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Health Reform Historic vote, but some unfinished business

Linda Havlin, Chicago

Rich Bailey, Richmond

Amy Bergner, Washington, DC

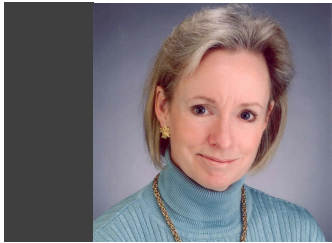
Derek Guyton, Chicago

Geoff Manville, Washington, DC

Kelly Traw, Washington, DC

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Today's speakers



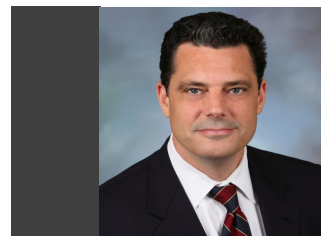
Linda Havlin
Chicago
+1 312 917 0706
linda.havlin@mercer.com



Derek Guyton
Chicago
+1 312 917 0696
derek.guyton@mercer.com



Rich Bailey
Richmond
+1 804 344 2637
rich.bailey@mercer.com



Geoff Manville
Washington, DC
+1 202 263 3957
geoff.manville@mercer.com



Amy Bergner
Washington, DC
+1 202 263 3930
amy.bergner@mercer.com



Kelly Traw
Washington, DC
+1 202 263 3904
kelly.traw@mercer.com



Agenda

- Current legislative state-of-play
- Key elements and timelines
- Understanding the cost impact
 - Modeling the cost impact
 - Considerations for retiree medical plans
- Short-term considerations



Current legislative state-of-play

Senate heading toward final vote on reconciliation bill (HR 4872)

- House-passed reconciliation, or “sidecar” bill makes key changes to the Patient Protection and Affordable Care Act (Public Law 111-148)
- Democrats may have the votes, but Republicans vow to slow the process
 - Byrd rule challenges
 - Parliamentarian will play key role in when, what form the bill passes
 - Role of the Vice President as Senate’s Presiding Officer
- Final Senate vote could come today, but bill will head back to House
 - Democrats want to finish the job before two-week Easter break
- Enactment of health care reform starts “Phase Two” of debate
 - Implementation will be critical to winning public approval



Key elements and timelines

Patient Protection and Affordable Care Act

- Patient Protection and Affordable Care Act (PPACA) will change the health care landscape in the coming years as it becomes fully implemented by 2018 or later
- Goals of reform embedded in the law's voluminous provisions
 - Expand coverage relying on many existing mechanisms, including public programs, employers, and the private insurance market
 - Remove perceived barriers to coverage
 - Address affordability issues
- Key questions include:
 - How will this affect short, medium and long-term costs?
 - How much latitude and flexibility will an employer have in designing and delivering benefits?
 - What administrative and compliance challenges will the new law present?
 - Are insured and self-insured plans treated differently?

Patient Protection and Affordable Care Act

- To help you think through and respond to what's most time sensitive and possibly of greatest cost impact
 - PPACA provisions that take effect immediately or near-term
 - Management/strategic considerations
 - Analysts inquiries
 - Government or other contractual obligations to estimate cost impact
 - Employee questions and concerns
 - Involvement in regulatory process
- We assume that the “sidecar” reconciliation bill (HR 4872) as passed by the House on March 21, 2010 will be passed by the Senate without changes to the employer provisions we will be discussing here

Patient Protection and Affordable Care Act

- Health plan standards that will take effect for all plans starting with plan years beginning on or after six months after March 23, 2010*
 - Dependent coverage to age 26 for covered employee's child lacking access to other employer coverage
 - No lifetime dollar limits
 - Restricted annual dollar limits
 - Insured plans subject to medical loss ratio rules
- Additional standards for new or “nongrandfathered” health plans
- Other issues for 2010
 - Change in Medicare retiree drug subsidy tax treatment
 - Early retiree medical reinsurance
 - Medicare prescription drug “donut hole” beneficiary rebate

*Collectively bargained plans under agreements ratified before 3/23/10 have until termination of last CBA

Patient Protection and Affordable Care Act

- Employer issues for 2011
 - Form W-2 reporting of health coverage
 - No health FSA/HRA/HSA reimbursements for over-the-counter medications
 - Increased penalties for nonqualified HSA distributions
- 2012 – Presidential Election Year
 - Employers must distribute uniform benefit summaries to participants

Patient Protection and Affordable Care Act

- Starting in 2013...
 - Change in Medicare retiree drug subsidy tax treatment takes effect
 - \$2,500 health FSA contribution cap takes effect (indexed)
 - Higher Medicare payroll tax on wages for employees with incomes exceeding \$200,000/individual or \$250,000/couples
 - New Medicare tax on net investment income for taxpayers with incomes exceeding \$200,000/individual or \$250,000/couples

