



# Developing a Strategy for Health Care Reform: 2012 and Beyond

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- Recent court decisions
- What employers should be doing
- Market changes
- 2012 - 2013 summary of requirements
- 2014
  - ◆ Auto-enrollment
  - ◆ Shared responsibility/Employer mandate
- 2014 Strategy considerations
- 2018 Excise tax on high cost coverage
- Political landscape

# Courts split on constitutionality of individual mandate

- On Jan. 31, federal judge in Florida became the second court to find health reform law's individual coverage mandate unconstitutional
  - ◆ Court said this means the entire health care reform law is invalid
    - ☞ Judge declined to issue an injunction to stop implementation
  - ◆ Previous Virginia decision held individual coverage mandate unconstitutional, but left the rest of the law intact
- Three other federal courts have ruled the individual mandate is constitutional
- The US Supreme Court will almost certainly be asked to settle the conflicts. If the high court agrees to hear a case or cases, it will likely be a year or more before a decision is handed down.
- The Obama Administration has appealed the Florida decision and will move forward with efforts to implement the health reform law.
- ***Until the Supreme Court issues a decision, employers should continue with adoption and implementation of health reform strategy***



# What employers should be doing

## Completed

- Implement 2011 health reform requirements
- Establish regulatory monitoring process
- Inform executives of key changes – and the need for a strategic plan
- **For retiree medical plans:**
  - Account for drug subsidy changes
  - File for reimbursement for high cost pre-65 claimants
  - Revisit long term strategy

## In process

- Analyze effect of requirements for 2012 through 2014
- Evaluate and choose preferred strategies. Assess effect on:
  - Company costs
  - Employee costs
  - Benefit and reward programs
  - Attraction and retention
  - Workforce structure
  - Bargaining agreements
- **Create Implementation plan**
- **Set financial targets**
- **Identify and monitor risks**

Association of Washington Cities

## Going forward

- Implement changes for 2012 and 2013
- Plan and execute a communication program in 2013 and 2014
- Prepare for 2013 and 2014 benefit administration requirements
- Improve benefit plan results: Engage members and improve health and productivity
- Update strategy to respond to future reforms and market changes



# Market changes and health reform are converging

<b>Consumers</b>	<ul style="list-style-type: none"><li>▪ Greater accountability for health status</li><li>▪ More choices and financial consequences</li><li>▪ Direct to consumer retail marketing</li></ul>
<b>Providers</b>	<ul style="list-style-type: none"><li>▪ Consolidation, integration, and risk sharing</li><li>▪ Community based care management</li></ul>
<b>Insurers</b>	<ul style="list-style-type: none"><li>▪ Drive for retail market share</li><li>▪ New products and services</li><li>▪ Changing risk sharing and insurance models</li></ul>
<b>Employers</b>	<ul style="list-style-type: none"><li>▪ Considering new strategies</li><li>▪ Understand new public and private benefit markets</li><li>▪ More employee responsibility and incentives</li></ul>
<b>Government</b>	<ul style="list-style-type: none"><li>▪ Over 35 million more people get tax credits or Medicaid</li><li>▪ Create exchanges and individual insurance markets</li><li>▪ Political and implementation uncertainty</li></ul>



# 2012 and 2013: Upcoming mandates and responsibilities

2012 Mandates	
<b>Form W-2 Reporting</b>	<ul style="list-style-type: none"> <li>▪ <b>New guidance issued in 3/11</b></li> <li>▪ Gross costs, like COBRA</li> <li>▪ Need not include stand-alone dental and vision</li> <li>▪ Reporting for 2012 takes place in 2013</li> <li>▪ Employer exemption if &gt;250 W-2s</li> </ul>
<b>Group Health Plan Fee</b>	<ul style="list-style-type: none"> <li>▪ Annual fee of \$1, then \$2 indexed, assessed per participant until 2019</li> <li>▪ Fund federal program on comparative effectiveness research</li> </ul>
<b>Uniform Benefit Summary (By March 23, 2012)</b>	<ul style="list-style-type: none"> <li>▪ In addition to SPD and other currently required disclosures</li> <li>▪ Four pages, 12-point font summary provided at initial and annual enrollment</li> <li>▪ Includes information about covered benefits, exclusions, cost-sharing and continuation coverage</li> <li>▪ Requirement to notify participants 60 days prior to material plan modifications likely effective in 2012 as well.</li> </ul>

