

# Prospering in a post reform world the revolution in healthcare and other benefits

Host sponsors:



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## Today's presenters

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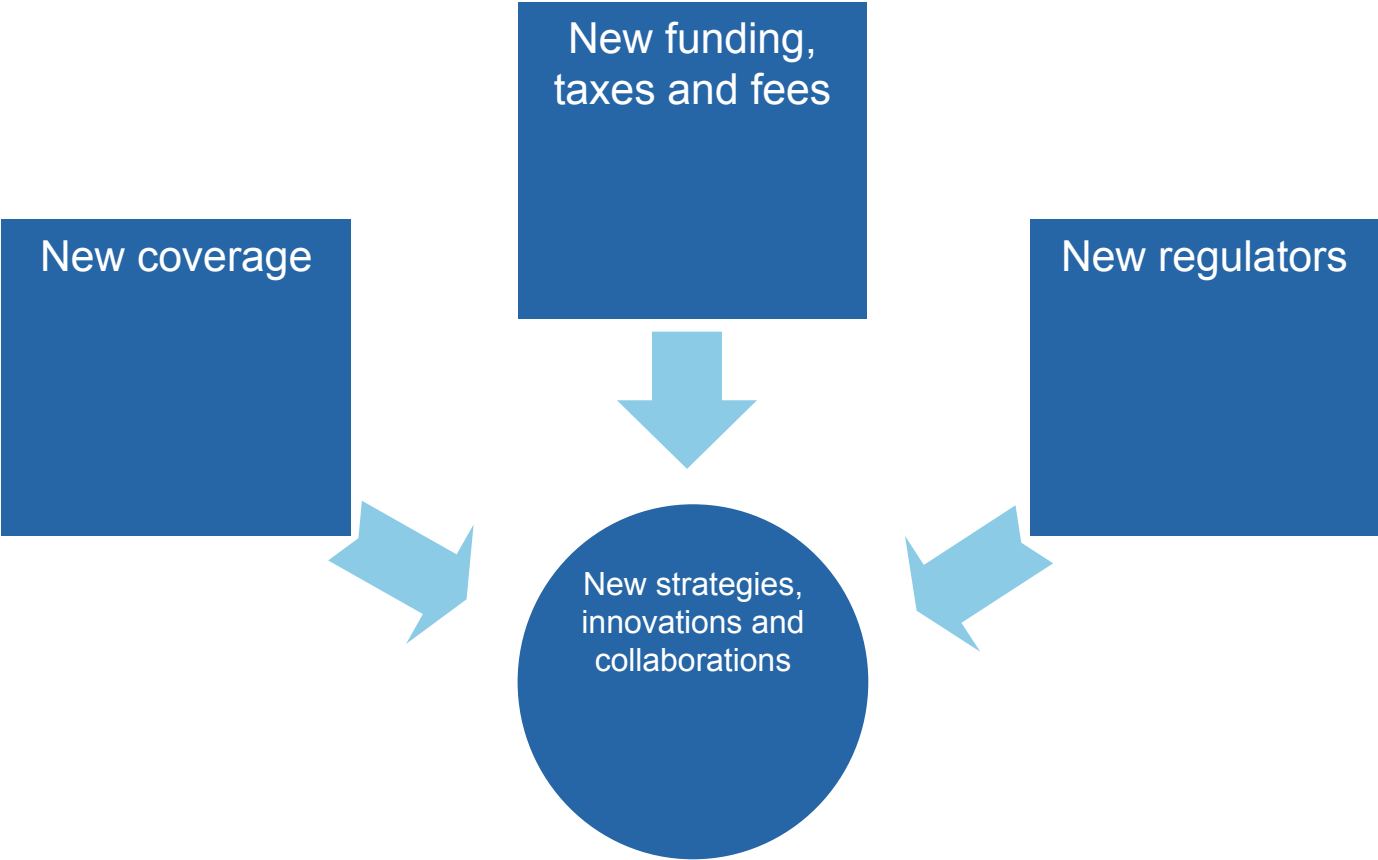
Presenter

