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March 1, 2010

What About Health Reform?

Current state of play & what's at stake for employers
- moving ahead amidst uncertainty

**Prepared for 2010 Health Care Benefits
New York**

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Health Reform: March 5, 2009 White House Forum on Health Reform

“Since Teddy Roosevelt first called for reform nearly a century ago, we have talked and tinkered. We have tried and fallen short, stalled time and again by failures of will, or Washington politics or industry lobbying.”

President Obama



Health Reform: December 24, 2009 Senate Passes Its Health Reform Bill

“Ever since Teddy Roosevelt first called for reform in 1912, seven presidents...have taken up the cause of reform. But with passage of reform bills in both the House and the Senate, we are now finally poised to deliver on the promise of real, meaningful health-insurance reform.”

President Obama



Health Reform: January 20, 2010 Massachusetts Senatorial Election Day+1



“It was like calling a timeout in basketball. Everybody came back to the sides; now they can go back on the court.”

John D. Podesta

Head of President Obama’s transition team and chief of staff to President Bill Clinton



Agenda

- Current legislative state of play
- Stepping back: The challenge of passing reform
- Potential risks and implications for employers
 - With or without reform, trend is vulnerable
 - How employers are controlling trend today
 - Suggested actions



Current legislative state of play



The way forward?

- Change in Senate makeup dramatically altered the political landscape
- President offered little guidance in State of the Union or FY2011 budget
- Job of drafting legislation was assigned to Congress; now President Obama has a plan
- Emphasis on affordability, access, accountability, fraud protection
- Increased focus on insurance industry practices
- Framed as pre-empting the bi-partisan spirit of the “summit meeting”



Access to Coverage

- Retains federal exchange for individuals and small businesses
 - “Same plans as provided to Members of Congress” (2014)
- Requires individual coverage
 - Penalty of \$695 or 2.5% of income by 2016
- Retains premium tax credits
 - For low-income families below 400% of the Federal Poverty Level
- Expands Medicaid to 133% of Federal Poverty Level
- Funds new Medicaid members in every state
 - In full starting in 2014 and phasing to 90% starting in 2020
- Follows Senate approach to employer “mandate”
 - Eases the penalty to \$2,000 per full-time employee, but not clear if the trigger is “no coverage” or “unaffordable coverage”



Plan changes

- Closes the Medicare Part D donut hole
 - Provides a \$250 rebate to Medicare beneficiaries reaching it (2010)
 - Phases down coinsurance to standard 25% by 2020
- Extends waiting periods up to 90 days before triggering a penalty
- Sets plan cost-sharing at 70%
 - Additional assistance for lower-income families
- Caps Flexible Spending Accounts at \$2500
- Mandates certain changes, including “grandfathered” plans
 - Offer dependent coverage up to age 26 (within months of enactment)
 - Ban annual or lifetime maximums, pre-existing condition exclusions, and discrimination in favor of highly compensated (2014 for all)
 - Cover preventive services with no cost-sharing (2018)

Proposed revenue

- Expands Medicare tax
 - Applies to unearned income; raises the rate for the more highly paid
- Retains 40% excise tax on high cost plans, but delays date to 2018
 - \$8,500/\$9,850 → \$10,200 single
 - \$23,000/\$26,000 → \$27,500 family
 - Removes dental and vision from calculation
 - Keeps age & gender adjustments
- Increases industry assessments
 - Pharma industry: \$33 billion over 10 years (2011)
 - Manufacturer's excise tax: \$20 billion over 10 years (2013)
 - Insurance industry: \$67 billion (2014)
 - Exceptions for some non-profits



Other key items

- Increases federal oversight of insurance companies
 - Health Insurance Rate Authority reviews rates, trends, affordability
- Provides \$40 billion in tax credits to small businesses
- Adjusts Medicare Advantage payments
- Controls on fraud and abuse
 - Variety of measures to monitor Medicare contractors, stop alleged “pay for delay” tactics by drug companies, track Medicaid drug usage patterns
- Additional item: partial repeal of McCarran-Ferguson Act

It wasn't so long ago...

Top issues for employer-sponsored plans: House and Senate bills

Issue	House: HR 3692 Affordable Health Care for America Act	Senate: HR 3590 Patient Protection and Affordable Care Act
Employer mandate	<ul style="list-style-type: none"> ■ Play-or-pay provisions apply to employers with annual payroll higher than \$500,000 ■ Contribute 72.5% for single coverage and 65% for family coverage (pro-rated for part-time employees) ■ Employers that do not offer qualifying coverage pay 8% of payroll, capped at the minimum contribution levels ■ Employers offering coverage must pay 8% of payroll, capped at the minimum contribution levels, for employees opting out and enrolled in Exchange-based coverage <p>2013</p>	<ul style="list-style-type: none"> ■ Shared responsibility provision apply to employers with more than 50 employees ■ Employers not offering coverage <ul style="list-style-type: none"> – \$750 annually for every full-time employee (i.e., working at least 30 hours a week, determined on a monthly basis) if at least one FTE receives income-based premium assistance to buy coverage through new health insurance Exchanges ■ Employers offering coverage that is unaffordable (i.e., contribution constitutes more than 9.8% of household income) or does not meet minimum standards (i.e., 60% minimum actuarial value) <ul style="list-style-type: none"> – \$3,000 annually for each FTE receiving income-based assistance for health insurance Exchange coverage – Penalties capped at \$750 times total number of FTEs ■ No penalties for employees receiving free-choice vouchers <p>2014</p>

It wasn't so long ago...

