Health Care Reform: Preparing for the Near and Longer Term Implications for Employers

August 5 & 6, 2011

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Today’s discussion

- Setting the context for Health Care Reform and detailed timeline
- Mandates requiring employer attention
- Future state of Health Care Reform
- What’s next
- Questions

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Setting the Context for Health Care Reform

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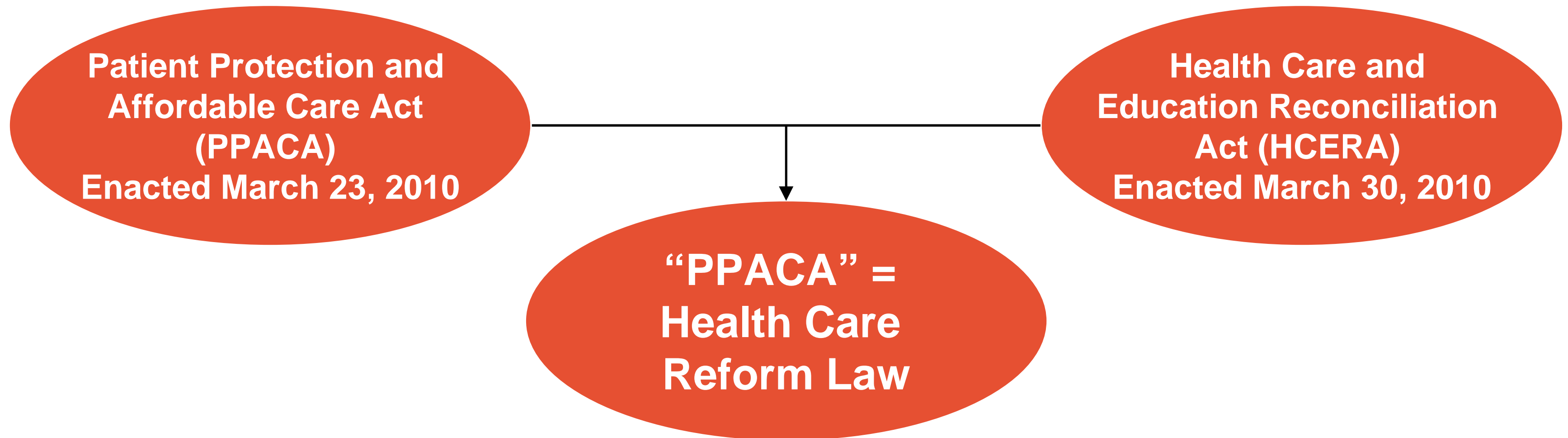
Health Care Reform is here — and brings significant short- and long-term challenges for employers



- Reform has significant implications for employers, employees/individuals, insurers, health care providers and others
- Impact starts immediately for employers
  - Major changes continue for years to come
- Employers face short-term and long-term challenges
  - *Short-term* challenges include understanding the new law and its implications and implementing immediate provisions
  - *Long-term* challenges include managing compensation and benefit strategy in a new environment

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Building blocks of Health Care Reform

Key Element	Provisions
Individual mandate	• Most individuals are required to enroll in basic health coverage or pay penalty • Limited exemptions
Health insurance market reform	• Guaranteed issue, renewal, no rescissions, premium rating restrictions, other consumer protections • Health Benefit Exchanges and standard benefit designs
Premium and cost-sharing subsidies	• Federal premium assistance and cost-sharing subsidies for individuals with household income up to 400% of the federal poverty level (FPL) • Available only for coverage obtained through Exchanges, not through employer-sponsored plans
Health Benefit Exchanges	• Established by States, structure the market • Initially, for individual and small group coverage – large groups may be allowed to participate (2017)
Employer mandates	• Comply with new group health plan benefit mandates/market reforms and reporting/disclosure requirements • Offer full-time employees who work on average 30 hours per week (or 130 hours per month), coverage meeting minimum requirements or pay penalties to the government • Auto enroll new full-time employees in coverage and continue enrollment of current employees
New and expanded public plans	• Medicaid eligibility expanded up to 133% of FPL • New, private, nonprofit Health Insurance Cooperatives and federally-administered multistate options through Exchanges

Revenue raisers	• 40% nondeductible employer excise tax on high cost employer-sponsored health coverage
	• Medicare HI taxes
	  – Increased .9% employee-only tax on wages in excess of $200,000 for individuals and $250,000 for joint-filers
	  – New 3.8% tax on certain unearned income for individuals with income $200,000+ and $250,000+ for joint-filers
	• Eliminate favorable employer tax treatment of Part D retiree drug subsidy
	• Changes for account-based plans (i.e., Health FSAs, HRAs, HSAs)

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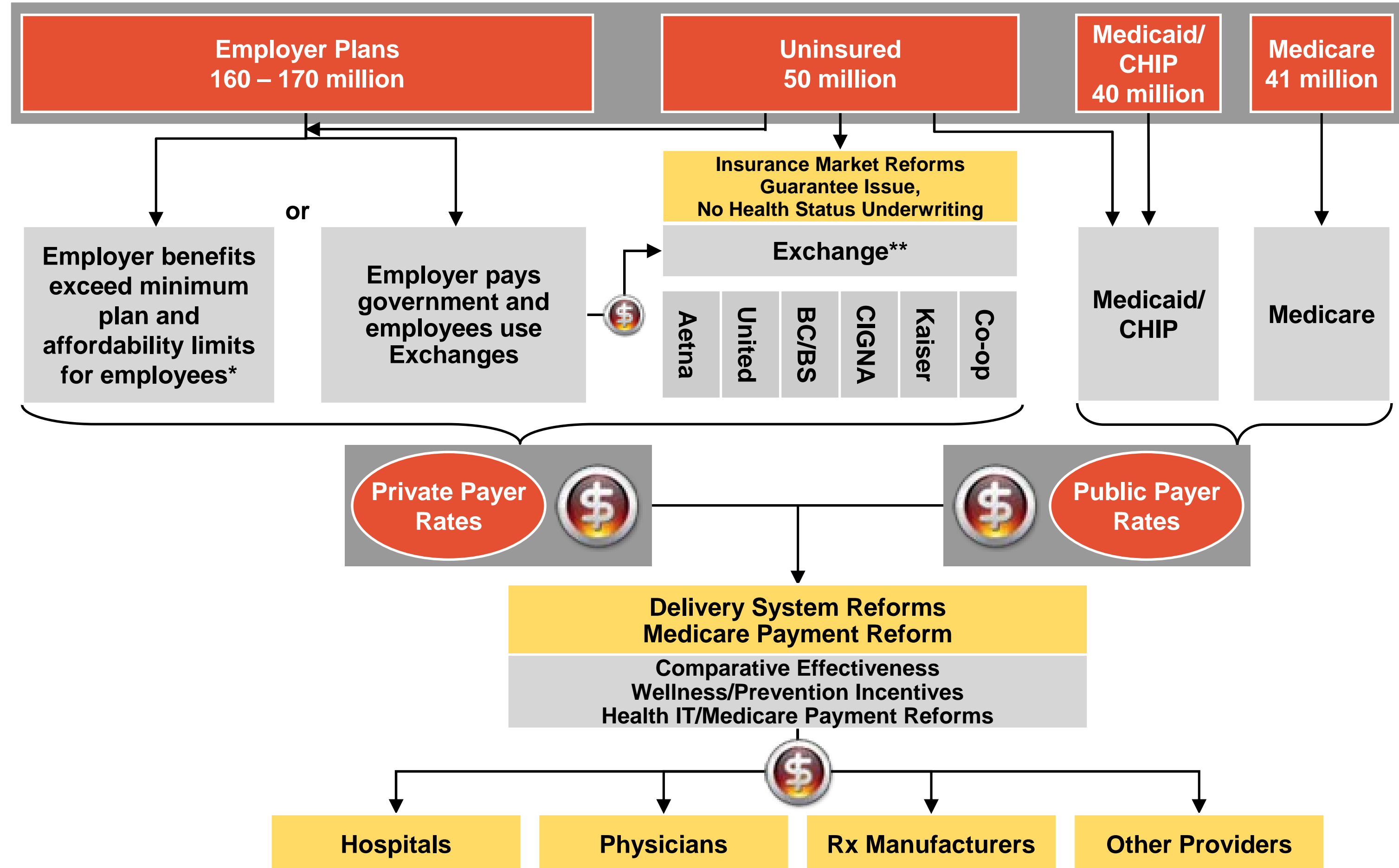
The new health care insurance market in 2014



