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May 20, 2010

Health Care Reform:
The facts you need to know

Rhode Island Business Group on Health- General Membership Meeting

Marie Chalmers, Boston

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Agenda

- Overview
- First things first…Getting down to basics on health plan standards
- Other near-term changes and concerns
- 2014-2018 key employer issues
- Considerations and strategies for the reform era

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Overview

Health care reform
Overview

- The Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA), is now law
  - The new law will have significant impact on employers and the health care marketplace over the coming decade and beyond

- Goals of reform are 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

- Lack of detail and unknown consequences will require ongoing interpretation, monitoring and a flexible approach
  - Various government agencies must develop regulations, and this is likely to be a long and staggered process taking many years
    - With long implementation timeline and intervening elections, it's possible that modifying legislation could be passed before some PPACA provisions are effective

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Health care reform
Potential implications

- Many variables can influence direct cost impact, including
  - Current plan design and need/timing to conform to new health plan standards
  - Workforce demographics (for example, employer shared responsibility and free choice voucher provisions (2014) will likely have a bigger impact on employers with generally lower-paid workforces and less generous employer-provided benefits)
  - Richness of benefits (for example, excise tax on high cost coverage (2018) will have a bigger impact for employers with more generous benefits, who may consider mitigating measures)
  - Direct fees, and administration and process adjustments
  - Retiree medical coverage
- Indirect costs likely to have an impact, including
  - Employee communications and compliance efforts
  - Cost shifting from government programs, and from controlled rates for individual and small group coverage
  - Fees charged to insurers and drug manufacturers, tax on DME
  - Uncertainty of future revenue to support reform initiatives

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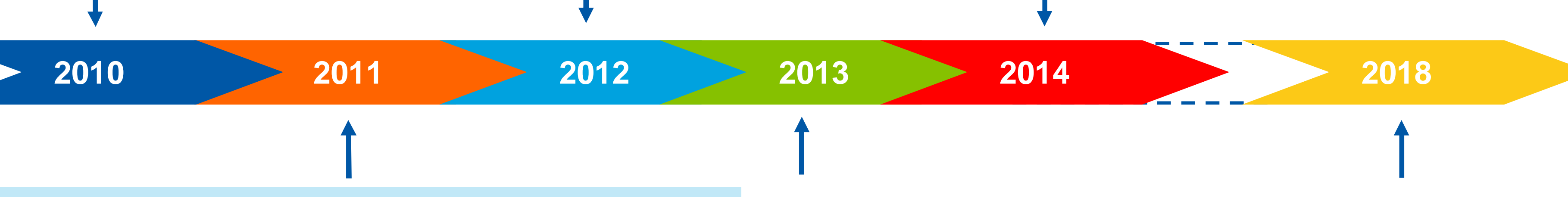
Key elements of Health Care Reform for Employers

- 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 (TBD)
- Form W-2 reporting for 2011 health coverage

- Health insurance exchanges
- Individual coverage mandate
- Financial assistance for exchange coverage of low-income individuals
- Medicaid expansion
- New health plan regulations
- 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 (no other employer coverage available)**
- *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 Medicare tax on net investment income for taxpayers with incomes exceeding $200,000/ individual; $250,000/couples
- Research fees begin
- 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.*

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First things first…Getting down to basics on health plan standards

First things first… getting down to basics on health plan coverage and cost-sharing standards

- New health plan standards take effect in two phases
  - Plan years beginning on or after September 23, 2010
  - Plan years beginning on or after January 1, 2014
  - Special delayed effective date for certain collectively bargained plans
    - Coverage under a CBA ratified before March 23, 2010 need not comply until the last CBA relating to the coverage terminates
- New health plan standards apply to insured and self-insured medical plans, and likely to retiree medical plans, but not to separate dental and vision plans
- New health plan standards apply to plans subject to ERISA, including plans maintained in Puerto Rico
- Some, but not all, standards apply to “grandfathered” plans that were in place before March 23, 2010

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Health care reform issues for employer-sponsored plans
Beginning in 2010

Issue	Patient Protection and Affordable Care Act, as amended
Health plan standards – all plans Effective for plan years beginning on or after September 23, 2010; delayed for certain collectively bargained plans*	Insured and self-insured plans ▪ Offer extended dependent coverage to age 26 for covered employee's child (without access to other employer 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 ▪ Generally, no lifetime dollar limits ▪ Restricted annual dollar limits on essential health benefits ▪ No pre-existing condition exclusions for children under age 19 ▪ No rescissions ▪ All insured (but not self-insured) group health plans must meet minimum medical loss ratios – 85% if employer has more than 100 employees – 80% if employer has 100 or fewer employees

***"Collectively bargained coverage"** For health coverage under collective bargaining agreements (CBAs) ratified *before* March 23, 2010, PPACA's coverage and cost-sharing mandates will apply on the termination date of the last CBA relating to the coverage. Any CBA amendment to comply with these new mandates will not be treated as terminating the CBA. Thus, while collectively bargained plans may get a postponement, they don't have a permanent exemption from the new standards.

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Grandfathering – What is it?

- A grandfathered plan is one in place *before* March 23, 2010
  - Grandfathered plans can enroll new hires and family members of existing participants
  - But, the law does not explain how or when a plan could lose grandfathered status
    - For example, it is not clear whether grandfathered status would be lost if a plan design element is changed, when a network is changed, or when existing employees enroll in a plan for the first time

- Assess your plan provisions against the standards that apply only to nongrandfathered plans

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Health care reform issues for employer-sponsored plans
Beginning in 2010

<table>
<tr><th>Issue</th><th>Patient Protection and Affordable Care Act, as amended</th></tr>
<tr><td>Health plan standards – new and nongrandfathered plans**
Effective for plan years beginning on or after September 23, 2010; delayed for certain collectively bargained plans*</td><td>Insured and self-insured plans
▪ Provide mandated preventive services with no cost-sharing
▪ Establish and provide notice of internal and external appeals procedure
▪ Emergency services coverage
– Cannot be limited to in-network providers
– Cannot impose higher cost-sharing for out-of-network providers
– Cannot require preauthorization
▪ Plans requiring or providing for primary care physician designation
– 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 (significant implications for insured executive medical plans)</td></tr>
</table>

"Grandfathered plans" A grandfathered plan is one in place *before* March 23, 2010. The law doesn't say how a plan's grandfathered protection can terminate or be lost. The PPACA does permit a grandfathered plan to enroll new hires and their family members, as well as the family members of any employee covered before March 23, without affecting its status. However, the law doesn't say whether a plan can enroll employees who weren't covered before March 23 or make cost-sharing, benefit or other changes – including PPACA-required changes – without losing grandfathered status. Just how long a plan will enjoy grandfathered status will be difficult to know until regulatory guidance is issued.

