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Health Care Reform Overview

Bill Scott, Los Angeles

June 2, 2011

Agenda

- What we know and what we don’t know about health care reform
- Changes in store for 2014 and beyond
- Case studies

“*There are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we know we don't know. But there are also unknown unknowns. There are things we don't know we don't know.”*

Health care reform – what we know and don’t know…

Key elements of health reform for employers

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
- Break time/private room for nursing moms

2011

- Employers to distribute uniform benefit summaries to participants
- Employers to provide 60-day advance notice of material modifications
- Form W-2 reporting for health coverage (delayed until 2012 W-2 form)
- Comparative effectiveness group health plan fees begin
- Auto-enrollment of full-time employees (applicability date TBD)

2012

- Health insurance exchanges
- Individual coverage mandate
- Financial assistance for exchange coverage of lower-income individuals
- Medicaid expansion
- HIPAA wellness limit
- Employer shared responsibility
- Additional reporting and disclosure

2013

- 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 and deductibles
- Health insurance industry fees begin

2014

- 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, phased amounts until 2014*
- No pre-existing condition limitations for enrollees up to age 19*
- No rescissions*
- Additional standards for new or "non-grandfathered" health plans, including mandatory preventive care in network with no cost-sharing and non-discrimination provisions for insured plans***

- No health FSA/HRA/HSA reimbursement for non-prescribed drugs
- Increased penalties for non-qualified HSA distributions
- Income-based Medicare Part D premiums
- Pharmaceutical importers and manufacturers' fees start
- Medicare, Medicare Advantage benefit and payment reforms to begin
- Insurers subject to medical loss ratio rules

2018

- $2,500 health FSA contribution cap (indexed)
- Employers to notify employees about exchanges
- 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
- CLASS program may begin

- 40% excise tax on "high cost" or Cadillac coverage

** 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).*

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

**** Delayed until regulations issued/date TBD*

Standards that apply to all plans – regardless of grandfather status

For plan years beginning on or after September 23, 2010

- Offer coverage to dependent children to age 26 (grandfathered plans may limit coverage to those without other coverage available)
- No lifetime dollar limits on essential health benefits
- Restricted annual dollar limits on essential health benefits
- No preexisting condition exclusions for enrollees under age 19
- No rescissions
- Minimum medical loss ratio rules (insured plans only)

For plan years beginning on or after January 1, 2014

- No waiting periods exceeding 90 days*
- Offer coverage to dependent children to age 26 with no limitations
- No annual dollar limits on essential health benefits
- No preexisting condition exclusions

*Guidance not issued as of April 18, 2011

Essential health benefits

- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Maternity & Newborn Care
- Mental Health & Substance Use Disorder Benefits, including behavioral health treatment)
- Prescription Drugs
- Rehabilitative & Habilitative Services & Devices
- Laboratory Services
- Preventive & Wellness Services & Chronic Disease Management
- Pediatric Services, including Oral & Vision Care

- HHS to draft regulations and ensure the scope of essential health benefits is equal to the scope of benefits provided under a typical employer plan.
- To inform HHS rulemaking:
  - Dept. of Labor is conducting a survey of employer-sponsored coverage of benefits typically covered by employers, including multiemployer plans.
  - Institute of Medicine is developing criteria and policy principles for HHS to use in achieving an appropriate balance among categories of care, need of diverse populations, and nondiscrimination on age, disability or expected length of life.
- CMS chief actuary to certify in report to Congressional committees that the essential health benefits definition do meet the scope limitations above
- Employers to use good faith in complying with a "reasonable interpretation" of essential health benefits, and must be consistent for lifetime and annual dollar limit purposes

Key employer health care reform elements

- Must remove any annual limits on essential health benefits by 2014
- Until 2014, minimum annual dollar limits permitted to transition to 2014