DLA Piper LLP

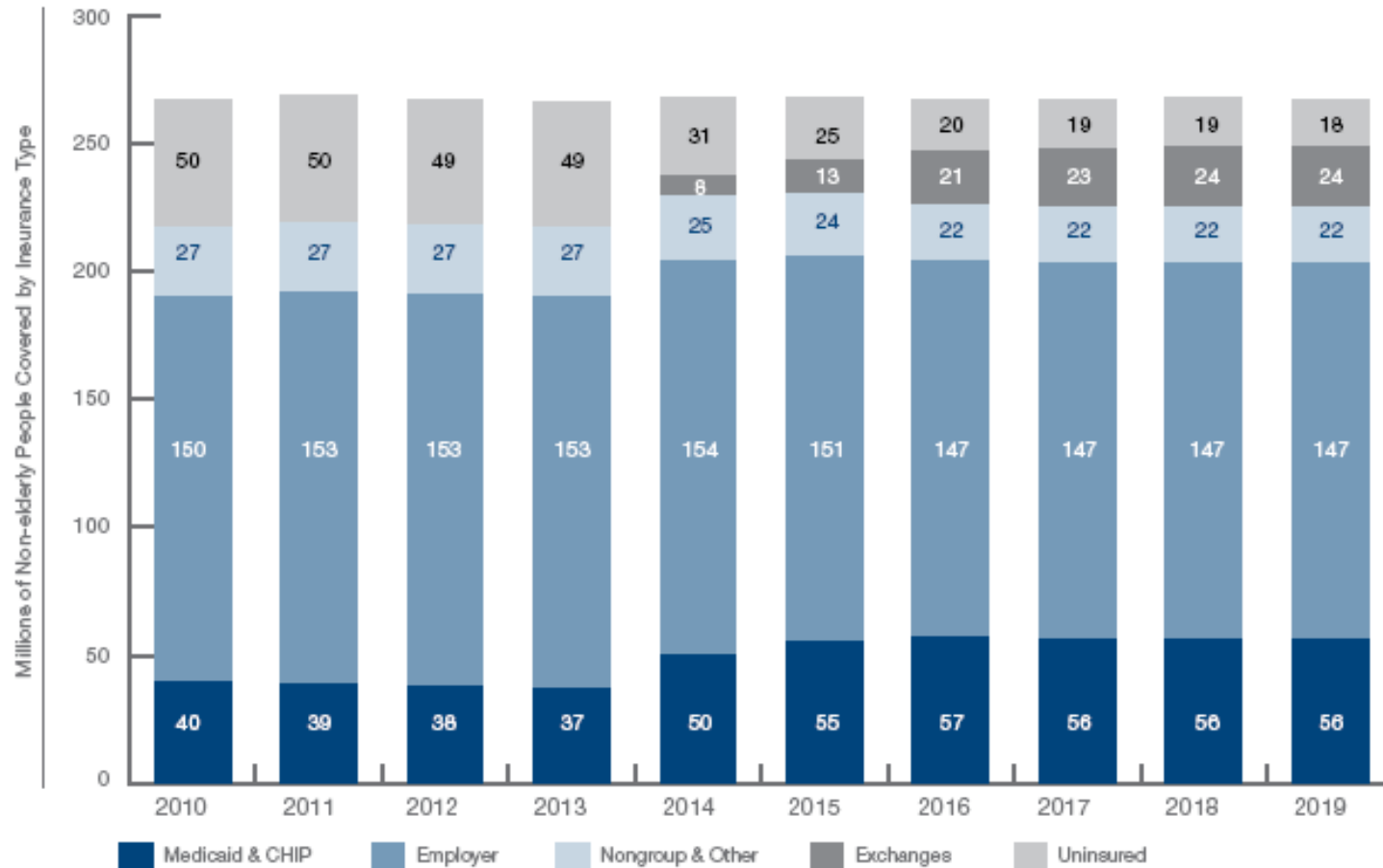
# Section 1

## Health Reform Overview

# Health reform makes collaboration an important strategy for success



## Health reform reduces the number of uninsured by 32 million by expanding Medicaid and creating exchanges

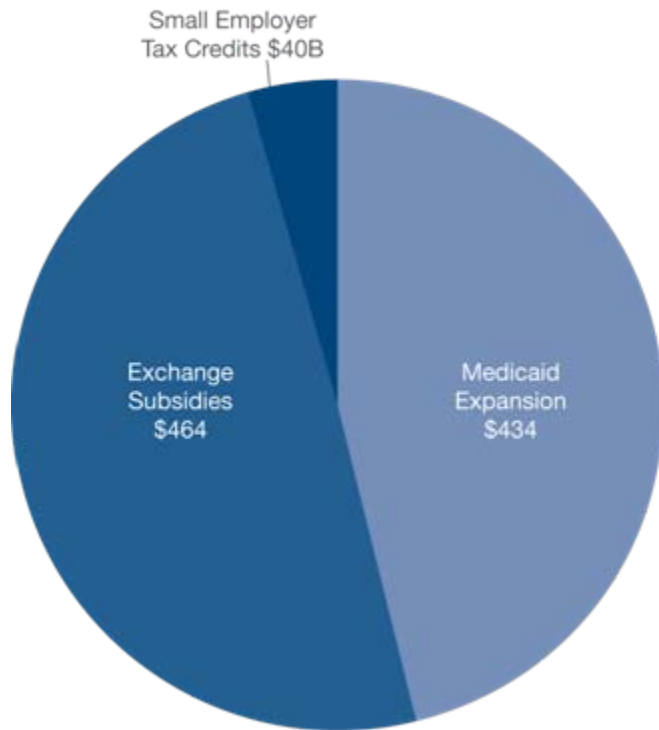


32 million individuals gain insurance coverage at a cost of \$214 billion in 2019