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Preview of health plan standards for 2014

- All insured and self-insured plans
  - Offer coverage to dependent children to age 26 (regardless of access to other employer coverage)
  - No preexisting condition exclusions
  - No waiting periods over 90 days
  - No annual dollar limits

- New and non-grandfathered insured and self-insured plans
  - Cost-sharing limited to high deductible plan limits (out-of-pocket limits and, possibly, deductibles)
  - Mandated coverage of routine patient costs in connection with clinical trial participation
  - Provider nondiscrimination
  - HIPAA wellness incentives increase

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Other near-term changes and concerns

Health care reform issues for employer-sponsored plans

Some additional reforms

Issue	Patient Protection and Affordable Care Act, as amended
Early retiree reinsurance program (2010)	▪ $5 B government fund available on first-come, first-served basis ▪ 80% of per-person claims between $15,000 and $90,000 ▪ Sponsors must maintain their level of effort in supporting the plan – Use payments to defray sponsor's premium increases, increases in other health benefit costs; to reduce participant costs – Applications must explain how payments will be used to satisfy the maintenance of effort requirement ▪ Process similar to Medicare Part D Retiree Drug Subsidy program
No reimbursement for non-prescribed over-the-counter drugs (2011)	▪ No reimbursement for non-prescribed over-the-counter drugs from a health plan, health flexible spending account, health reimbursement arrangement, or health savings account
Form W-2 reporting	▪ Employers must include aggregate cost of employee 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) ▪ 2011 actions will include valuation of aggregate cost to be reported on employee W-2 Forms issued in early 2012

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Health care reform issues for employer-sponsored plans
Some additional early reforms

Issue	Patient Protection and Affordable Care Act, as amended
CLASS Act (2011)	▪ Long term care-type insurance benefit offered through federal government ▪ Employers may decide to offer to employees ▪ Compare with other LTC products
Medicare changes	▪ Medicare beneficiaries with high incomes face higher Medicare Part D premiums starting in 2011 ▪ Medicare Advantage plan payments for 2011 will be frozen at 2010 levels, and reductions will be phased in starting in 2012 ▪ Gradual elimination of the Medicare Part D donut hole
Health industry fees	▪ Pharmaceutical manufacturers and importers (2011) ▪ Durable medical equipment (2013) ▪ Health insurers (2014)

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Health care reform issues for employer-sponsored plans
Beginning in 2012

Issue	Patient Protection and Affordable Care Act, as amended
Group health plan fee to fund "patient-centered outcomes research"	▪ Group health plan sponsors and insurers 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 ▪ Applies to policy years or plan years ending after Sept. 30, 2012 ▪ Sunsets in 2019
Uniform benefit summary	▪ 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

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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	▪ Annual contributions to health FSAs capped at $2,500 – Adjusted annually for increases in the cost of living
Health insurance exchange notice	▪ Employers must notify new hires about health insurance exchanges: – Eligibility for federal assistance to buy exchange-based coverage if employer's plan pays less than 60% of covered benefits – Note discrepancy in notice requirement and 2014 target date for exchanges
New Medicare taxes for high-income households	▪ Additional Medicare taxes imposed on taxpayers with income over $200,000/individual or $250,000/couple: – 0.9% increase in Medicare payroll tax on wages above the thresholds – 3.8% tax on net investment income
Retiree drug subsidy tax treatment changes	▪ Employers' tax deduction for prescription drug claims paid will be reduced by the 28% RDS subsidy received in 2013 or after – Companies may have to recognize accounting impact in early 2010
Tax on medical devices	▪ A 2.3% tax will apply to medical devices

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Health care reform issues for employer-sponsored plans
Effective date is unclear

Issue	Patient Protection and Affordable Care Act, as amended
Auto-enrollment requirement for employers with more than 200 full-time employees Effective date is unclear	▪ Unclear when it applies; may be effective – March 23, 2010 – Once DOL issues regulations – 2013 or 2014 ▪ 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
60-day advance notice of plan design changes Effective date is unclear	▪ Unclear when it applies; may be effective – Plan years starting on or after March 23, 2010 – Plan years beginning on or after March 23, 2012 ▪ Must give 60-days prior notice before any material modifications can be made to the plan

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2014-2018 key employer issues

Health care reform issues for employer-sponsored plans
Some reforms beginning in 2014

Issue	Patient Protection and Affordable Care Act, as amended
Employer shared responsibility penalties	▪ 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 the coverage either – The plan's share of total allowed benefit costs is less than 60%, or – An employee's contribution represents more than 9.5% of household income ▪ 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)
No penalties for certain employees	▪ No penalties for employees enrolled in Medicaid or receiving free choice vouchers

*Full-time employee is one who works, with respect to any month, an average of at least 30 hours a week

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Health care reform issues for employer-sponsored plans
Some reforms beginning in 2014

Issue	Patient Protection and Affordable Care Act, as amended
Employee free choice vouchers	▪ Any employer offering health coverage and making plan contributions must provide “free choice vouchers” to eligible employees
Eligible employees	▪ Any employee - whether full- or part-time – offered employer coverage and who – Opts out of the employer coverage, – Has household income at or below 400% of federal poverty level, – Faces a required contribution representing 8%-9.8% of household income, – Buys coverage through a health insurance exchange
Voucher payments	▪ Amount will equal what employer’s cost would have been had employee enrolled in option with largest employer-paid share of the contribution ▪ Amount will vary on whether employee buys individual or family coverage on an exchange. ▪ Employer to pay exchange for the cost of the employee’s coverage, and to pay any excess to the employee ▪ Voucher payments will be deductible by employers

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Approach to avoid both shared responsibility surcharge and free choice voucher

- This table highlights projected monthly contributions which would avoid both Shared Responsibility Surcharge and Free Choice Voucher in 2014*
  - Can have other programs with higher contributions
  - If employee premiums for at least one plan are less than or equal to "affordable premium at Medicaid threshold", then neither surcharge nor voucher applies

	2010	2014		
Family Size	1.33 FPL (Medicaid)	1.33 FPL** (Medicaid)	Affordable Premium* at Medicaid Threshold	
			Annual	Monthly
1	$14,412	$16,221	$1,298	$108
2	$19,391	$21,825	$1,746	$146
3	$24,355	$27,412	$2,193	$183
4	$29,334	$33,016	$2,641	$220
5	$34,314	$38,621	$3,090	$257
6	$39,278	$44,207	$3,537	$295
7	$44,257	$49,812	$3,985	$332
8	$49,237	$55,416	$4,433	$369

* 8% of income at Medicaid threshold to avoid both Shared Responsibility Surcharge and Free Choice Voucher

**FPL assumed to increase 3% per year

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2014: Some additional key employer issues
Other provisions on access, coverage and affordability

- Medicaid expansion to include more people (up to 133% FPL)
  - Mandatory state premium assistance for employer coverage

- Individual coverage mandate with penalties
  - Penalty would be the greater of a flat dollar amount ($325 in 2015, rising to $695 in 2016) or 2.5% of income

- Health insurance exchanges offering individual and small group coverage, initially

- Financial assistance for lower-income people getting coverage through an exchange

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Health care reform issues for employer-sponsored plans
Some reforms beginning in 2018

<table>
<tr><th>Issue</th><th>Patient Protection and Affordable Care Act, as amended</th></tr>
<tr><td>40% excise tax on “high cost” employer coverage</td><td>

- 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)