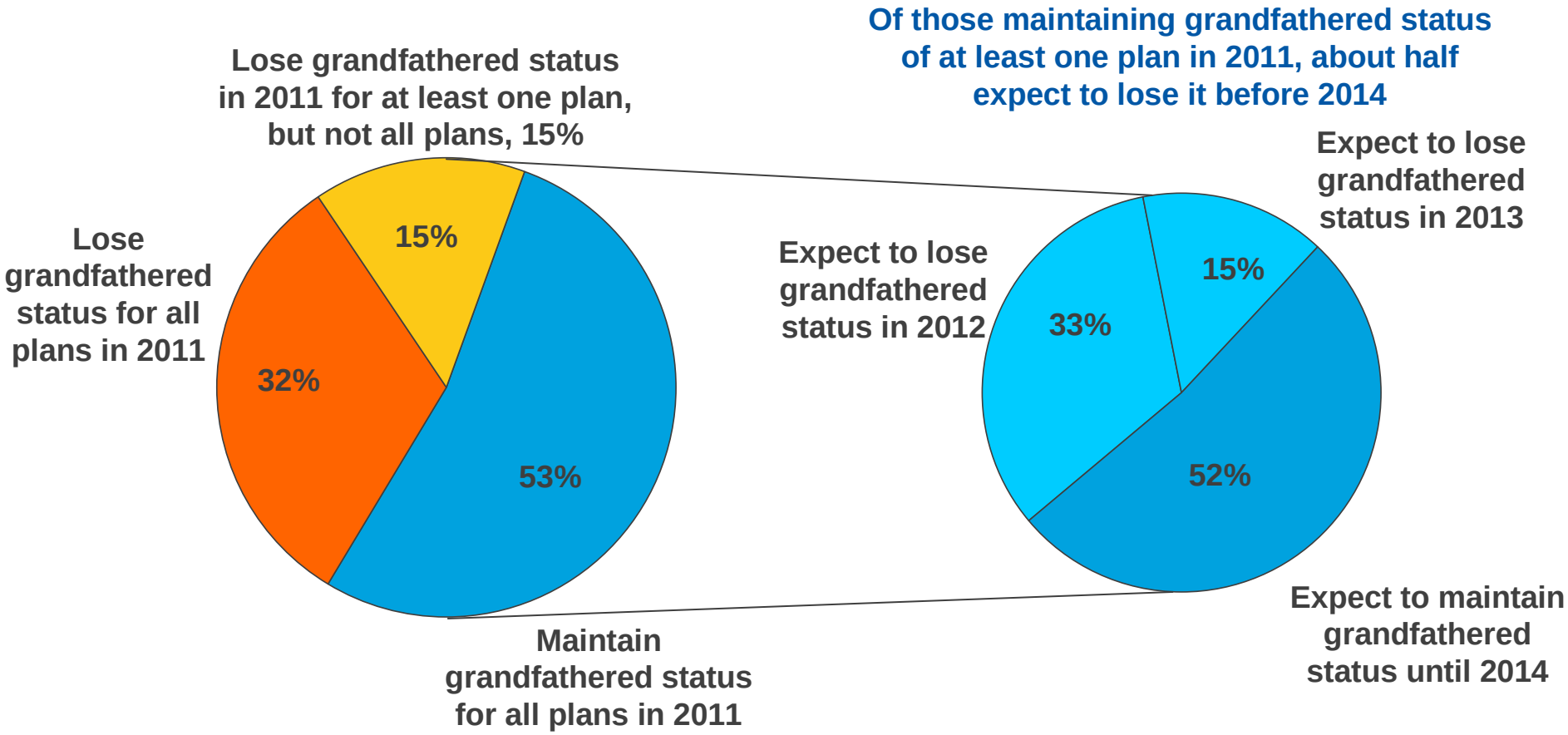
Plan years starting:	Minimum dollar limit:
▪ 9/23/10–9/22/11	$750,000
▪ 9/23/11–9/22/12	$1.25 million
▪ 9/23/12–1/1/14	$2 million

- Limits apply to each individual
- Health FSAs and HSAs exempt; retiree-only and “integrated” HRAs exempt, but some HRAs may become subject to the rule
- Mini-med, limited medical and other plans may seek a one-year waiver
  - Notice required
  - Carriers may apply for waivers for insured plans
- Non-dollar limits may be OK
  - Challenge of defining essential health benefits, particularly with inconsistent lists from vendors