Source: U.S. Census Bureau. Does not depict 15 million now with individual insurance expected to move to Exchange or other sources.
*Employees may decline employer's plan in favor of Exchange-based coverage, but they may obtain federal premium subsidies for Exchange-based coverage only if employer coverage does not meet minimum requirements or is "unaffordable."
**Low- and middle-income premium and out-of-pocket cost sharing subsidies available up to 400% of federal poverty level.

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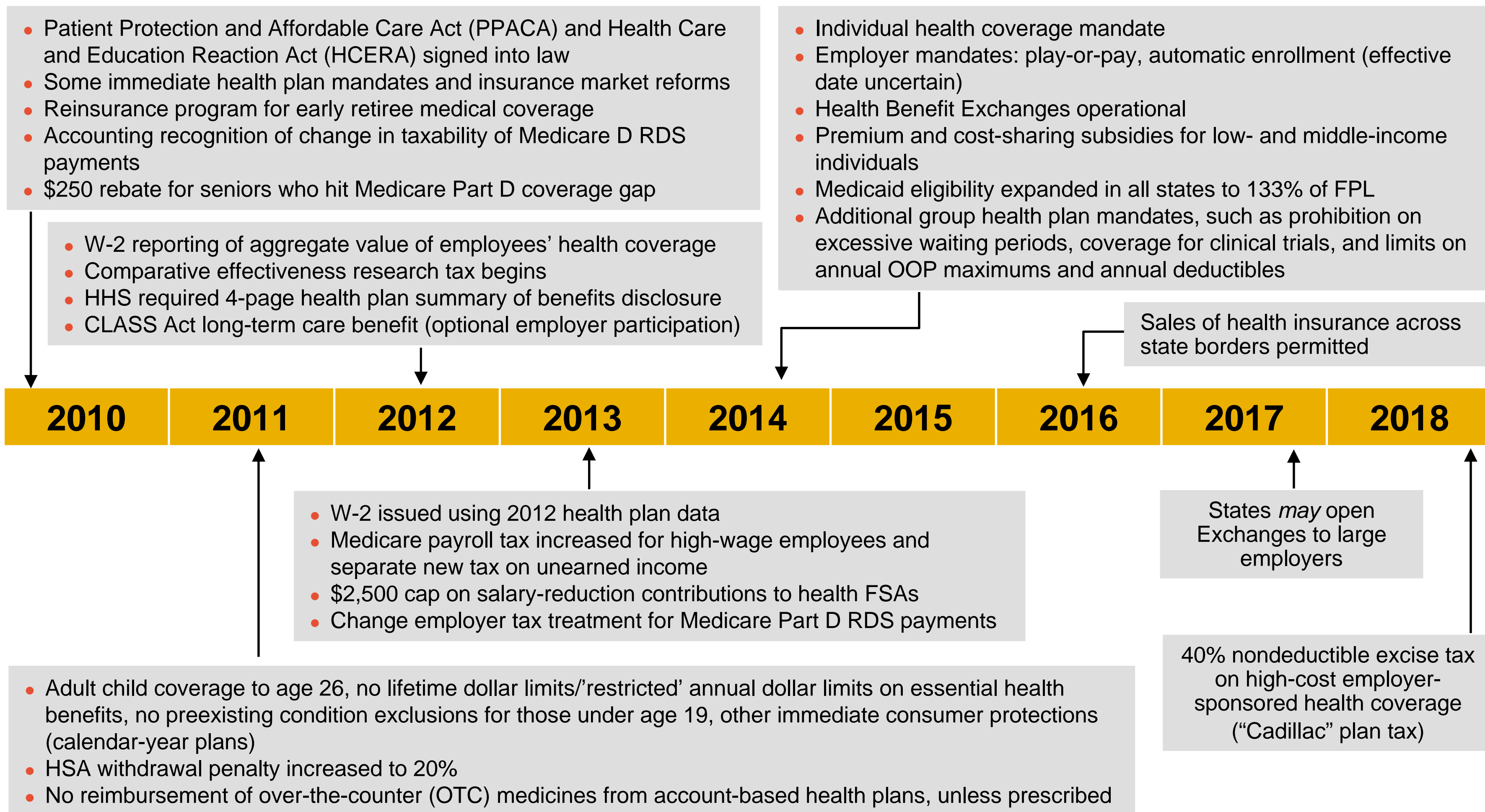
Health Care Reform — high-level timeline



Evolving interpretations, proposed regulations, (interim) final regulations, technical corrections, legislative amendments, judicial decisions, elections, preparation for major changes, unpredictability

