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## Health Reform: Risks for Employers

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## **Timeline for Complying With Health Reform**

# Key Elements of Health Reform for Employers

June 21, 2010

- 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 (effective TBD)
- Form W-2 reporting for 2011 health coverage
- Group health plan fees begin

- Health insurance exchanges
- Individual coverage mandate
- Financial assistance for exchange coverage of low-income individuals
- Medicaid expansion
- 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 (grandfathered plans may limit to children without access to other employer coverage, other than parent’s coverage)\*
  - 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 tax on net investment income for taxpayers with incomes exceeding \$200,000/ individual; \$250,000/couples
- 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).

\*\* Applies to all plans, including grandfathered plans, effective for plan years beginning on or after Jan. 1, 2014.

## Health Care Reform - Short-term Top Tier Issues

Short-term Top Tier Issues	Potential Cost Impact	Potential Effective Date(s)
Extend federal income tax exclusion for employer-provided coverage until the end of the year in which the child turns 26	Small FICA savings; adds administrative expense	Immediate
Offer coverage to covered employees' dependent children to age 26 if children lack access to other employer coverage	\$	Applies plan years beginning after 9/23/2010
Implement plan changes <ul style="list-style-type: none"> <li>• Eliminate lifetime maximum</li> <li>• Eliminate pre-existing condition exclusions for children &lt; 19</li> <li>• Restrict annual maximums</li> <li>• Restrict coverage rescissions</li> </ul>	\$ - \$\$	Applies plan years beginning after 9/23/2010

## Health Care Reform - Short-term Top Tier Issues

Shorter-Term Top Tier Issues	Potential Cost Impact	Potential Effective Date(s)
<p>Implement plan changes unless plan is <b>“grandfathered*”</b></p> <ul style="list-style-type: none"> <li>• Cover certain preventive services without cost-sharing</li> <li>• Eliminate pre-authorization of emergency services and referral for OB-GYN services</li> <li>• Allow enrollees to choose, rather than be assigned, a participating primary care physician (may include pediatrician)</li> <li>• No discrimination in favor of highly compensated employees in insured plans</li> <li>• Comply with new appeal process</li> <li>• Cannot include higher cost sharing for non-network providers ER and cannot limit ER services to network providers only</li> </ul>	\$	Applies plan years beginning after 9/23/2010

## New Health Reform Guidance – \*Grandfathering

- The law attempts to strike a balance between allowing people to keep coverage they had on March 23, 2010, and expanding access and coverage
- Interim final rules publicly available June 14, 2010 from the Departments of Labor, Treasury and HHS
- What is a grandfathered health plan?
  - An existing group health plan or insurance coverage in which a person was enrolled on March 23, 2010
- Who can be covered under a grandfathered plan?
  - Current enrollees can re-enroll, even if the plan or policy is renewed
  - Family members can enroll
  - Children eligible under the new extended child coverage rules can enroll
  - Newly hired and newly enrolled employees and their families

## New Health Reform Guidance – Grandfathering

- What changes can be made to a grandfathered plan that will not cause the loss of the grandfather status?
  - Voluntary increase in benefits or adoption of other consumer protections
  - Changes to conform to legal requirements
  - Changes to third party administrators
  - Some or all covered participants cease to be covered, as long as there is continuous coverage of at least one person since March 23, 2010
- What other steps must be taken to preserve grandfather status?
  - In any plan materials describing benefits, include a statement that the plan believes it is grandfathered, and contact information
    - Model statement included
  - Keep records documenting plan terms or coverage in effect March 23, 2010, and supporting documents

## New Health Reform Guidance – Grandfathering

- What changes will cause a plan to lose grandfathered status?
  - Eliminating all or substantially all benefits (or any necessary element thereof) to diagnose or treat a particular condition
  - Any increase in a percentage cost-sharing requirement
  - Increases in copayments in excess of the greater of medical inflation plus 15 percentage points, or \$5 increased by medical inflation
  - Increases in other fixed cost-sharing (deductibles, OOP limits) in excess of medical inflation plus 15 percentage points
  - Decreases in employer contribution by more than 5 percentage points below March 23, 2010 rate
  - Imposing certain new overall annual limits on dollar value of benefits
  - Entering into a new policy, certificate or contract of insurance after March 23, 2010, e.g., prior policy is not being renewed (with exception for certain collectively bargained plans)
  - Violating anti-abuse rules