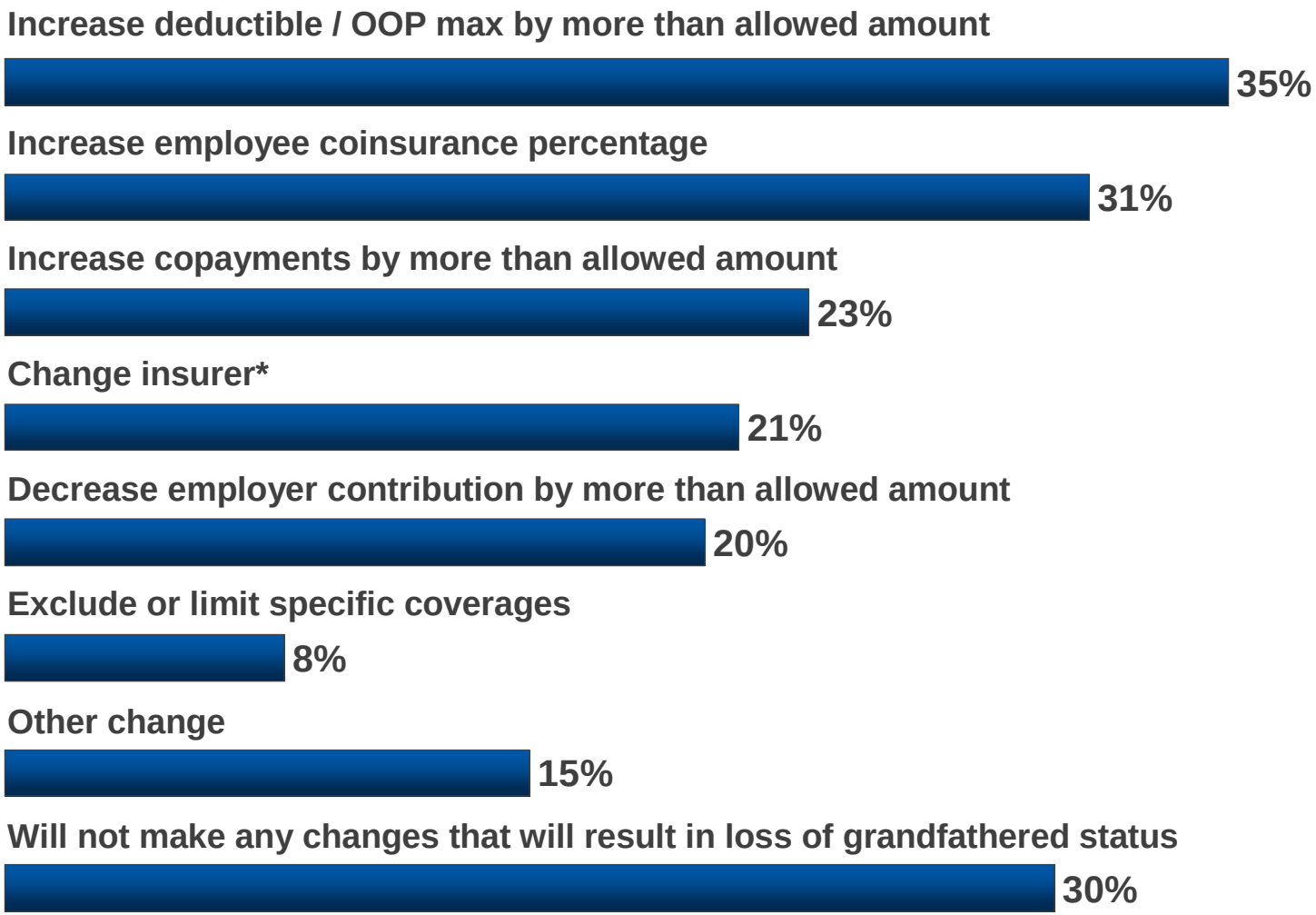
Reminders for grandfathered plans

- If you want to remain grandfathered, don't…
  - Eliminate all or substantially all benefits to diagnose or treat a particular condition
  - Increase coinsurance percentage amount
  - Increase copayments by more than medical inflation plus 15 percentage points, or $5 increased by medical inflation
  - Increase other fixed cost-sharing (deductibles, OOP limits) in excess of medical inflation plus 15 percentage points
  - Decrease employer contribution by more than 5 percentage points below March 23, 2010 rate
  - Impose new overall annual limits on dollar value of benefits
  - Violate anti-abuse rules
  - Enter into a new policy, certificate or contract of insurance after March 23, 2010 with an effective date **before** Nov. 15, 2010 (after which employers that enter into a new policy do not automatically cause loss of grandfathered status)
- … but you must give a notice of grandfathered status
- Additional FAQs on grandfathered status released March 29, 2011
  - Clarifications include that a plan loses grandfathered status on date a change becomes effective (not at the end of that plan year)

Nearly half of respondents will lose grandfathered status of at least one medical plan in 2011