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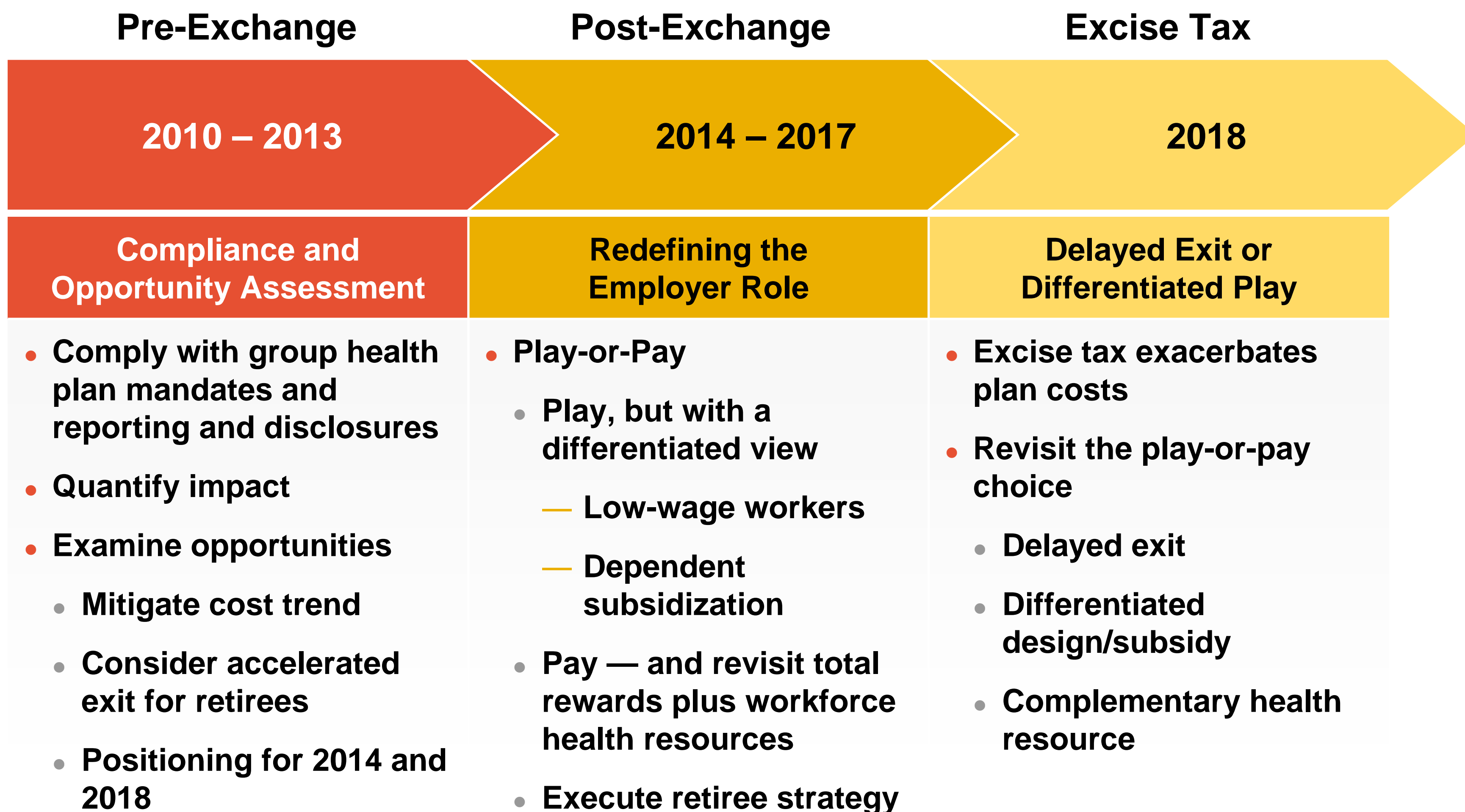
Three critical time periods for employers



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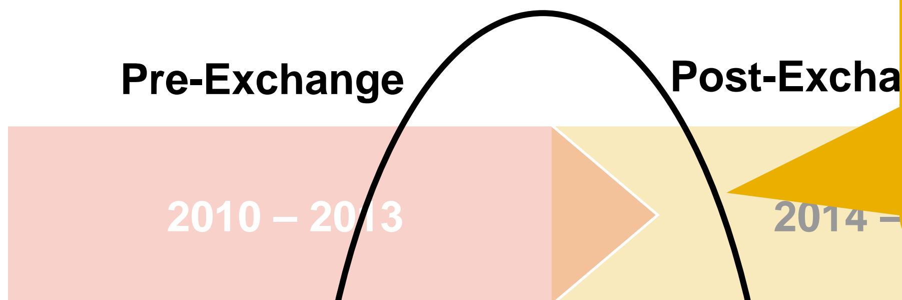
Three critical time periods



How the Exchanges develop will shape many employer decisions.

- How will the Exchange work?
- When would my employee benefit from participation in the Exchange?
- What new risks will accompany the development of the Exchange?

Pre-Exchange	Post-Excha	
2010 – 2013	2014 –	
Compliance and Opportunity Assessment	**Redefining the Employer Role**	**Delayed Exit or Differentiated Play**

• Comply with mandates and reporting
• Quantify impacts
• Examine opportunities
  • Mitigate cost trend
  • Optimize value
  • Consider accelerated exit for retirees
  • Positioning for 2014 and 2018
	• Play or Pay
	  • Pay — and revisit total rewards plus workforce health resources
	  • Play, but with a differentiated view
	    — Low-wage workers
	    — Dependent subsidization
	  • Execute retiree strategy
		• Excise tax exacerbates plan costs
		• Revisit the play or pay choice
		  • Delayed exit
		  • Differentiated design/subsidy
		  • Complementary health resource

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Roles in exchange development and operation for 2014

HHS will:

- Issue rules regarding implementation and operation of Exchange
- Issue rules around broad qualified health plan requirements
- Issue standards for “Navigators”
- Develop IT systems to help Exchanges:
  - Rate qualified health plans
  - Evaluate member satisfaction with health plans
  - Make eligibility determinations for federal programs and subsidies
  - Provide standardized information
- Develop streamlined application form income based plans and subsidies
- Provide funding until 2014

All Exchanges will:

- Make eligibility determinations
  - State resident, citizen or legal immigrant, not incarcerated
  - Income qualifications for Medicaid, CHIP or subsidy
  - Exemptions from individual mandate
- Enroll individuals and families in health insurance
- Certify and rate qualified health plans
- Establish enrollment process
  - Maintain website and call center with toll-free number
  - Present plan information in standard format
  - Offer “cost-sharing reduction” calculator
  - Establish Navigator program to facilitate enrollment
- Notify employers of employee eligibility for subsidies
- Notify IRS and enrollees of Exchange coverage

States can choose:

- How many Exchanges there will be:
  - More than one in state?
  - Separate for individual and small group?
  - Participation in a regional Exchange?
  - No state-sponsored Exchange (Federal intervention)
- Whether it’s a governmental or not-for-profit entity
- Exchange Governance
- Regulatory role with insurers
- Determine product offering requirements within HHS guidelines in the Exchange
- Interaction between products and rates in the Exchange vs. those sold outside of the Exchange

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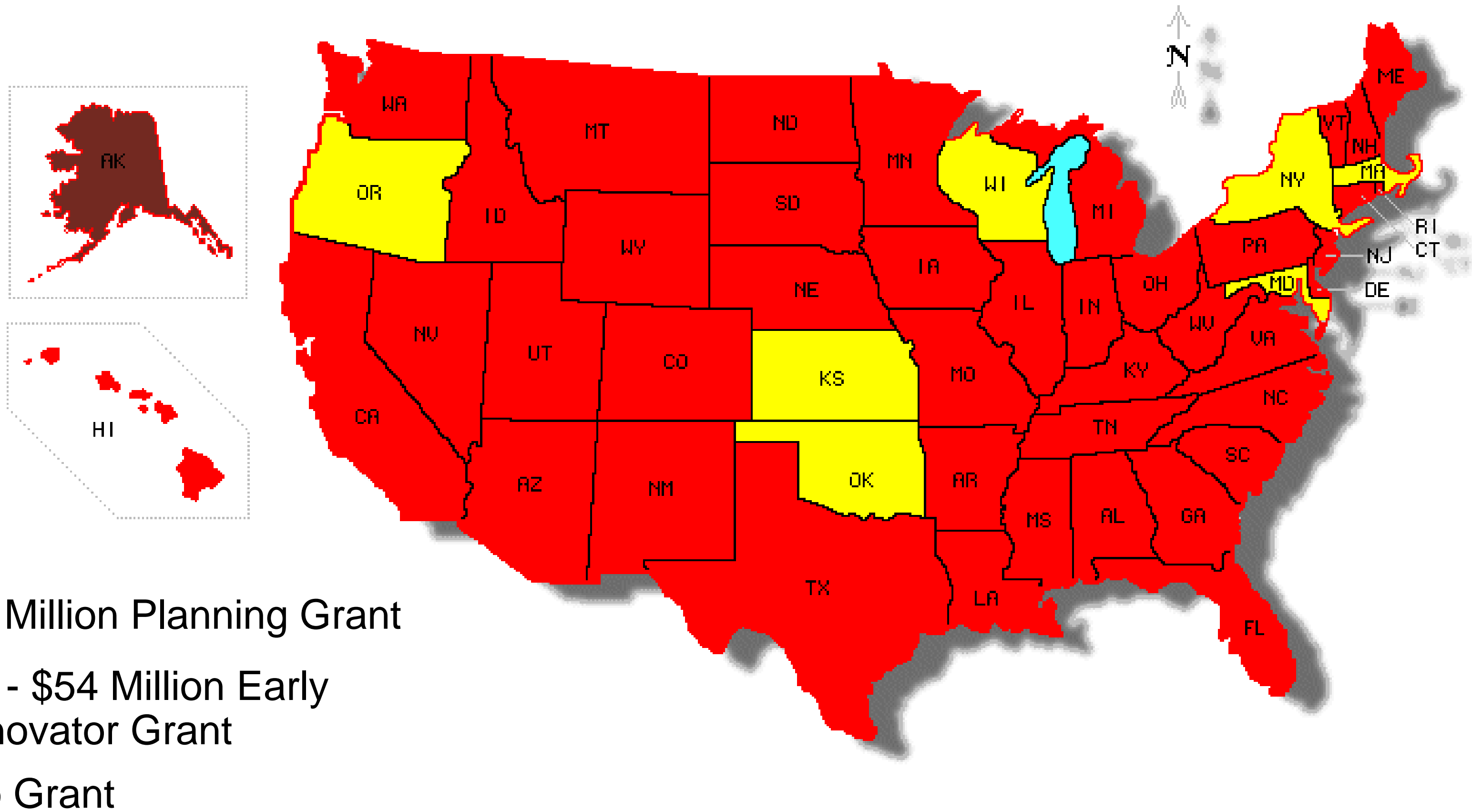
Are exchanges being developed?
States receiving federal exchange grants