Patient Protection and Affordable Care Act - 2014

- Health plan standards that will take effect for all plans starting with plan years beginning on or after January 1, 2014*
 - Dependent coverage to age 26 for any covered employee's child
 - No annual dollar limits
 - No preexisting condition exclusions
 - No waiting periods over 90 days
- Additional standards for new or “nongrandfathered” health plans
- “Shared responsibility” penalties if a full-time employee obtains coverage through a health insurance exchange and is eligible for income-based assistance to better afford it
 - Penalty amount depends on whether employer offers coverage to full-time employees and their dependents
- Free-choice vouchers for certain employees

*Collectively bargained plans under agreements ratified before 3/23/10 have until termination of last CBA

Patient Protection and Affordable Care Act

- Other developments in 2014
 - Individual coverage mandate with penalty
 - Health insurance exchanges
 - HIPAA wellness limit increased to 30%
 - Medicaid expansion
- And finally, in 2018...
 - Excise tax on “high cost” or cadillac plans

*Collectively bargained plans under agreements ratified before 3/23/10 have until termination of last CBA



Understanding the cost impact

Key employer concerns

Employer Characteristics	Shared Responsibility and Free Choice Voucher	Excise Tax
Low participation rates (i.e., high number of waivers)	✓	
Plans with significant employee cost-sharing (low actuarial value)	✓	
High employee contributions	✓	
Significant full-time population with lower salaries	✓	
Significant part-time population with low/no coverage		
Generous medical plan design		✓
High FSA participation/election amounts		✓
High health program costs (>\$7k S/\$19k F); high trends		✓
Collectively-bargained plans (which typically are generous designs)		✓

Case Study: Hospitality industry employer

Current coverage

Current Coverage: 16 Plans

Lowest Value Medical Plan:				
83% Actuarial Value				
19% of covered full time employees in low plan				

Contributions	Single	%	Family	%
Employer	\$294	65%	\$790	62%
Employee	\$160	35%	\$480	38%
Total	\$454	100%	\$270	100%

Highest Value Medical Plan:				
Highest Value Plan: 89% Actuarial Value				
1% of covered full time employees in high plan				

Contributions	Single	%	Family	%
Employer	\$307	50%	\$944	50%
Employee	\$307	50%	\$944	50%
Total	\$614	100%	\$1,888	100%

Red Flags / Observations

- 83% actuarial value qualifies under bill
- High employee contributions cause potential problems for Shared Responsibility Surcharge and Free Choice Voucher

Case Study: Hospitality industry employer

Current population and aggregate cost

Current Program

Current Population	Full Time	Part Time	Total
Total Employees	18,582	7,286	25,868
Total Covered	6,841	0%	6,841
% Covered	37%	0%	26%
Average Salary			\$23,000
FSA Participation			5%
FSA Average election			\$1,114

Aggregate Annual Health Care Cost		
Coverage	Single	Family
Highest Value Medical Plan	\$7,368	\$22,664
Dental + Vision*	\$302	\$1,072
Sub-Total without FSA	\$7,670	\$23,736
Total with \$2,500 FSA	\$10,170	\$26,236

Red Flags / Observations

- Low full time participation will bring increased cost of coverage and/or penalties
- Lack of part time coverage is not an issue under the Bill
- Large number of full time employees with low salary in combination with high employee contributions presents significant Shared Responsibility and Free Choice Voucher risk
- High value medical plan combined with dental, vision and FSA, presents Excise tax risk*

* Under reconciliation bill HR 4872, Excise Tax will not consider dental or vision coverage

Case Study: Impact of HCR on employer cost for full-time coverage

- Current coverage projected to 2014: \$35.6 million
- **Scenario 1:** Maintain current program (except for changes to meet minimum requirements)

Cost	HR 3590	
	\$ (Millions)	% of Total Cost
Cost of employer coverage	\$24.1	40%
-- <i>Change in coverage</i>	\$0.7	
-- <i>Change in enrollment</i>	(\$12.2)	
Shared Responsibility Surcharge	\$21.4	35%
Vouchers	\$15.3	25%
Excise Tax*	\$0.1	0%
Total cost with HCR	\$60.9	100%
Increase from current	71.1%	

* Under reconciliation bill HR 4872, Excise Tax will not be effective until 2018

- Almost 2,000 employees newly eligible for Medicaid have no employer cost
- High contributions + many with low salary make coverage unaffordable for many, generating opportunity for movement to Exchange
- Additional enrollees assumed in exchange due to subsidy and individual mandate

Coverage	Current	After HCR
Employer Plan	6,841	4,478
Exchange with subsidy		5,511
Exchange with Voucher		2,480
Opt-outs	11,781	3,905

Case Study: Impact of HCR on employer cost for full-time coverage

- Current coverage projected to 2014: \$35.6 million
- **Scenario 2:** Offer minimum qualifying coverage

Cost	HR 3590	
	\$ (Millions)	% of Total Cost
Cost of employer coverage	\$32.7	63%
-- Change in coverage	(\$10.3)	
-- Change in enrollment	\$7.4	
Penalties/surcharge	\$4.7	9%
Vouchers	\$14.2	27%
Excise tax	\$0	0%
Total cost with HCR	\$51.6	100%
Increase from current	44.9%	