2013 Mandates	
<b>\$2,500 Health FSA Contribution Cap</b>	<ul style="list-style-type: none"> <li>▪ CPI-adjusted after 2013</li> </ul>
<b>Health Insurance Exchange Notice (By March 1, 2013)</b>	<ul style="list-style-type: none"> <li>▪ Inform employees about health insurance exchanges and a description of the exchange's services</li> <li>▪ Notice that employees may be eligible for premium tax credits and cost-sharing reductions</li> </ul>
<b>New Taxes For High-income Households</b>	<ul style="list-style-type: none"> <li>▪ Additional <i>employee-only</i> 0.9% Medicare tax and higher taxes on investment income for taxpayers with income over \$200,000/individual or \$250,000/couple</li> </ul>



# 2014: The impact of higher enrollment

The most significant issue for many employers

## 2014 provisions will increase enrollment on employer plans – How much?

- Effective 2014:
  - ◆ Employers will be required to automatically enroll newly-hired full-time employees in self-only medical coverage (and continue enrollment year to year for current enrollees)
  - ◆ The individual mandate becomes effective
  - ◆ Waiting periods limited to 90 days
  - ◆ Shared responsibility mandate generally requires employer coverage of all full-time employees
  - ◆ Definition of “Full-Time” employee is 30 hours per week
- Employers need to assess their opt-out population and current ineligibles to gauge potential enrollment/cost impact.



# Employer mandate to provide coverage beginning in 2014

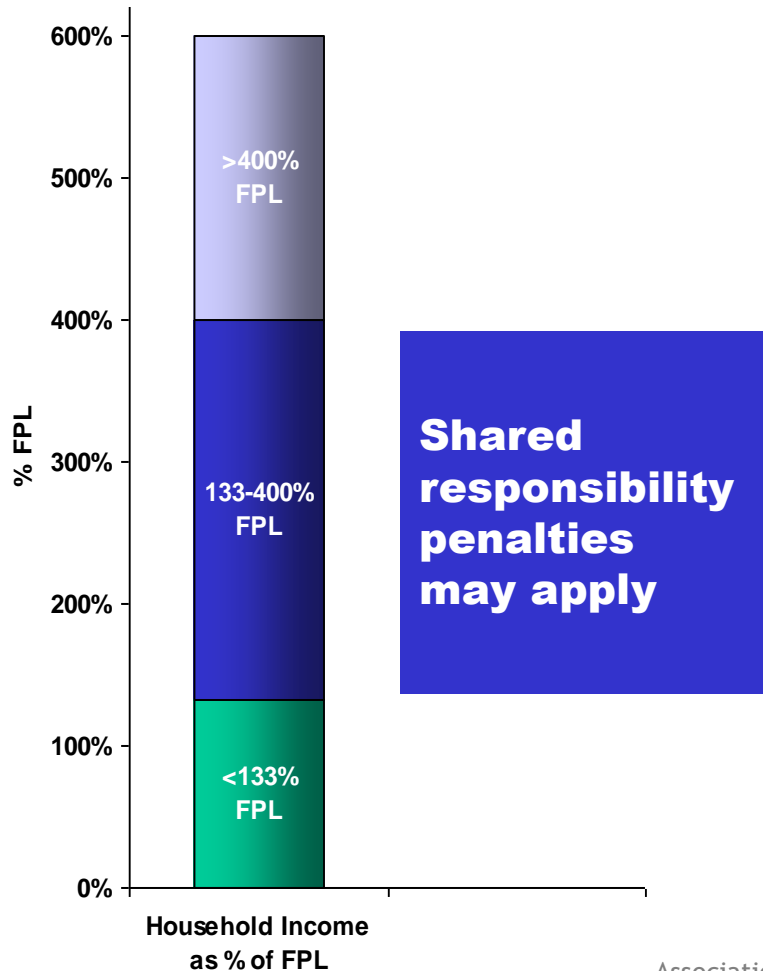
Issue	Patient Protection and Affordable Care Act, as amended
<p><b>Employer shared responsibility penalties</b></p>	<ul style="list-style-type: none"> <li>▪ Shared responsibility provision applies to employers with more than 50 full-time employees (FTEs) defined as employees working 30 or more hours per week on average in a month</li> <li>▪ Employers <i>not offering</i> coverage to all FTEs               <ul style="list-style-type: none"> <li>– \$2,000 annually multiplied by the total # of FTEs if at least one FTE receives income-based premium assistance to buy coverage through new health insurance exchanges</li> <li>– Penalties do not apply to first 30 FTEs</li> </ul> </li> <li>▪ 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"> <li>– \$3,000 annually for each FTE receiving income-based assistance for health insurance exchange coverage</li> <li>– Penalties capped at \$2,000 times total number of FTEs - not counting first 30 FTEs</li> </ul> </li> </ul>