Top issues for employer-sponsored plans: House and Senate bills

Issue	House	Senate
Free choice vouchers	<ul style="list-style-type: none"> ■ No provision 	<ul style="list-style-type: none"> ■ Offer vouchers to employees with household incomes at or below 400% of the federal poverty level (FPL) if their contribution for employer-sponsored coverage would be 8%* to 9.8% of household income <ul style="list-style-type: none"> – Voucher amount equal to highest (percentage) employer contribution to any of its own plans ■ Vouchers to be used for purchasing Exchange-based coverage ■ Employees could keep any excess amounts <p>2014</p> <p>* Individual coverage mandate penalties do not apply if over 8%</p>

It wasn't so long ago...

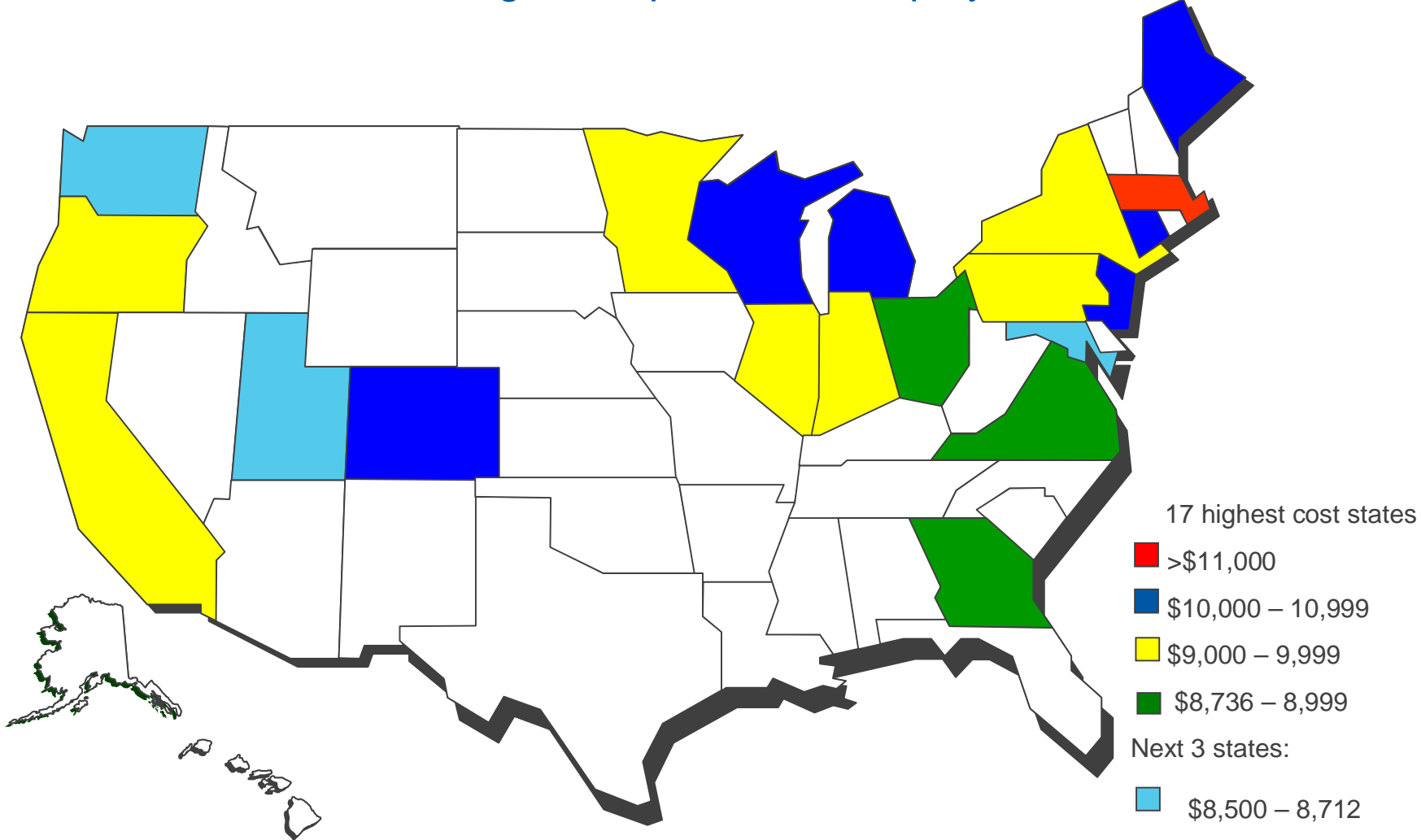
Top issues for employer-sponsored plans: House and Senate bills

Issue	House	Senate
Excise tax on high cost coverage	<ul style="list-style-type: none">■ No provision	<ul style="list-style-type: none">■ 40% excise tax on “high cost” coverage, including medical, dental, vision, health FSA contributions, onsite medical clinics, and employer contributions to HSAs■ Initial cap set at \$8,500/single and \$23,000/family■ Higher thresholds for retirees and individuals in high risk professions - \$9,850/single and \$26,000/family■ Temporary higher thresholds for people in highest cost states■ Indexed to CPI + 1% 2013



Proposed: 17 states would have delayed excise tax

Three are below the average cost per active employee: \$8,945



SOURCE: 2009 Mercer National Survey Of Employer-sponsored Health Plans

It wasn't so long ago...