Source: www.StateHealthFacts.org

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How will a person get coverage in 2014?

Family Income less than 133% of Poverty

Family is eligible for Medicaid

If employer coverage is available

Family may choose the employer plan or Medicaid

Family Income less than 400% of Poverty

Family is eligible for subsidy in Exchange

If employer coverage is available, but either inadequate (<60% benefit) or unaffordable (premiums >9.5%)

Family may choose the employer plan or subsidized coverage in Exchange

If employer coverage is available and adequate and premiums are affordable

Family may choose the employer plan or *unsubsidized* coverage in Exchange

Family Income greater than 400% of Poverty

Family may purchase *unsubsidized* coverage in Exchange

If employer coverage is available

Family may choose the employer plan or *unsubsidized* coverage in Exchange

2011 FPL	Single Individual	Family of 4
100%	$10,890	$22,350
133%	$14,484	$29,726
400%	$43,560	$89,400

Note that the Free Choice Voucher potential option no longer exists!

Note: Coverage purchased through the Exchange will always be made with after tax dollars, except in the case of the Free Choice Voucher

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What kind of coverage will be available in the Exchanges?

Plan Offerings

Platinum	Gold	Silver	Bronze
(90% Value)	(80% Value)	(70% Value)	(60% Value)

Other Requirements: -Guarantee issue; -No medical underwriting; -No pre-existing condition limits; -Essential health benefits; -Preventive care at 100%; -No lifetime or annual limits; -Maximum Out-of-Pocket limits $5,950/$11,900; -Rating rules (highest age bracket can be no more than 3 times lowest age bracket)

Premium and Cost Sharing Subsidies

Premium Subsidies
(Refundable premium tax credit)
Based on Cost of SILVER (70% value) Plan

Family Income as % of FPL	Maximum Premium Cost as a % of Family Income
< 133%	2.0%
133% - 150%	3.0% - 4.0%
150% - 200%	4.0% - 6.3%
200% - 250%	6.3% - 8.05%
250% - 300%	8.05% - 9.5%
300% - 400%	9.5%

Cost-Sharing Subsidies
(Reduced Copayments)
Enhanced benefits to SILVER (70% value) Plan

Family Income as % of FPL	Actuarial Value	Maximum Out-of-Pocket Single/Family
< 133%	94%	$1,983 / $3,967
133% - 150%	94%	$1,983 / $3,967
150% - 200%	87%	$1,983 / $3,967
200% - 250%	73%	$2,975 / $5,950
250% - 300%	70%	$2,975 / $5,950
300% - 400%	70%	$3,987 / $7,973

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Employers decision to Pay or Play in 2014

Important Context: The "Pay or Play" decision is made at the Controlled Group level

Full Time (>30 hrs/wk) Employees with Family Income under 400% of Poverty

No employer plan is provided to any portion of the full-time employee population, and at least one employee gets a subsidy through the Exchange

$2,000 **annual non-deductible penalty per FT employee (penalty applied monthly)**

Employer coverage is available, but either inadequate (<60% benefit) or unaffordable (premiums >9.5%) ***and*** **employee purchases subsidized coverage through Exchange**

$3,000 **annual non-deductible penalty per affected FT employee (penalty applied monthly)**

Full Time (>30 hrs/wk) Employees with Family Income over 400% of Poverty

No employer plan is provided to any portion of the full-time employee population, and at least one employee gets a subsidy through the Exchange

$2,000 annual non-deductible penalty per FT employee (penalty applied monthly)

Note that the Free Choice Voucher potential option no longer exists!

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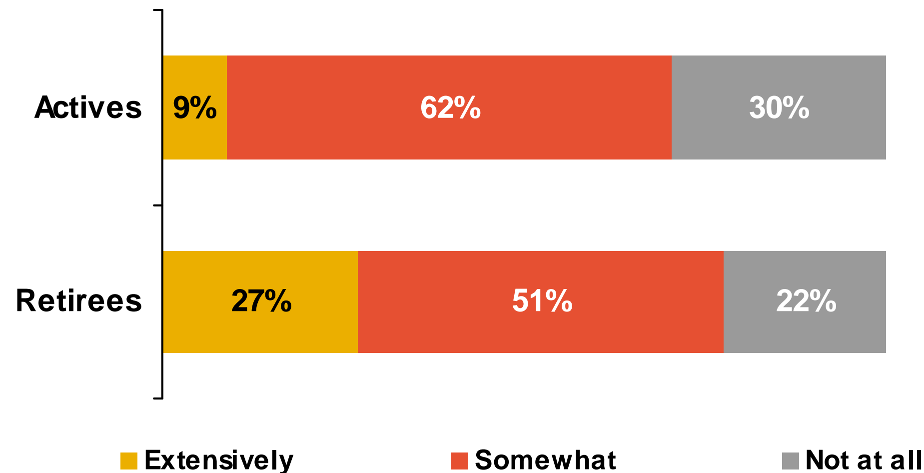
How will Exchanges impact employers?