# Shared Responsibility

## 2014 Affordability mandate - income segments

Income Segments Under Health Reform



	Single individual	Family of Four
% of FPL	Annual Household Income	
<b>Household income in excess of 400% of Federal Poverty Level Not eligible for subsidy through Exchange</b>		
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: Projected contributions at Medicaid thresholds Provisions - Shared Responsibility

- If employee premiums for at least one plan are less than or equal to approximately \$133 (“Employer Contribution Affordability Threshold” at the 138% or Medicaid level), then the shared responsibility penalties would not apply
- Employers may pursue a strategy of keeping “employee-only” contribution rates low, while increasing other coverage tiers (employee + one and employee + family)



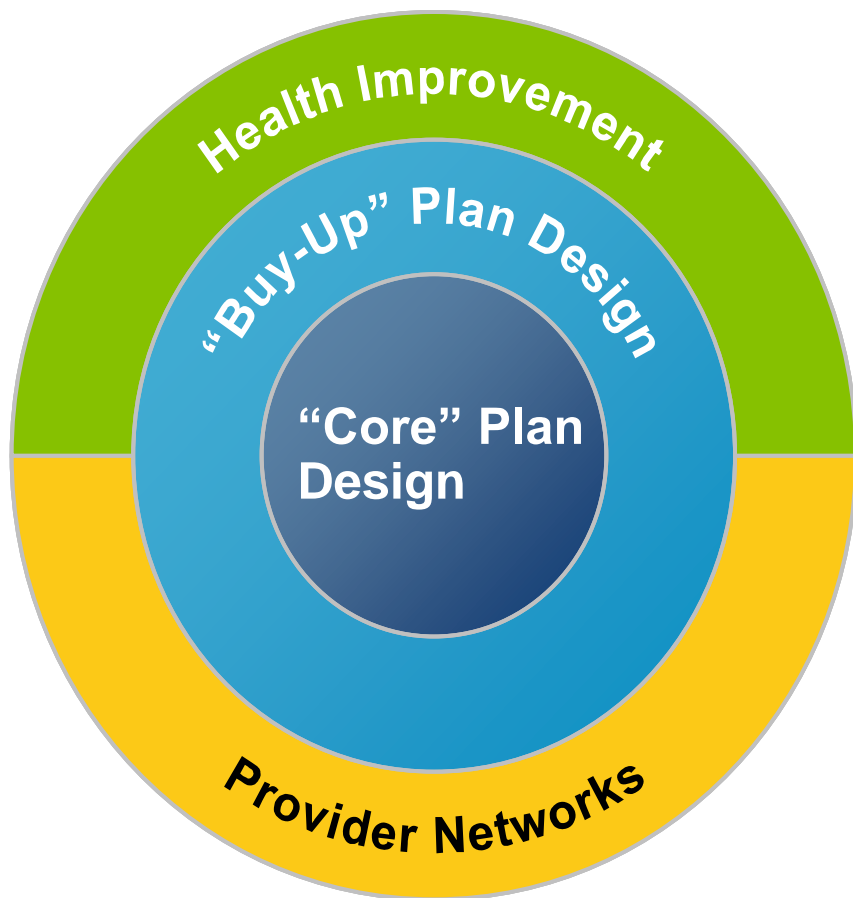
# Primary consideration for 2014

Employers have two major strategic options



- 1. Most companies will retain and optimize their current programs**
  - 2. Few companies will terminate their plans and exit**
- Companies will reduce benefits to avoid the high-cost excise tax*