Top issues for employer-sponsored plans: House and Senate bills

Issue	House	Senate
Excise tax on high cost coverage	<ul style="list-style-type: none">■ No provision	<p><i>Possible agreement - same as previous slide, except:</i></p> <ul style="list-style-type: none">■ Initial cap set at \$8,900/single and \$24,000/family■ Exemption until 1/1/2018 for<ul style="list-style-type: none">■ collectively bargained plans■ state and local plans■ VEBA's■ Higher thresholds if plan's gender and/or age demographics are greater than "average"■ Exclude dental and vision coverage as of 2015

Potential elements

Likely to be “in”

- Expand Medicaid
- Extend dependent eligibility
- Tax credits and subsidies for low-income
- Insurance market reforms
- FSA cap
- Medicare payment reforms & Medicare Advantage cuts
- Demonstration projects
- Medicare tax increase, apply to unearned income

On the bubble

- Employer mandate
- Free choice voucher
- Individual mandate
- Group health plan standards
- Exchanges
- Excise tax
- Wellness incentives
- Industry fees

What's likely to be “out”

- Public plan option
- Retiree medical anti-cutback
- Change to Part D RDS subsidy taxation
- Tort reform

The way forward?

- Democratic leaders now looking to move ahead, weighing options
 - Option 1 – try to move forward with broad reform based on Senate bill, adjustments possible via budget reconciliation
 - Political, procedural problems abound
 - Option 2 – move incremental reforms, possibly with GOP help
 - Insurance reforms, quality incentives eyed
 - Option 3 – start over, work with Republicans to draft new legislation
 - Republicans not seeing much advantage in cooperation, but President's push may increase the likelihood of this approach
 - Option 4 – temporarily drop reform effort
 - Focus on jobs and the economy this year, reassess after elections
- Post-summit path still unclear
 - Of course, everyone could agree with each other...
 - President appears willing to take Option 1

2011 federal budget proposal retains focus on addressing costs, primarily in Medicare and Medicaid programs

- Expand electronic medical record adoption
 - Improve quality & continuity of care
 - Provide incentives to Medicare and Medicaid providers
- Enhance clinical quality
 - Quality Improvement Organizations would focus on prevention, care coordination to avoid re-hospitalizations, correcting health care disparities, increasing patient safety
- Improve program integrity and beneficiary quality of care
- Provide the infrastructure for value-based purchasing and comparative effectiveness research
- Continues support for low-income children and their families (extend Federal Medical Assistance Percentage for Medicaid, originally provided by the Recovery Act)

State reform activity may pick up in the wake of faltering federal efforts

- States may take up reform efforts to expand coverage and address costs
 - Expand coverage of children through increased limiting ages
 - Exchanges or Connectors
 - Market reforms
 - Medical loss ratios
 - Rescission restrictions
 - Studies or commissions
 - Assistance to small business
 - Expanded public programs

State reform activity may pick up in the wake of faltering federal efforts

- Other approaches may be considered
 - California: Senate passed single payer legislation
 - Prior attempts were vetoed by the Governor
 - California: Proposed authority to regulate insurance rates
 - Died in Committee
 - Washington: Health security trust would be single financing entity, collecting insurer and individual premiums
 - State facing budget shortfalls restricting low-income programs
- 30 states with 2009-2010 legislation opposing federal reform efforts, including unfunded mandates, individual mandates



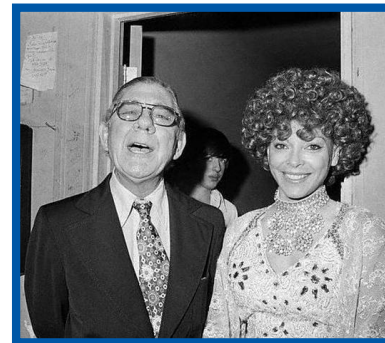
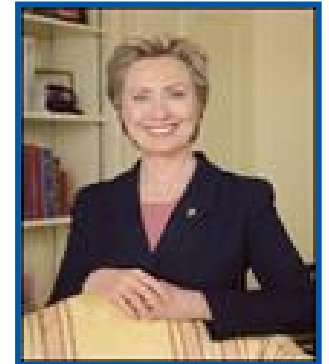
The challenge of passing health reform

Challenge of achieving health reform

- Health Reform has been a mainstay of the legislative agenda
 - 1930's: President Roosevelt's New Deal
 - 1940's: President Truman's Fair Deal
 - 1960's: President Johnson's Great Society
 - 1970's: Sen. Kennedy & Rep. Mills Health Security
 - 1990's: President Clinton's Health Security
- Only one broad reform effort succeeded
 - Medicare and Medicaid
 - Part of Lyndon Johnson's Great Society initiative
- Narrow "reforms" are continually enacted at national and state levels
 - See recent history, post-Clinton effort: Newborns' and Mothers' Health Protection Act; Mental Health Parity; HIPAA
- Broad reform of an entire industry is far more challenging

Why has health reform been so difficult to pass?

- A. Fear of change, uncertainty
- B. Complexity
- C. Sheer volume
- D. Something to upset every stakeholder
- E. Spouses
- F. Exotic dancers
- G. Transparency on “pork”
- H. All of the above



Adopting a new direction

- Success may depend on making tough decisions up front
 - Priorities: what changes are most critical to advance now?
 - Constraints: can funding come from increasing the budget deficit?



1-3/10



Employers continue to take actions

What are employers doing to control cost in 2010?