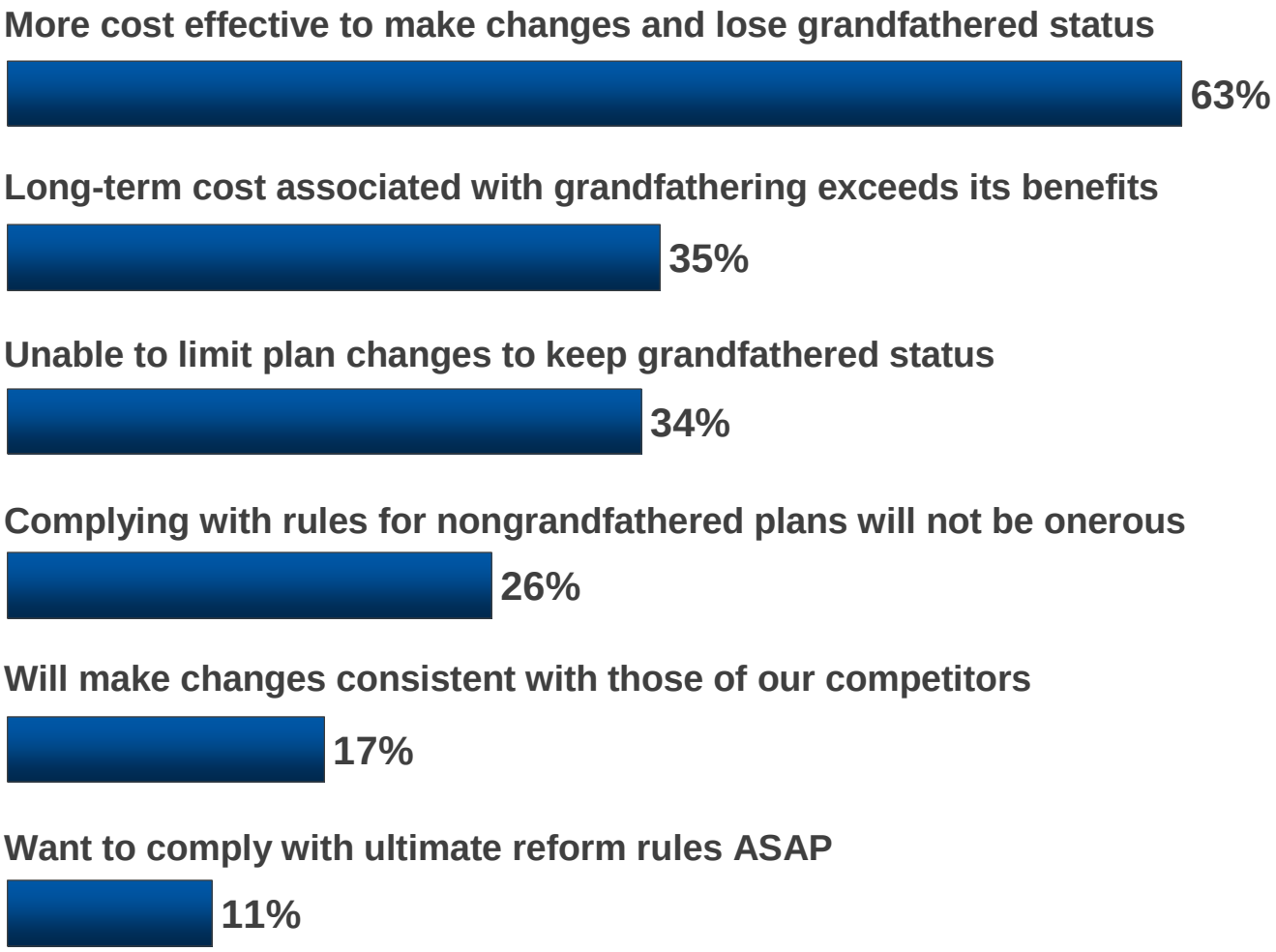
Planned changes that will result in loss of grandfathered status



*Survey was completed before the Nov. 15, 2010 amended regulations on changing insurers.

Reasons for forgoing grandfathered status for one or more plans in 2011

Among respondents that will forgo grandfathered status



Additional standards for nongrandfathered plans

For plan years beginning on or after September 23, 2010

- Cover certain preventive services with no cost sharing
- Extended child coverage cannot be limited to those without other employer 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
- Enhanced government and participant disclosures*
- Insured plans subject to nondiscrimination rules**

For plan years beginning on or after January 1, 2014

- Cover routine care for patients in clinical trials*
- Annual cost sharing and deductible limits*[o]
- Provider nondiscrimination rules*
- Changed wellness incentives*
- Additional rules for small employer plans* (comprehensive coverage, rating rules, guaranteed availability and renewal)

* Guidance not issued as of April 18, 2011

** Delayed until regulations are issued

[o] Appear to apply to employer group health plans

Key issues for non-grandfathered plans

Cover required preventive care with no cost sharing

- Nongrandfathered plans must include in-network coverage for certain preventive care with no cost sharing, including certain screening tests, immunizations, and exams and screenings for infants, children, adolescents and women
- Plans are not required to cover preventive care out-of-network, and, if preventive services are covered out-of-network, the plan can impose cost sharing
- Cost sharing still allowed for:
  - Separately billed office visit when preventive service or item involved
  - Treatments to follow up on the preventive service or item
  - If preventive screening or service is delivered and the primary purpose of office visit was not preventive
  - Covering non-recommended preventive screenings or tests
- Reasonable medical management techniques allowed to determine the method, frequency, treatment or setting for the recommended services
- Uncertainties around what, precisely, must be covered

Key considerations for non-grandfathered plans

Nondiscrimination rules for insured plans

- Plans cannot discriminate in favor of highly compensated individuals in terms of eligibility to participate or benefits
- Rules to be similar to those that already apply to all self-insured plans
- Failure to comply results in excise tax penalty of $100 per day for every non-highly compensated individual (people affected by the discrimination)
- ERISA penalties may apply also, and non-ERISA plans (e.g., state or local government) subject to similar penalties under Public Health Services Act
- IRS has delayed applicability until regulations are issued (date TBD)
- Cafeteria plan nondiscrimination rules may apply as well

Other new requirements
No reimbursement for non-prescribed medicines and drugs

- Applies to group health plans, including health FSAs and health reimbursement arrangements, and HSAs
- Starting January 1, 2011, no reimbursement of medicines and drugs without a prescription, except insulin
- Still OK to reimburse for over-the-counter equipment, supplies or diagnostic devices (e.g., band-aids, crutches, blood sugar tests)
- Transition may be challenging for non-calendar year plans, and plans with grace periods
- No debit card use for unsubstantiated expenses, so must submit Rx with receipt, or other permitted documentation, before getting reimbursement
  - Slight delay to January 15, 2011 for debit card programs to comply
- Cafeteria plan amendments are needed, and may be adopted by June 30, 2011 (retroactive amendments OK in this situation)
- Employers need to coordinate with vendors

