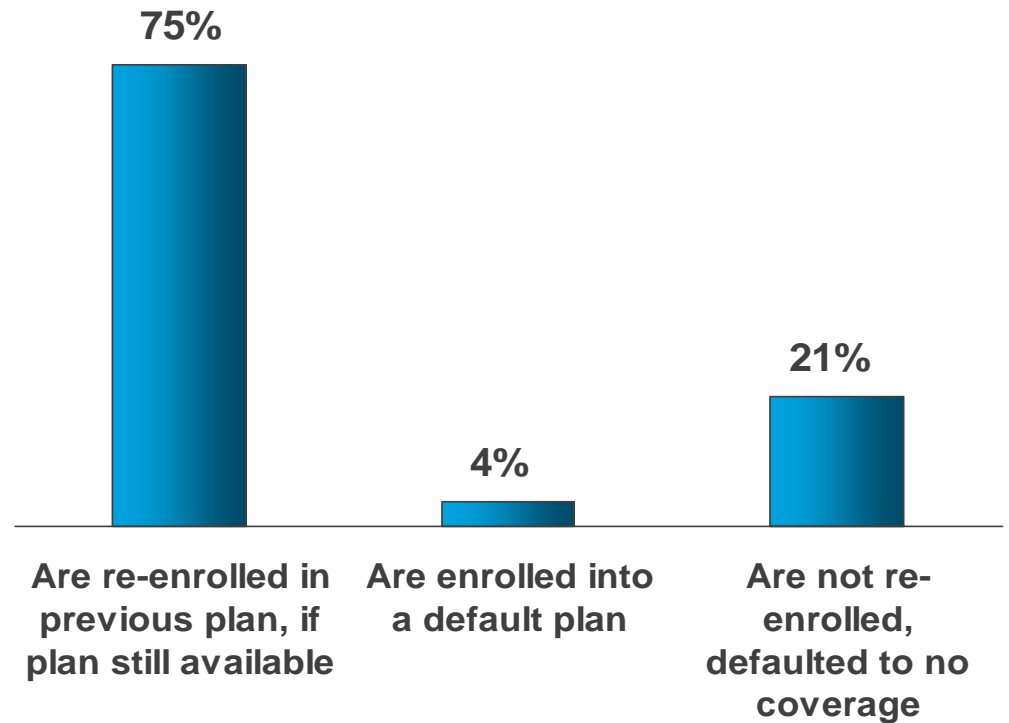
Impact of auto-enrollment

Most employers do not automatically enroll new hires

Newly hired employees who do not make an election:



Members who do not make an election during open enrollment:



Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge

Will strongly consider the following actions with regard to auto-enrolling new hires