- Mercer's H&B Client Pulse Survey (January 2010)
 - About 900 surveys completed by Mercer consultants (individual responses kept confidential) on 2010 strategies and changes
- Mercer's 2009 National Survey of Employer-sponsored Health Plans
 - About 3000 participants, statistically represents the nation's employers
 - Detailed insights on how plans are being managed
- Employers reduced 2010 initial cost increases significantly
- Cost shifting was the most frequently used strategy
- Employers also relied on pharmacy plan changes, value-based design, CDHPs and health management strategies

Initial rate / projected cost increase* for 2010 higher than in past years, but employers brought final increase in line with 2009

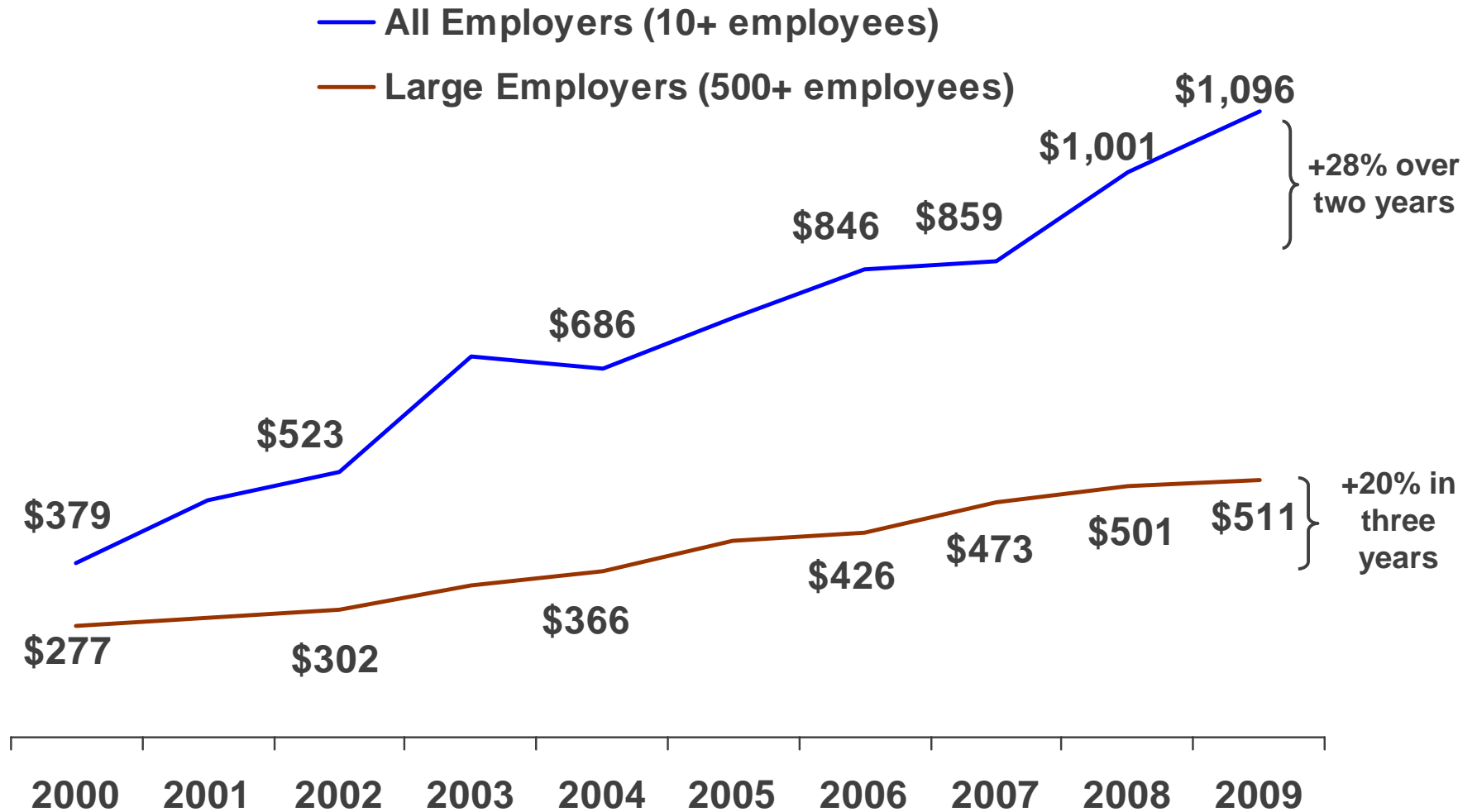
	2010 initial rate change/ projected cost increase*	2010 final negotiated rate change/projected cost increase	2009 actual rate change/cost increase
Fewer than 500 employees	15%	9.1%	8.1%
500 – 4,999	12%	7.0%	6.6%
5,000 or more	10%	6.5%	6.3%

*Before making any changes to plan design or vendor

Source: Mercer Client Pulse Survey 2010

Employee cost features continue to rise

PPO – average individual in-network deductible



Source; 2009 Mercer National Survey of Employer-sponsored Health Plans

Top cost-management tactics for small and mid-sized employers in 2010

- Fewer than 500 employees
- 500-4,999 employees

Raised employee cost-sharing (deductibles, copays, etc.)



Raised employee contributions



Changed RX plan design



Source: Mercer Client Pulse Survey 2010

Top cost-management tactics for small and mid-sized employers in 2010 (continued)