## Grandfathered Plans – Special Rules for Collectively Bargained Plans

- Collectively bargained plans will be treated like all other plans for purposes of new health plan standards
  - Some take effect for plan years starting on or after September 23, 2010
- Self-insured collectively bargained plans in effect on March 23, 2010 will be treated like all other grandfathered plans for purposes of determining when and how grandfather status is lost, and will become subject to health plan rules accordingly
- Insured collectively bargained plans are treated as grandfathered plans until the end of the last bargaining agreement under which coverage was provided on March 23, 2010
  - Change in issuer does not cause loss of grandfather status during period of the agreement

## Impact of Grandfather Status (or Lack of Grandfather Status)

- Some new health plan standards taking effect soon apply only to new or non-grandfathered plans, including
  - Cover certain preventive services with no cost-sharing
  - Insured plans subject to nondiscrimination rules
  - Dependent child extended coverage cannot be limited to children without access to other employer-sponsored coverage
  - New internal and external appeals rights
  - Emergency services access, including same cost-sharing in and out-of network
  - Participant flexibility to choose providers in plans assigning or designating primary care physicians
- Health plan standards taking effect in 2014 for new or non-grandfathered plans
- Individuals can satisfy 2014 mandate for “minimum essential coverage” with grandfathered coverage



## Limited Transition Relief

- Certain changes made prior to March 23, 2010 but that are not effective until later don't cause a loss of grandfather status
  - Legally binding contract entered into on or before March 23, 2010
  - Pursuant to a filing with a state insurance department made on or before March 23, 2010
  - Written plan amendments adopted on or before March 23, 2010
- Changes made after March 23, 2010 and adopted before regulations issued won't cause a loss of grandfather status, but only if
  - Changes are revoked or modified effective as of the first day of the first plan year beginning on or after September 23, 2010, and the terms of the plan on that date, as modified



## Other Important Guidance

- Rules apply separately to each benefit package offered under a group health plan
- Dental-only and vision-only plans are exempt from new health plan standards
- Retiree-only plans will be exempt from new health plan standards
  - Nonfederal governmental retiree-only plans also exempt
- Very small plans (less than two participants who are current employees) will be exempt from new health plan standards
- Other “excepted benefits” including Medigap, most health FSAs, and accidental death and dismemberment coverage are exempt from new health plan standards

## Health Care Reform - Short-term Top Tier Issues

Shorter-Term Top Tier Issues	Potential Cost Impact	Potential Effective Date(s)
Eliminate reimbursement of non-prescribed over the counter medications	None	Tax year beginning on or after 12/31/2010
Increase HSA penalty from 10% to 20% for nonqualified (non-health care) distributions	None	Distributions made after 12/31/2010
Determine whether to participate in <b>CLASS**</b> Act employee-pay-all voluntary long-term care program	Administrative expense	1/1/2011
Implement auto-enrollment	\$-\$\$	Effective date is unclear



## **\*\*CLASS Act – What Employers Should Know**

- PPACA contains a provision that establishes a voluntary long term care (LTC) program for employees CLASS
  - Technically bill provides for a 1/1/2011 plan
  - Specific rules regarding the program are not required to be promulgated until 2012 which could delay implementation
- CLASS is a guaranteed LTC benefit with no underwriting
- The CLASS Act program is funded entirely by enrollee contributions either through payroll deductions or direct enrollee contributions
- Employers are NOT required to participate
- Employers that choose to participate must provide specific services
  - Administer an automatic enrollment program
    - Employees must take action to opt out of the program
  - Administer voluntary payroll after tax deductions

## CLASS Act – What Employers Should Know

- Eligibility
  - 18 years old
  - Receive wages
  - Actively at work during enrollment – Must pay premiums for five years
- Premiums are aged based – Rates not yet established
- CLASS benefits are eligible to be paid after five years of participation when an individual has a LTC triggering event
- Benefits payments are scheduled to be a minimum of \$50 per day adjusted for cost of living
- No lifetime benefit limits



## CLASS Act – Implications

- Currently 17% of employers offer a voluntary long term care program
  - Average voluntary participation is less than 10%
- CLASS highlights the need for long term care protection and should result in more employers offering a program
- Program is intended to provide a partial cost offset since actual costs of care are currently much higher than benefits
- Employer considerations
  - Offer a stand alone CLASS program
  - Do not offer a CLASS program
  - Offer a private LTC program instead of a CLASS Program
  - Offer a CLASS program and a supplementary private LTC Program