<table>
<tr><th rowspan="2"></th><th colspan="2">Thresholds for excise tax
(Indexed to CPI + 1% in 2019, CPI thereafter)</th></tr>
<tr><th>Self-only</th><th>Any other tier</th></tr>
<tr><td>General</td><td>$ 10,200</td><td>$ 27, 500</td></tr>
<tr><td>High-risk professions</td><td rowspan="2">$ 11,850</td><td rowspan="2">$ 30,950</td></tr>
<tr><td>Retiree aged 55 through 64</td></tr>
<tr><td>Multiemployer plan</td><td>$ 27,500</td><td>$ 27,500</td></tr>
</table>

- Employers to determine aggregate cost, report to responsible entities

</td></tr>
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Now what?
Considerations and strategies for the reform era

Connecting the dots
Top employer concerns

Expanding Eligibility

- Current opt outs
- New enrollees and auto enrollment
- Potentially more dependents

Expanding Plan Design

- Eligibility change (dependents to 26)
- No lifetime maximum
- Restricted annual maximums
- No cost share on preventative care
- Qualified plan (If not currently qualified)

Expanding Government fees and Reporting

- Excise tax for high cost plans
- Surcharge / Free Choice Vouchers
- RDS/SFAS 106
- Retiree medical reinsurance

Expanding Pressures for Cost Shifting

- Industry and manufacturer fees
- Mandatory loss ratios
- Government program cost controls
- Medicare/Medicaid fee schedules and potential impact on group insurance provider fee schedules

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What it means for your cost

- Reform will increase cost for most employers

- Initial assumption: 4-6% impact on cost
  - Expanded eligibility .5-1.5%
  - Expanded plan design 1-2%
  - Industry fees .5-1%

- Other sources of potential cost shifting
  - Government sponsored programs
  - Uncompensated care until individual market becomes viable
  - Insufficient rates for individual and small group coverage

- Additional costs could have a 2-3% cumulative impact on trend over 10 years

- Cost shifting, mandates and potential for insufficient individual rates have a higher impact on fully insured plans
  - Prompting employers to consider moving to self-insured plans

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Who is at risk?

Evaluating financial impact – Key financial risks vary based on employer characteristics

Employer Characteristics	Shared Responsibility and Free Choice Voucher	Excise Tax
Low participation rates/unaffordable coverage (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	✓	
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)		✓

The goal: Structure plans based to minimize financial risks and maximize the value of each benefit dollar spent

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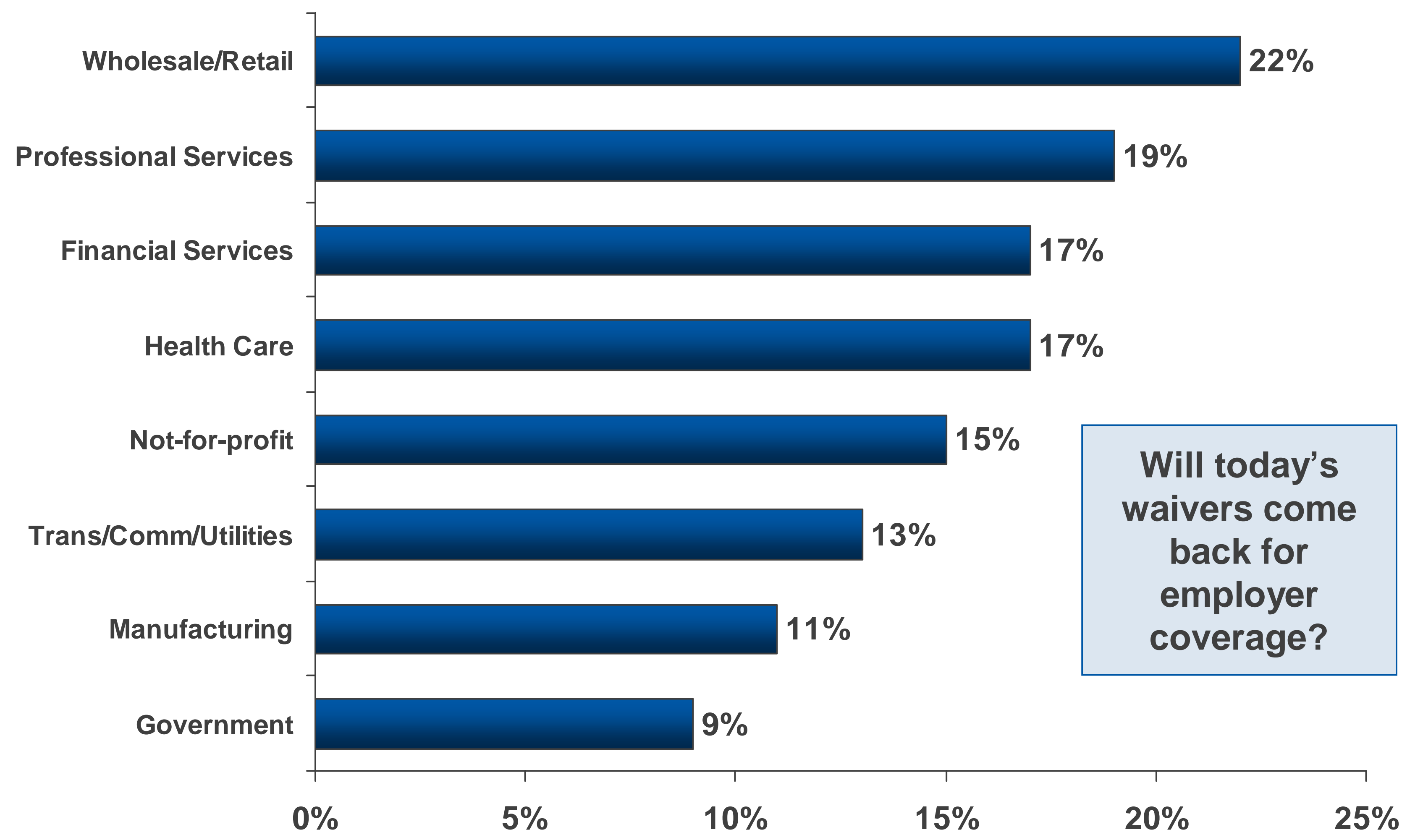
Waving the red flags
Current levels of opt-outs by industry



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Challenges in administration and communication

- Now for the hard part
- Capturing and processing new information
  - Household income & Exchange elections(?)
  - Medicaid eligibility
  - Vouchers, payments and taxes

- New reporting and tracking needs
  - Plan standards
  - Tax withholding and reporting
  - CLASS enrollment

- Communication – requirements and needs
  - New plan summaries
  - New options: Medicaid, Exchanges, Vouchers
  - New plan standards and limitations: from “free” preventive care to caps on FSA contributions

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What should you do now?

- Reassess 2011 health care strategy in light of reform
  - Interpretation and guidance on grandfathered plan status
  - Establish baseline for 2011
  - Highlight 2011 cost increments due to HCR
  - Adjustments needed to stop loss insurance
  - Benefit tweaks; administrative processes
  - Begin employee communications

- Long term health care strategy needed to address 2014 and 2018 requirements

- Model financial impact of all aspects of reform
  - Gap analysis – where are you today and where do you want to be?

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Health Care Reform financial modeling
What should you study?