# Potential path to optimization



- "Core Plan" = Low cost option
- Employees default to "Core" if auto-enrolled

- Employees can "buy up" to richer benefits
- Can be based on current or new designs
- Consider adding new benefits, e.g., voluntary programs to enhance value

- Targeted health management for all employees
- "Core Plan" includes incentives for healthy behaviors and outcomes (carrots and sticks)

- "Core Plan" uses smaller provider network (lower cost, equal quality)
- Buy up option uses current networks



# Potential path to optimization

## Core plan design, health improvement and networks

### Core Plan Design (High Deductible + HSA) (Minimum 60% value; can be increased)

	In Network	Out of Network
Deductible	\$2,000 / \$4,000	\$4,000 / \$8,000
HSA Account	Up to \$250 can be earned for compliance with one or more health management programs	
Coinsurance	50%	
Preventive Services	100%	Not covered
Out of Pocket Maximum	\$5,950 / \$11,900 (incl. deductible)	\$11,900 / \$23,800 (incl. deductible)
Pharmacy	Subject to deductible & coinsurance	

### Health Improvement

#### Choose one or more of the following:

- Penalties for tobacco users
- Incentives based on completion of health assessment and biometric screenings
- Incentives for meeting health status targets (weight, tobacco, cholesterol, blood pressure) or showing progress on goals
- Incentives for completion of coaching programs

### Provider Networks

- Narrow provider network with selection based on lower cost and equal or better quality
- Adequate geographic access for members
- Significant plan design features to steer members to preferred providers



# Consideration of an exit strategy

## 1. Exchange viability can't be judged until 2014

- The status of exchanges and individual insurance markets outside exchanges is highly unpredictable – and will vary significantly from state to state. 2014 is the earliest date to assess their potential value as an option for employees
- **Possibility of higher future shared responsibility taxes is a major risk to employers**

## 2. Lower-wage workers benefit from tax credits, but higher-wage workers don't

- Higher wage workers might seek additional pay because they do not get tax credits
- Spreading payments to all employees – including opt outs – dilutes contributions per employee
- Those needing family coverage will be hit hardest by an exit strategy

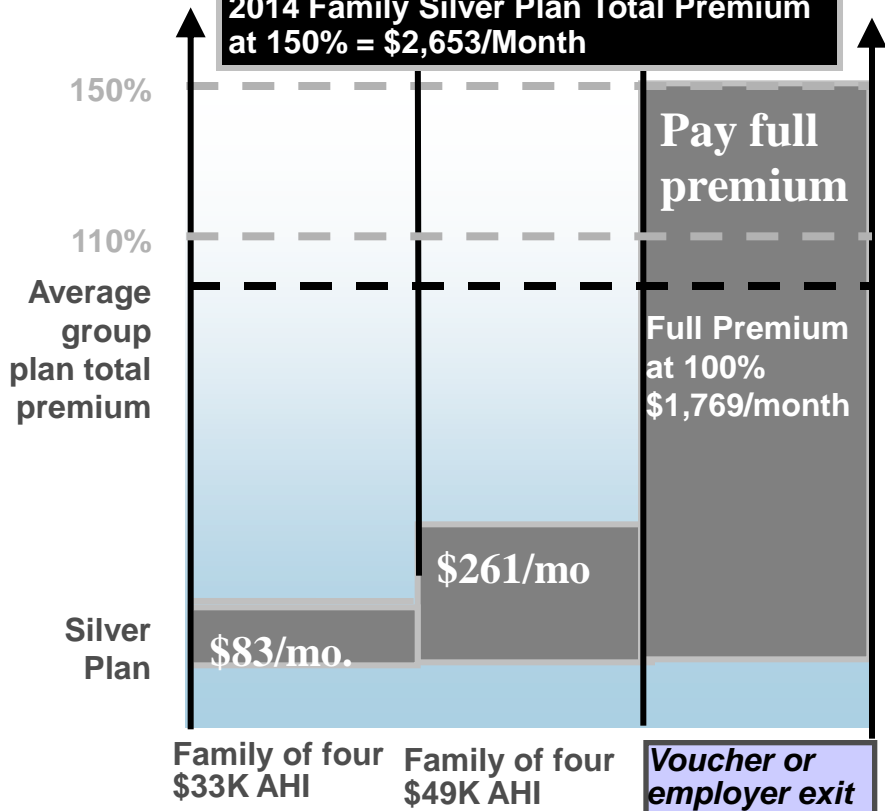
## 3. Any payment to employees in exchange for benefits (to make employees “whole”) will reduce employer savings