- Nearly three-quarters of respondents expect the opening of the insurance Exchanges in 2014 will have an impact on their active medical plans
- Employers anticipate Exchanges will offer affordable alternatives for pre-Medicare-eligible retirees



Note: Responses to retiree programs based on companies that offer a retiree program today.
Source: 16th Annual NBGH/TW Employer Survey on Purchasing Value in Health Care, 2011

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Exchange related concerns for employers

- Administrative requirements associated with electronic verification process
- Consistency of exchange and plan structures across states
- Potential for adverse selection
- Member experience in the Exchange
- Uncertainty around availability of the Exchange on a timely basis

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Mandates Requiring Employer Attention

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2011 group health plan mandates and market reforms — plans that must comply

These Provisions Generally Effective For Plan Year Beginning on or After September 23, 2010

Provision	Insured Plans	Self-insured Plans	Grandfathered Plans	Retiree-Only Plans*
Extend medical plan eligibility for adult children to age 26	Y	Y	**Y**	N
No lifetime dollar limits on essential health benefits	Y	Y	**Y**	N
'Restricted' annual dollar limits on essential health benefits until 2014; waivers available	Y	Y	**Y**	N
No rescissions	Y	Y	**Y**	N
No preexisting condition exclusions for enrollees under age 19	Y	Y	**Y**	N
Uniform explanation of coverage documents and standardized definitions; notice of material modifications	Y	Y	**Y**	N
Bringing down the cost of health care coverage (medical loss ratio requirements)	Y	N	**Y**	N
Cover preventive health services without cost-sharing	Y	Y	N	N
Prohibition on discrimination in favor of HCEs under *insured* plans	Y (delayed eff. date)	Currently applies	N	N
New internal claims and appeals and external review requirements	Y	Y	N	N
Patient protections	Y	Y	N	N
Group health plan reporting and disclosures (including wellness reporting and disclosures)	Y	Y	N	N

*"Retiree-only" plans *are exempt* from all of PPACA's GHP mandates and reforms based on long-standing exemption for such plans under ERISA and IRC.

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Essential health benefits

- PPACA requires regulations defining essential health benefits to include at least the following general categories and the items and services covered within the categories:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care
- For 2011 - 2014:
  - No lifetime dollar limits and only 'restricted" annual dollar limits may apply to essential health benefits (see list above),
  - Lifetime/annual dollar limits may be permitted for non-essential health benefits,
- Unclear how limits on infertility treatment, durable medical equipment, chiropractic services affected
  - DOL issued a report to HHS on a survey of selected medical benefits under typical employer plan
- Until regulations are issued, the government will take into account good faith efforts to comply with a reasonable interpretation of the term 'essential health benefits'
- PPACA does not requires group health plans to cover 'essential health benefits…for now

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2014 group health plan mandates and market reforms — plans that must comply

These Provisions Generally Effective For Plan Year Beginning on or After January 1, 2014

Provision	Insured Plans	Self-insured Plans	Grandfathered Plans	Retiree-Only Plans*
Prohibition on excessive waiting periods	Y	Y	**Y**	N
No annual dollar limits on essential health benefits	Y	Y	**Y**	N
No preexisting condition exclusions for all participants	Y	Y	**Y**	N
Fair health insurance premiums	Y	N	N	N
Guaranteed availability and renewability of coverage	Y	N	N	N
No discrimination against individuals based on health status	Y	Y	N	N
Provider nondiscrimination	Y	Y	N	N
Annual OOP maximum no greater than HDHP limits (e.g., $5,950 self-only/$11,900 family in 2011) Annual deductible no greater than $2,000 self-only/$4,000 family	Y	Y	N	N
Coverage for individuals participating in approved clinical trials	Y	Y	N	N

*"Retiree-only" plans *are exempt* from all of PPACA's new mandates and reforms based on long-standing exemption for such plans under ERISA and IRC.

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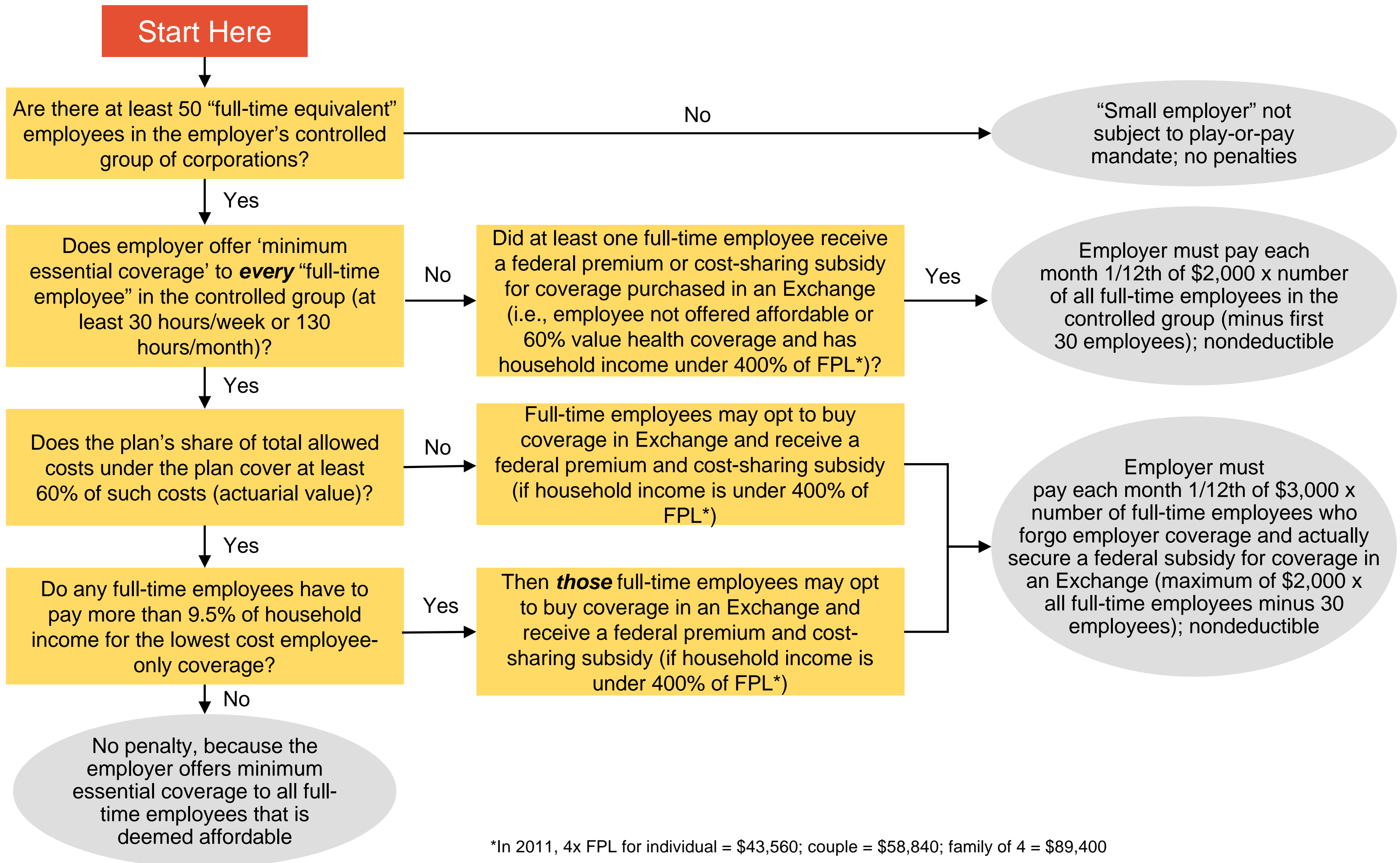
Play or pay employer mandate (2014) — applies monthly



*In 2011, 4x FPL for individual = $43,560; couple = $58,840; family of 4 = $89,400

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Play-or-pay decision (2014)