- Impact of 2011 changes – cost ranges
  - Dependents to age 26 and no lifetime maximums
  - Zero cost share for preventative services

- Identify cost implications associated with current opt outs

- Address Surcharge / Free Choice Vouchers
  - Plan potential extra cost, design and contributions issues

- Consider pay or play strategies and 60% actuarial value plan
  - What happens if employer drops coverage
  - What other cost avoidance strategies should you consider

- Excise tax – when does it occur and how large is the tax?
  - What actions can be taken to defer when excise tax emerges

It's not only about what you will do but what other employers will do too – this is a timing and strategy issue

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Will employers drop coverage?

- Employers appear to have an incentive to drop coverage
  - Average 2009 PPO cost per employee: $8,334*
  - Penalty for not offering coverage: $2,000 for full-time employees
    - If at least one FTE receives income-based assistance to buy exchange coverage
    - Excluding first 30 employees

- But, there are several complicating factors
  - Individual market is not viable in all states at this time
  - Group rates are more favorable than individual rates
  - What's an appropriate contribution
    - Tax implications of moving from tax-favored to taxable compensation

Source: Mercer National Survey of Employer-Sponsored Plans, 2009, employers with > 500 employees

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Currently, employer-sponsored coverage has a price advantage

Individual coverage

- A less stable market
- Enrollment and billing done one person at a time
- High risk individuals have been excluded, but will now have ability to enroll
- Individuals can decline coverage, opt in and out of coverage
- State mandates apply
- Allowed retention: 20%

Employer-sponsored coverage

- A more stable market
- Efficient electronic enrollment and billing processes provide more reliable cash flow to insurers
- Individuals cannot opt in and out of coverage during a plan year
- Flexibility to be self-insured and avoid mandates
- Allowed retention: 15%

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Summary of Health Care Reform cost impact
What should employers be doing in 2010?

In the next 30 days…	In the next 90 days…	In the next 180 days…
▪ Understand the impact of reform – Inform executives of key changes ▪ Communicate with your employees ▪ If retiree medical benefits exist: – Address financial reporting requirements for retiree drug subsidy – Prepare to file for high cost claim reimbursement (retiree and dependent claims age 55+ not Medicare eligible)	▪ Model the impact of complying with reform ▪ Evaluate alternative strategies for compliance ▪ Develop a short and longer term strategy ▪ Determine required changes for the next plan year ▪ Consider whether to participate in CLASS Act employee-pay-all voluntary long term care program	▪ Evaluate and develop a long-term vendor management program ▪ Develop action steps needed to implement a long-term strategy to manage your post-reform costs

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Employer perspectives

Health care reform: Sizing up the challenge
About the survey

- Survey was fielded between April 27 and May 7 to employers registered for our 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

Caution: Survey allowed gut reactions

- Will probably take this action
- Would strongly consider
- Would consider
- Not likely to consider
- Would definitely not consider

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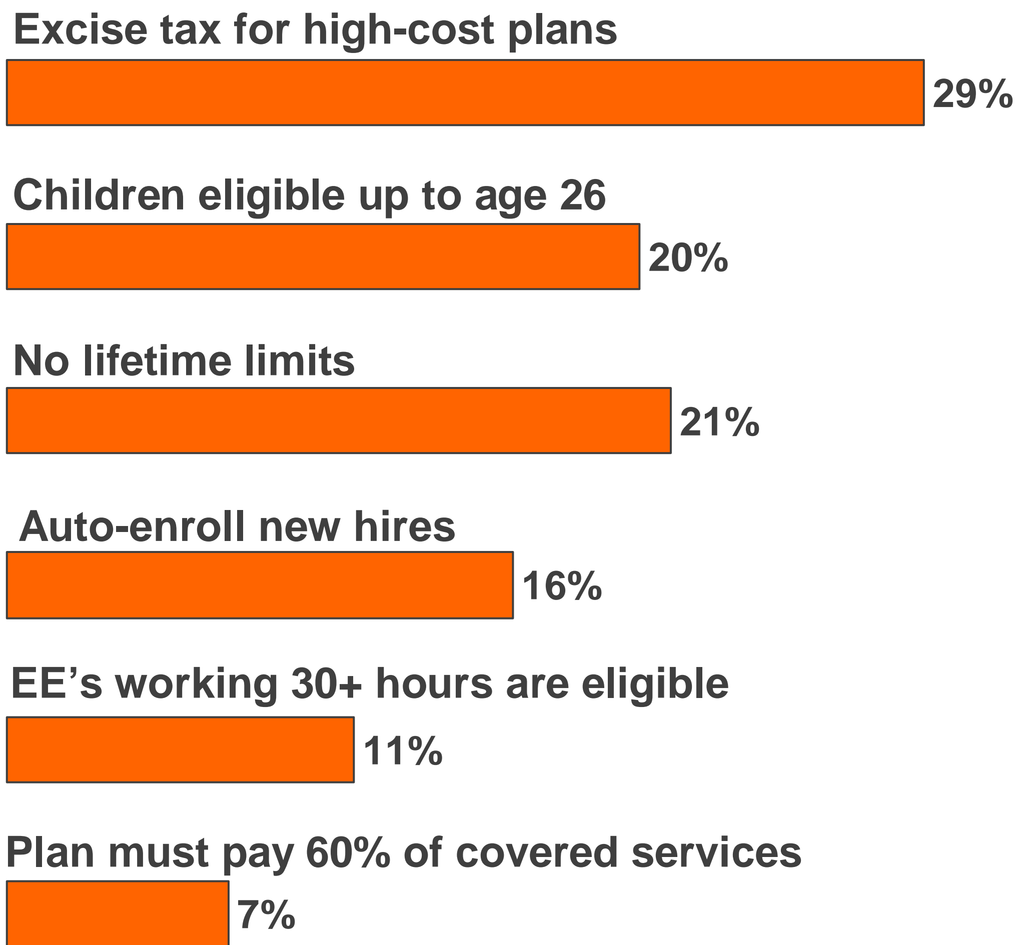
Excise tax is the reform provision that worries employers the most

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



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

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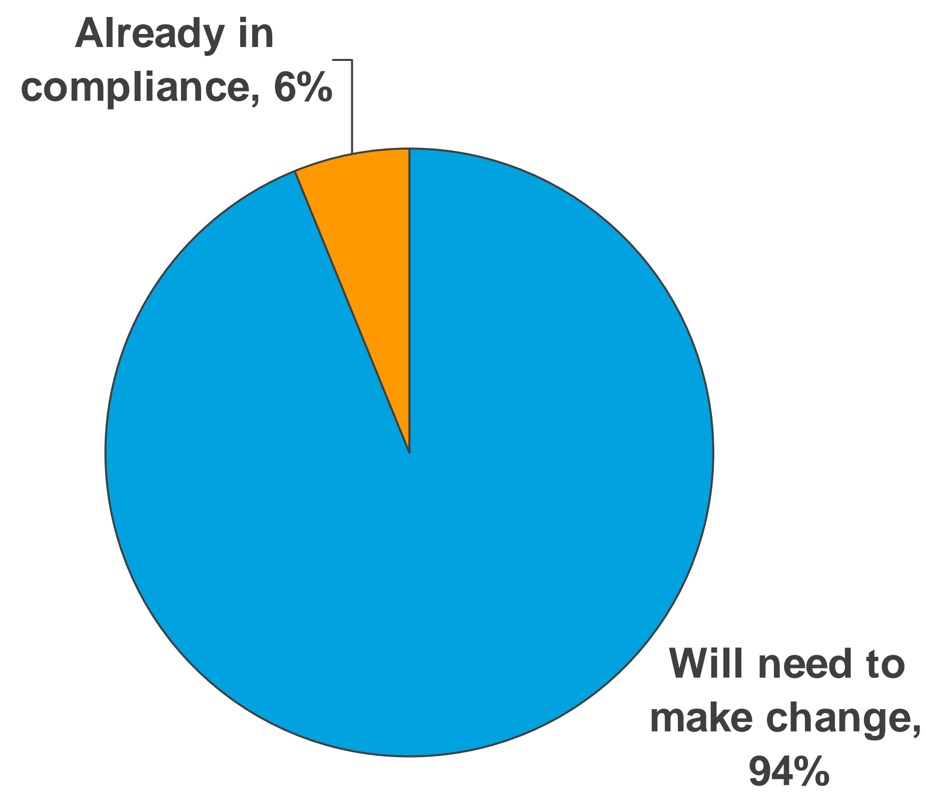
Need to change their dependent eligibility rules to comply with the PPACA requirement that children up to age 26 be eligible for coverage