Use lowest-cost plan or only plan as the default



Impose a waiting period of up to 90 days before auto-enrolling

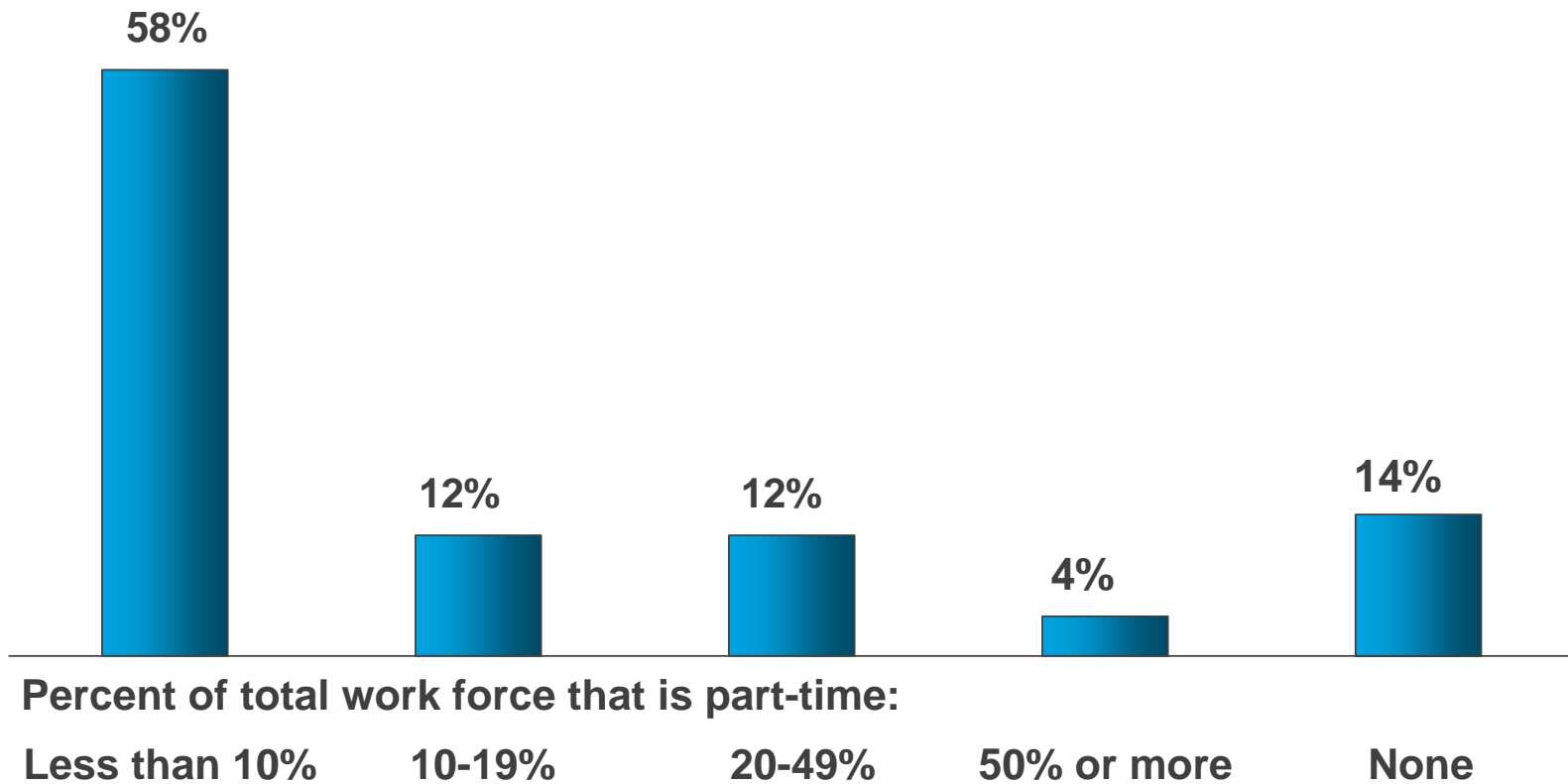


Add a new plan to use as the default



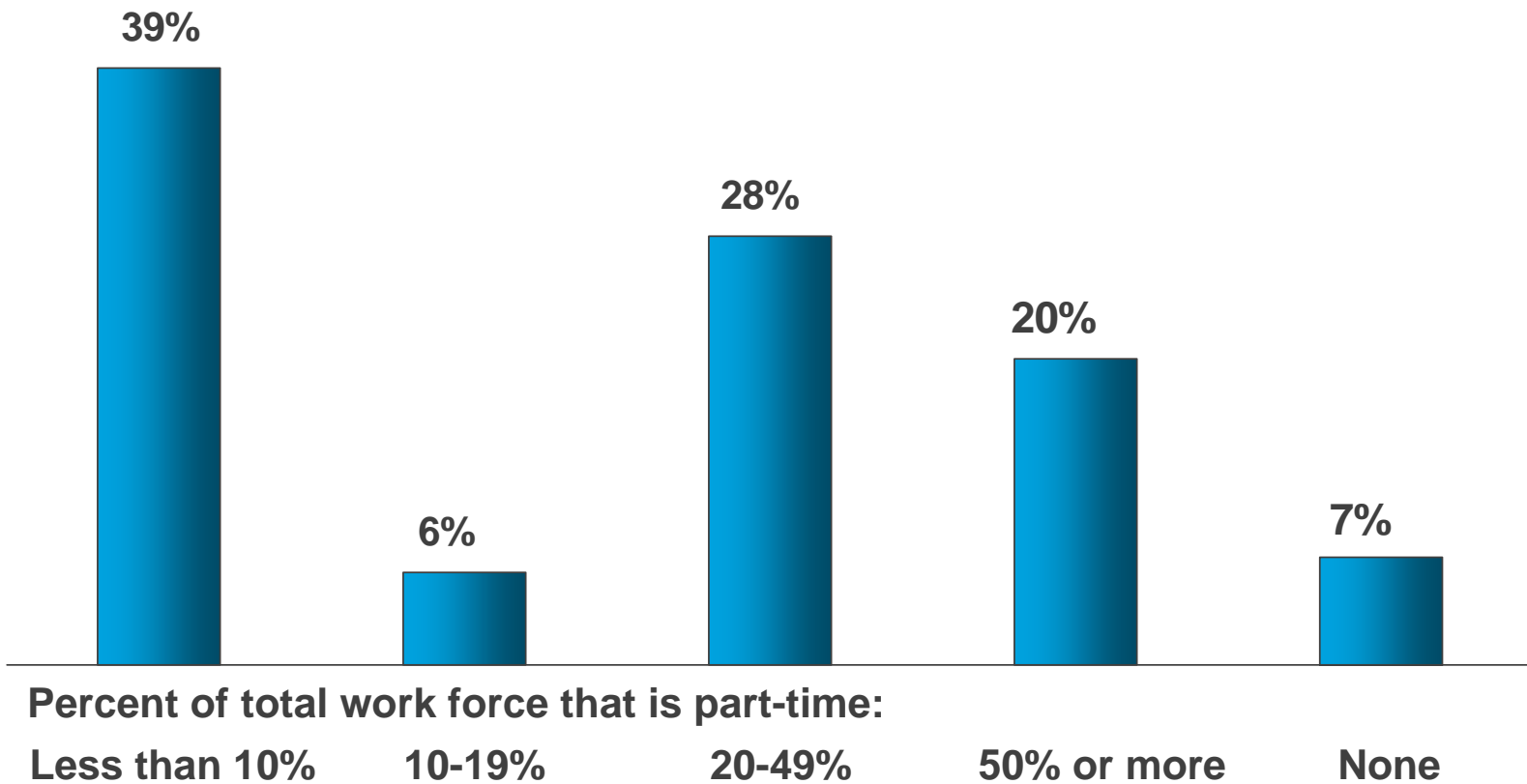
Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge

For a majority of employers, less than 10% of the total workforce is considered part-time – but that varies significantly by industry



Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge

For nearly half of retail employers, 20% or more of the total workforce is considered part-time

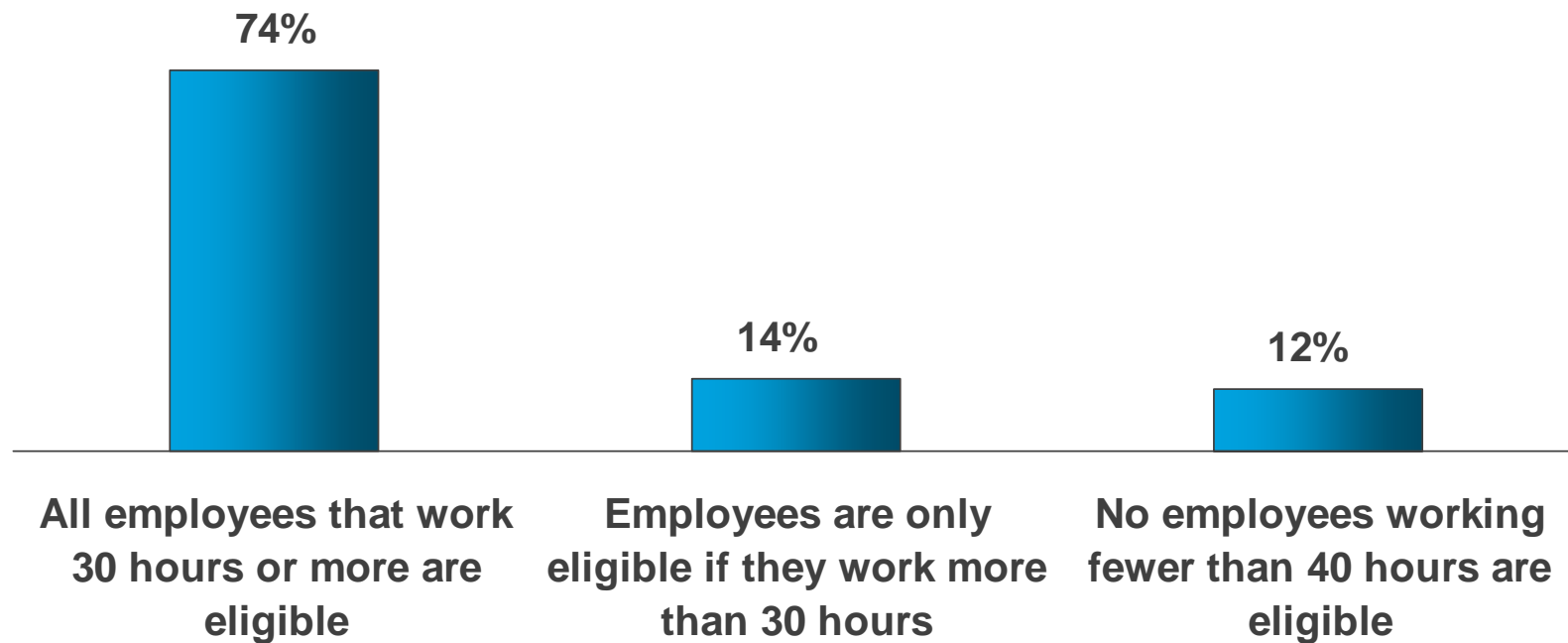


Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge



Only about three-fourths of employers currently extend eligibility to all employees who work 30 or more hours per week