The decision appears to be made on a controlled group basis — excluding eligibility for even a small subset of the employer's "full-time" population may (pending future guidance) result in the $2,000 penalty being applied for all full-time employees — even those eligible for a plan

PLAY

- Offer "minimum essential coverage" to all "full-time" employees (>30 hrs./wk. or >130 hrs./month)
- Manage plan cost/mitigate cost trend
- Avoid hitting excise tax cap (2018)
- Balance cost-sharing strategy with federal subsidy penalties
- Implement required administrative rules

PAY

- Pay nondeductible annual penalty of $2,000 x all full-time employees
- Change health care "deal" with employees
- Employees faced with buying through Exchanges with after-tax dollars
- Revisit total compensation
- Face competitive impact on recruiting/retention

PLAY AND PAY

- $2,000 "pay" penalty may still apply to entire controlled group if any full-time employees are not eligible for coverage
- $3,000 "play" penalty for lower-wage FTEs (i.e., household income ≤400% FPL) who receive federal subsidies to purchase Exchange-based health coverage due to employee's required self-only contribution for employer's plan exceeds 9.5% of household income

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Implications for employers

Company Cost	Employee Impact	Competitive Position	Corporate Image
• Company direction must consider the total people cost • Company margins will not support cost increases greater than $	• Employee change should be minimal • Company direction should consider all options available to the employee • Tax efficiency for the employee is not a critical decision criteria	• Benefits must be at or above industry average • Skilled positions may require a different approach to overall compensation • Benefits should but create artificial barriers to entering or exiting the company	• Benefit decisions should not detract from company image • Affiliated company decisions should be monitored for impact on company image

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Workforce characteristics and current employer plan offerings will affect decisions in 2014

Pre-2014 Plan Type / Eligibility: Comprehensive (Low EE Premiums); Comprehensive (High EE Premiums); Limited; None

PT <30 hours

Why offer coverage when you don't have to?

But what if you've used health benefits as a differentiator?

PT/FT Straddles 30 hours

Should you limit hours to less than 30 hours/week?

Should you extend benefit eligibility only when an employee is over 30 hours with maximum waiting period?

Can this be administered effectively?

Seasonal FT – Partial Year

Can you "Play" with year-round employees, but not seasonal employees?

What's the impact of "Pay"-ing for everyone?

Do you think differently if seasonal employees are FT during the high season and PT for the rest of the year?

FT-Low Wage >30 hours

Would your employee be "better off" in the Exchange?

So many employees waive coverage today – will they continue?

How much more will it cost if you have to default employees into coverage?

FT-High Wage >30 hours

Will you need to modify the "typical" plan you currently offer to your traditional workforce in order to avoid non-discrimination issues?

What is the impact to the traditional worker if you decide to discontinue health benefits?

Type of Employee

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These changes will require coordinated planning

Strategy/Design

- Adjust workforce and reward strategies?
- Increase focus on workforce health and productivity?
- Leverage current health program tactics that remain attractive?
- Effectively manage costs: “Pay” or “play” implications? Cost-sharing?

Communications

- Take a stand or calm the waters?
- Restate my benefits philosophy and the employee value proposition?
- Keep my people informed of what’s changing and when?
- Align culture of health initiatives with business mission and values?

Administration

- What system programming changes are needed and when?
- Can administration resources meet immediate requirements?
- Are tools/resources in place to answer employee questions?
- How to support new and grandfathered plans?

More questions will emerge as we learn more!!!!

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Excise tax on high-cost employer-sponsored health coverage (2018)

- Aggregate cost of employer-sponsored health coverage
  - 40% of amount with respect to an employee's or retiree's coverage above certain thresholds
  - Medical (e.g., PPO, HMO, HDHP), health FSA, HRA, employer and employee pre-tax HSA contributions, EAP, onsite primary care medical clinics (and self-insured dental and vision plans?*)
  - NOT applicable to separate fully insured vision and dental plans,* and dread disease and fixed-dollar indemnity policies (e.g., Aflac)
  - Determine plan value based generally on 100% of COBRA premium (minus 2% admin. fee)
  - May elect to value benefits of pre-65 retirees together with post-65 retirees
- Tax imposed on insurers (insured plans), employers or TPA (self-insured plans)

Thresholds in 2018

- **Basic**
  - $10,200 individual
  - $27,500 family
- **Retirees** (55 to 65), actives in plan in which majority of covered employees repair or install electrical or telecommunication lines or are engaged in high-risk professions
  - $11,850 individual
  - $30,950 family
- **Additional adjustments**
  - Age/gender demographics of plan
  - Higher-than-expected U.S. health care cost increases prior to 2018
- **Indexed**
  - CPI-U plus 1% for 2019
  - CPI-U only, beginning in 2020

*Legislative language raises the possibility that only *insured* vision and dental plans will be exempted.

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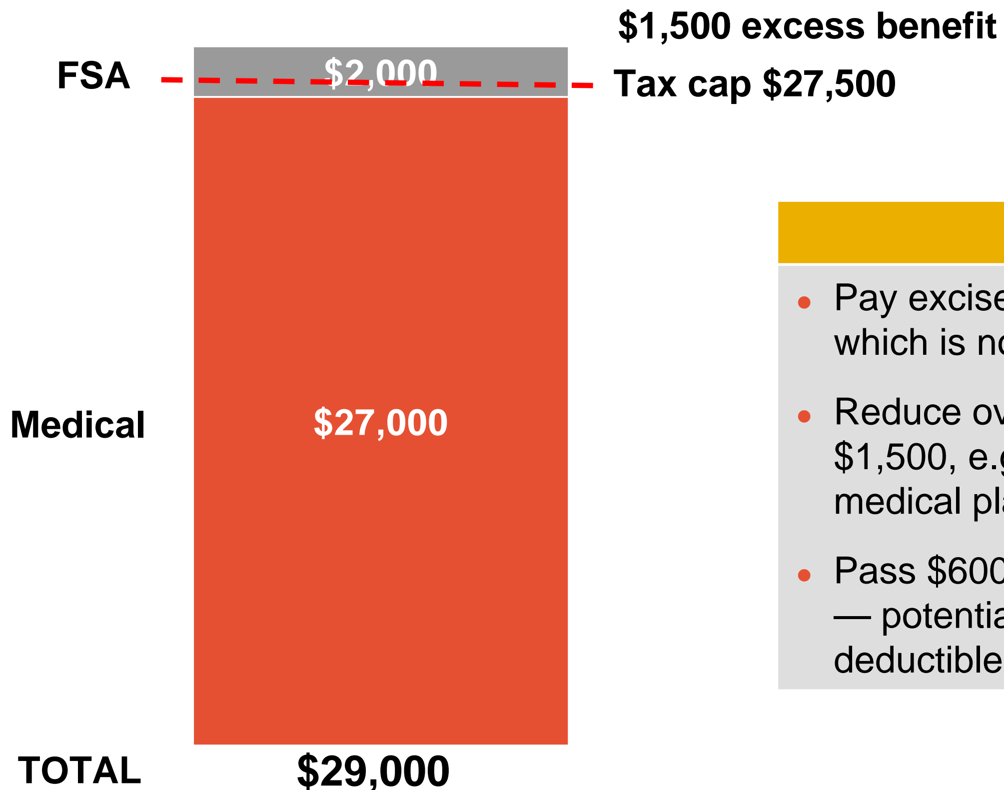
Excise tax on high-cost employer-sponsored health coverage (2018)



Employer Options

- Pay excise tax of $600 ($1,500 x 40%), which is non-deductible
- Reduce overall value of health benefits offered by $1,500, e.g., reduce FSA elections, reduce medical plan value through design changes
- Pass $600 cost of excise tax along to employee — potentially adjusted to reflect the non-deductible nature

*Illustration based on standard thresholds in PPACA ($10,200 individual/$27,500 family). Threshold amounts are increased for pre-65 retirees and for high-risk professions ($11,850/$30,950), can be adjusted based on higher-than-expected cost increases in U.S. health care system and age/gender demographics in plan.

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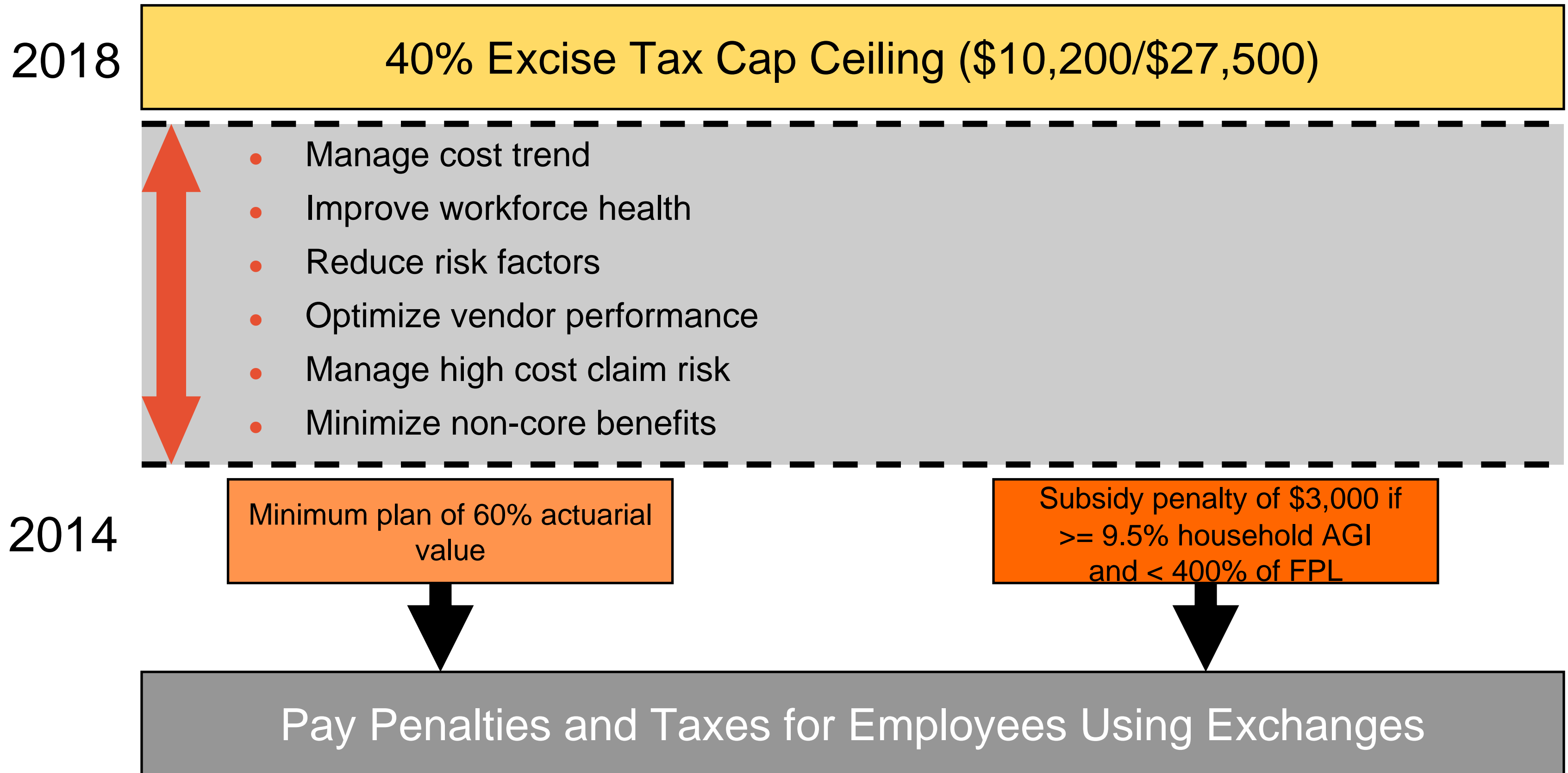
Excise tax management



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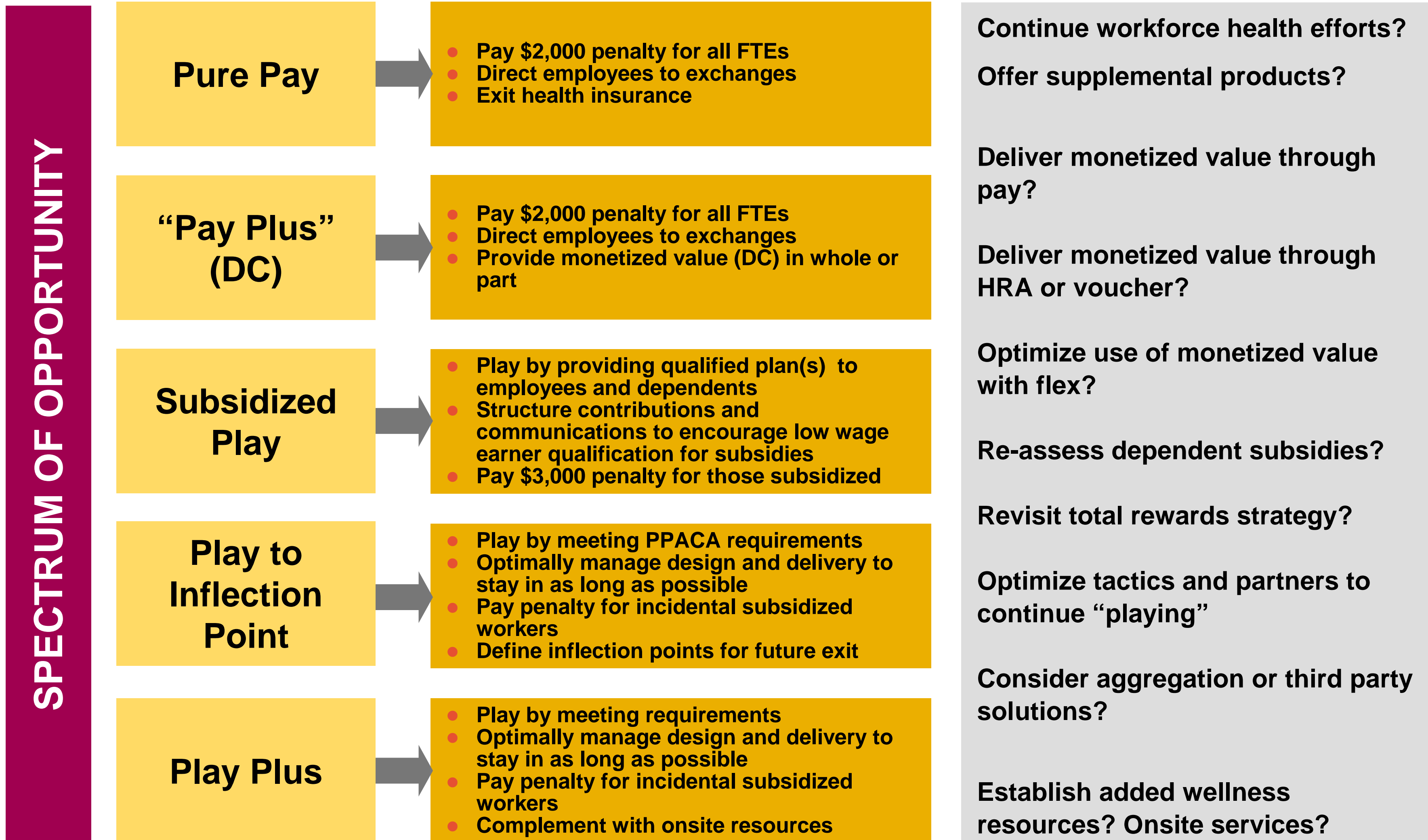
The employer's role post-2014: A spectrum of opportunity



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Summary of major provisions by employer size

Number of Employees	25	50	100	200+
Individual mandate	All	All	All	All
Health insurance market reform	All	All	All	All
Premium and cost-sharing subsidies	All < 400% FPL	All < 400% FPL	All < 400% FPL	All < 400% FPL
State-based Exchanges	All	All	All	All
Employer play or pay mandate	No	50+	50+	50+
Tax credit for small business	<25	No	No	No
Exchange policies eligible for pre-tax employer cafeteria plan [a]	All	All	>101 (2017?)	>101 (2017?)
New and expanded public plans	All < 133% FPL	All < 133% FPL	All < 133% FPL	All < 133% FPL
Revenue raisers (excise tax) [b]	All	All	All	All
Automatic Enrollment	No	No	No	Yes

Note: The chart above is a general summary of the applicability of major provisions of Health Care Reform law as it applies to the number of employees of an employer.
[a] Employers with less than 101 employees will have the ability to offer exchange coverage within a cafeteria plan. Employers with 101 employees or more might be able to offer exchange coverage beginning in 2017.
[b] Insurance companies are subject to the excise tax for fully-insured plans; employers are subject to the excise tax for self-insured plans.

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Future State of Health Care Reform

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Future state of Health Care Reform legislative

- Republicans have gained control of the House and have vowed to repeal (and replace) or significantly scale back HCR
  - Such a result is unlikely before 2013 due to President Obama's veto power and Democrats' slim majority in the Senate
  - House passed legislation to repeal HCR; Senate defeated repeal legislation
- HCR will remain a prominent issue of debate during the 2011 - 2012 legislative session
  - Republicans focus on HCR hearings and limiting HCR implementation funding
- The outcome of the 2012 elections will be key to the ultimate fate of HCR
  - Will the Republicans re-gain control of the White House? The Senate?
- Federal budget agreement for FY2011 repealed the free-choice voucher provision
  - Lesson learned: anything can happen!
- Short of repealing the entire HCR law, specific provisions may be targeted for repeal or amendment
  - Examples: excise tax, individual mandate, employer play-or-pay, general defunding

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Future state of Health Care Reform judicial

- Over 20 cases filed in lower federal District Courts challenging the constitutionality of the individual mandate
  - Mixed results to date; Regardless of who wins in these District Court rulings, appeals are inevitable and currently underway
  - *Current status*: The U.S. Court of Appeals for the 6th Circuit ruled on 6/29/2011 that the individual mandate in the HCR law is constitutional. Two other U.S. Courts of Appeal (in the 4th Circuit and the 11th Circuit) are expected to rule soon on this same issue. Some or all of these cases are still expected to make their way to the U.S. Supreme Court for final resolution over the next one to two years
  - The political composition of Congress and the White House at the time of a Supreme Court decision could produce a range of possible outcomes, from significant redesign of the law to outright repeal
  - Related issue of "severability": If the Supreme Court rules the individual mandate is unconstitutional, will it rule that only the individual mandate is unconstitutional or, would it rule the *entire* HCR law is unconstitutional (as one lower court Judge has ruled)?
- Without the individual mandate, there would not likely be enough insurer participation in the Exchanges to produce a competitive market for guaranteed access to individual and small group coverage
  - Without functioning Exchanges, the goal of universal access to health coverage would be jeopardized

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Future state of Health Care Reform regulatory

Significant regulatory guidance since March 2011…

- Request for public comments on employer play-or-pay mandate and 90-day limit on waiting periods; for example, definition of ‘employer’, ‘employee’, ‘hours of service’, methods for determining ‘full-time’ employee status (IRS Notice 2011-36)
- Request for public comments on comparative effectiveness research fee which is assessed on insurers (fully insured plans) and employer plan sponsors (self-insured plans) beginning in 2012 (IRS Notice 2011-35)
- Form W-2 guidance on reporting of aggregate cost of applicable employer-sponsored health coverage (IRS Notice 2011-28)
- No new ERRP applications accepted after May 5
- Waivers of the annual dollar limit requirements for mini-med / limited benefit plans extended until 2014; no new applications after 9/22/2011 (CCIIO 2011 – 1D)
- Proposed regulation implementing the application and approval process for states to seek waivers from major HCR provisions in 2017
- Amendment to the internal claims and appeals and external review process interim final regulations; also, some rules delayed until 2012 (DOL Technical Release 2011-01)
- Part VI FAQs on grandfathering rules
- On-going state tax law conformity with Federal IRC for adult child coverage

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Future state of Health Care Reform regulatory (cont'd.)

HCR guidance coming in 2011/2012…?

- Four-page summary of benefits and coverage explanation; template
- Rules for establishment of state Health Benefit Exchanges
- Finalization of various pieces of 2010 group health plan mandate/insurance market reform interim final regulations
- Calculation of the COBRA applicable premium
- Definition of "essential health benefits"
- Automatic enrollment into employer group health plans

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Next Steps

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Key issues for a large employer plan sponsor

- What is the cost of Health Care Reform on employer?
  - Up to 20 group health plan mandates and insurance market reforms, 15 for self-insured health plans
  - Employer play-or-pay mandate (2014)
  - 40% excise tax on high cost employer-sponsored health coverage (2018)
- What risks does Health Care Reform present and how can they be managed?
  - Employer play-or-pay mandate in 2014 is 'all-in' decision made on controlled group basis; what is employer's controlled group?
- What business advantage can an employer identify and how may it be realized?
  - Shrink to minimum 'floor' plan?
  - Leverage Exchange-based coverage if that offers attractive pricing?

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Moving forward with Health Care Reform

Identify	Decide	Implement
Know the law and the key questions, issues and data	**Analyze options and make decisions**	**Develop and execute implementation plan**

• Understand law, effective dates and compliance requirements
• Understand tactical and strategic issues
• Collect data
• Find opportunities, costs and risks in all plans
• Identify issues for different segments of employees
• Identify issues for different segments of pre-65 and post-65 retirees
	• Conduct financial, qualitative and other analyses
	• Conduct employee and retiree impact analysis
	• Evaluate options
	  ◦ Design
	  ◦ Financial management
	  ◦ Delivery
	  ◦ Change management
	  ◦ Strategy
	• Make decisions
		• Formulate multi-year plan for implementation, change management and communication
		• Secure resources, suppliers, commitments and budgets
		• Implement tactics to meet 2011 requirements
		• Incorporate health reform into 2011 – 2018 annual benefit planning process

Create an implementation plan and governance process		

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Questions

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