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

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Will strongly consider the following actions with regard to dependent eligibility

Based on employers that will need to change dependent eligibility rule

Action	Percentage
Require children above specified age to verify no other coverage available	49%
Impose a premium surcharge on dependents above a specified age	21%
Change premium rate tiers	20%
Impose higher premium share for all dependents	16%
Use more restrictive eligibility rules for dental and/or vision	12%

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

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

Use lowest-cost plan or only plan as the default

43%

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

20%

Add a new plan to use as the default

8%

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

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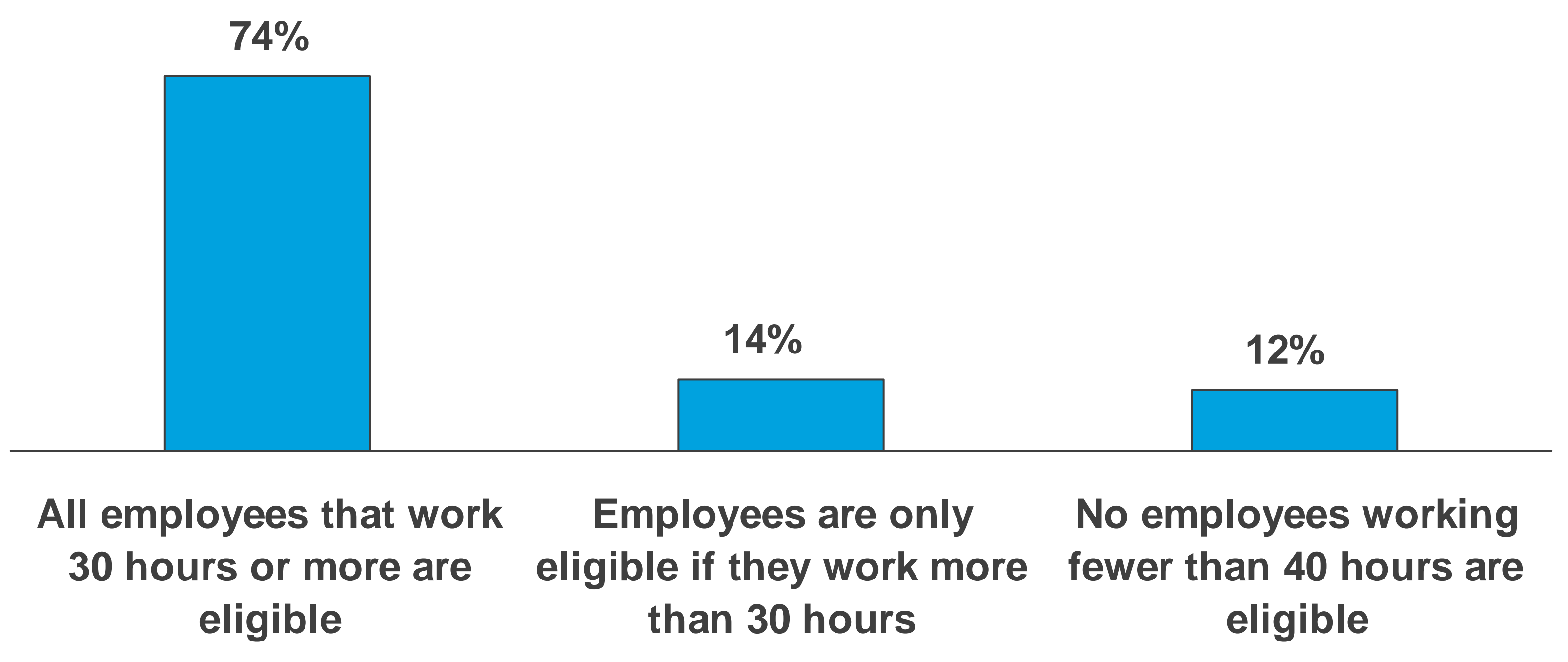
Only about three-fourths of employers currently extend eligibility to all employees who work 30 or more hours per week
Based on employers with part-time employees