## 4. Employers would lose financial control over a valued employee benefit

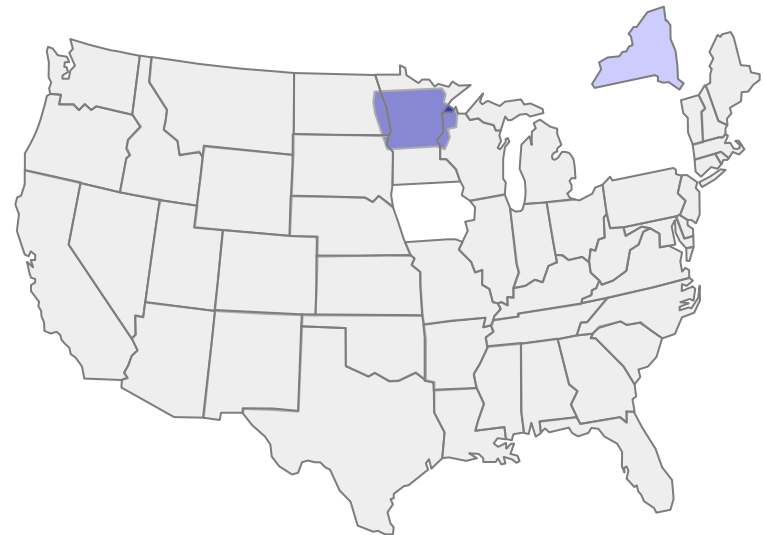
# 2014: Individual products and subsidies in exchanges

Individual product prices could be higher than in Group Plans<sup>1</sup> – and may rise faster

2014 Family Silver Plan Total Premium at 150% = \$2,653/Month



Individual product costs will vary by state



Total monthly premium at 150% of average

Family of 4	Average	Iowa	New York
Silver	\$2,653	\$2,202	\$2,918

1. Oliver Wyman. Impact of the PPACA on costs in the individual and small-employer health insurance markets



# Health care reform issues - Finally in 2018 - Excise tax on high cost plans

## Issue: Patient Protection and Affordable Care Act, as amended

**40% excise tax on “high cost” employer coverage**

- 40% excise tax on “high cost” coverage, including medical, employee and employer health FSA contributions, onsite medical clinics, and employer (but not employee) contributions to HSAs (but not insured stand-alone dental and vision coverage)

	<b>Thresholds for excise tax</b> (Indexed to CPI + 1% in 2019, CPI thereafter)	
	<b>Self-only</b>	<b>Any other tier</b>
<b>General</b>	\$ 10,200	\$ 27, 500
<b>High-risk professions</b>	\$ 11,850	\$ 30,950
<b>Retiree aged 55 through 64</b>		
<b>Multiemployer plan</b>	\$ 27,500	\$ 27,500

- Employers to determine aggregate cost, report to insurers and TPAs who must pay the tax

# Current political landscape

- GOP leaders say they will try to honor their pledge to repeal the health care reform law - recent vote largely symbolic
  - ◆ More likely is to slow implementation and change some provisions through aggressive oversight and funding cuts
- “De-fund” reform by denying annual federal budget appropriations
  - ◆ Specifically enforcement of the individual coverage mandate
- House GOP lawmakers plan to use their new control over committees to pursue aggressive oversight of the law’s implementation
  - ◆ Republican push-back may help shape regulations more to the GOP’s liking
- Republicans gained in gubernatorial, legislative, attorney general and insurance commissioner races across the country
  - ◆ States attempting to legislate opposition to health reform
  - ◆ Proposals for 2014 state opt out, provided can achieve the same results
- ***Most of the law will be undisturbed - 2012 elections may change course***

# Questions?

Source of Materials & Graphs: Mercer Health & Benefits; and Stoel Rives