■ Fewer than 500 employees
■ 500-4,999 employees

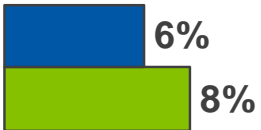
Changed carrier/market plan



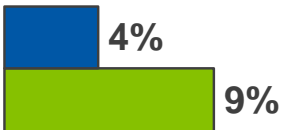
Added lower cost option



Added CDHP



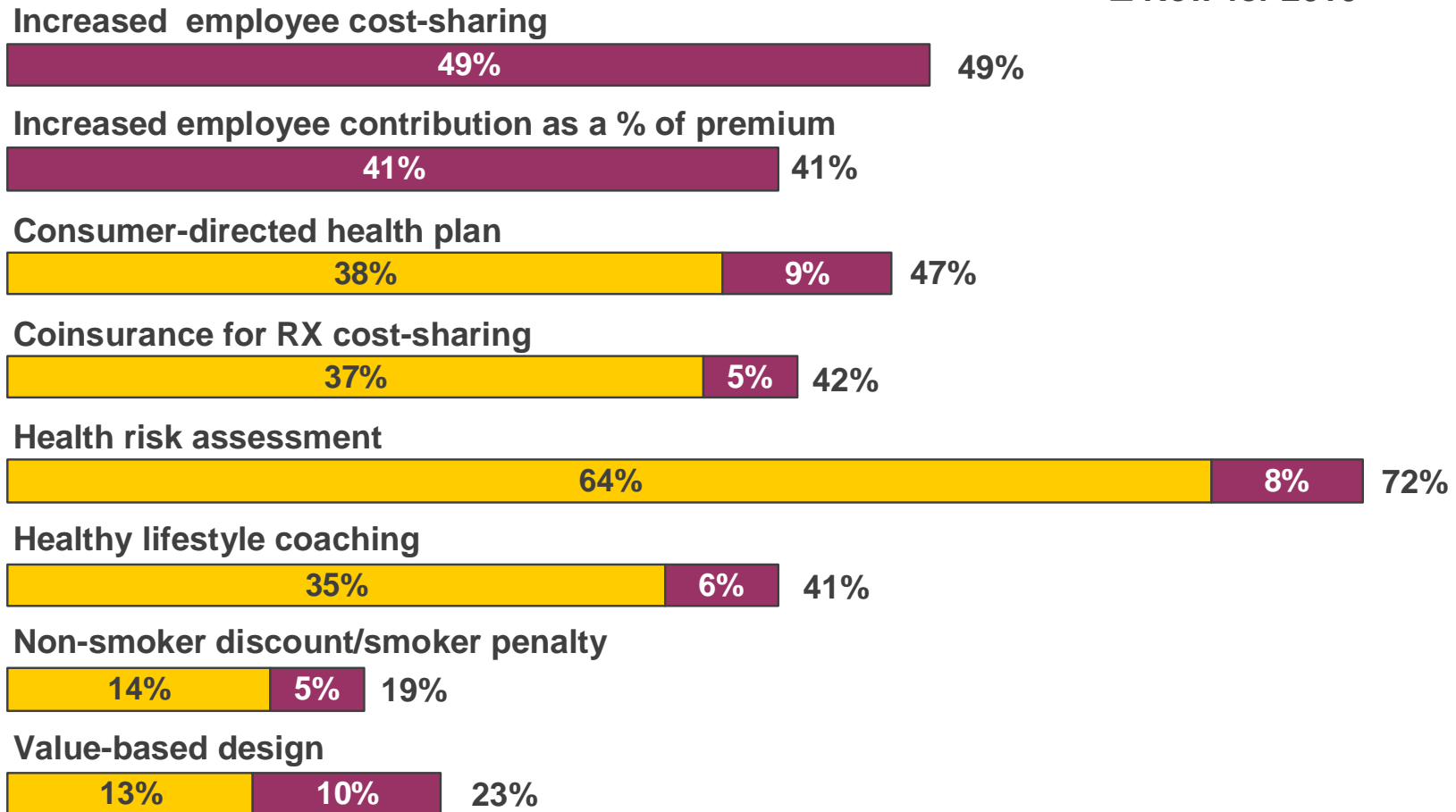
Implemented/enhanced health management



Source: Mercer Client Pulse Survey 2010

Top cost-management strategies for larger employers in 2010

■ Used in 2009 or earlier
■ New for 2010



Source: Mercer Client Pulse Survey 2010 – Employers with 5,000 employees