Current eligibility provisions among employers with part-time employees

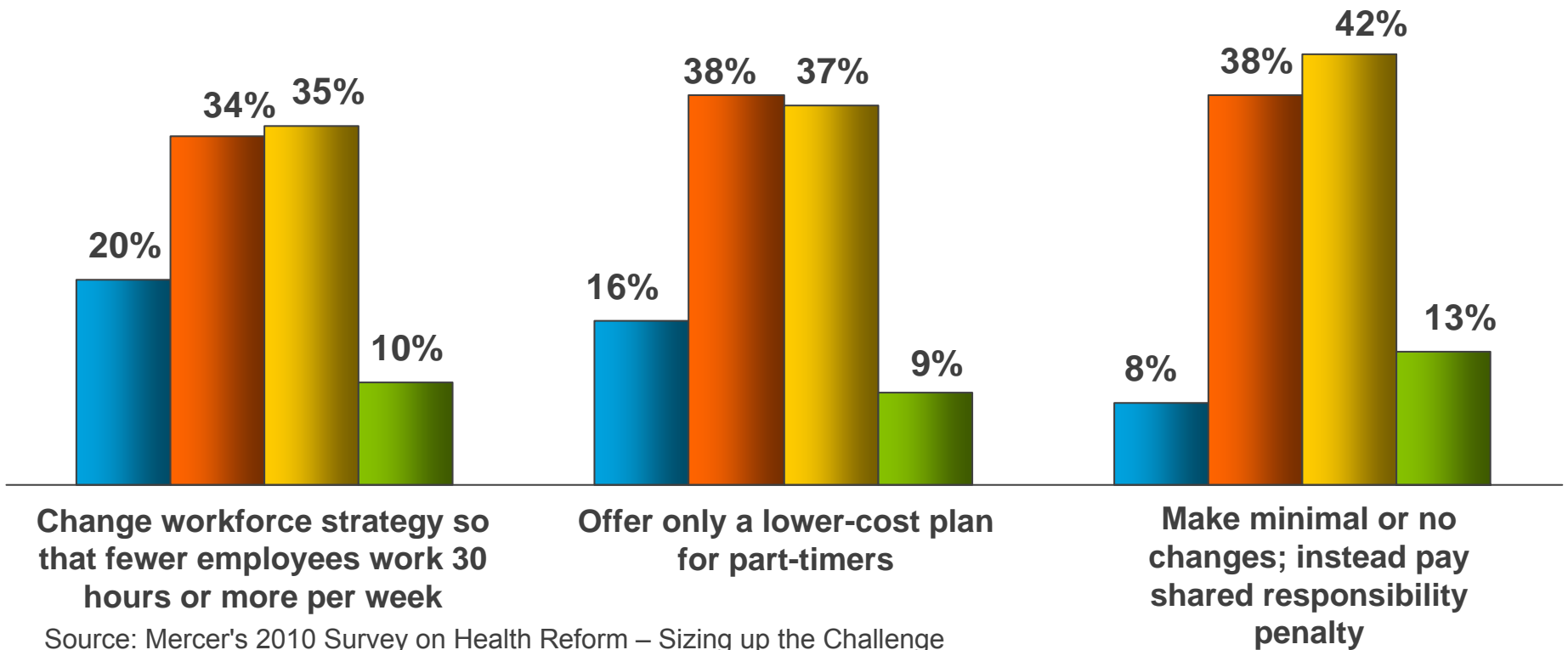


Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge

Possible actions with regard to the requirement that all employees working 30 hours or more per week must be eligible

Based on employers currently not in compliance

- Will strongly consider
- Would consider
- Not likely to consider
- Definitely would not consider

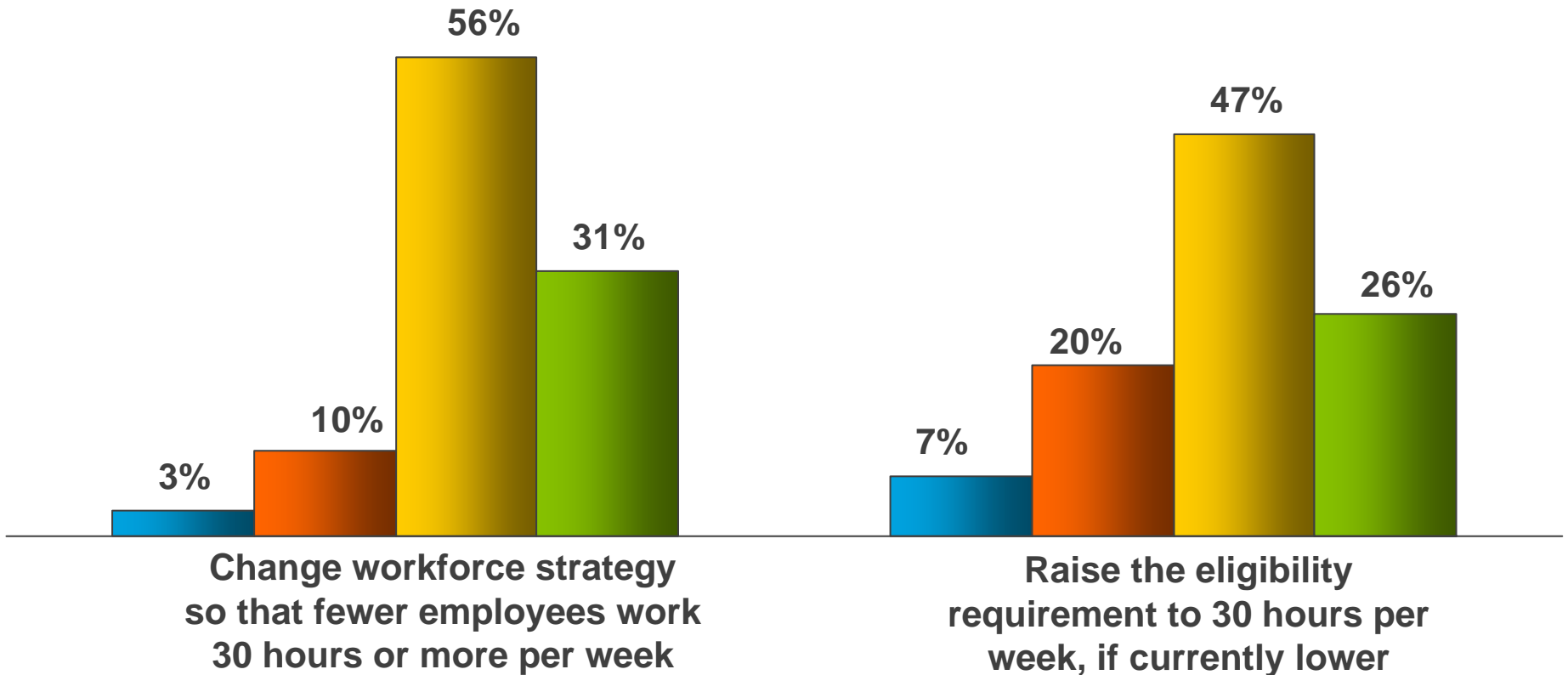


Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge

Possible actions with regard to the requirement that all employees working 30 hours or more per week must be eligible

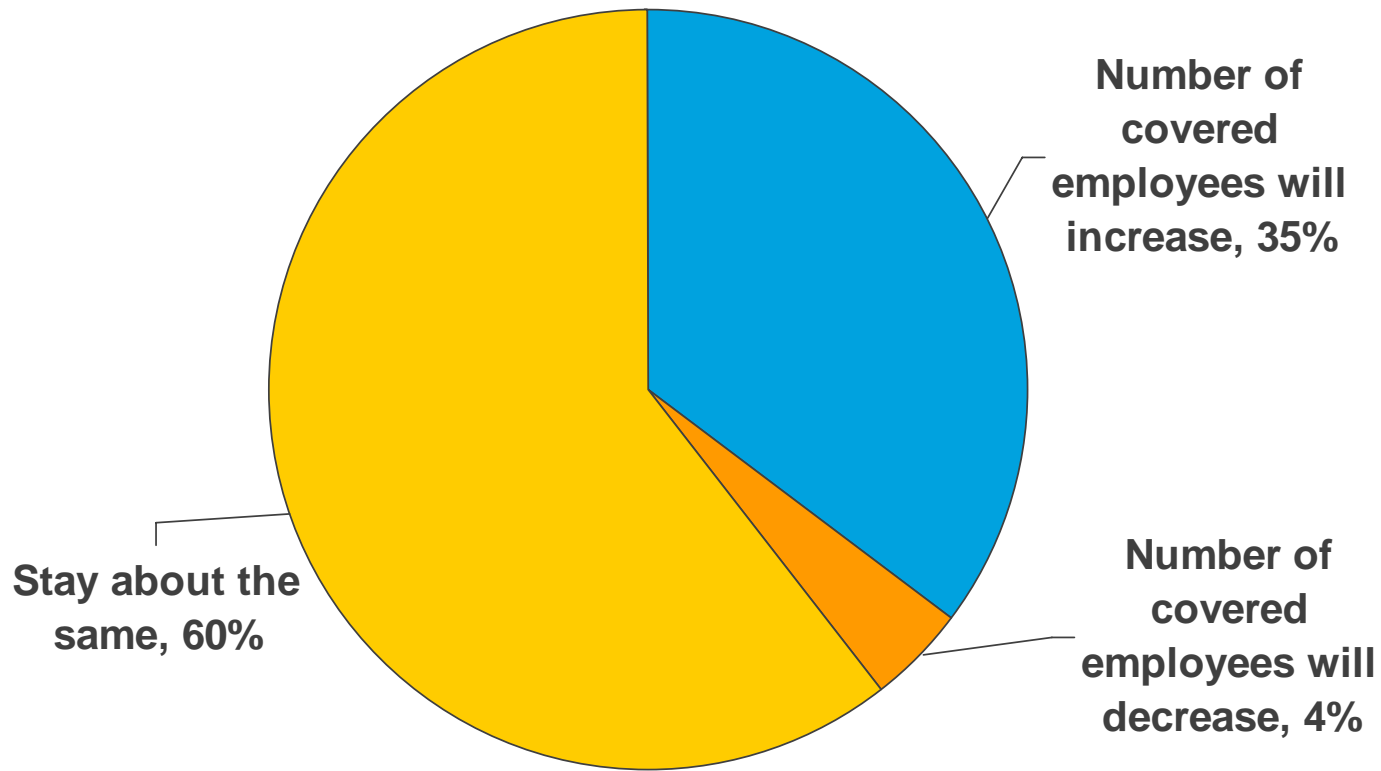
Based on employers already in compliance