Other new requirements
W-2 reporting

- Employers will have to report the value of employer-sponsored health on employee W-2 forms
  - This is informational reporting only and won't affect the tax treatment of employer-sponsored coverage
- Employers generally must report an employee's 2012 employer-sponsored coverage on W-2 forms issued early in 2013
  - IRS guidance released March 2011 clarifies aspects of this reporting duty and extends transition relief for certain employers and types of coverage
  - No W-2 reporting required in some cases, including:
    - if no W-2 is required (e.g., most retirees, surviving spouses)
    - of COBRA continuation coverage or insured dental or vision coverage
  - For now, temporary exemptions include HRA coverage, W-2s provided mid-year to terminating employees, multiemployer plan coverage, non-integrated self-insured dental or vision coverage
- Employer-sponsored coverage to be reported on Box 12 of W-2 using code DD

Other uncertainties or unknowns

- When auto-enrollment becomes applicable and how will it work
- What content will be required for various notices and disclosures, such as a 60-day advance notice of material changes
- How to determine full-time employee status, and how part-time, seasonal, temporary, co-employed individuals will be treated
- And many more that relate to 2014…..

A quick look at the political environment

GOP targets health reform provisions

- House Republicans passed health care reform repeal
  - Democrat-controlled Senate, Obama veto power block progress
- Two-year GOP campaign against health care reform law
  - Bills to chip away at it, including measures to:
    - Remove individual coverage mandate
    - Remove employer shared responsibility
    - Allow state opt-outs
    - Enhance medical liability reforms
    - Block implementation
    - Repeal Independent Payment Advisory Board
    - Allow sale of insurance across state lines
    - Remove the ban on tax-free coverage for OTC medicines and drugs
    - Remove health FSA annual contribution cap set for 2013
  - Senate unlikely to pass significant changes

GOP targets health reform provisions

- Two-year GOP campaign against health care reform law (cont'd)
  - Power of the purse
  - Aggressive oversight
- Democrats focusing on benefits of the health care reform law
  - Senate hearings
- Areas for compromise?
  - Lawmakers to date have removed employers' free choice voucher obligation and expanded Form 1099 reporting duty, and revised repayment rules for premium tax credits that will be available starting in 2014
- Two years is a long time…
  - Moderate Democrats facing tight 2012 elections
  - Retiring senators

Courts, states also important fronts in reform battle

- Individual coverage mandate is a key focus of legal challenges
  - Each decision to be appealed, and the litigation process likely to lead to the U.S. Supreme Court
  - If found unconstitutional, no “severability clause”…
    - Only individual mandate falls? Entire law invalidated? What would not have been adopted “but for” the unconstitutional individual mandate?
  - Uncertainty remains until final judicial resolution
- States key to implementation as elections gave GOP firmer grip on state legislatures, governorships and big say on
  - Insurance exchanges
  - Medicaid expansion
  - Insurance regulation
- Some in Congress want to give states more authority and funding
  - Could pose challenges for ERISA preemption, large employers
- For their part, large employers want to revise, not repeal law
    - Seeking stronger provider payment, delivery system reforms

Looking ahead….