Sharp growth in use of health management programs

Percent of employers (500+ employees) offering programs

Behavior modification



Health advocate services



Health risk assessment



Disease management program



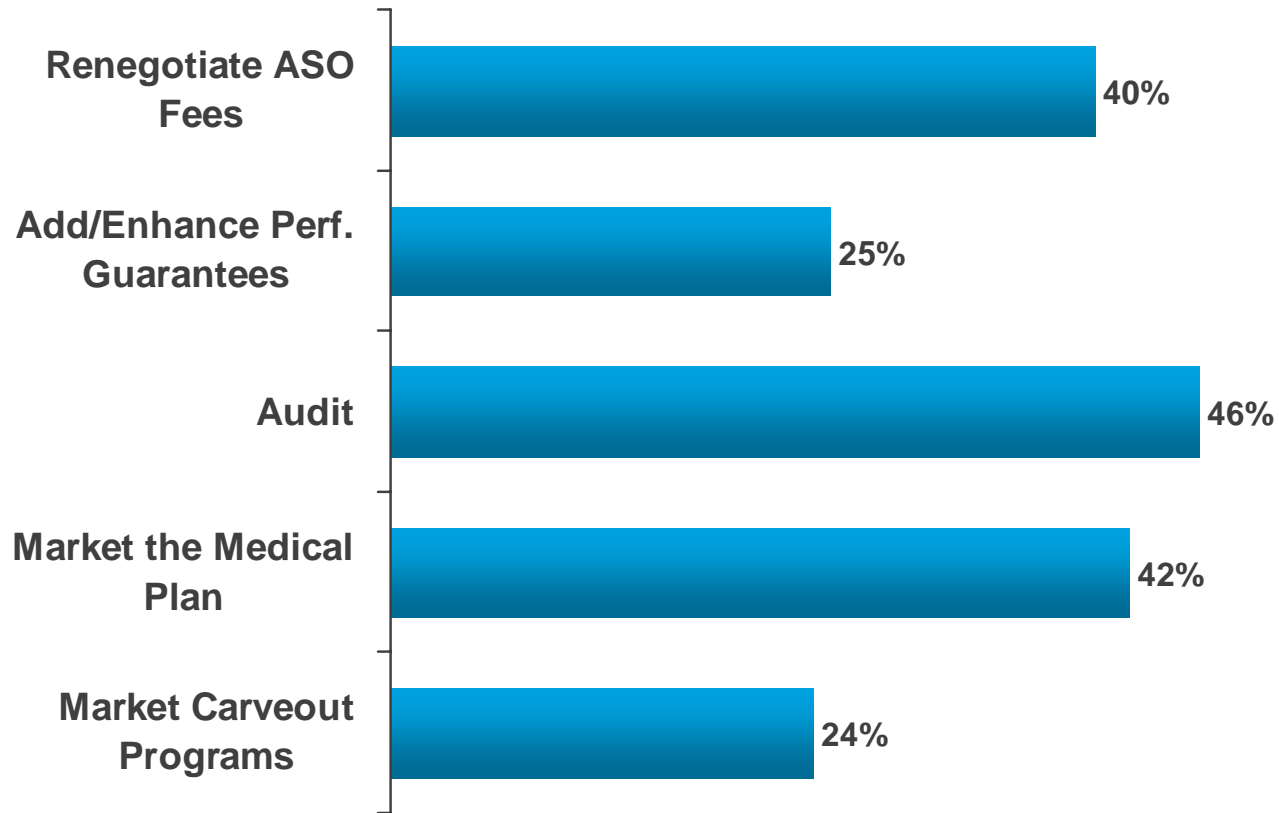
Nurse advice line



Source; 2009 Mercer National Survey of Employer-sponsored Health Plans

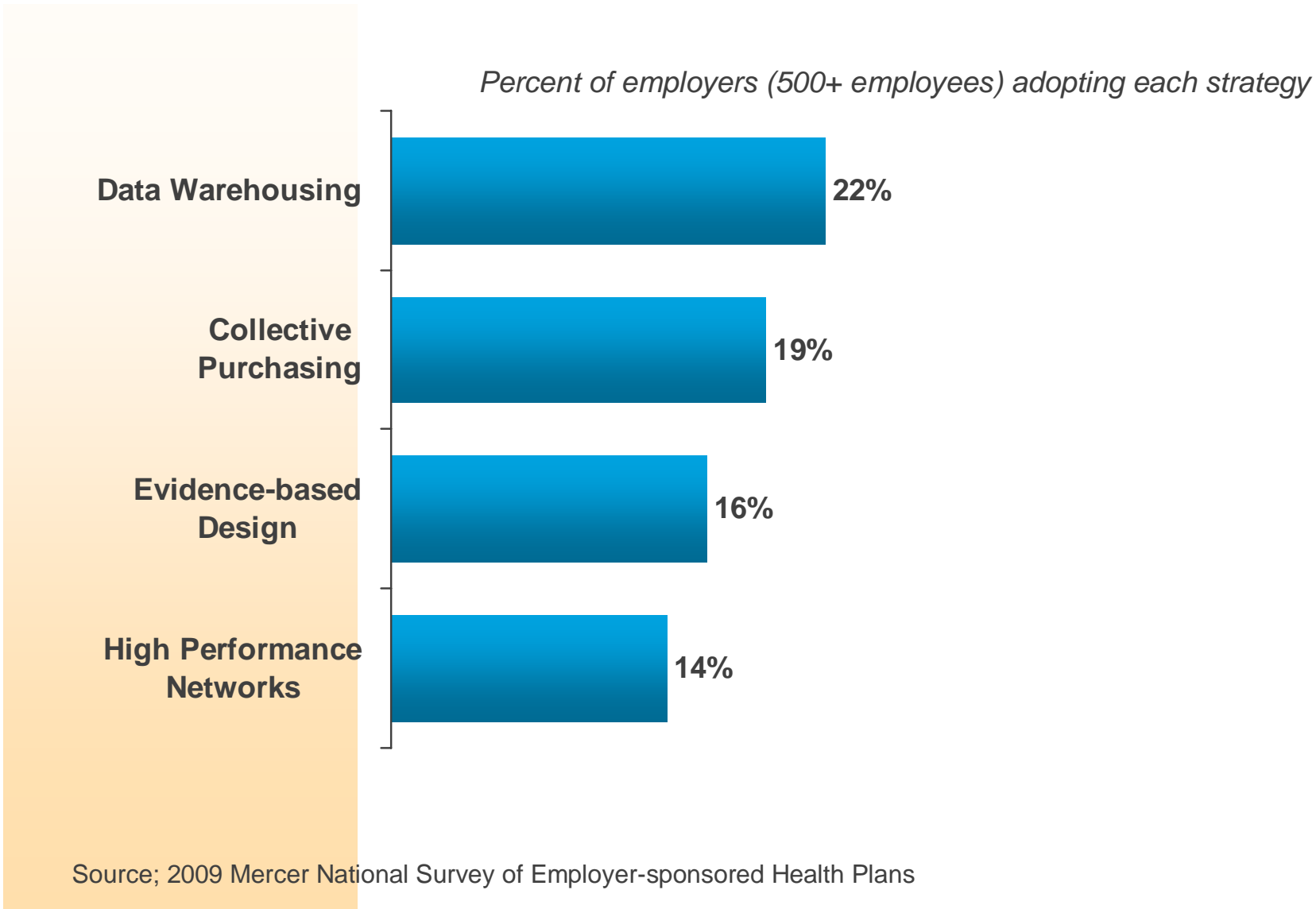
Pursue changes that are transparent (or nearly so)