- Will strongly consider
- Would consider
- Not likely to consider
- Definitely would not consider



Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge

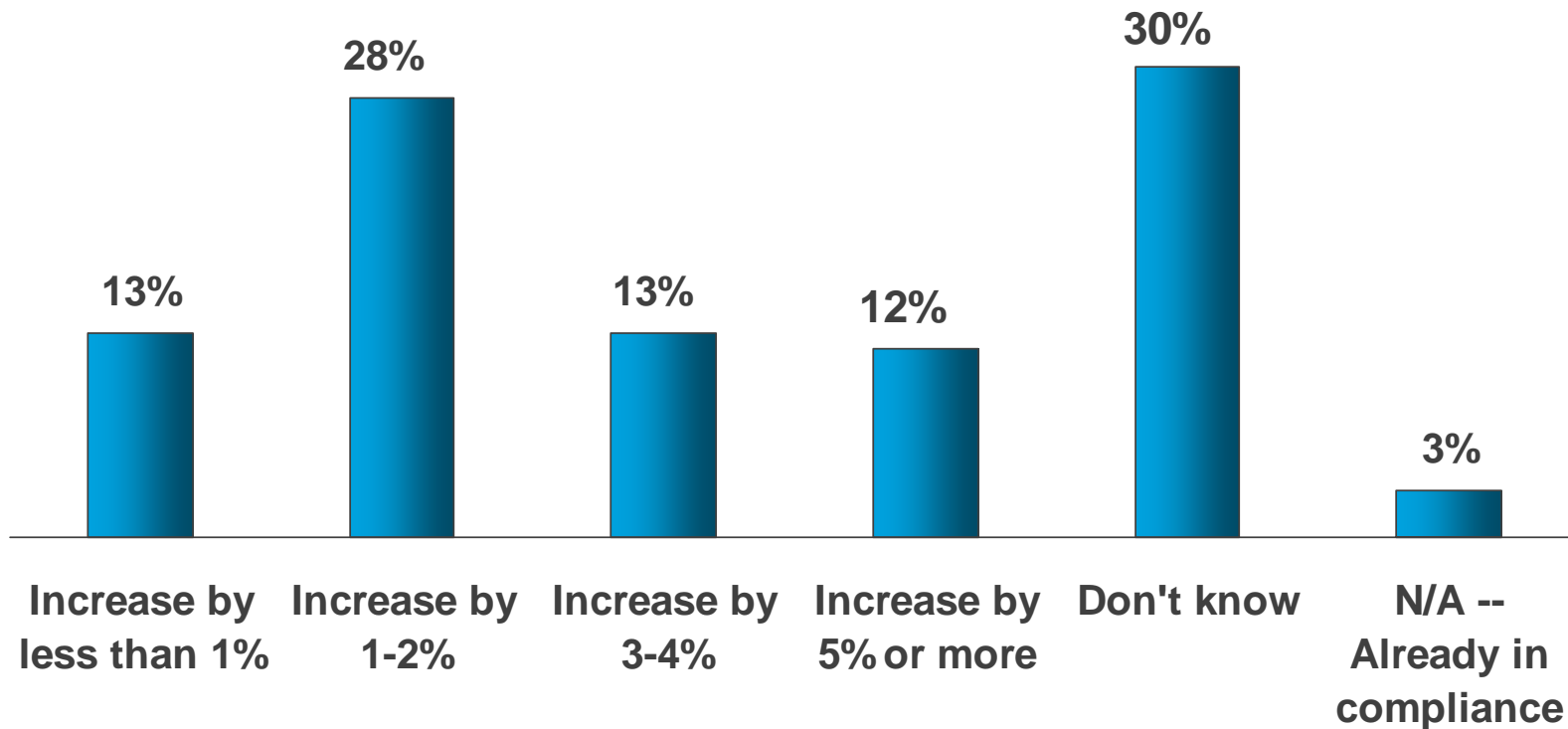
Enrollment will increase for about a third of employers



Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge

Employers expect cost to increase, but ranges vary

Employer estimates of cost increase due to covering children up to age 26 and eliminating benefit maximums



Source: Mercer's 2010 Survey on Health Reform – Sizing up the Challenge



Taking action

What should employers be doing in 2010?

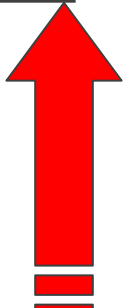
Completed...	In process...	Going forward...
<ul style="list-style-type: none"> ▪ Understand the basic reform requirements and timing ▪ Determine what aspects of your program require more definition through the regulatory process ▪ Inform executives of key changes ▪ If retiree medical benefits exist: <ul style="list-style-type: none"> – Address financial reporting requirements for retiree drug subsidy – Prepare to file for high-cost claim reimbursement (retiree/dependent claims age 55+ not Medicare eligible) 	<ul style="list-style-type: none"> ▪ Model the impact to comply with health reform requirements ▪ Evaluate alternative strategies and develop a short and longer-term strategy to comply ▪ Determine required changes for the next plan year and \$ impact ▪ Communicate with employees and constituents ▪ Consider whether to participate in CLASS Act employee-pay-all voluntary long term care program 	<ul style="list-style-type: none"> ▪ Evaluate and develop a longer-term vendor management plan ▪ Develop action steps needed to implement a long-term strategy to manage your post-reform costs ▪ Build a process to regularly update your strategy to respond to future reform and market changes

Thinking ahead to 2018

Finding the “sweet spot” for compliance

New Cost Pressures

- Eliminate lifetime maximums, most annual maximums and preventive care cost sharing
- Expand eligibility for some FTEs and dependents
- Increase administrative expense for compliance, auto-enrollment, salary-based contributions, CLASS Act
- Absorb cost shifting from government programs, uncompensated care, insufficient rates



Don't go below 60% value!

Don't incur excise tax!

Thinking ahead

- Does the 60% minimum value provide a new competitive benchmark?
 - Could be a basic option or only option
 - Provides a default coverage for auto enrollment
 - Could be supplemented by other group or individual options as a buy up or tied to incentives
- How well positioned is your carrier to create sustainable, innovative health care delivery solutions that will impact trend and improve outcomes?

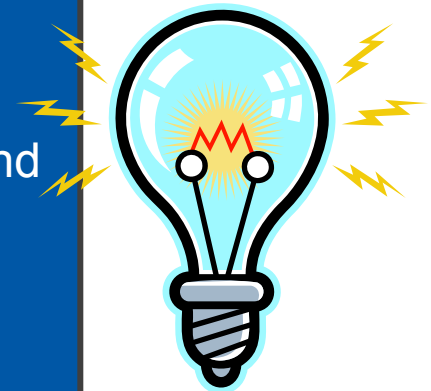
Is your carrier a long term player?