The road to 2014

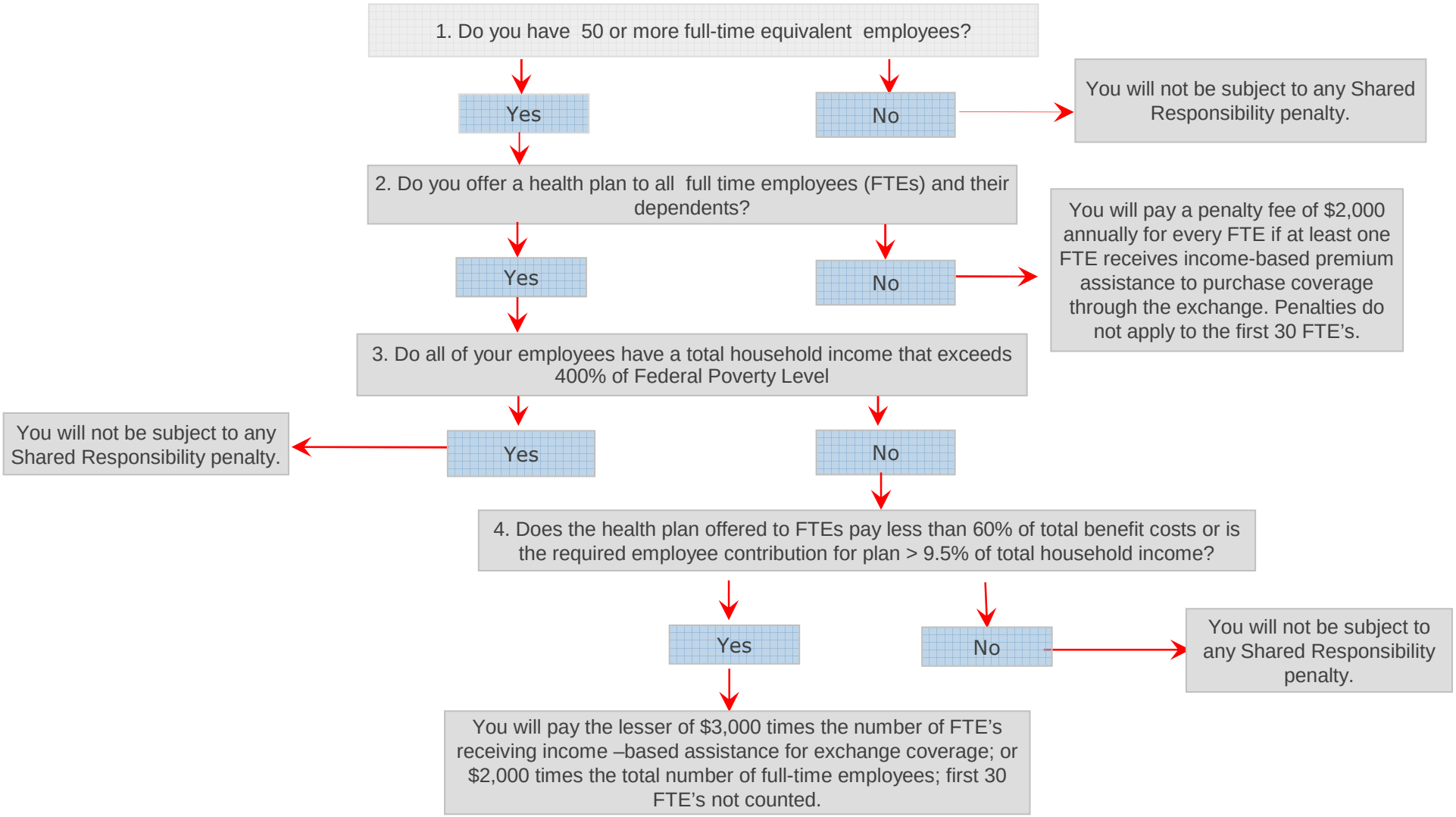
- Automatic enrollment for new full-time employees
- Shared responsibility obligations
- Health insurance exchanges
- Income-based assistances for exchange coverage

Health Care Reform
Employer shared responsibility

Employer Shared Responsibility	
General rule	■ Employers with 50 or more *full-time equivalent employees* may be subject to shared responsibility penalties if at least one *full-time* employee* obtains exchange-based coverage and is eligible for financial assistance to better afford it
Employers *offering* coverage to full-time* employees (and their dependents)	■ Subject to penalties if either – the plan's share of total allowed benefit costs is less than 60% ("minimum value" test), or – an employee's contribution to self-only coverage represents more than 9.5% of household income ("affordability" test) ■ Penalty is the lesser of: (1) up to $3,000 for each *full-time* employee eligible for income-based assistance, or (2) up to $2,000 for every *full-time* employee (minus the first thirty)
Employers *not offering* coverage to full-time* employees (and their dependents)	■ Subject to penalty of up to $2,000 for each *full-time* employee (minus the first thirty)

* A full-time employee is one who, with respect to any month, is employed an average of at least 30 hours of service a week

Shared responsibility – Decision tree
Effective in 2014



Health Care Reform
Health insurance exchanges

Health Insurance Exchanges	
General rule	■ State-based health insurance exchanges to facilitate purchase of health insurance by individuals and small employers