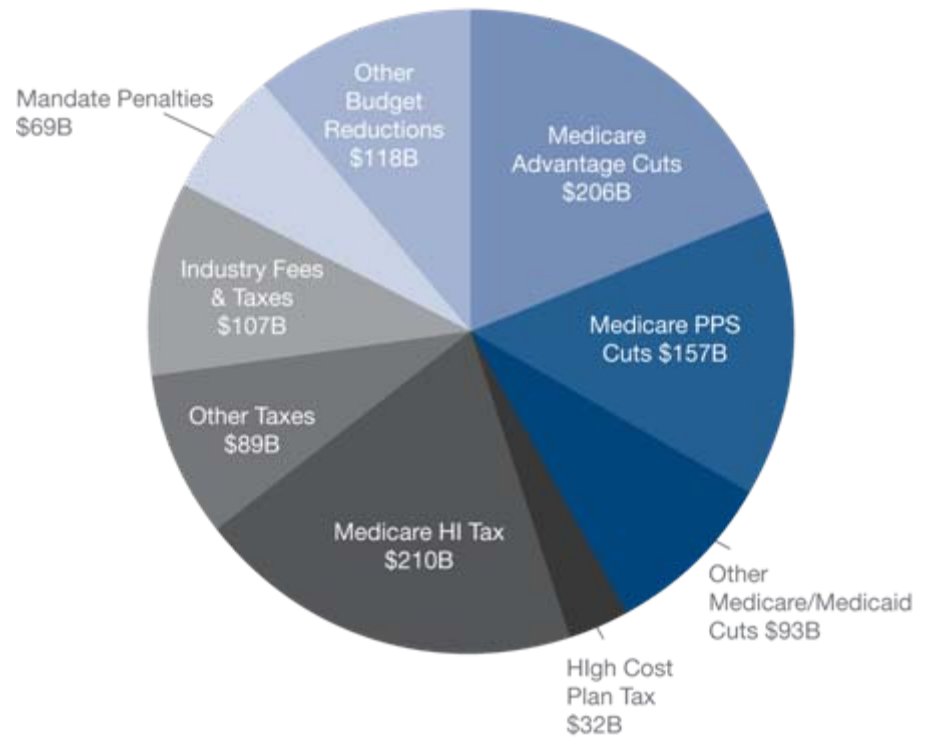
Sources: CBO, Letter to Nancy Pelosi, 20 March 2010.

# Federal funding of coverage is paid for with new fees, taxes and payment reductions

Spending on health reform-\$938B



Paying for health reform-\$1,081B



Sources: CBO Letter to Nancy Pelosi, 20 March 2010;  
Joint Committee on Taxation Report JCX-16-10, 20 March 2010;  
PricewaterhouseCoopers Analysis

# Regulators involved in the implementation of health reform

## Major new regulators will oversee cost control and innovation

### Control cost of existing programs

- Independent Payment Advisory Board
- National Prevention Health Promotion and Public Health Council
- Patient-centered Outcomes Research Institute