## Health Care Reform - Longer Term Issues

Longer term issues	Potential Cost Impact	Potential Effective Date(s)
Cap Healthcare Flexible Spending Account (FSA) at \$2,500	Reduces FICA savings	Taxable year on or after 12/31/2012
New taxes for workers earning over \$200,000 (individual) or \$250,000 (family) <ul style="list-style-type: none"> <li>- 2.35% Medicare tax on income above thresholds (employee portion)</li> <li>- 3.8% tax on net investment income</li> </ul>	Administrative expense	Taxable year on or after 12/31/2012
Pay patient-centered outcomes research fee (\$1/participant for plan year ending 2013, \$2 thereafter)	\$	Policy or plan year ending after 9/30/2012

## Health Care Reform - Longer Term Issues

Longer term issues	Potential Cost Impact	Potential Effective Date(s)
Assess indirect cost impact of fees on health insurers and medical device manufacturers	\$ - Indirect	Beginning 2013 for medical devices, 2014 for health insurers
Offer coverage to dependent children to age 26 regardless of marital status or access to other employer coverage	\$	Plan year on or after 1/1/2014
Implement shared responsibility provision to provide affordable coverage (essential benefits, 60% value, contribution more than 9.5% of household income) to employees working 30 or more hours per week	\$-\$\$\$	2014

## Federal Health Care Reform - Longer Term Issues

Longer-term issues	Potential Cost Impact	Potential Effective Date(s)
Offer free choice vouchers for exchange coverage to employees with household income below 400% of federal poverty level if employee contribution would be between 8 - 9.8% of household income	\$	2014
Determine potential for 40% excise tax on high cost coverage	\$-\$\$\$	2018
May increase available wellness incentives from 20% to 30%	\$	Plan year on or after 1/1/2014

## Federal Health Care Reform - Longer Term Issues

Longer-term issues	Potential Cost Impact	Potential Effective Date(s)
Group health plan standards (eliminate all annual dollar limits, pre-existing condition exclusions, waiting periods > 90 days)	\$	Plan year on or after 1/1/2014
Group health plan standards for non-grandfathered plans (limit annual cost-sharing to high-deductible plan limits, cover clinical trials)	\$	Plan year on or after 1/1/2014

## Health Care Reform - Retiree Medical Issues

Retiree Medical Issues	Potential Cost Impact	Potential Effective Date(s)
Reflect accounting impact of eliminating 2013 tax deduction for retiree medical Part D subsidy	\$-\$\$	Immediate adjustment to financial statements
File for 80% reimbursement of high-cost claims (\$15,000 – 90,000) for early retirees and their dependents	\$ Funds are limited	6/23/2010