Guarantees performance, demonstrates ROI

Integrates with other vendors for seamless delivery of benefits and health care a seamless solution

Drives improvements in quality of care

Demonstrates leadership with innovative solutions



Thinking ahead

- Strengthen consumer skills, knowledge and behavior
 - Educate employees and their families to raise awareness of health risks, lead healthy lifestyle, use health resources appropriately and discuss treatment options
 - Adopt value-based design to encourage compliance with medication and treatment plans
 - Integrate meaningful incentives for taking health risk assessments, participating in programs, demonstrating sustained engagement and health improvements
 - Increase transparency of provider cost and quality

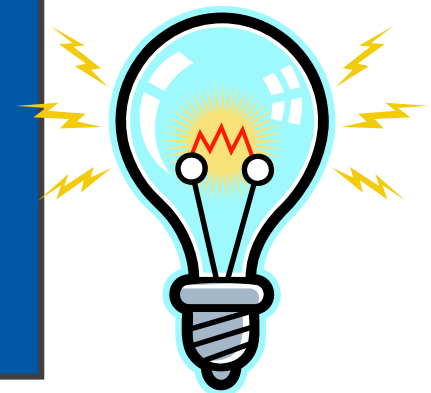
Adopt high-deductible plans with savings accounts

\$6,400 average cost vs. \$8,200 for PPOs and \$8,600 for HMOs

Provides a longer-term perspective on health care spending

Engages the consumer through tools, better financial decisions

Becomes the new low option for default coverage



Thinking ahead

- Provide comprehensive programs for the highest cost, most complex illnesses
 - Provide incentives for participants to seek highest quality care

Adopt innovative solutions that focus on individuals driving cost today and those people posing highest risk for future cost

Adopt “medical homes” with nurse practitioner patient coordinator to facilitate care for patients with high-cost, complex conditions

Provide incentives for individuals to select highest quality providers for procedures and conditions that pose highest risk for uneven outcomes

Encourage individuals to think beyond local provider networks for high quality solutions

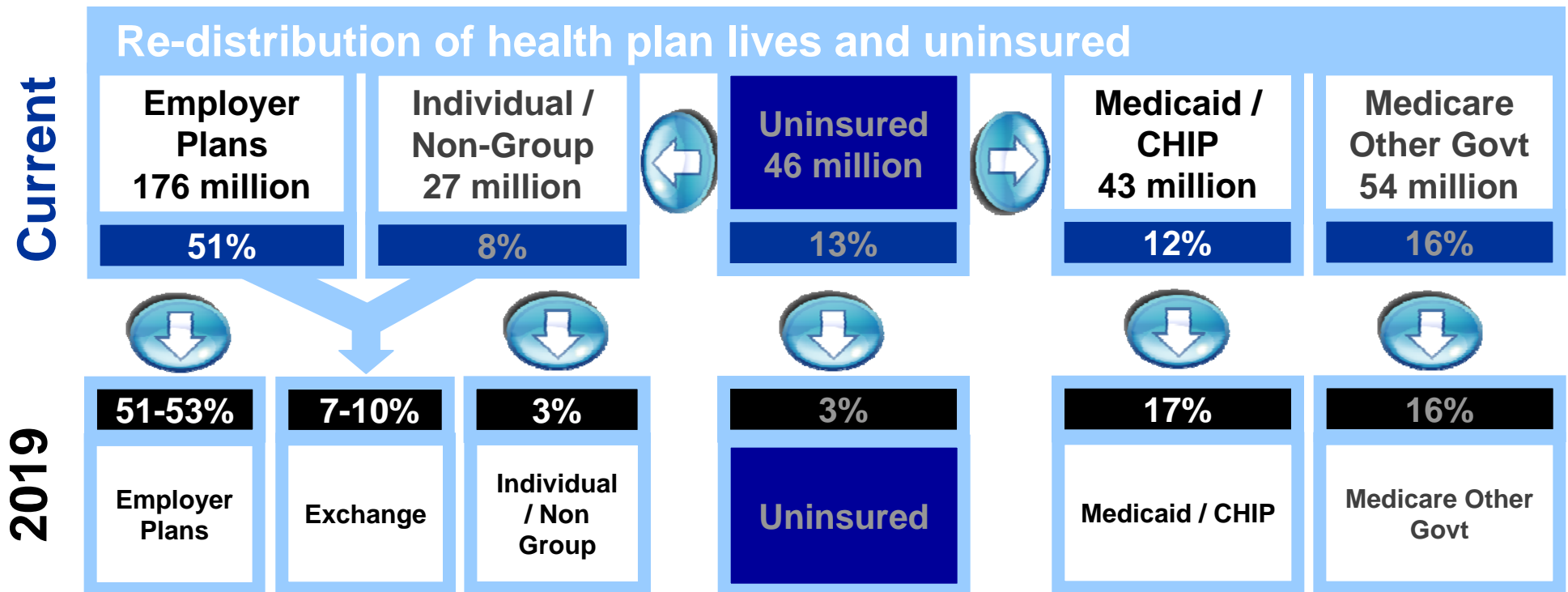




Looking ahead: Changes in market dynamics

Potential changes to market dynamics

Absorbing the uninsured



May re-shape the insurance markets and delivery systems in some unanticipated ways

Potential changes to market dynamics

Current state: Individual coverage is more expensive

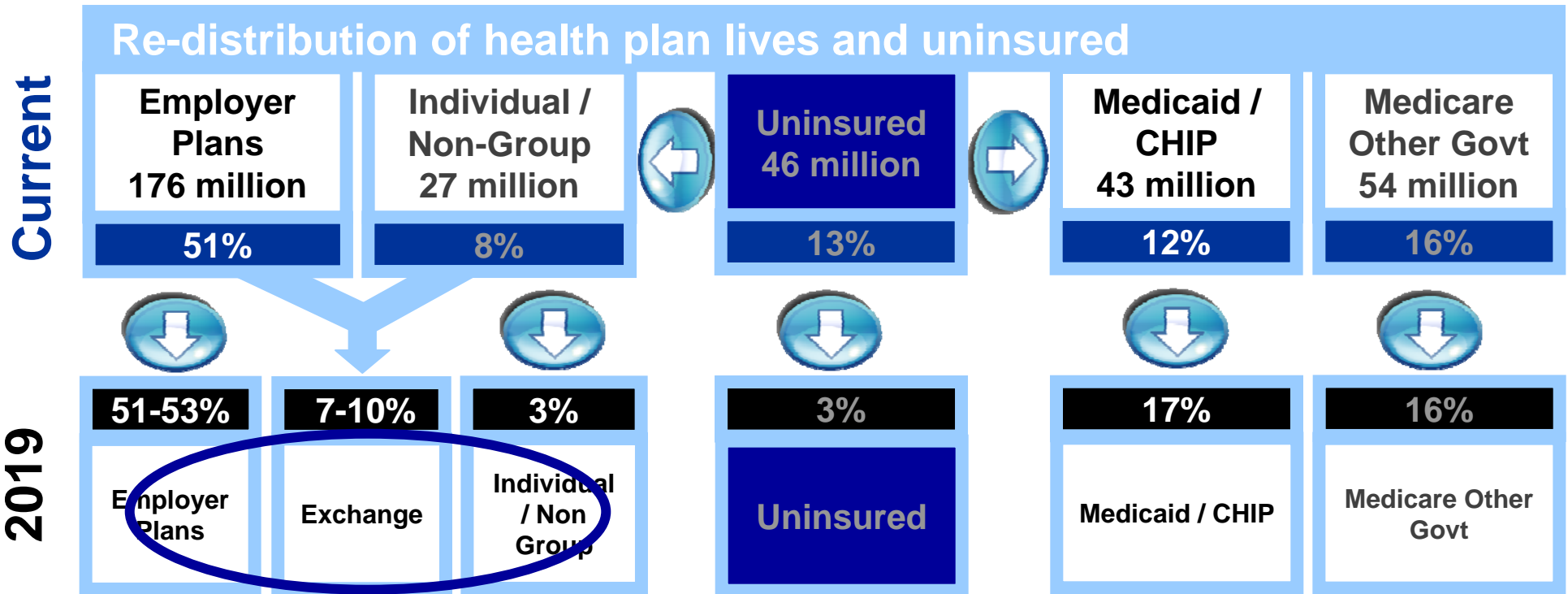
Individual coverage

- A less stable market and risk pool
Increased risk of adverse selection
 - Individuals can enter and exit for periods of time without significant penalties (no exit barrier)
 - High cost of coverage creates adverse selection -- attracts people who *need* coverage
- Administrative expense is higher due to providing services on a person by person basis (e.g., sales, enrollment, billing and premium collection)
- State mandated benefits apply
- Allowed retention: 20%

Group coverage

- A more stable market and risk-pool
 - Employees stay enrolled for duration of employment. Tougher rules apply for opting out of coverage
 - Most employers have a mix of high and low risk individuals
- Administrative expense is lower due to more timely, efficient enrollment and billing processes, and more reliable cash flow
- Flexibility to be self-insured and avoid mandates
- Allowed retention: 15%

Game change in market dynamics



CBO estimates that exchanges will be able to offer small groups and individuals coverage that is 14-20 percent lower than it would cost under current law due to competition, lower insurance overhead and increased pooling and purchasing power.