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

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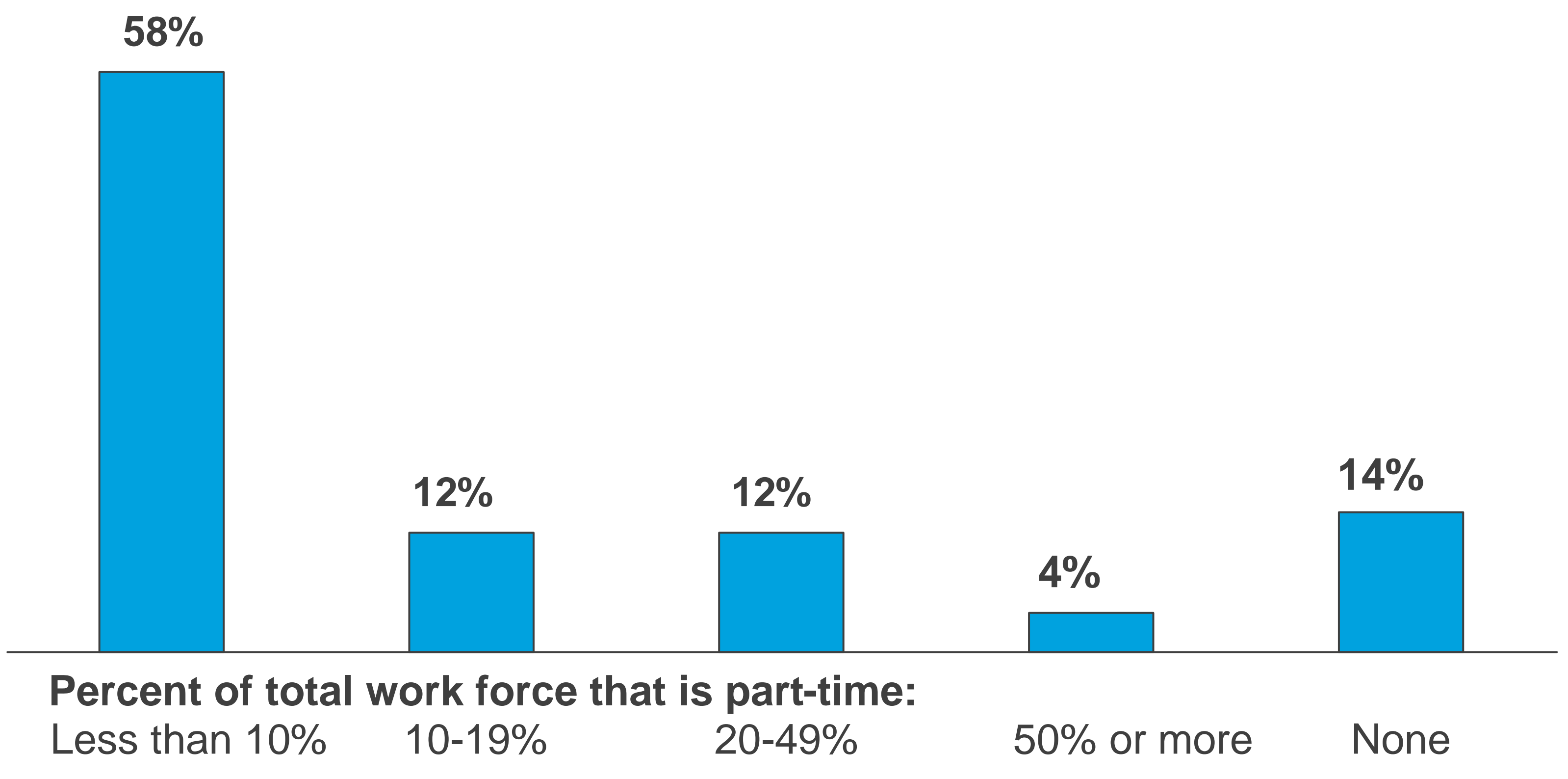
For a majority of employers, less than 10% of the total workforce is considered part-time – but that varies significantly by industry



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

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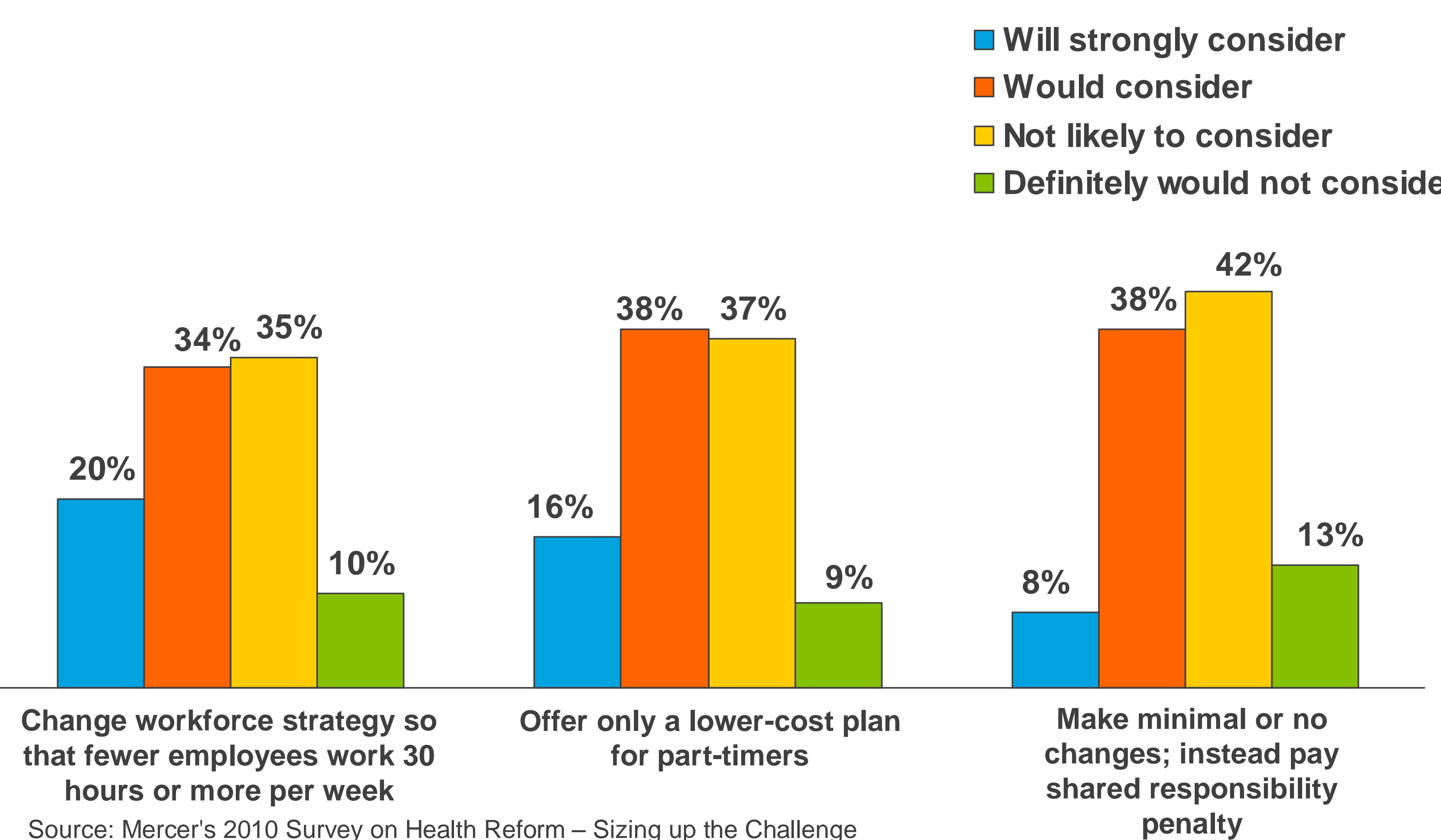
Possible actions with regard to the requirement that all employees working 30 hours or more hours per week must be eligible