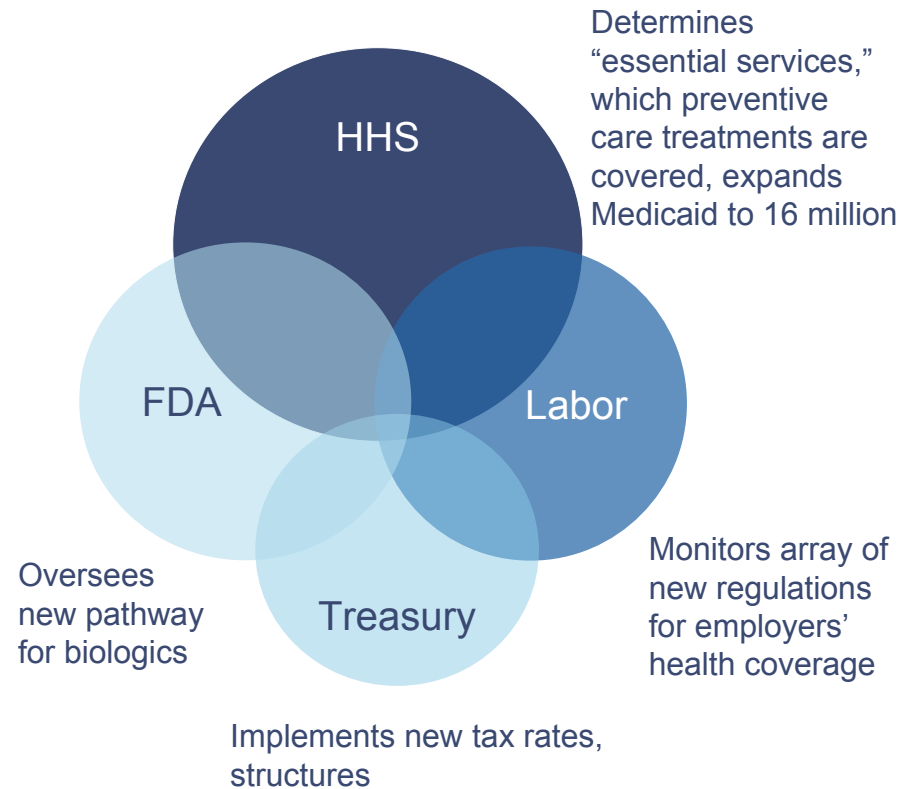
### Implement new programs

- Community Living Assistance Services and Supports
- Health Insurance Reform Implementation Fund

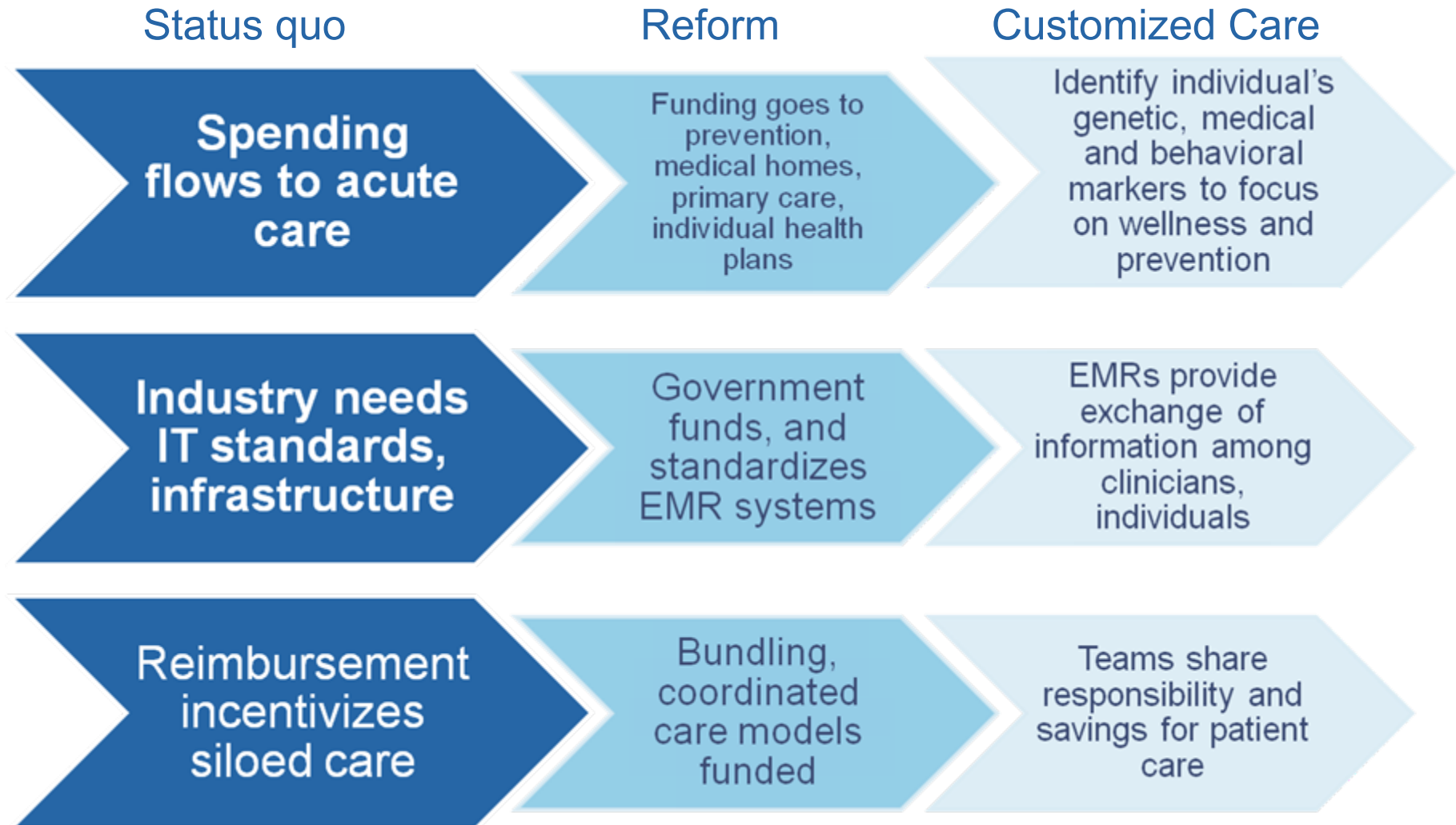
### Create new ways of funding, delivery

- CMS Innovation Center
- Community-based Collaborative Care Network Program

## Existing federal agencies take on complex new responsibilities



# How health reform is moving the status quo to customized care



## Section 2

# Employer Implications – Legal Analysis

# The Road to Universal Health Care

## A Historical Outline of Regulation in the United States

### **First Insurance – 1930s**

- Blue Cross forms in Dallas, Texas at Baylor Hospital as a privately owned company giving discounted health care rates to members.

### **First Health Care Legislation – 1946**

- Harry Truman enacts the National Mental Health Act to support soldiers returning from WWII with mental trauma.

### **Beginning of Employer-Provided Health Care – 1940s - 1950s (WWII)**

- Shortage of workers/imposition of price and wage freezes to limit inflation
- Expansion of employer-based health care because Code section 22(b)(5) provides that sickness benefits would be tax deductible
- Commercial insurance agencies enter into market-creating higher competition

### **Nationwide Coverage – 1965**

- Lyndon Johnson signs Medicare bill to cover all citizens age 65 or older.
- Intended to provide medical care to recipients of Social Security and as a first step toward a national health care plan

# The Road to Universal Health Care

## A Historical Outline of Regulation in the United States

### **Expanding Insurance (COBRA) – 1985**

- Ronald Reagan enacts the Consolidated Omnibus Budget Reconciliation Act.
- Requires continued access to employer-provided health coverage after termination of employment or other events that result in loss of coverage
- Requires hospitals to give emergency care to consenting individuals regardless of citizenship or ability to pay (EMTALA)

### **Bill Clinton and an Unsure Nation – 1990's**

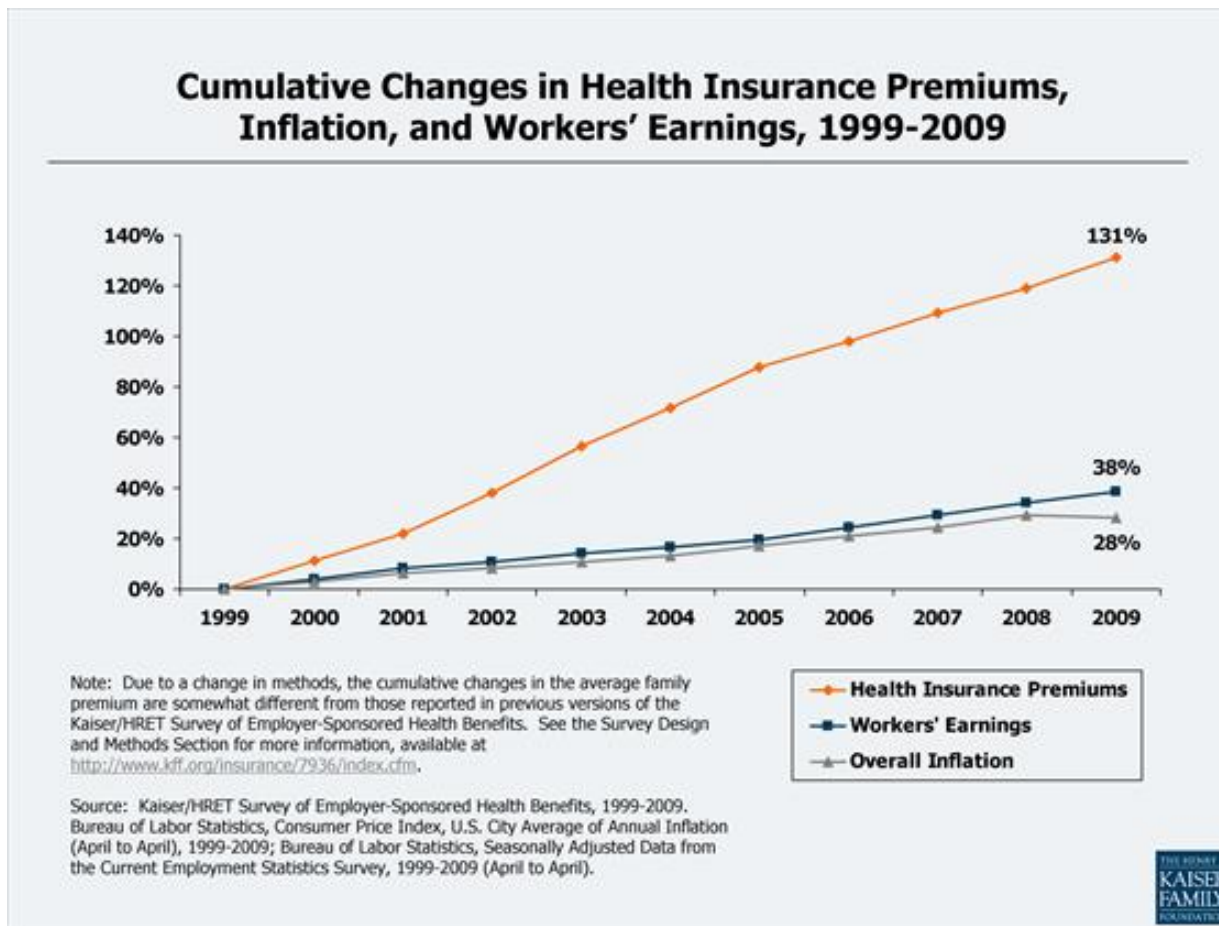
- 1993 – Clinton health care plan, which would have provided universal health care, was never realized because it was expensive and over-regulated.
- 1996 – Health Insurance Portability and Accountability Act
  - Covers workers and their families when they change or lose their jobs
  - Encourages the widespread implementation of electronic data interchange throughout the U.S. health care industry to protect privacy

### **Barack Obama and Universal Coverage – 2010**

- ARRA – COBRA subsidy
- Patient Protection & Affordable Care Act and Health Care and Education Reconciliation Act of 2010 signed into law

# Health Care Inflation

## Health Care Inflation Outpaces Overall Inflation (1999-2009)



Source: Kaiser Family Foundation/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

# Health Care Reform: 2011 Requirements

## Significant Provisions

### Coverage for Dependents Under 26 Required

- Health plans that provide coverage to dependent children must cover children to age 26.
- Eligibility for dependent child must be based only on relationship between participant and child (i.e., no requirements relating to financial dependency, residency, student status, or eligibility for other coverage)
- There are exceptions for grandfathered plans (see below)

### No Pre-existing Condition Exclusions for Children Under Age 19

- Children under age 19 with pre-existing conditions may not be denied coverage

### No Annual or Lifetime Limits

- “Essential Benefits” - no lifetime limits and limited annual limits may be allowed

### Preventative Services Required

- Preventative services (e.g., mammograms, certain vaccinations) with no cost sharing must be provided

# Health Care Reform: 2011 Requirements

## **Nondiscrimination Rules Expanded to Insured Plans**

- Nondiscrimination rules previously applied only to self-insured plans, now apply to fully insured plans
- Violations result in a \$100 per-day, per-participant excise tax

## **Early Retiree Reinsurance Program**

- Employers providing coverage to retirees 55/older ineligible for Medicare can apply for limited claim reimbursement from Government
- Reimbursement limited to 80% of claims between \$15,000 and \$90,000
- First-come-first-serve basis – draft application forms now on-line
- Government budget limited to \$5 billion

## **Over-the-Counter Drugs No Longer Reimbursable on a Pre-Tax Basis**

- Flexible spending accounts and health reimbursement arrangements may no longer reimburse over-the-counter drugs without a prescription

# Health Care Reform: 2011 Requirements

## **Administrative Reforms**

- Required Form W-2 reporting of the aggregate “cost” of employer-sponsored plan coverage, other than contributions to any Archer medical savings account, health savings account, or cafeteria plan

## **CLASS Act**

- Provides benefits for assisted living services and support
- Employers are encouraged to automatically enroll employees, but employees may opt out
- Employee pays premiums
- Not government subsidized at present

## **External Appeals and Advance Notice of Plan Changes**

- Mandatory implementation of external appeals review process
- 60 days notice required before making material changes (notification necessary as early as November 1, 2010 possibly)

# Health Care Reform: 2014 Requirements

## Employer Mandate

- Large Employers (more than 50 full-time employees)
  - fail to provide full-time employees coverage
  - Coverage must be affordable (employee contribution must be less than 9.5% of household income)
- Penalties
  - failure to offer coverage: \$2,000 per year per employee
  - failure to provide affordable coverage:
    - \$3,000 per year, per full-time employee for whom coverage is unaffordable and gets coverage through a government health exchange

## Individual Mandate

- Penalty for individuals with no coverage:
  - For 2014, greater of \$95 per uninsured person or 1% of household income over 4X poverty level
  - For 2015, greater of \$325 per uninsured person or 2% of household income over 4X poverty level
  - For 2016 and beyond, greater of \$695 per uninsured person or 2.5% of household income over 4X poverty level

# Health Care Reform: 2014 Requirements

## **Free Choice Vouchers**

- Employers that subsidize coverage must provide “free choice vouchers” to non-participating low-income employees (i.e., employees who would be required to contribute between 8%-9.8% for coverage whose household income does not exceed 4X poverty level)
- A free choice voucher represents the amount of the employer subsidy that the employee can use to purchase alternative coverage on the state exchanges

## **State Exchanges**

- States to establish exchange through which individuals may purchase coverage

## **Automatic Enrollment**

- Employers with more than 200 full-time employees that offer coverage must automatically enroll new and current full-time employees, who may opt out.

## **Essential Benefits**

- Group health plans are required to provide specified essential benefits (e.g., emergency services, hospitalization, pediatric care, prescription drugs).

# Health Care Reform: 2014 and 2018 Requirements

## **Wellness Programs**

- Expand wellness program incentives to 30% (increased from 20%) of cost of coverage

## **Additional Reporting Requirements**

- Employers required to provide government with annual reports containing participant information and plan coverage data

## **2018: Cadillac Plan Tax**

- 40% excise tax on employer providing coverage with value exceeding \$10,200 for individual coverage and \$27,500 for family coverage
- Higher thresholds apply for retirees over age 55 and certain high-risk professions (e.g., law enforcement, fire fighting, construction, mining, agriculture, forestry, and fishing)

# Health Care Reform: Grandfathered Plans

## Grandfathered Plans

- Group health plan in effect on March 23, 2010
- Grandfathered plans exempt from:
  - Age 26 dependent coverage for dependent with other employer-provided group health plan until 2014
  - preventative services with no cost sharing
  - nondiscrimination rules
  - external appeals process
  - essential benefits without cost sharing
  - maximum deductibles \$2,000 single coverage/\$4,000 family coverage
  - clinical trial participation
  - restrictions on annual limits on essential benefits until
  - pre-existing condition prohibition until 2014
  - 90 day limit on waiting periods until 2014
- The following will not change the status of a grandfathered plan:
  - renewal of coverage of existing participants or enrollment of existing participants' dependents
  - enrollment of new employees
  - expanding coverage to include dependents to age 26

# Health Care Reform: 2019 Cost Projections; Consequences

## **Health Care Reform Cost Estimate**

- CBO 10-year cost estimate of the health care law prior to passage: \$940 billion
- CBO revised estimate after passage: \$1.055 trillion

## **Comparison: Medicare Part D Prescription Drug Benefit Cost Estimate**

- CBO 10-year cost estimate of Medicare Part D prior to passage: \$350 billion
- CBO revised estimate after passage: \$1.2 trillion

## **Medicare and Social Security**

- Actual costs far exceed estimates

## **Impact of Budget Deficit Pressures**


- Overall inflationary pressures on the economy
- Related health care cost inflation pressures on health insurers, health care providers, employers, and individuals
- Increased likelihood of higher taxes in some form
- Amendments to the health care law

# Section 3

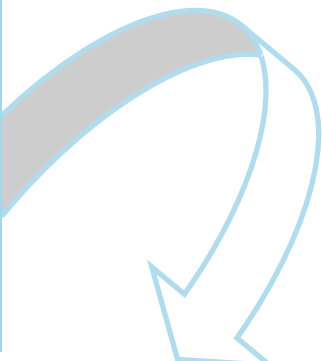
## Strategic Considerations

# Three tranches of health reform

## Regulation and coverage (2010-2013)

- Elimination of pre-existing coverage exclusions for children and lifetime coverage limits and rescissions; dependent coverage through age 26
  - MLR minimums for non-grandfathered plans
  - Medicare Part D gap narrows, Medicare Advantage rates frozen, bonuses available, beneficiary rebates, free preventive care
  - Temporary high risk pools
  - Fee on brand -name pharmaceutical manufacturers
  - Community Living and Support Services Act (CLASS Act)
- 

## Major expansion of coverage (2014)

- Mandates for individuals
  - Employer penalties for those that do not provide coverage
  - Health insurance exchanges
  - Small employer and individual subsidies
  - Health insurer industry fee
  - Guaranteed issue, rating bands, and risk adjustment
  - Medicaid expansion
  - Disproportionate share payment reductions to hospitals
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## Bending the cost curve (2015-2020)

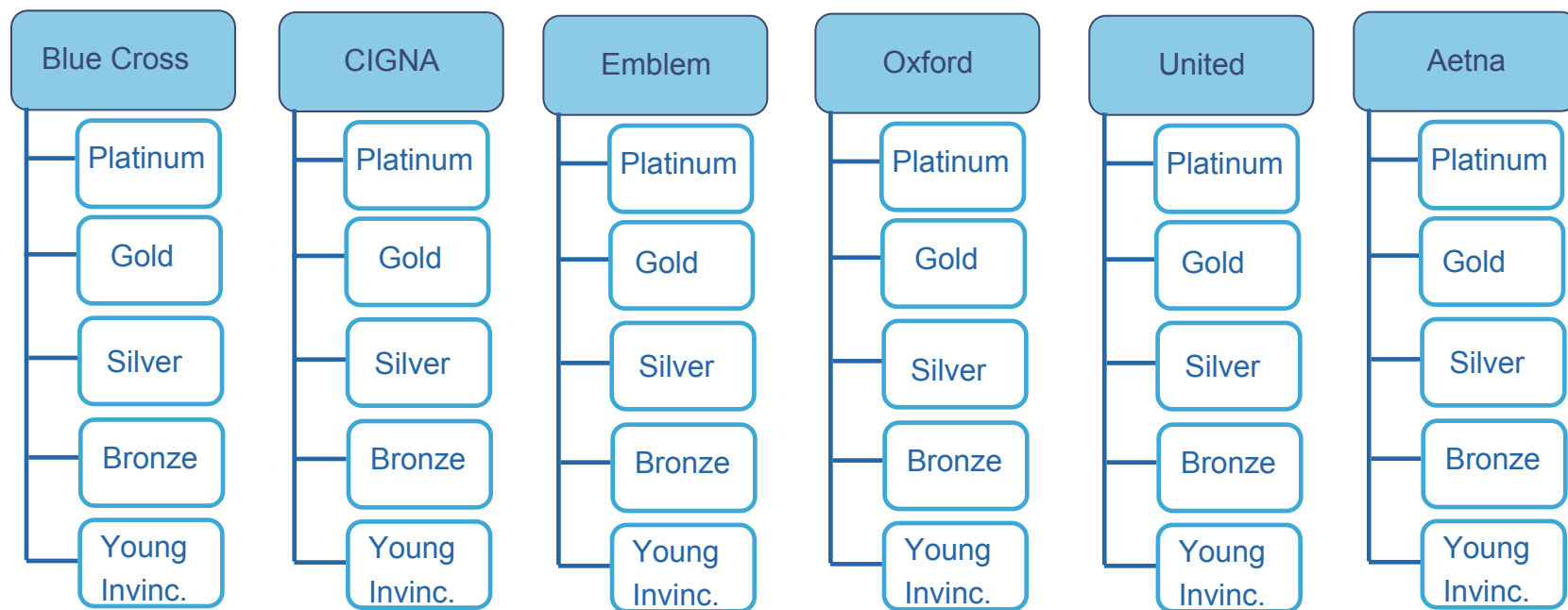
- Penalty for not adopting electronic medical records
- Independent Payment Advisory Board (IPAB)
- High-cost plan excise tax
- Medicare Part D “Doughnut Hole” closes
- Reduced payment for hospital-acquired conditions

# Key New Taxes (Effective 2013)

- **Additional 0.9% tax on income in excess of:**
  - \$200,000 for single taxpayers, or
  - \$250,000 for married filing jointly
- **Employers will withhold on wages above the \$200,000 threshold; taxpayers may owe additional amounts (or may be entitled to refunds) based on family income**
- **Unearned income over the same threshold amounts will be subject to a new 3.8% Medicare tax as well**
  - Investment income includes gross income from interest, dividends, annuities, rents and royalties as well as net capital gain.
  - investment income does not include distributions from a qualified retirement plan or amounts subject to self-employment taxes.

# Overview: Health Exchanges (By 2014\*)

- State or region-based marketplaces for health insurance for individuals and small businesses
- Private health plans sell their products side-by-side
- Health benefits standardized
- Enrollment and information through website and phone hotline
- Improved consumer choice and pricing transparency



- \* Employers must provide Notices to Employees about the Exchanges (3/2013)
- For plan years beginning before 1/2016, states may provide that only  $\leq 50$  employees can participate
- States may open to large employers in 2017

# Strategic Issues For Consideration

## **Eligibility**

What role should you play with respect to health benefits when access is guaranteed in the open market?

How will employment policies (e.g. minimum work week) be influenced by “free rider” requirements?

How does the perceived value of health benefits compare to other rewards?

If employers elect not to offer coverage, will individual penalties under reform ensure coverage?

How will health benefits policies be influenced by labor issues?

Will there need to be specific solutions targeted for unique populations?

## **Contribution and Funding Strategies**

What coverage should businesses provide for dependents?

How will tax policies and tax subsidies influence contribution and funding strategies?

Should you move toward a defined contribution medical plan designs in the state exchanges?

How should a defined contribution plan design take into account age, gender, area, and health status?

How can aggregators be utilized to make state exchanges more accessible and viable for national employers?

# Strategic Issues for Consideration

## **Mitigating cost increases and impact on financial statements**

- How can we ensure payment reform is accelerated to fundamentally realign incentives in the system?
- How should new provider infrastructures like ACOs and medical homes be integrated into our strategies?
- How should personal responsibility for health behaviors be defined and rewarded?
- How can we leverage community health initiatives to accelerate our efforts?
- How do we avoid continued cost shift and promote transparency and accountability for cost management?

## **Retiree Health**

- How will insurance reforms (e.g. guaranteed issue, subsidies) mitigate need for pre-65 retiree medical?
- How should Medicare solvency issues and future reforms be factored into our planning?
- How should we support employees in retirement planning for health security in a post-reform world?

## **Compliance and administration**

- What are the long term risks and burdens associated with a post-reform environment?
- How could third parties relieve the increased burden and risk of compliance and administration?
- How could outsourcing help to simplify support in a post-exchange world?

# Section 4

## Questions and Answers