Potential changes to market dynamics

Desired state: Make individual coverage more affordable and accessible

- Actual cost of individual coverage will rise due to entry of higher risk individuals and loss of barriers (e.g., pre-existing conditions)
 - Weak individual mandate allows people to opt in/out as needed
 - Risk mitigated somewhat by federal subsidies that mask real cost, but make coverage more affordable
 - By 5th year of reform, average medical claims in the individual market could be 50% higher excluding impact of inflation*
- *What if insurance regulators try to keep individual premium rates artificially low?* Forces carriers to make tough decisions
 - Deplete reserves => jeopardizes financial ratings
 - Shift the short-fall to insured groups => squeezed by 85% MLR
 - Increase retention rates for larger self-insured groups
 - Consolidate to get more scale and leverage
 - Exit the market
 - Develop new products

Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability, Oliver Wyman, 10/09

Potential changes to market dynamics

Future state: Making individual coverage more affordable and accessible

- *What if insurers try to recoup losses from individual market by raising insured group premiums?* Forces small and mid-size employers to make tough decisions
 - Smaller employers will move to self-insured coverage to control their cost
 - Or, they could exit the market?
 - Shared responsibility mandate creates an incentive for exiting
 - Average 2009 PPO cost per employee: **\$8,334***
 - Penalty for not offering coverage is **\$2,000** per FTE if at least one FTE receives income-based assistance to buy exchange coverage (excludes first 30 employees)
 - Exiting does not become truly viable until 2014 when the individual mandate and health plan standards take effect

Potential changes to market dynamics

Employers dropping coverage have to consider impact on compensation

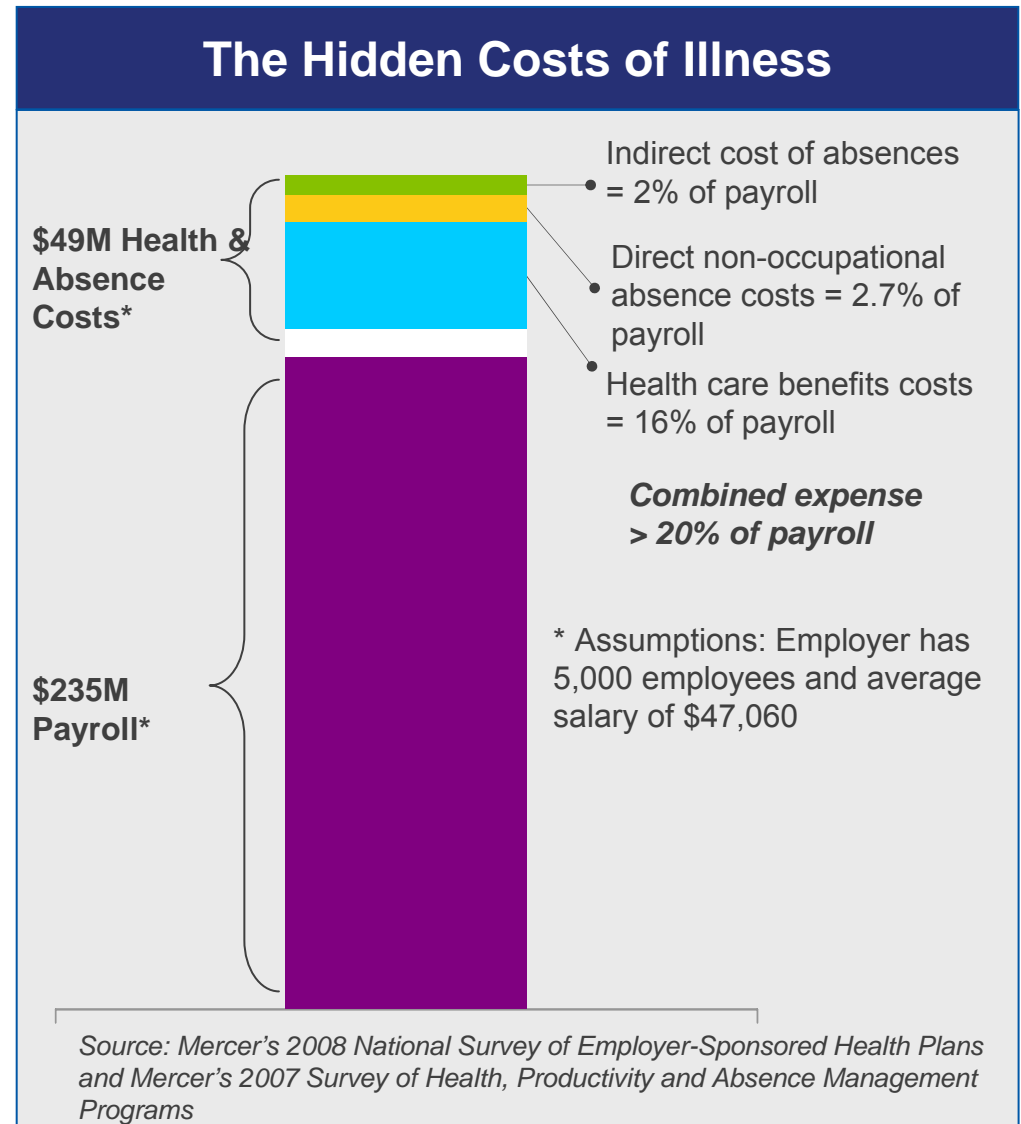
- *What if an employer decides to drop coverage?* How do you compensate employees who now have to buy coverage through an exchange?
 - Annual defined dollar contribution
 - How should it be calculated? Average net cost per employee? Adjusted for family status? Creates winners/losers
 - One time adjustment to salary
 - How do you communicate the value going forward?
 - Tax implications of tax-favored vs. taxable compensation
- *What are the upsides of dropping coverage?*
 - Create new mix of rewards that can be tailored to the individual
 - Exit some or all parts of administration

Downside to exiting

Dropping coverage reduces ability to understand productivity drivers

Exiting shifts the employer's focus to causes of absenteeism, lost productivity on the job, worker's compensation

Makes it more difficult to look at productivity holistically and address the "hidden" costs associated with poor health (e.g., multiple risks leading to illness and injury)



