Health Care Reform: Spectrum of Opportunity

Presented by Andy Hiles,
Towers Watson
March 14, 2012
Overview

• Requirements of Current Law
• State Exchanges and Demonstration Projects
• Potential Judicial and Legislative Impact
• Retiree Opportunities
• Active Employees: Spectrum of Opportunity
• Business Issues
• Your Questions
REQUIREMENTS OF CURRENT LAW
A Transformational Moment

- An unprecedented convergence:
  - Rising health costs
  - Poor health/mounting health risks
  - Health Reform
  - An uncertain economic outlook

Health care is becoming a total business issue that will ultimately affect:

- Benefits and compensation
- Retiree health commitments
- The employee value proposition
- Corporate financial planning
- Workforce strategies
- Administration and payroll
Time Periods for Employer Actions

**Pre-Exchange**
- 2010 – 2013
  - Compliance and Opportunity Assessment

**Post-Exchange**
- 2014 – 2017
  - Redefining the Employer Role

**Excise Tax**
- 2018
  - Delayed Exit or Differentiated Play
### Health Care Reform – High-level Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
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<tbody>
<tr>
<td>2010</td>
<td>PPACA signed into law (March 23, 2010)</td>
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<tr>
<td></td>
<td>Some immediate health plan mandates and insurance market reforms</td>
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<td></td>
<td>Reinsurance program for early retiree medical coverage</td>
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<td></td>
<td>Accounting recognition of change in taxability of Medicare D RDS payments</td>
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<td></td>
<td>$250 rebate for seniors who hit Medicare Part D coverage gap</td>
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<td></td>
<td>W-2 reporting of aggregate value of employees’ health coverage</td>
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<td>Comparative effectiveness research tax begins</td>
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<td>Presidential election</td>
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<td>Supreme Court ruling on individual mandate (likely)</td>
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<tr>
<td>2011</td>
<td>W-2 issued using 2012 health plan data</td>
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<td>HHS required 4-page health plan summary of benefits disclosure</td>
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<td></td>
<td>Medicare payroll tax increased for high-wage employees and separate new tax on unearned income</td>
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<td>$2,500 cap on salary-reduction contributions to health FSAs</td>
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<td></td>
<td>Change employer tax treatment for Medicare Part D RDS payments</td>
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<td>HHS approves/conditionally approves state Exchanges</td>
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<td>2012</td>
<td>Individual health coverage mandate</td>
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<td></td>
<td>Employer mandates: play-or-pay, automatic enrollment</td>
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<tr>
<td></td>
<td>Health Benefit Exchanges operational</td>
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<tr>
<td></td>
<td>Premium and cost-sharing subsidies for low- and middle-income individuals</td>
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<td></td>
<td>Medicaid eligibility expanded in all states to 133% of FPL</td>
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<td></td>
<td>Additional group health plan mandates, such as prohibition on excessive waiting periods, coverage for clinical trials, and limits on annual OOP maximums and annual deductibles</td>
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<td></td>
<td>Sales of health insurance across state borders permitted</td>
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<tr>
<td>2013</td>
<td>States may open Exchanges to large employers</td>
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<tr>
<td>2014</td>
<td>40% nondeductible excise tax on high-cost employer-sponsored health coverage (“Cadillac” plan tax)</td>
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<tr>
<td>2015</td>
<td>Adult child coverage to age 26, no lifetime dollar limits/restricted annual dollar limits on essential health benefits, no preexisting condition exclusions for children under age 19, etc. (calendar-year plans)</td>
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<td>HSA withdrawal penalty increased to 20%</td>
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<td></td>
<td>No reimbursement of over-the-counter (OTC) medicines from account-based health plans, unless prescribed</td>
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**Evolving interpretations, proposed regulations, (interim) final regulations, technical corrections, legislative amendments, judicial decisions, elections, preparation for major changes, unpredictability**
### Most State Legislative Sessions