Percent of employers (500+ employees) pursuing each strategy



Source; 2009 Mercer National Survey of Employer-sponsored Health Plans

New initiatives expand employers' approaches to controlling costs



Source; 2009 Mercer National Survey of Employer-sponsored Health Plans



**Potential risks and
implications to employers;
actions to consider**

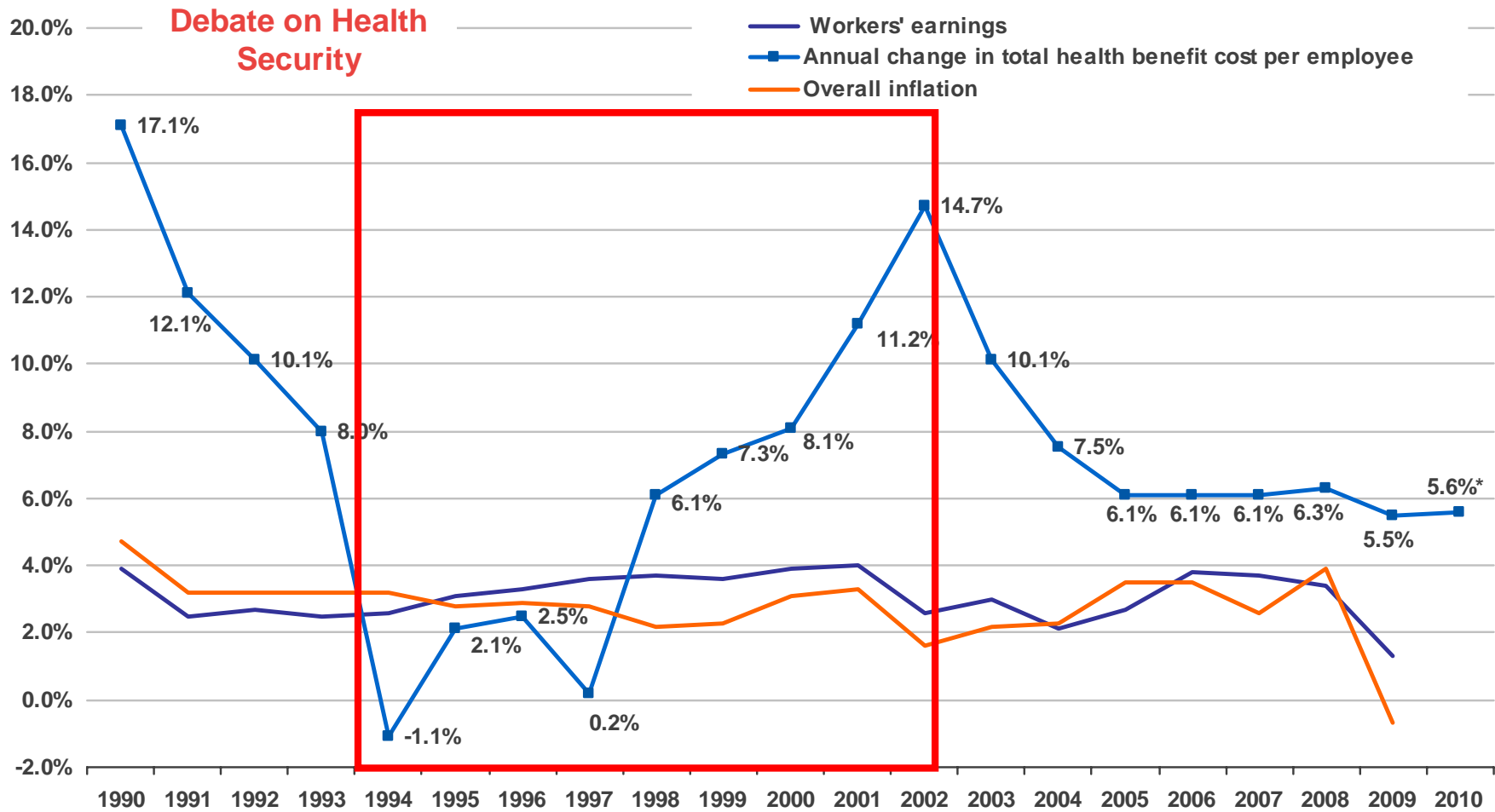
What should employers keep thinking about?

- Keep federal reform efforts at least in sight; note timing
- Keep state reform activity on the radar
- Consider how some of the more likely federal group health plan standards would impact the current plan
- Identify potential trouble-spots
 - No coverage for part-time employees
 - No coverage for dependents over age 19 unless they have student status
 - Waiting periods over 60/90 days
 - High rate of opt-outs
 - Cost sharing for preventive services
 - Annual or lifetime maximums

Without reform, what are the short-term risks facing employers?

- Cost shifting
 - Pressure on Medicare and Medicaid to control provider cost
 - Uncompensated care
- State health reform initiatives
- Cost shifting from carriers if individual market reform is passed at federal or state level
 - Rates may not be adequate to cover adverse selection caused by a weak or non-existent individual mandate
- Potential for further expansions to COBRA
- Providers and suppliers may view the legislative uncertainty as a window for increasing cost

After the Clinton health security plan failed to pass, cost rose significantly for 7 of the next 9 years



*Projected

Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1990-2009; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1990-2009.

What should employers consider doing in the short term?

- Understand likely areas of risk
 - Potential for inflation, cost shifting and price increases
 - Current cost drivers
- Ensure plans and vendors are operating at optimal levels of efficiency
 - Accuracy and management of participant eligibility
 - Percent of providers using electronic medical records, submitting claims electronically and accepting electronic funds transfer
- Evaluate current vendor's ability to adopt advanced strategies
 - Pay-for-performance
 - Bundled payments for specific conditions
 - Centers of excellence, world-class surgical centers
 - Medical homes
 - Value-based design

What should employers consider doing in the short term?

- Adopt Consumer Directed Health Plans as a full-replacement if deductibles are already high or as a low cost option
- Provide incentives to increase participation and compliance
 - Health risk assessment
 - Health management program
 - Lifestyle modification program
- Ensure participants are using best-in-class resources for education and treatment decisions
 - Condition-specific performance comparisons of providers and treatment options
- Align internal programs and services to support a healthy workforce
 - Cafeteria pricing and selection
 - Worksite programs

What should employers with retiree medical plans consider doing in the short-term?