Potential changes to market dynamics

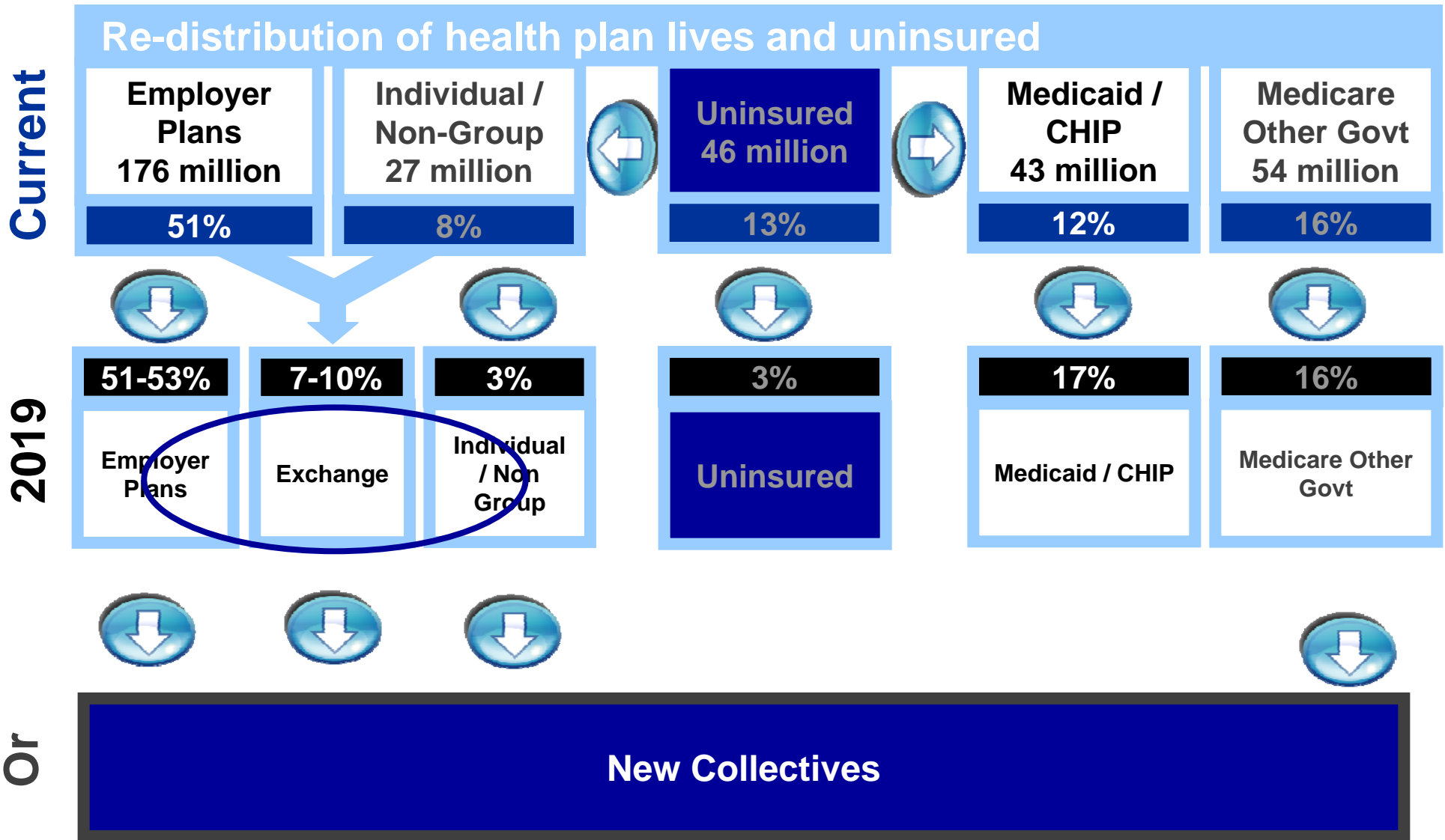
Will a two-tier market emerge?

- Factors that could influence the development of private market solutions
 - Medicare continues to reduce provider payments →
 - Increasing number of MDs not taking Medicare patients
 - Weak individual mandates continues adverse selection →
 - Increasing number of individuals who look for more affordable solutions and a more stable market
 - Rising cost pressures lead employers to adopt 60% value plan →
 - Increasing demand for voluntary benefit or direct to consumer solutions to supplement basic plan

Do these combinations of events lead to growth of a two-tier delivery system with regulated public plans as a safety net and private plans as supplemental coverage? Will private plans be sponsored by collectives, not employers?

Potential changes to market dynamics

Possible evolution to collectives, direct to consumer market



Collectives could be a new vehicle to help employers facilitate tailored choices for health, voluntary benefits, direct to consumer market

Membership



Lifestyles



Professional



Social Networks



Closing thoughts

Prioritize concerns and efforts

- Be tactical: Determine what has to change in the short term
- Be strategic: Develop a longer term strategy and develop contingencies based on how the market may evolve



Reminder of earlier warning:

- Many requirements are poorly defined
- Regulations may or may not be helpful
- Provisions that are clear now may change



Appendix

Health care reform issues for employer-sponsored plans

Beginning in 2010

Issue	Patient Protection and Affordable Care Act, as amended
<p>Health plan standards – all plans Effective for plan years beginning on or after Sept. 23, 2010; effective date may be delayed for certain collectively bargained plans</p>	<p>Insured and self-insured plans must:</p> <ul style="list-style-type: none"> ▪ Offer extended dependent coverage to age 26 for covered employee’s child (regardless of whether tax dependent, student, married, or residing with employee) <ul style="list-style-type: none"> – If grandfathered, can limit offering to those adult children without access to other employer coverage until 2014 except for other parent coverage – Effective March 30, 2010, extend tax-free treatment for employer-provided health care to an employee’s child until the end of the year in which the child turns age 26 ▪ No lifetime dollar limits on essential health benefits ▪ Restrict annual dollar limits on essential health benefits ▪ No pre-existing condition exclusions for children under age 19 ▪ No rescissions
<p>Health plan standards – insured plans only Effective January 1, 2011</p>	<p>All insured (but not self-insured) group health plans must meet minimum medical loss ratios:</p> <ul style="list-style-type: none"> ▪ 85% if employer has more than 100 employees ▪ 80% if employer has 100 or fewer employees

Health care reform issues for employer-sponsored plans

Beginning in 2010

Issue	Patient Protection and Affordable Care Act, as amended
<p>Health plan standards – new and nongrandfathered plans** Effective for plan years beginning on or after Sept. 23, 2010; delayed for certain collectively bargained plans *</p>	<p>Insured and self-insured plans must:</p> <ul style="list-style-type: none"> ▪ Provide mandated preventive services with no cost-sharing ▪ Establish and provide notice of internal and external appeals procedure ▪ Emergency services coverage <ul style="list-style-type: none"> – Cannot be limited to in-network providers – Cannot include higher cost-sharing for out-of-network providers – Cannot require preauthorization ▪ Plans requiring or providing for primary care physician designation <ul style="list-style-type: none"> – Must allow designation of any participating primary care physician or pediatrician – May not require preauthorization or referral for OB/GYN services ▪ Insured plans cannot discriminate in favor of highly compensated individuals

***"Grandfathered plans" A grandfathered plan is one in place *before* March 23, 2010.

Health care reform issues for employer-sponsored plans

Effective date is unclear

Issue	Patient Protection and Affordable Care Act, as amended
<p>Auto-enrollment requirement for employers with more than 200 full-time employees Effective date is unclear</p>	<ul style="list-style-type: none"> ▪ Unclear when it applies; may be effective: <ul style="list-style-type: none"> – March 23, 2010 – Once DOL issues regulations ▪ Must automatically enroll new full-time employees in employer-sponsored plan ▪ Must automatically continue plan enrollment for current employees ▪ Required notice and opt-out opportunity
<p>60-day advance notice of plan design changes Effective date is unclear</p>	<ul style="list-style-type: none"> ▪ Unclear when it applies; may be effective: <ul style="list-style-type: none"> – Plan years starting on or after March 23, 2010 – March 23, 2012 ▪ Must give 60-days prior notice before any material modifications can be made to the plan <ul style="list-style-type: none"> – Includes premium and cost-sharing increases, benefit decreases

Health care reform issues for employer-sponsored plans

Beginning in 2011

Issue	Patient Protection and Affordable Care Act, as amended
Form W-2 reporting	<ul style="list-style-type: none">▪ Employers must include the aggregate cost of an employee's health coverage▪ "Aggregate cost" to be determined using methodology similar to that for determining COBRA premiums (excluding pre-tax health FSA contributions, employee HSA contributions)▪ Appears reporting must first be made in 2012 to reflect 2011 coverage
No reimbursement for over-the-counter drugs	<ul style="list-style-type: none">▪ No reimbursement for over-the-counter drugs from a health plan, health flexible spending account, health reimbursement arrangement, or health savings account<ul style="list-style-type: none">– Reimbursements limited to physician-prescribed drugs and insulin
Increased penalty for nonqualified HSA distributions	<ul style="list-style-type: none">▪ Penalty for using health savings account (HSA) funds for nonqualified medical expenses (including over-the-counter drugs) will increase to 20% (in addition to income tax)