# Understanding the Cost Impact

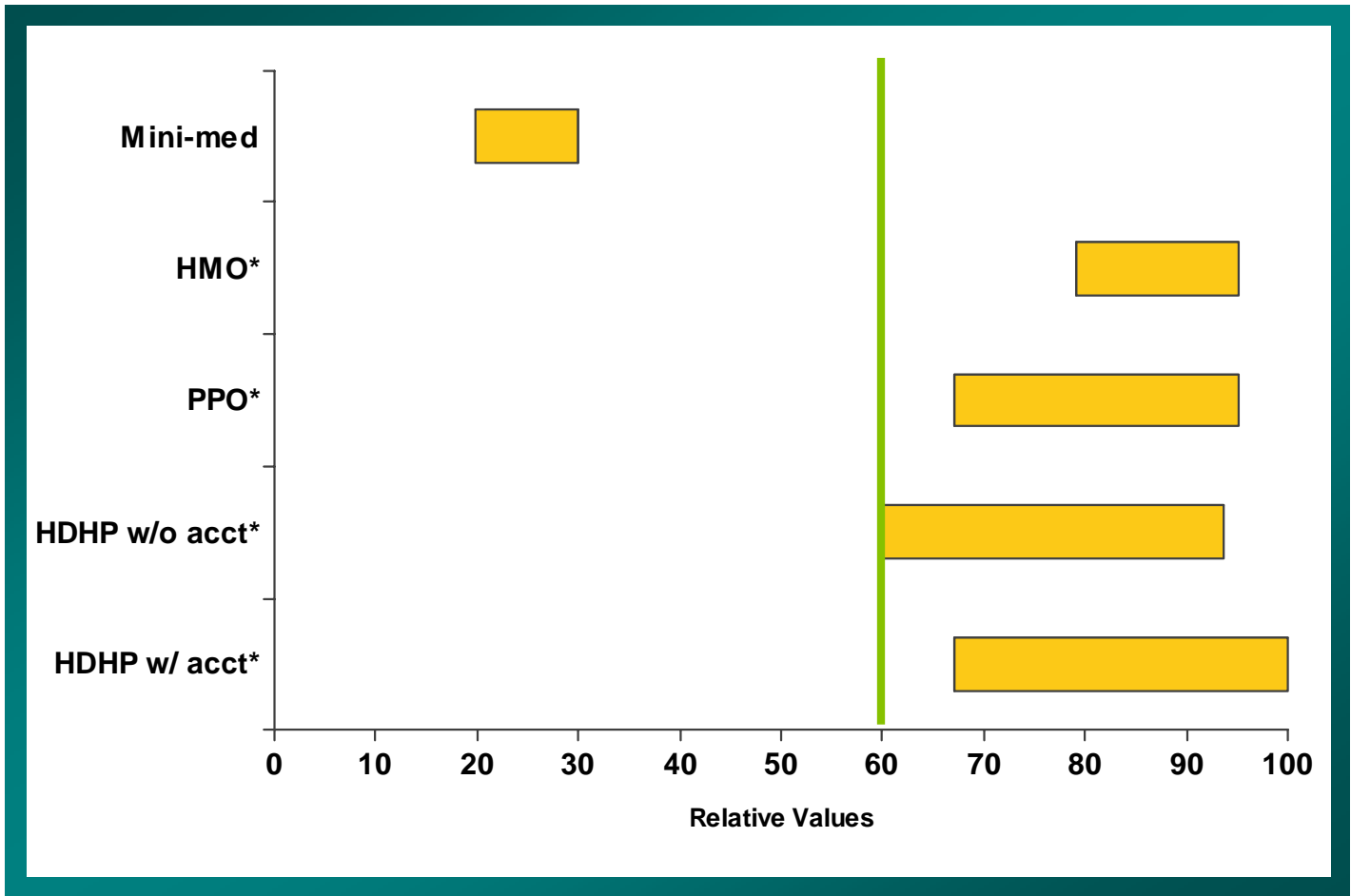


## Cost Impact: The Downside of Reform

- 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%
  - Cost shifting Potentially significant
    - 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

# Is Your Plan Design At Risk?

Most plan designs have a value higher than 60% - except mini-med



\*Based on plan designs data submitted in 2008 Mercer Survey for large employers (500+ employees)

## Will Employers Drop Coverage?

- The trade-offs
  - Provide affordable coverage that meets criteria
  - Or, pay a penalty of \$3,000 for each full-time employee who receives income-based assistance to buy exchange coverage
    - Fee capped at \$2,000 x total FTEs (working 30 or more hours per week)
  - Or, pay \$2,000 per FTE excluding first 30 employees for offering no coverage at all

*What would you do? Not a simple answer*



## Strategies for the Reform Era

- Evaluate plan design to change behavior and improve outcomes
  - Adopt high deductible plans with savings accounts
    - \$6,393 average cost vs. \$8,223 for PPOs and \$8,570 for HMOs
    - Provides a longer term perspective on health care
    - Engages the consumer through tools, better financial decisions
    - The new low option for default coverage
  - Adopt value-based designs
    - Improve compliance with medical advice and best outcomes
    - Use short-term, time-limited incentives to stimulate a change in prescriptions
  - Provide incentives for participants to seek care from highest quality providers
    - Medical homes for high cost, complex conditions
    - Domestic tourism for high risk, high cost surgical procedures



## Strategies for the Reform Era

- Evaluate eligibility
  - Are you covering spouses and dependents who have access to other employer-sponsored coverage?
  - What procedures will you use to hold participants accountable for terminating coverage if they have access to other coverage?
- Evaluate contribution strategy
  - Should you change your approach if more dependents will be eligible?
    - 4 tiers
    - Per participant charges
- Evaluate your carrier's performance
  - Long-term viability as a market leader
  - Ability to create sustainable, innovative health care delivery concepts that will impact trend and improve outcomes

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