- Understand potential areas of risk
 - Potential for inflation, cost shifting and price increases
 - Current cost drivers
 - Ability to control cost through lifetime maximums
 - Plans that have not been changed or amended
 - Potential problems for retirees if there is continued growth in the number of physicians closing their practices to Medicare patients
- Identify potential actions and triggers
 - Alternative to Medicare Advantage or Medigap plans if costs increase
 - Alternative to Part D if RDS subsidy is eliminated
 - Alternative to defined benefit
 - Defined dollar, subsidy cap or defined contribution approach

How might employers at the community level collectively address the issue of quality?

- Promote local partnerships to discuss how to improve provider quality and cost efficiency
 - Eliminate services that have little or no impact on improving health
 - Improve adherence to quality standards
- For example, Health Grades conducts an annual evaluation of hospital clinical quality
 - 269 hospitals are in the top 5% of all 5,000 hospitals
 - Compared to other hospitals, the top 5% had
 - 28.6% lower mortality rates
 - 8.6% lower rate of complications
- What are local hospitals doing to improve performance?
- Does it make sense for health plan contracts to cover all services provided by a hospital?

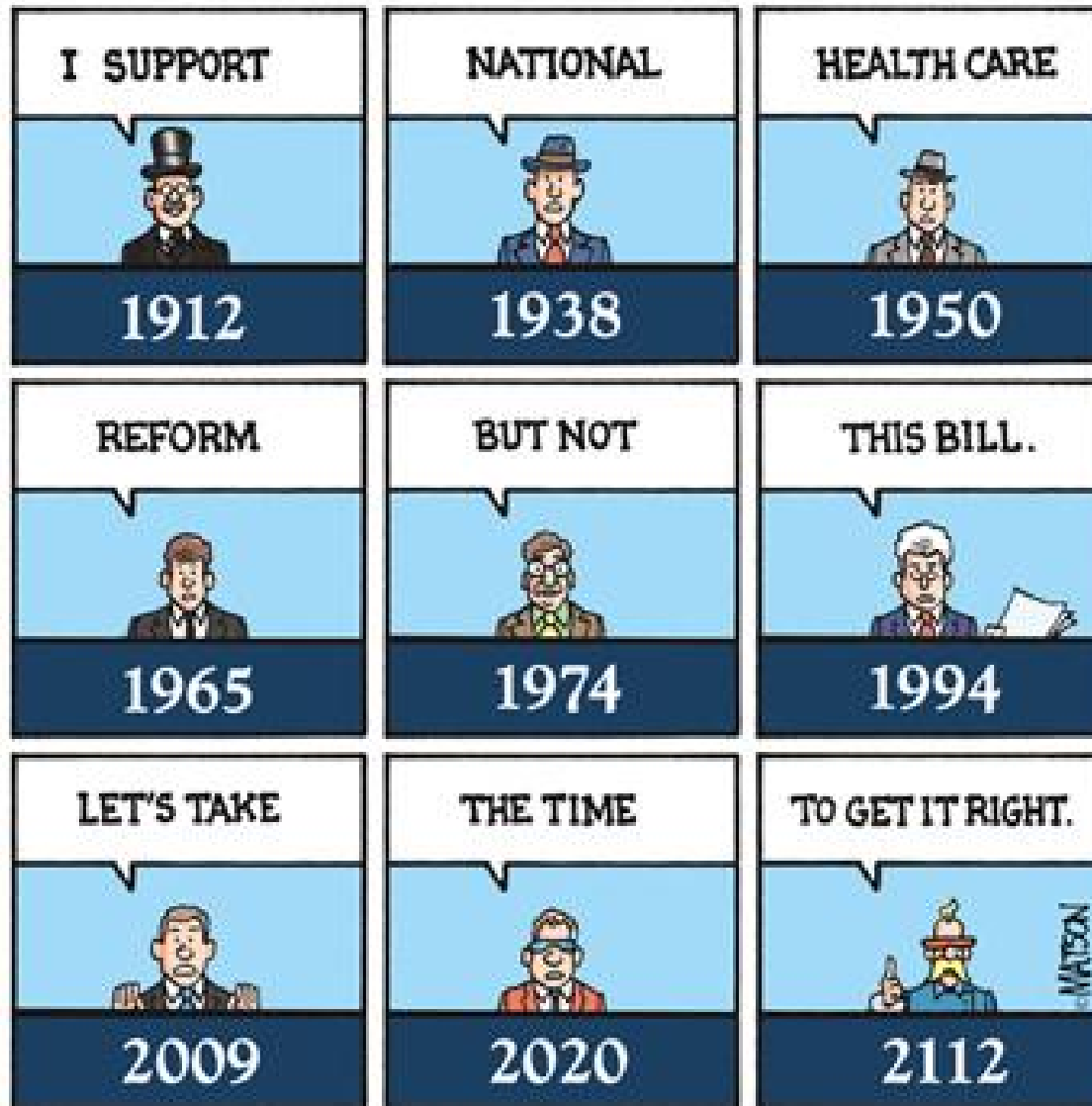
Should employers be providing incentives to direct participants to best providers for high risk procedures?

- Health Grades evaluated 266 hospitals performing kidney, heart, liver and/or lung transplants
- 20 hospitals recognized for statistically significant 3 year survival rates

Procedure	Total # procedures performed	Total # hospitals evaluated	# recognized*
Kidney	16,517	266	10
Heart	2,163	134	6
Liver	6,318	73	4
Lung	1,478	141	2

* New York Presbyterian and University of Wisconsin received awards in two categories

So, until next time ...



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