Based on employers currently not in compliance



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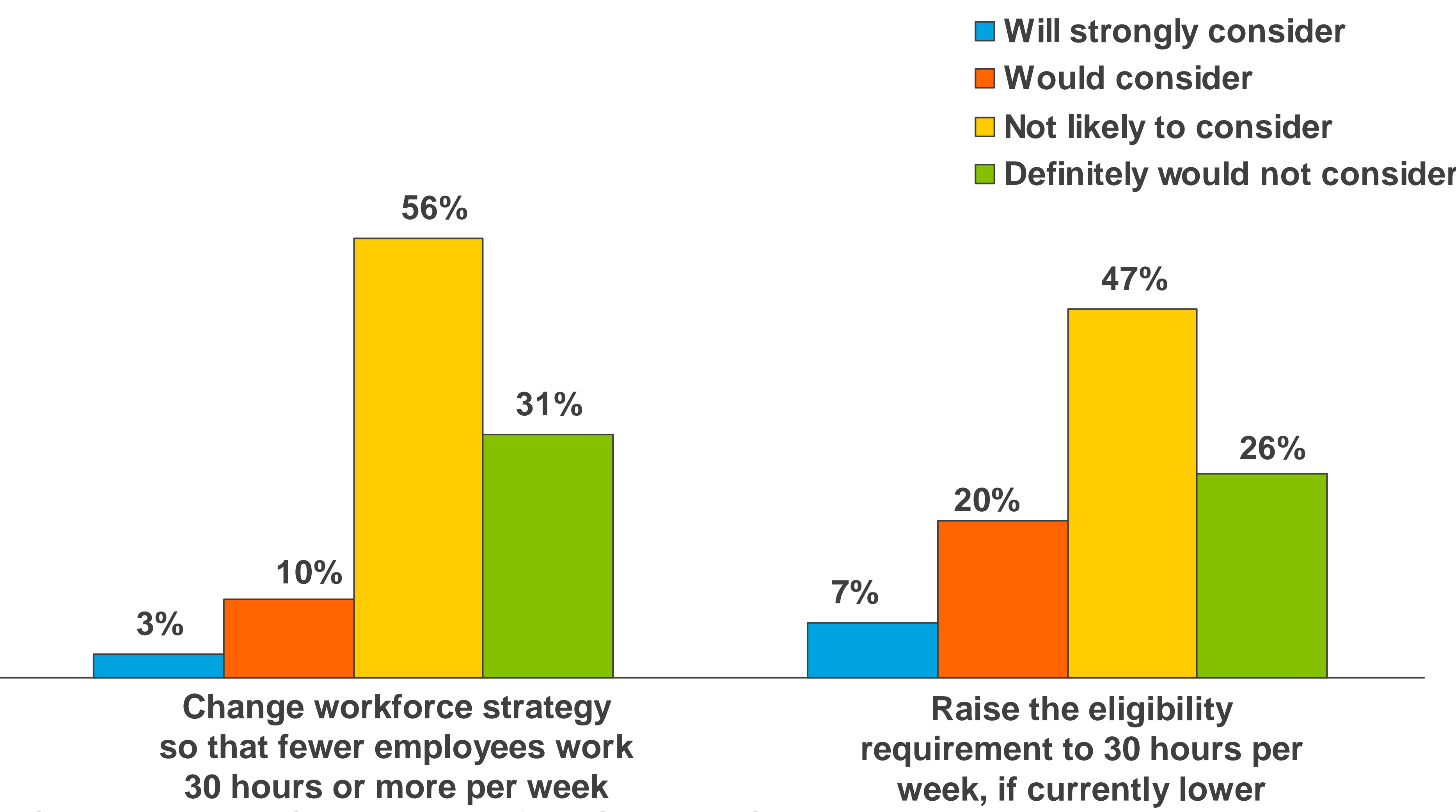
Possible actions with regard to the requirement that all employees working 30 hours or more hours must be eligible

Based on employers already in compliance



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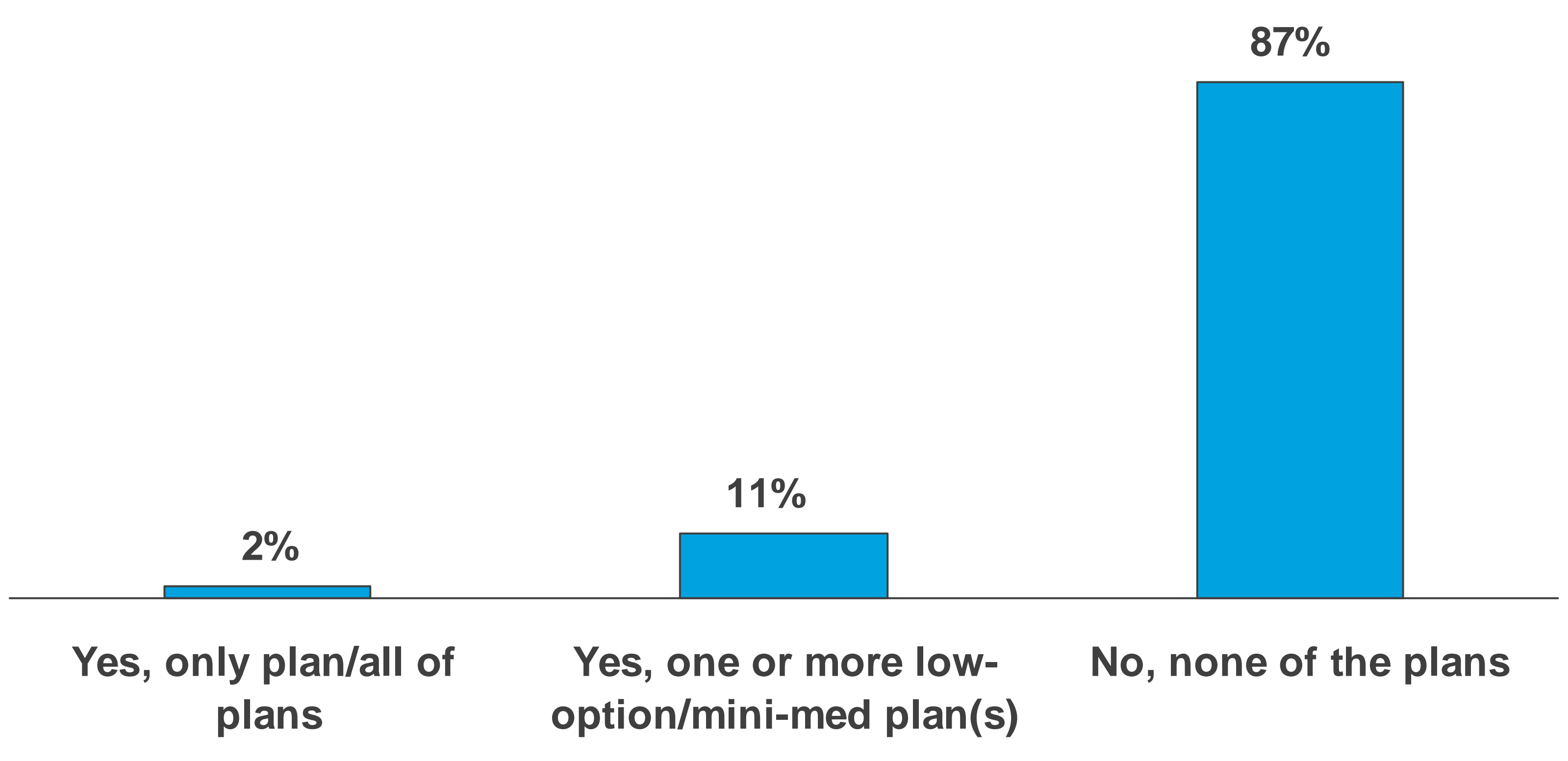
Believe that at least one health plan is at risk for failing the requirement that plans must pay at least 60% of covered services