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Sep</th>
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- **Presidential Election – November 6**
- **Supreme Court Ruling Anticipated**
- **State Exchanges – by June 29**
STATE EXCHANGES AND DEMONSTRATION PROJECTS
State Activity by Purpose of Legislative or Executive Action

- Legislation enacted that authorizes exchange or expresses an intent to do so (15 states)
- Legislation authorizing exchange introduced but action by the Legislature is still pending (5 states and D.C.)
- No action taken/will be taken by Legislature or Governor, or legislation has been defeated (12 states)
- Legislation or Governor commissioned exploratory action (18 states)

Source: Towers Watson, as of December, 2011
### Mixed Results on Demonstration Projects

<table>
<thead>
<tr>
<th>Demonstration</th>
<th>Participating Organizations</th>
<th>Incentive Offered</th>
<th>Effects on Medicare Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay for Performance</td>
<td></td>
<td></td>
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<tr>
<td>Physician Group Practice</td>
<td>10 Physician group practices</td>
<td>Keep some of estimated reductions in total Medicare spending, partly on the basis of quality of care</td>
<td>Little or none</td>
</tr>
<tr>
<td>Premier Hospital Quality Incentive</td>
<td>278 Hospitals</td>
<td>Receive bonus for meeting quality-of-care targets</td>
<td>None</td>
</tr>
<tr>
<td>Home Health Pay-for-Performance</td>
<td>273 Home health agencies</td>
<td>Keep estimated reductions in total Medicare spending, if quality-of-care targets are met</td>
<td>Little or none in the first year[^1]</td>
</tr>
<tr>
<td>Bundled Payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Participating Heart Bypass Center</td>
<td>7 Hospitals and relevant physicians[^2]</td>
<td>Bundled payments negotiated for coronary bypass surgeries</td>
<td>10 percent decline in spending on bypass surgery</td>
</tr>
</tbody>
</table>

Source: Congressional Budget Office

[^1]: Results are available only for the first year of the two-year demonstration
[^2]: Physicians who treated heart bypass patients while they were hospitalized
POTENTIAL JUDICIAL AND LEGISLATIVE IMPACT
Health Care Reform After 2012 Election

Some provisions are likely to remain, even if Republicans sweep 2012 election

Other provisions are likely to go if Republicans win

Finally, repeal or significant changes raise practical, technical and political difficulties...like the deficit and areas where implementation is underway
PPACA Litigation Continues

• Supreme Court expected to rule on individual mandate – timing of any Supreme Court ruling unclear
• Lower courts divided
• Focus now on appeals rulings; appeals courts also divided
  – First ruling – Sixth Circuit Court of Appeals – upheld law
  – Second ruling – Eleventh Circuit Court of Appeals – struck down individual mandate
  – Third Ruling – Fourth Circuit Court just ruled it lacked standing to hear and dismissed
• Speculation that Supreme Court could rule close to the 2012 elections
• Severability: If Supreme Court rules against individual mandate, does rest of the law stand?
 RETIREE OPPORTUNITIES
There’s A Rapid Shift Taking Place In the Post-65 Environment

<table>
<thead>
<tr>
<th>The employer-sponsored plan world</th>
<th>The Medicare/individual coverage world</th>
</tr>
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<tbody>
<tr>
<td>● Fewer than <strong>6 million individuals</strong> covered under employer-sponsored retiree medical</td>
<td>● <strong>45 million</strong> Medicare participants, 39 million without employer coverage</td>
</tr>
<tr>
<td>● Pool is shrinking</td>
<td>● Growing with boomer retirements</td>
</tr>
<tr>
<td>● Retirees aging out, <strong>fewer new entrants</strong>, poor risk pool, reform cutting RDS value,</td>
<td>● Over 60 million in Medicare by 2020</td>
</tr>
<tr>
<td>● <strong>Plan costs increasing</strong></td>
<td>● Market already “reformed” with universal access</td>
</tr>
<tr>
<td>● Significant employer administration</td>
<td>● Significant federal subsidies and private insurance market to complement or replace Medicare</td>
</tr>
<tr>
<td>● Suboptimal value for retirees given reform enhancements for private plans</td>
<td>● Enhanced pharmacy benefit under Health Care Reform makes Rx benefits <strong>comparable</strong> to employer benefits by 2020</td>
</tr>
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</table>
Opportunities for Employers

1. Revise retiree medical strategy… the WHAT
   - Should we consider change in plan sponsorship and/or funding?
   - What retiree groups can be changed?
   - How would the benefits differ in the future?
   - What is the impact to the employer and the retiree?
   - Who are the winners and losers?

2. Implement the strategy… the HOW and WHEN
   - EGWP (+Wrap), Medicare Coordinator, both, or whatever…..?
   - Exit versus EGWP
   - Administration support
   - Communication support
   - Vendor selection, contracting and management support
Choices and decisions for employers today, when the status quo is not a sustainable option for tomorrow

Considerations for Continuing Plan Sponsorship

► You have a legal obligation to provide a specified benefit
► The plan offering is market competitive – although benchmarking may not be reflective of current environment
► The aggregate value of your current plan exceeds the value of individual market options for more than 50% of our retirees

Discontinue plan sponsorship?

NO

YES

Marketplace Opportunities Without Plan Sponsorship

► Robust, choice-filled marketplace includes many attractive, competitively priced individual insurance options for Medicare-eligible retirees
► Medicare Coordinators facilitate retirees' plan choices and enrollment, and manage premium billing for retirees and employer
► Specialized Retiree Medical Transition Services to enable employers to exit plan sponsorship in a responsible manner

Different approaches may be appropriate for different cohorts of your retiree medical population
Potential Actions to Consider

• Exit medical and pharmacy plan sponsorship during 2012 or by 2013 for Medicare-eligible retirees
  – There is a robust individual market available today for Medicare retirees
  – There are vendors that facilitate this transition and provide administrative support known as “Medicare coordinators”
• Continue financial support and plans for current retirees until Exchanges emerge
• Convert current financial subsidy for retiree medical and pharmacy into an annual dollar allocation
  – Monetary value can be calculated separately for retirees in differing subsidy categories
  – Consider ending financial support for a portion of the active population if additional savings is desired (i.e., those with >5 years to retirement)
• Prepare to exit medical and pharmacy plan sponsorship in 2015 for non-Medicare retirees assuming:
  – Exchange plans should be available in 2014; we recommend holding off until 2015 to ensure that plans are up and running successfully, but
  – Establish a contingency plan in the event that Exchange plans are not sufficiently viable by 2015
ACTIVE EMPLOYEES: SPECTRUM OF OPPORTUNITY
Employers Remain Committed to Health Benefits

Health benefits are seen as core to the EVP

Will rethink their long-term health care strategy in 2012

Developing plans to control their costs

Will be more prescriptive

Of those that offer retiree health, plan to discontinue this coverage
Health Care is Crowding Out Other Workforce Investments

<table>
<thead>
<tr>
<th>Benefits as a Percentage of Direct Compensation</th>
<th>2000</th>
<th>2009</th>
<th>Percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>87.4%</td>
<td>84.1%</td>
<td>- 3.7%</td>
</tr>
<tr>
<td>Defined Benefit</td>
<td>3.4%</td>
<td>1.8%</td>
<td>- 47.1%</td>
</tr>
<tr>
<td>Defined Contribution</td>
<td>2.7%</td>
<td>3.5%</td>
<td>+29.6%</td>
</tr>
<tr>
<td>Retiree Medical</td>
<td>0.6%</td>
<td>0.2%</td>
<td>- 66.6%</td>
</tr>
<tr>
<td>Active Medical</td>
<td>5.9%</td>
<td>10.3%</td>
<td>+74.6%</td>
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Companies with the most effective health programs have:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Impact</th>
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<tbody>
<tr>
<td>$2,000 less in health care costs per employee per year*</td>
<td></td>
</tr>
<tr>
<td>1.8 fewer days of unplanned absence per employee</td>
<td></td>
</tr>
<tr>
<td>11% higher workforce productivity</td>
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*Consistently high performers over low performers in the *Employer Survey on Purchasing Value in Health Care, 2011*.