Note: Cost in penalties for dropping coverage is \$13.9 million under HR 3590; \$37.1 million under HR 4872

- Minimum coverage reduces employer cost and employee premiums from Scenario 1
- High contributions + low salaries still make coverage unaffordable for many. However:
 - Lower premium for minimum plan makes coverage affordable for more employees than Scenario 1
 - Fewer additional enrollees in exchange and more in employer plans than with Scenario 1

Coverage	Current	After HCR
Employer Plan	6,841	8,805
Exchange with subsidy		1,016
Exchange with Voucher		3,417
Opt-outs	11,781	3,436

Case study: Hospitality industry employer summary

Red Flags

- Shared Responsibility and Free Choice Voucher
 - Large number of full time employee with low salary
 - High employee contributions
- Excise Tax
 - High value medical plan, coupled with dental*/vision*/FSA

Potential Solutions

- Shared Responsibility Surcharge/ Free Choice Voucher
 - For one plan, reduce contribution to make coverage affordable for low income employees (\$96/month for single, \$129/month family) to avoid both Shared Responsibility surcharge and Free Choice Voucher
- Excise tax
 - More aggressively manage cost of medical plan
 - Reduce or drop FSA
 - Reduce or drop dental/vision*; or move to voluntary individual coverage
 - Reduce or drop medical plan

* Under reconciliation bill HR 4872, Excise Tax will not consider dental or vision coverage



Considerations for retiree medical plans

■ Considerations for retiree medical plans

Impact of reform is broad and immediate

- Changes affecting retiree medical plans will hit many different aspects
 - **Accounting:** liabilities, deferred taxes
 - **Compliance:** Part D, design, eligibility
 - **Cost:** temporary reinsurance, cost shifting, Medicare Advantage
 - **Strategy:** drug coverage, continuation of plans
- New regulations on insurance companies and the changes to Medicare will surely drive shifts in the market for senior health care plans in ways that are difficult to predict today
- Some of the accounting changes could hit financial statements immediately, other will take longer to assess

■ Considerations for retiree medical plans

Change in preferential tax treatment of Part D Retiree Drug Subsidy

- Under the previous legislation, the Part D Retiree Drug Subsidy (RDS) received was not taxable income and employers were able to fully deduct the prescription drug claims for retirees
 - For tax paying entities, this tax preference made the RDS option especially attractive
- **The PPACA will end the preferential tax treatment of the RDS payment effective for 2013** (or 2011 if sidecar legislation not passed)
 - Employer tax deduction for prescription drug claims will be reduced by the RDS amount payable to employer
- Accounting impact likely to be immediate, with an adjustment made to the employer's deferred tax asset
 - Employer, auditor and actuary will need to work together

Considerations for retiree medical plans

Many changes could affect retiree liabilities and Part D attestation

- While it is too soon to know exactly how these changes will affect accounting results or the exact impact on liabilities, there will certainly be many items to consider
 - **Changes that could increase liabilities:** closing of the donut hole, cost shifting to non-Medicare plans, elimination of lifetime and annual maximums, covering dependents until age 26, required design changes, Medicare Advantage funding cuts, excise tax
 - **Changes that could decrease liabilities:** closing of the donut hole, cuts in payments to Medicare providers, temporary reinsurance for large claims on non-Medicare retirees
 - **Part D RDS attestation:** closing of the donut hole, immediate \$500 increase in initial coverage limit, \$250 rebate on copayments in donut hole for 2010, income-based Part D premiums



Short-term considerations

What to say to employees?

- Set the tone and context for immediate change
 - Tell them what you know – specifics about immediate term benefit enhancements and changes
 - Educate employees about cost implications of enhancements
- Address employee fears about
 - Disappearing employer coverage
 - Taxes on high cost coverage
 - Individual coverage mandate

Keep messaging general for now regarding: provisions that take effect beyond 2011

- Ensure employees you are following legislative process closely and will update them as you know more
- Begin to plan how to communicate change during annual enrollment

Health reform will not help employers control trend

- Federal and state health reform initiatives impacting eligibility, plan design, contributions, COBRA, benefit mandates
- Provider cost shifting due from Medicare and Medicaid
- Continued expense of absorbing uncompensated care until there is a viable individual market solution
- Cost shifting from carriers if regulators restrict their costs
 - If administrative expense is set at 15%
 - What services might be cut? Care management?
 - If rates are not adequate to cover adverse selection caused by a weak individual mandate
- Providers and suppliers may take defensive action
- Employers must continue to adopt advanced cost management strategies



Questions

Questions and contacts

Linda Havlin
Chicago
+1 312 917 0706
linda.havlin@mercer.com

Rich Bailey
Richmond
+1 804 344 2637
rich.bailey@mercer.com

Amy Bergner
Washington, DC
+1 202 263 3930
amy.bergner@mercer.com

Derek Guyton
Chicago
+1 312 917 0696
derek.guyton@mercer.com

Geoff Manville
Washington, DC
+1 202 263 3957
geoff.manville@mercer.com

Kelly Traw
Washington, DC
+1 202 263 3904
kelly.traw@mercer.com

Questions

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MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN