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Health Reform
What to do now

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Agenda

- Introductions and overview
- First things first…Getting down to basics on health plan standards
- Other near-term changes and concerns
- 2014-2018 Key employer issues
- Health care reform financial impact
- How employers are communicating about health care reform

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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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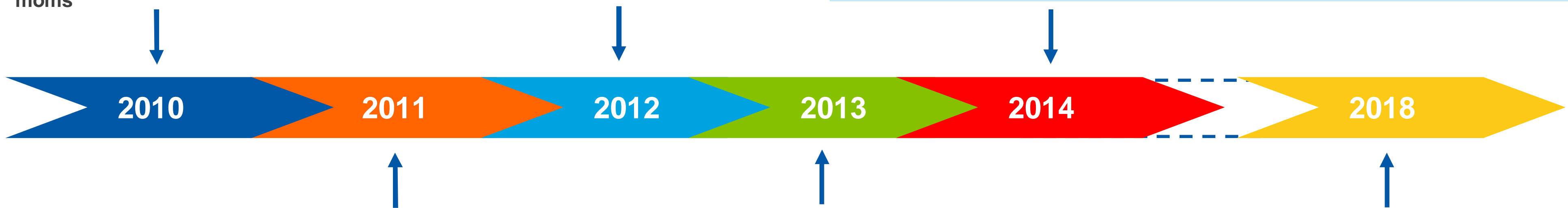
Key elements of health reform for employers

- 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
- 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

Issue	Patient Protection and Affordable Care Act, as amended
Health plan standards – new and nongrandfathered plans** Effective for plan years beginning on or after September 23, 2010; delayed for certain collectively bargained plans*	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)**

****"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

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Other near-term changes and concerns

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

Issue	Patient Protection and Affordable Care Act, as amended
Form W-2 reporting	■ Employers must include the aggregate cost of an employee's 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
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 – Reimbursements limited to physician-prescribed drugs and insulin
Health industry fees	■ Pharmaceutical manufacturers and importers (2011) ■ Durable medical equipment (2013) ■ Health insurers (2014)
Health FSA contribution cap (2013)	■ Annual contributions to health flexible spending accounts limited to $2,500

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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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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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2014-2018: Some additional key employer issues
Other provisions on access, coverage and affordability

- Medicaid expansion to include more people
  - Mandatory state premium assistance for employer coverage
- Individual coverage mandate with penalties
- Health insurance exchanges offering individual and small group coverage
- Financial assistance for lower-income people getting coverage through an exchange

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Health care reform financial impact

Health Care Reform Financial Impact
Categories of potential cost impact

- Additional covered lives
  - Coverage of current opt outs due to individual mandate, automatic enrollment
    - Additional cost for new enrollees in employer's plan
    - Surcharge or Free Choice Voucher for employees receiving subsidy in exchange
- Changes in program to comply with legislation
  - Plan design changes (e.g., no lifetime maximums)
  - Eligibility changes (e.g., dependents to age 26)
  - Administrative changes (e.g., automatic enrollment)
- Excise tax for high cost plans
- Cost pass through and cost shifting
  - Industry fees
  - Government program cost controls
- Cost reduction possibilities
  - Employees to Medicaid
  - Reduction of benefits, potentially to 60% actuarial value
  - Dropping coverage
- Cost impact shown: $ to $$$$
  - $: ≤ 3% of pre-HCR cost
  - $$: >3%, ≤ 10%
  - $$$: >10%, ≤ 20%
  - $$$$: > 20%

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Impact of Additional Covered Lives

Cost impact for employers offering qualifying coverage

- Cost for opt outs varies based on choice of coverage (year of impact: 2014; cost: $ to $$$$)
  - Medicaid (if eligible), exchange (if eligible), employer plan or opt out
- Illustrative example of coverage options for single employee in 2014
  - Employer offers qualifying coverage: Employee Premium = $190/mo.; Employer Contribution = $300/mo.
  - Income level where premium = 9.5% of income: $2,000/month, $24,000/year
  - Income level where premium = 8% of income: $2,375/month, $28,500/year

Annual Income: 2014		Coverage Options in 2014	Comments
Greater Than	Less Than or Equal		
-	$16,221	Medicaid or Employer	• Medicaid threshold: 133% of FPL ($16,221 single*) • No cost to employer for Medicaid enrollees
$16,221	$24,000	Exchange with tax credit or Employer	• Premium "unaffordable" if ≥ 9.5% of income • Surcharge if in exchange: $3,000/FT (max $2,000 X FTE)
$24,000	$28,500	Exchange with Free Choice Voucher or Employer	• Premium between 8% and 9.5%** of income • Voucher if in exchange: Employer Premium ($300/mo.)
$28,500	$48,784	Only Employer	• Coverage is "affordable"
$48,784	-	Only Employer	• Income >400% FPL ($48,784* single)

* Federal Poverty Level (FPL) projected from 2010 to 2014 assuming 3% increase/year; in 2014, 133% FPL = $16,221, 400% FPL = $48,784
** Assuming technical correction from 9.8%

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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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Changes in Plan Design

- Plan changes for all plans, including grandfathered (2010*; $)
  - Eliminate lifetime maximum
  - Restrict annual maximums
  - Eliminate pre-existing condition exclusions for children < 19
  - Restrict coverage recessions
- Plan changes for new (non-grandfathered) plans (2010*, $)
  - Cover certain preventive services without cost-sharing
  - Eliminate pre-authorization of emergency services and referral for OB-GYN
  - Allow enrollees to choose, rather than be assigned, a participating PCP
  - No discrimination in favor of highly compensated employees in insured plans
  - Comply with new appeal process
- Plan changes for all plans, including grandfathered (2014, $)
  - Eliminate annual maximums
  - Eliminate pre-existing condition exclusions for all ages
  - No waiting periods > 90 days
- Plan changes for non-grandfathered plans (2014; $)
  - Limit annual cost-sharing to high deductible plan limits
  - Cover clinical trials

*Applies to plan years beginning after 9/23/2010

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Changes Which Affect Eligibility and Operations

- Eligibility Change
  - Offer coverage to covered employees' dependent children to age 26 if children lack access to other employer coverage (2010*; $)
  - Offer coverage to any dependent child to age 26, regardless of marital status or access to other employer coverage (2014; $)
  - Full time employees: 30+ hours/week (2014; varies)
- Operational change
  - Implement auto-enrollment (timing unclear; administrative expense – extra medical cost of new enrollees is shown in "Additional Covered Lives")
  - Cap Healthcare Flexible Spending Account (FSA) at $2,500 (taxable year on or after 12/31/2012; reduces FICA savings)
  - New taxes for workers earning over $200,000 (individual) or $250,000 (family) (taxable year on or after 12/31/2012; administrative expense)
    - 2.35% Medicare tax on income above thresholds (employee portion)
    - 3.8% tax on net investment income

*Applies to plan years beginning after 9/23/2010

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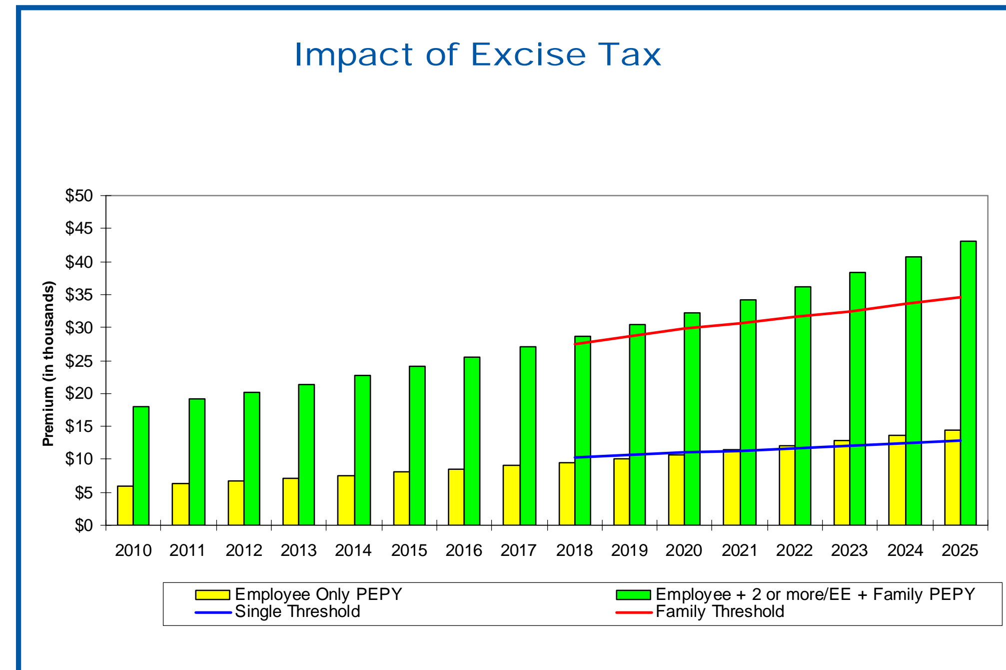
Excise Tax

Illustrative example of impact of Excise Tax

- Program cost in 2010 is $6,000 single (2,000 with single coverage), $18,000 family (3,000 with family)
- Costs (after plan design changes) are projected at 6% per year
- Family plan generates Excise Tax of in 2018; Tax is 1% of total costs
- Single employee plan first generates Excise Tax in 2021; Tax for single employees is <0.1% of total costs
- Total single and family Excise Tax in 2021 is 3% of total costs
- Total Excise Tax in 2025 is 7% of total costs



Note: 2018 tax threshold = $10,200 single, $27,500 family, (higher values for retirees, high risk industries, and multi-employer plans) indexed at CPI +1% in 2019, then at CPI in 2020 and thereafter

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Fee Pass Through and Cost Shifting

Fee and Cost Concerns	Initial Year applicable	Comments
Pharmaceutical Manufacturers fees	2011	$2.8 B (2012) to $4.1 B (2018)
Medical Device Manufacturers fees	2013	2.9% of sales
Research fees	2012	$1.00/employee (2012), $2.00/employee from 2013 to 2020
Insurance industry fees	2014	$8.0 B (2014) to $14.3 B (2018)
Medicare payment reduction	Varies	$400 billion
Medicaid reduction	Varies	State specific
Rate approvals/controls	2014	State, Federal controls
Total	Multiple	$ to $$

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Cost Reduction Opportunities

- Medicaid expansion to 133% Federal Poverty Level will move some employees out of the employer's plan (2014; savings varies by employer, based on household income and employee migration; savings of $ to $$)
  - Requirement for states to provide premium assistance to Medicaid eligibles so they will remain in employer plan may reduce savings
- Reduction in benefits – gradually or all at once – to minimum 60% actuarial value (timing at employer's discretion; potential savings dependent on current plan and future plan changes; savings of $ to $$$$)
- Elimination of coverage
  - Subjects employer to $2,000 per full time employee shared responsibility surcharge; payment is not tax deductible (timing at employer's discretion; net savings after tax effect depends on current coverage and cost, as well as employer tax bracket; savings of $$ to $$$$)
  - Attraction and retention concerns for early adopters of approach

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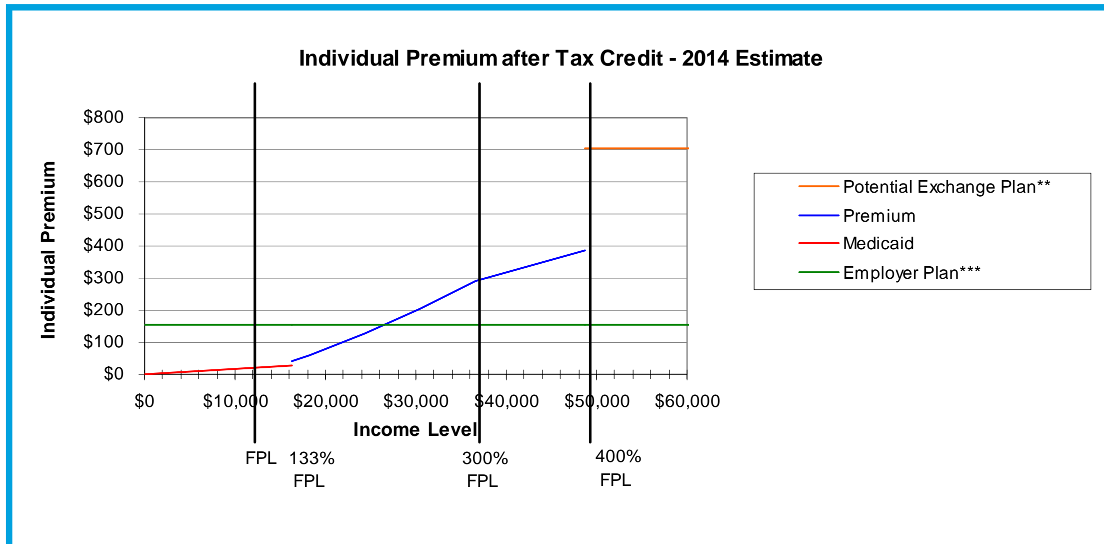
Impact of Tax Credit on Individual Premium

Coverage options for employees with no employer coverage or "unaffordable" coverage (if income ≤400%FPL)

- Tax credits for individuals with income ≤400% FPL will reduce premiums to specified percent of income
  - Subsidized premiums estimated for 2014* range from $41/month (at Medicaid threshold of 133% FPL = $16,221) to $386 (at 400% FPL = $48,784)
  - Low income individuals in exchange also have reduced out-of-pocket cost
  - For individuals >400% FPL, there are no tax credits; individual seeking coverage in exchange pay full premium (exchange coverage available only if qualifying employer plan is not available)
- Premium for those on Medicaid ranges from $0/month to $27/month



* FPL assumed to increase 3% per year

** Estimate for average of second lowest cost silver plan; prices will vary by age

*** Based on Mercer Survey – 2009 projected to 2014

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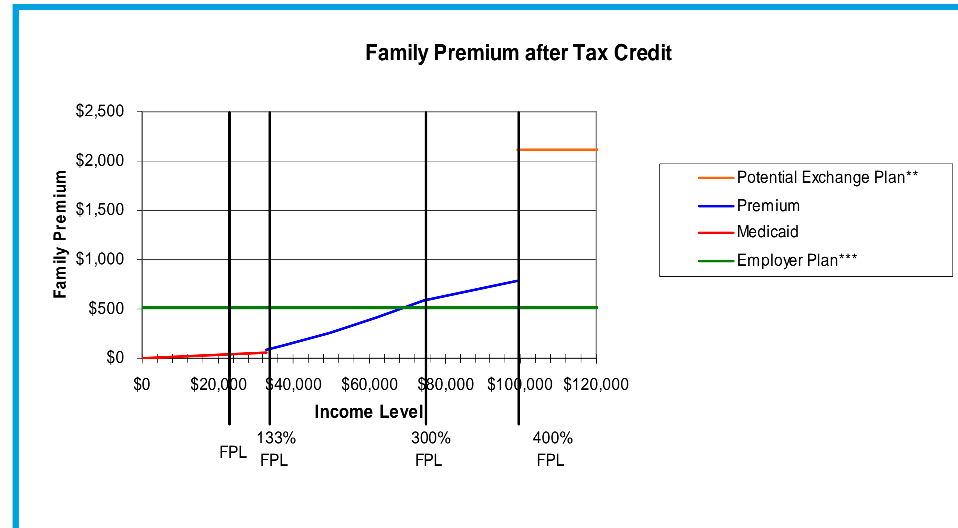
Impact of Tax Credit on Premium for Family of Four

Coverage options for employees with no employer coverage or "unaffordable" coverage (if income ≤400%FPL)

- The level of subsidized premium in an Exchange varies based on income and the number of members in the family (which affects the FPL)
- Subsidized premium for family of four ranges from $83/month (133% FPL) to $786/month (400% FPL)
- Medicaid premium for a family of four ranges from $0 to $55

Example for Family of Four



* FPL assumed to increase 3% per year

** Estimate for average of second lowest silver plan; prices will vary by age

*** Based on Mercer Survey – 2009 projected to 2014

2014 Level of affordability and Medicaid eligibility cutoff

Family Size	2014 Federal Poverty Level*	1.33 FPL (Medicaid)	4x FPL (eligible for Exchange)
Single	$12,196	$16,221	$48,784
Family of 2	$16,410	$21,825	$65,640
Family of 3	$20,610	$27,412	$82,441
Family of 4	$24,824	$33,016	$99,297
Family of 5	$29,038	$38,621	$116,153
Family of 6	$33,239	$44,207	$132,954
Family of 7	$37,452	$49,812	$149,810
Family of 8	$41,666	$55,416	$166,665

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Case Study 1

Employer Coverage – 2010 Benefits

Full Time Coverage (January 1 Plan Year)

- PPO Coverage: actuarial value 68% (low), 75% (high)
  - Lifetime dollar maximum
  - Copays apply to preventive coverage
  - Pre-existing condition limitations
  - Dependents to 25 if in school

Monthly Premium*

High Plan	Employee	Employer	Total
Single	$ 95	$225	$ 320
Family	$380	$632	$1,012

Low Plan	Employee	Employer	Total
Single	$ 77	$205	$282
Family	$308	$583	$891

Enrollment (Full Time)

	High	Low	Total
Single	6,975	2,275	9,250
Family**	4,397	1,728	6,125
Total Covered	11,372	4,003	15,375
Opt Out			5,125
Total			20,500

Average Full Time Salary: $31,200

Financial Impact of Health Care Reform

Plan Design Change: Increase due to elimination of lifetime maximum, elimination of copays for preventative care, elimination of pre-existing condition limitations

Eligibility Change: Additional dependents under age 26

Excise Tax: Over threshold in 2018 if average trend is over 7.7% for single, 9.0% for family

Additional Covered Employees:

- Individual mandate and automatic enrollment likely to increase covered lives
- Increased claims cost for new enrollees in employer's plan
- Extra cost for employees who enroll in exchange and receive tax credit or FCV (not for single employees because coverage is "affordable")
- Offset by new enrollees in Medicaid

* Premium for a medical plan; Employer also offers FSA ($2,500 assumed in Excise Tax calculation); No dental or vision coverage; ** All dependent tiers

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Health Care Reform Cost Impact for Case Study 1

Source	Mid-Range Estimate in 2014
Impact if current plans are changed only as needed to meet minimum requirements	
■ Additional cost for those currently without coverage (2014) (cost in employer plan; surcharge or voucher in exchange)	$19 Million (22%*)
■ Pass through of health care industry fees and cost shifting from government programs (multiple years)	$3 Million (4%)
■ Mandated Program Changes (Design and Eligibility)(2011, 2014)	$2 Million (2%)
■ Excise Tax on rich benefits (2018)	N/A (first impact in 2022)
■ Cost reduction for currently covered employees who enroll in Medicaid	$1 Million savings (-1%)
Total	$23 Million (27%)
Opportunities for cost reduction	
Impact of reduction to 60% actuarial value	$12 Million savings (-14%)
Impact of dropping coverage entirely (net savings after tax adjustment)	$9 Million savings (-11%)

*Percentage of projected 2014 “status quo” cost of $85 Million

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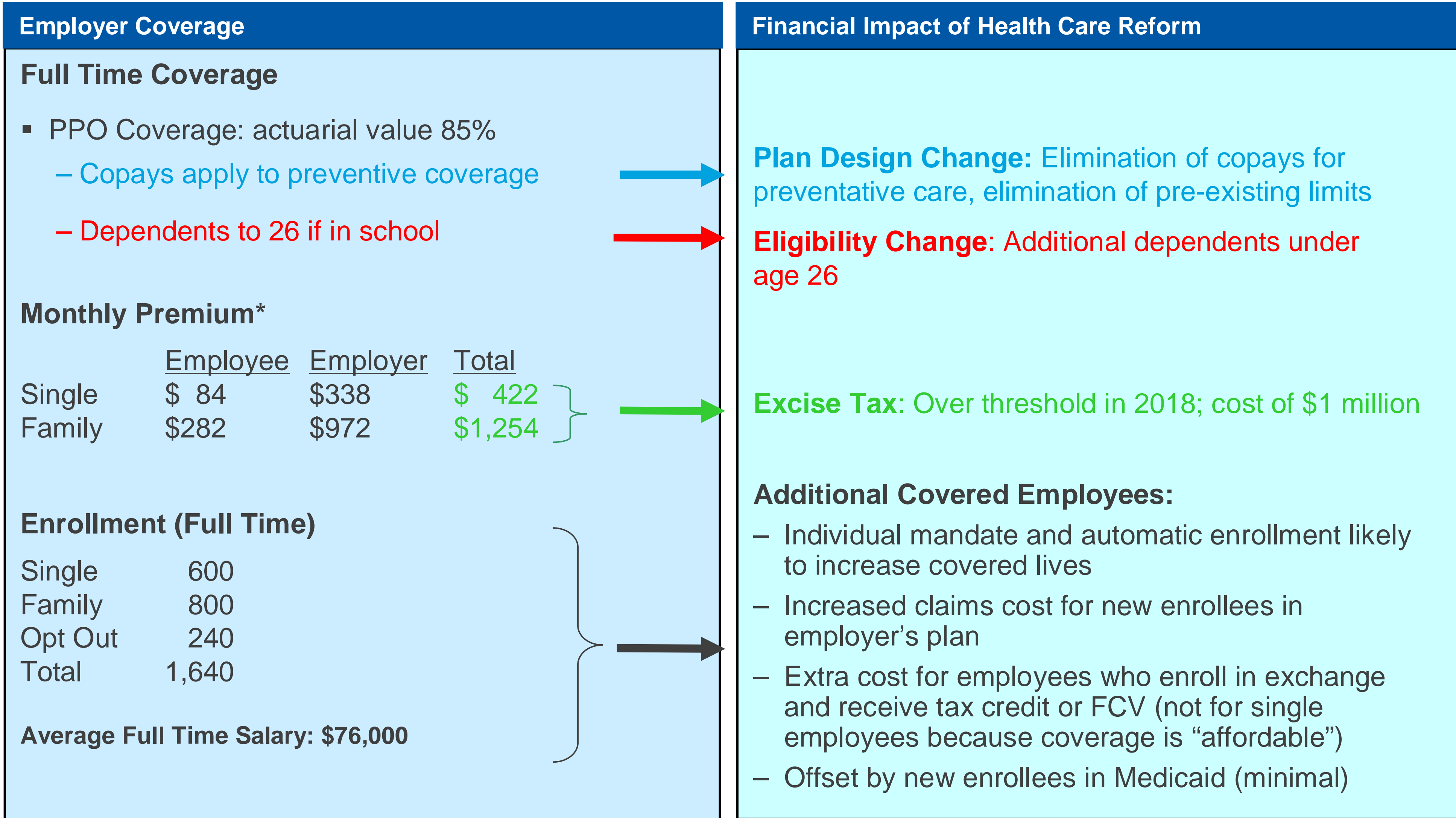
Case Study 2 (2010)



* Premium for a medical plan; Employer also offers FSA ($2,500 assumed in Excise Tax calculation); No dental or vision coverage

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Health Care Reform Cost Impact to Case Study 2

Source	Mid-Range Estimate in 2014
Impact if current plans are changed only as needed to meet minimum requirements	
■ Additional cost for those currently without coverage (2014) (cost in employer plan; surcharge or voucher in exchange)	$1.2 Million (6%*)
■ Pass through of health care industry fees and cost shifting from government programs (multiple years)	$0.9 Million (4%)
■ Mandated Program Changes (Design and Eligibility)(2011, 2014)	$0.3 million (1%)
■ Excise Tax on rich benefits (2018)	$0.9 Million (4%)
■ Cost reduction for currently covered employees who enroll in Medicaid	$0.03 Million savings (-0.1%)
Total	**$3.3 Million (15%)**
Opportunities for cost reduction	
Impact of reduction to 60% actuarial value	$6 Million savings (-27%)
Impact of dropping coverage entirely (net savings after tax adjustment)	$10 Million savings (-45%)

*Percentage of projected 2014 "status quo" cost of $21.4 Million

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Health Care Reform Financial Impact
Summary

- Cost increase for covering current opt outs: 2014; $ to $$$$
  - Cost for new enrollees in employer's plan
  - Surcharge or Free Choice Voucher if employees receive subsidy in exchange
- Cost pass through and cost shifting: ongoing; $ to $$
- Changes in program to comply with legislation 2010*, 2014; $
  - Plan design, eligibility, administration
- Excise tax for high cost plans: 2018; $ to $$$$ (increases over time)
- Cost reduction possibilities: ongoing; ($$) to ($$$$)
  - Reduction of benefits
  - Employees to Medicaid
  - Dropping coverage
- Net cost ($$$$) to $$$$

* Plan years beginning after September 23, 2010

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How employers are communicating about health care reform

Initial reaction is mixed about perceived need to communicate now

- Give employees all the information we can
  - Details on immediate provisions
  - Laundry list of most other provisions and effective dates
- Share what we can now – and add to that as we have more information
  - Details on immediate provisions
  - "We're watching and will be back to you as we learn more."
- Wait until later … when more details are available and we've sorted through the implications for our plans
  - Don't shape employee expectations until company's future approach is better defined

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For those in the middle group … “Share What We Know Now”

- Letters, emails, news articles … customized to reflect
  - Effective dates based on plan year
  - Current plan provisions that will change (but not provisions the employer may have already eliminated – for example, many plans have already eliminated pre-existing condition rules)
- FAQs that provide more information about
  - Specific provisions that take effect soon
  - Items like “individual mandates” that employees are hearing about in the news
- Some employers have added “Ask Your Health Care Reform Question” functionality to their web sites
- Employers are looking at how they integrate health care reform messaging into their annual enrollment materials

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Questions

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CLICK HERE TO ASK A QUESTION TO "ALL PANELISTS"

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