Planned Health Insurance Market in 2014

Employer Plans

Employer benefits meet minimum plan and affordability thresholds

Employer pays government and employees use Exchanges

Uninsured

Insurance Market Reforms:
• Guaranteed Issue
• No Health Status Underwriting

Exchange

Aetna
United
BCBS
CIGNA
Kaiser
Co-op

Medicaid/CHIP

Medicare

(Spectrum of Opportunity)

Optimal Play
Play and Redirect
Selective Play
Pay and Redeploy

(See next slide for detail on Spectrum of Opportunity)
# Employer Spectrum of Opportunities

<table>
<thead>
<tr>
<th>Play</th>
<th>Spectrum of Opportunity</th>
<th>Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal Play</td>
<td>Play and Redirect</td>
<td>Selective Play</td>
</tr>
<tr>
<td>Continue as a plan sponsor for all employees</td>
<td>Restructure contributions to qualify low-paid employees for federal subsidies</td>
<td>Limit eligibility to employer-sponsored plan and direct eligibles to Exchanges</td>
</tr>
</tbody>
</table>
BUSINESS ISSUES
What is an ACO?
- Physicians (PCPs and Specialists) and hospital(s) working together to coordinate care and held accountable for the cost and quality of care delivered to a defined set of individuals
- Care is managed across the continuum of inpatient and ambulatory settings

What is the purpose of an ACO?
- Provide integrated care to improve outcomes and reduce cost
- Provide a counter-balance to the fee-for-service system that incents volume of services rather than value of services

How is this different from an HMO?
- Accountability is focused directly on providers and the delivery systems instead of health plans
- CMS will contract directly with providers without the health plan as an intermediary
- No patient restrictions on changing PCPs
- Patients may see specialists without gatekeeper approval
- Any provider bonuses require meeting quality standards

Potential for Disintermediation: Accountable Care Organizations

Doctors

ACO

Hospitals
ACO Assumption: The right incentives will encourage providers to take broad responsibility for the patients they treat—resulting in higher quality care and lower costs.

“OLD” WORLD
- Fee-for-service compensation
- Independently practicing providers

“NEW” WORLD
- Performance-based & risk-based compensation
- Coordinated health care delivery systems
Physician Shortage

The Facts

- Approximately 800,000 physicians in the U.S. today
- About one-third are currently age 55+
- Over 30 million new insureds beginning in 2014
- Primary care physician shortage is acute
- Pipeline of new physicians is narrow
- Projected shortage of 45,000 PCPs and 46,000 surgeons by 2020

What Employers Are (Should be) Doing

- Direct contracting
- Physician extenders
- Onsite clinics
- Near-site urgent care
- Telemedicine
Possible Scenario – Hybrid Employer/Exchange Model

Employees Enrolled in Employer Plan

Workers with pay too high to receive subsidy

Employees Choose State Exchange

Lower-wage workers with plan premiums deemed “unaffordable” eligible for federal subsidy

- Transparency to low-wage workers about exchange opportunity
  - Modeling tools
  - Education
  - Counseling
- Employer no longer offers a low-cost option to employees
- Employer no longer provides premiums by pay band
- Employer wins if penalty plus any contribution to employee coverage is below current. Employee wins if premiums for comparable coverage are below employer’s plan
Possible Scenario – Defined Contribution Approach

The Situation
- Employer embraces defined contribution philosophy
- Employer wants arms-length position in employee health (private exchange)
- Employer contribution into HRA set at 2014 level, increasing at compensation levels*
- Assumes healthcare costs increase 7% per year**

What This Means to Employees
- More choice of plan options through the exchange
- Loss of employer as intermediary if issues arise
- Increase in employee premiums above 2014 level
  - In 2015: 23%
  - In 2019: 138%
- How will employees react?
- Can competition among insurers drive down this cost?

*Compensation levels increase 3% per year
**$7,000 per employer subsidy. Employer contributes 80% of costs in 2014
Questions?