Health care reform issues for employer-sponsored plans

Beginning in 2011

Issue	Patient Protection and Affordable Care Act, as amended
CLASS Act	<ul style="list-style-type: none">▪ Employers may participate in CLASS Act employee-pay-all voluntary long term care program
Tax on pharmaceutical manufacturers	<ul style="list-style-type: none">▪ Annual fee begins for pharmaceutical manufacturers and importers (\$2.8B, rising to \$4.1B by 2018)
Part D premium increase for high-income individuals	<ul style="list-style-type: none">▪ Medicare beneficiaries with high incomes face higher Medicare Part D premiums
Medicare Advantage payment reductions	<ul style="list-style-type: none">▪ Medicare Advantage plan payments for 2011 will be frozen at 2010 levels, and reductions will be phased in starting in 2012

Health care reform issues for employer-sponsored plans

Beginning in 2012

Issue	Patient Protection and Affordable Care Act, as amended
Group health plan fee	<ul style="list-style-type: none">▪ Group health plans must pay a fee of \$1 per participant, increasing to \$2 for the second year and then a formula thereafter, to fund federal research on comparative effectiveness research▪ Sunsets in 2019
Uniform benefit summary	<ul style="list-style-type: none">▪ Employers must provide a 4-page uniform benefit summary at initial enrollment and annual enrollment▪ Includes information about covered benefits, exclusions, cost-sharing and continuation coverage▪ In addition to SPD and other currently required disclosures

Health care reform issues for employer-sponsored plans

Beginning in 2013

Issue	Patient Protection and Affordable Care Act, as amended
\$2,500 health FSA contribution cap	<ul style="list-style-type: none"> ▪ Annual contributions to health FSAs capped at \$2,500 <ul style="list-style-type: none"> – Adjusted annually for increases in the cost of living
Health insurance exchange notice	<ul style="list-style-type: none"> ▪ Employers must notify new hires about health insurance exchanges: <ul style="list-style-type: none"> – Eligibility for federal assistance to buy exchange-based coverage if employer’s plan pays less than 60% of covered benefits
New taxes for high-income households	<ul style="list-style-type: none"> ▪ Additional taxes imposed on taxpayers with income over \$200,000/individual or \$250,000/couple: <ul style="list-style-type: none"> – 0.9% increase in Medicare payroll tax – 3.8% tax on net investment income
Retiree drug subsidy tax treatment changes	<ul style="list-style-type: none"> ▪ Employers’ tax deduction for prescription drug claims paid will be reduced by the 28% RDS subsidy received in 2013 or after <ul style="list-style-type: none"> – Companies may have to recognize accounting impact in early 2010
Tax on medical devices	<ul style="list-style-type: none"> ▪ A 2.3% tax will apply to medical devices

Health care reform issues for employer-sponsored plans

Beginning in 2014

Issue	Patient Protection and Affordable Care Act, as amended
<p>Health plan standards – all plans Effective for plan years beginning on or after Jan. 1, 2014; delayed for certain collectively bargained plans</p>	<p>Insured and self-insured plans</p> <ul style="list-style-type: none"> ▪ Offer coverage to dependent children to age 26 regardless of access to other employer coverage ▪ No preexisting condition exclusions ▪ No waiting periods exceeding 90 days ▪ No annual dollar limits on essential benefits
<p>Health plan standards – new and nongrandfathered plans**</p>	<p>Insured and self-insured plans</p> <ul style="list-style-type: none"> ▪ Mandated coverage of costs in connection with clinical trials ▪ Annual cost-sharing and deductible requirements ▪ Provider nondiscrimination <p>Insured plans—guaranteed availability and renewability of coverage</p>
<p>HIPAA wellness incentive limit increased to 30% Plan years beginning on or after Jan. 1, 2014</p>	<ul style="list-style-type: none"> ▪ HIPAA limit on group health plan wellness incentives based on health status increased to 30% (up from 20%) of the total cost of coverage ▪ Regulators given authority to raise the limit to 50%

Health care reform issues for employer-sponsored plans

Beginning in 2014

Issue	Patient Protection and Affordable Care Act, as amended
<p>Employer shared responsibility penalties Beginning in 2014</p>	<ul style="list-style-type: none"> ▪ Shared responsibility provision apply to employers with more than 50 full-time employees (FTEs) defined as employees working 30 or more hours per week on average in a month (or full-time equivalents based on separate statutory formula) ▪ Employers <i>offering coverage</i> to full-time employees that is unaffordable (i.e., employee contribution constitutes more than 9.5% of household income) or pays less than 60% of benefits covered by the plan (i.e., 60% minimum actuarial value) <ul style="list-style-type: none"> – Up to \$3,000 annually for each FTE receiving income-based assistance for health insurance exchange coverage – Penalties capped at \$2,000 times total number of FTEs - not counting first 30 FTEs – Employers <i>not offering coverage</i> <ul style="list-style-type: none"> – Up to \$2,000 annually for every FTE if at least one FTE receives income-based premium assistance to buy coverage through new health insurance exchanges – Penalties do not apply to first 30 FTEs

Health care reform issues for employer-sponsored plans

Beginning in 2014

Issue	Patient Protection and Affordable Care Act, as amended
Free choice vouchers for certain employees Beginning in 2014	<ul style="list-style-type: none">▪ Offer vouchers to employees with household incomes at or below 400% of the federal poverty level (FPL) if their contribution for employer-sponsored coverage would be 8% to 9.8% of household income<ul style="list-style-type: none">– Voucher amount equal to highest (percentage) employer contribution to any of its own plans▪ Vouchers to be used for purchasing exchange-based coverage▪ Employees could keep any excess amounts▪ No penalty associated with free choice vouchers

Health care reform issues for employer-sponsored plans

Beginning in 2014

Issue	Patient Protection and Affordable Care Act, as amended
<p>Individual coverage mandate Beginning in 2014</p>	<ul style="list-style-type: none"> ▪ Individuals must obtain minimum essential coverage ▪ Certain exceptions (e.g., lowest cost plan exceeds 8% household adjusted gross income, no coverage for less than 3 months, income below the income tax filing threshold) ▪ Penalty would be the greater of a flat dollar amount (\$325 in 2015, rising to \$695 in 2016) or a specified percentage of income
<p>Health Insurance Exchanges Beginning in 2014</p>	<ul style="list-style-type: none"> ▪ Federal funding for states to create health insurance exchanges to facilitate purchase of insurance by individuals and small groups ▪ Employer size initially limited to 50 or fewer employers <ul style="list-style-type: none"> – Federal threshold gradually rises to 100 or fewer, with state flexibility to let employers of any size participate ▪ Income-based assistance for individuals or families with incomes below 400% of federal poverty level
<p>New industry fees Beginning in 2014</p>	<ul style="list-style-type: none"> ▪ Health insurer fees begin with \$8B in 2014 and rise to \$14.3B by 2018

Health care reform issues for employer-sponsored plans

2018 and beyond

Issue	Patient Protection and Affordable Care Act, as amended
<p>Excise tax on high cost coverage Effective for all plans in 2018</p>	<ul style="list-style-type: none">▪ 40% excise tax on “high cost” coverage, including medical, health FSA contributions, onsite medical clinics, and employer contributions to HSAs<ul style="list-style-type: none">– Does not include stand-alone insured dental and vision coverage▪ Initial cap set at \$10,200/single and \$27,500 family<ul style="list-style-type: none">– Higher thresholds (\$11,850/\$30,950) for retirees and workers in high-risk professions– Higher threshold (\$30,950) for multiemployer plan coverage– Indexed to CPI+1%▪ Aggregate cost determined using a methodology similar to that used for determining applicable COBRA premiums▪ Employers must determine aggregate cost<ul style="list-style-type: none">– Insurers responsible for tax for insured coverage– Benefit administrators responsible for tax for self-insured coverage– Employers responsible for tax for HSA contributions

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