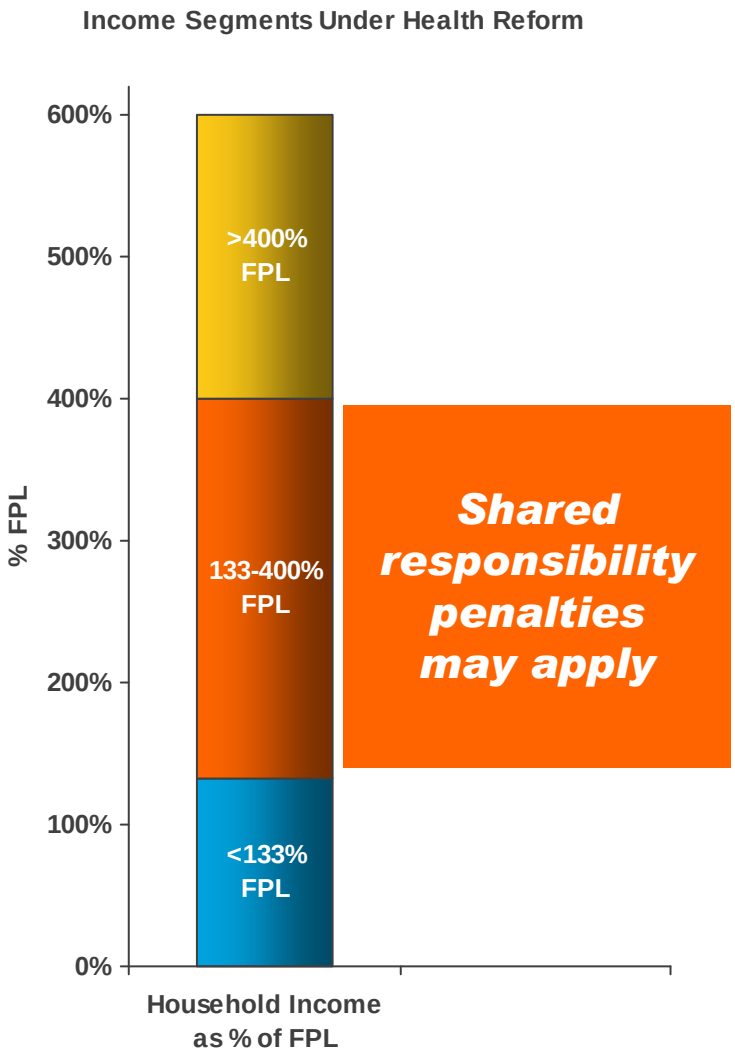
Eligible to enroll	■ Individuals residing in the state who are lawful residents and not incarcerated
	■ Certain employer groups
	  ■ 2014-2015: Up to 100 employees (states may use 50 employee limit)
	  ■ 2016: Up to 100 employees
	  ■ 2017: State discretion to expand
	■ State flexibility to merge individual and employer exchanges

Coverage	■ Exchange-certified qualified health plans

Financial assistance for certain people not Medicaid-eligible

- Federal premium tax credits and cost-sharing reductions
  - Household income ≤ 400% FPL
  - No employer coverage available or
  - Employer coverage is unaffordable or does not meet minimum actuarial value
    - Plan must cover at least 60% of the value of benefits
    - Employee contribution for self-only coverage does not exceed 9.5% of household income
  - If at least one full-time employee is eligible for premium tax credit or cost-sharing reduction, employer faces “shared responsibility penalties”

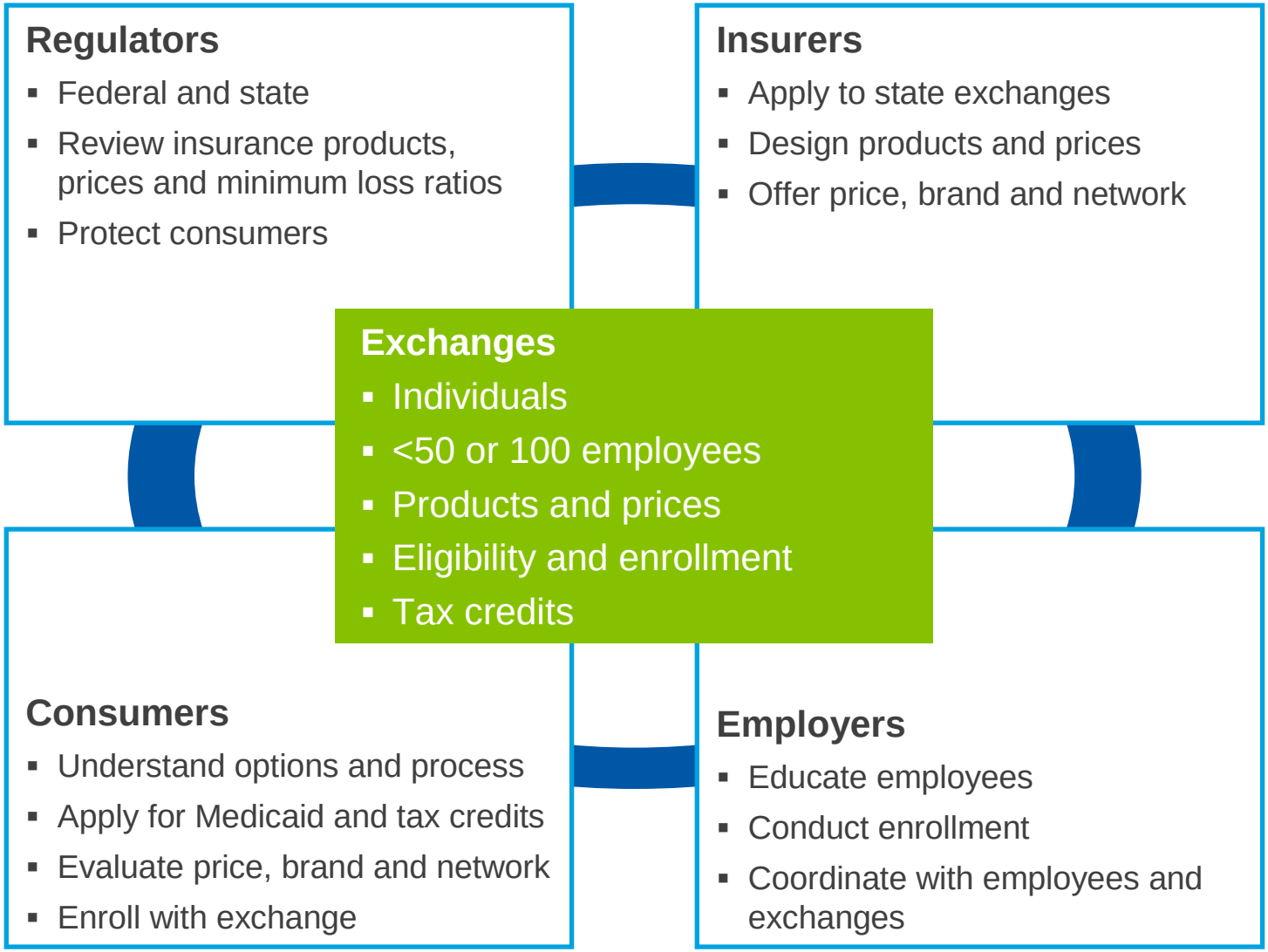
Shared Responsibility
2014 Affordability mandate – income segments