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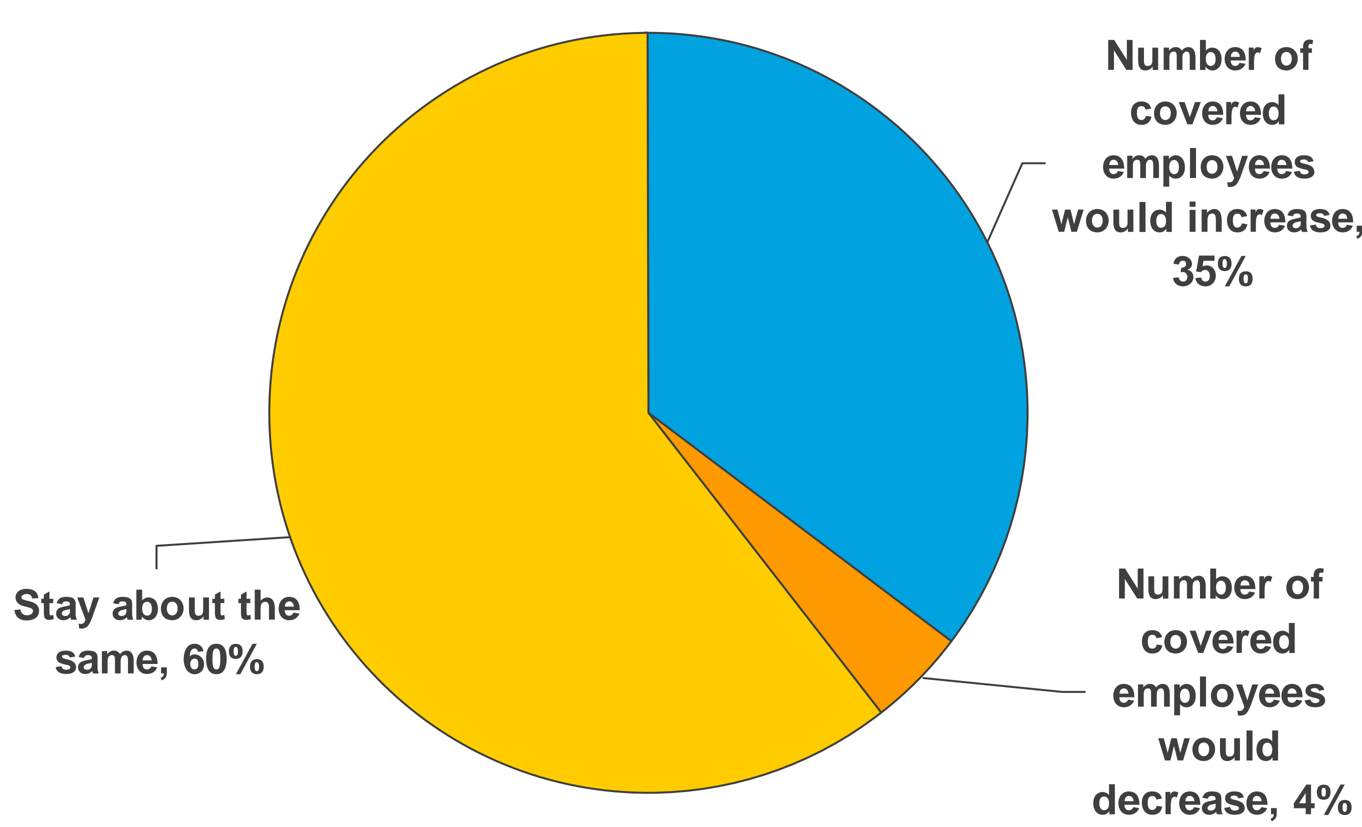
Employers' best guess: will the number of employees covered in your health plan increase or decrease as a result of PPACA?



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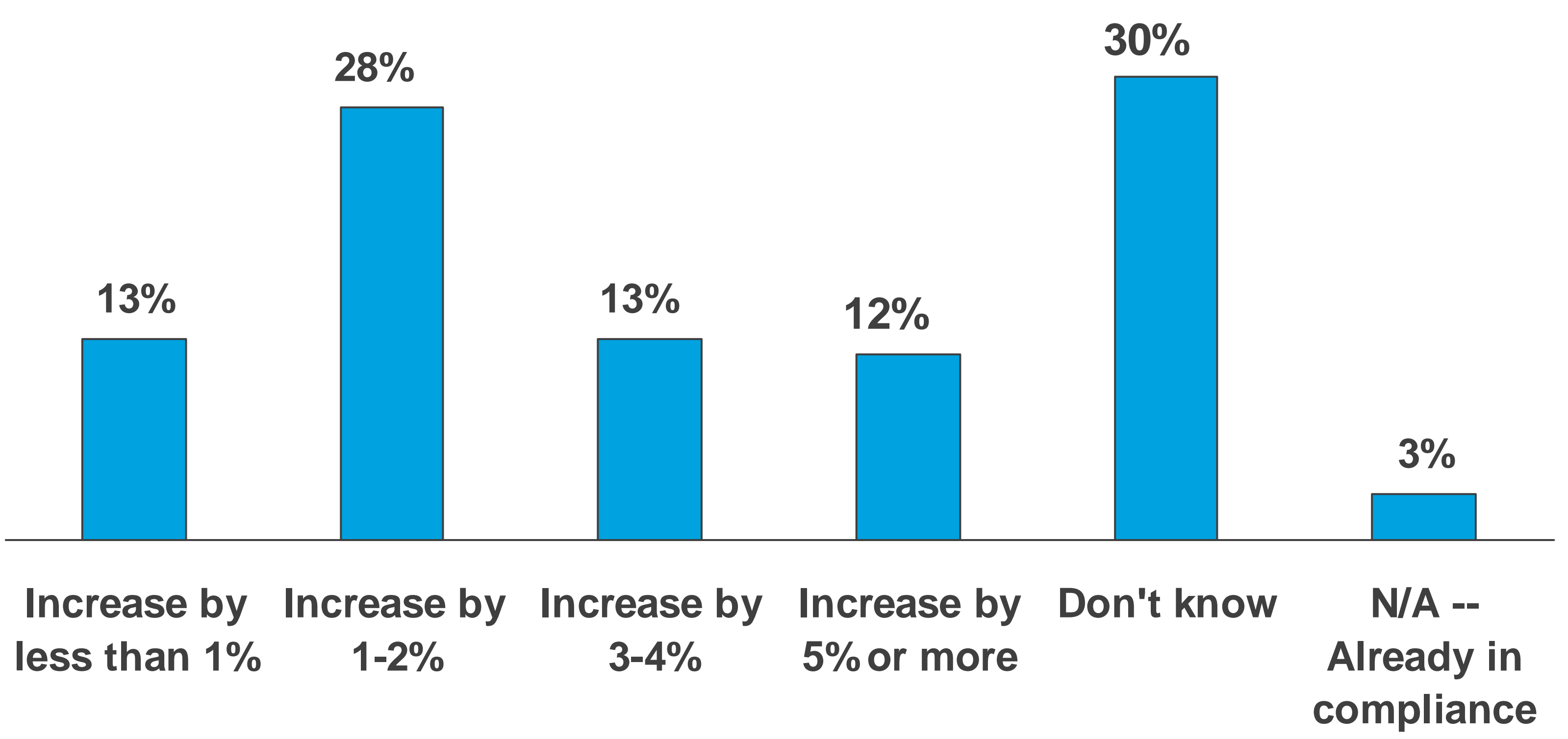
Close to half of employers expect PPACA-related changes to push up 2011 cost by no more than 2%; about 1 in 10 expect increase of at least 5%

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



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Thank you!

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