	Single individual	Family of Four
% of FPL	Annual Household Income	
Household income in excess of 400% of Federal Poverty Level Not eligible for subsidy through Exchange		
400%	$48,784*	$99,296*
300%	$36,588*	$74,472*
200%	$24,392*	$49,648*
150%	$18,294*	$37,326*
133%	$16,220*	$33,016*

* Note: Number based on Mercer forecasts for 2014 based on current contributions; illustrative only

2014: How exchanges will work
Exchanges have multiple roles – and will vary by state



Employers and Exchanges

1. Employer auto enrolls new FT employee
2. Employee applies to exchange with 2012 1040X and employer data
3. Medicaid & tax credit eligibility determined through exchange
4. Exchange notifies employee
5. Exchange notifies employer & IRS
6. Eligible employee disenrolls from employer plan, if permitted
7. Employer pays tax, if applicable

2014: Products offered in exchanges
Exchange products will differ from group plans

Features	Exchanges					Group
	Bronze	**Silver**	**Gold**	**Platinum**	**Catastrophic (age <30)**	**Plan design[1]**
Plan value	**60%**	**70%**	**80%**	**90%**	HSA rules	≥60%
Covered services	Essential & preventive benefits	Essential & preventive benefits	Essential & preventive benefits	Essential & preventive benefits	Essential & preventive benefits	Essential benefits not required
Essential benefits	No dollar limits	No dollar limits	No dollar limits	No dollar limits	No dollar limits	No dollar limits if covered
2014 deductible maximums[2]	HSA rules	HSA rules	HSA rules	HSA rules	HSA rules	$2,000 (I) $4,000 (F)
2010 cost sharing maximums[2] Will be indexed to 2014 levels	Up to $5,950 (I) $11,900(F)	Up to $5,950 (I) $11,900(F)	Up to $5,950 (I) $11,900(F)	Up to $5,950 (I) $11,900(F)	Up to $5,950 (I) $11,900(F)	Up to $5,950 (I) $11,900(F)

1. Some provisions apply differently for grandfathered and non-grandfathered plans
2. Appear to apply to employer plans and are based on current understanding, subject to change based on further guidance and regulations.

2014: Impact of the law
Most new requirements raise costs and risks

Eligibility and enrollment[1]	Plan design[1]
▪ Individual mandate ▪ Automatic enrollment ▪ 90-day waiting period maximum ▪ Medicaid ▪ Exchange coverage premium tax credits	▪ 60% plan value minimum ▪ Essential benefits are optional ▪ Eliminate dollar limits, if covered ▪ Deductibles up to $2,000/$4,000[2] (indexed) ▪ Cost-sharing up to HSA limits[2] (indexed)
Premium contributions[1]	**Delivery and insurance[1]**
▪ Affordability based on employee-only contribution[2] ▪ Dependent contributions can differ from employee contributions[2] ▪ For eligible workers in exchanges – Shared responsibility tax for full-time ▪ Annual increase in thresholds and taxes	▪ Medicaid and public exchanges ▪ Minimum loss ratios for insured plans ▪ Individual non-group product regulations ▪ Self-insured and insured group product rules

1. Partial list; some provisions apply differently for grandfathered and non-grandfathered plans; 2. Based on current interpretation

2014: Impact for employers that offer benefits
New costs from enrollment increases and taxes

Sources of new costs	Risk factors
✓ More employees enrolling ✓ More dependents enrolling ✓ New benefit requirements may increase plan costs ✓ Raising employer contributions to exceed affordability levels ✓ New taxes ✓ High-cost plan excise tax (2018)	▪ High employee opt-out/waiver rate ▪ High dependent opt-out rate ▪ Low-value plans ▪ Low employer contributions ▪ High premium tax credit eligibility ▪ High plan costs and trend

Cost impact will vary by industry and workforce segment

Cost mitigating strategies are available

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