Health Research Institute
Health reform:
Prospering in a post reform world

Institute of Internal Auditors
New challenges for employers and important strategic considerations
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Section 1
Health Reform Overview
Health Reform Makes Collaboration an Important Strategy for Success

New coverage

New funding, taxes and fees

New regulators

New strategies, innovations & collaborations
Health Reform Reduces the Number of Uninsured by 32 million by Expanding Medicaid and Creating Exchanges

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

Federal Funding of Coverage is Paid with New Fees, Taxes and Payment Reductions

Spending on health reform- $938B

Paying for health reform- $1,081B

Sources: CBO Letter to Nancy Pelosi, 20 March 2010; Joint Committee on Taxation Report JCX-16-10, 20 March 2010; PricewaterhouseCoopers Analysis
Regulators Involved in the Implementation of Health Reform

Major new regulators will oversee cost control and innovation

- Control cost of existing programs
  - Independent Payment Advisory Board
  - National Prevention Health Promotion and Public Health Council
  - Patient-centered Outcomes Research Institute

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

- Create new ways of funding, delivery
  - CMS Innovation Center
  - Community-based Collaborative Care Network Program

Existing federal agencies take on complex new responsibilities

- HHS
  - Determines “essential services,” which preventive care treatments are covered, expands Medicaid to 16 million

- FDA
  - Monitors array of new regulations for employers’ health coverage

- Labor
  - Oversees new pathway for biologics

- Treasury
  - Implements new tax rates, structures
Three Tranches of Health Reform

Regulation and coverage (2010-2013)
- Elimination of pre-existing coverage exclusions for children and lifetime coverage limits and rescissions; dependent coverage through age 26
- MLR minimums
- Medicare Part D gap narrows, Medicare Advantage rates frozen, bonuses available, beneficiary rebates, free preventive care
- Temporary high risk pools
- Fee on brand-name pharmaceutical manufacturers
- Community Living and Support Services Act (CLASS Act)

Major expansion of coverage (2014)
- Mandates for individuals
- Employer penalties for those that do not provide coverage
- Health insurance exchanges
- Small employer and individual subsidies
- Health insurer industry fee
- Guaranteed issue, rating bands, and risk adjustment
- Medicaid expansion
- Disproportionate share payment reductions to hospitals

Bending the cost curve (2015-2020)
- Penalty for not adopting electronic medical records
- Independent Payment Advisory Board (IPAB)
- High-cost plan excise tax
- Medicare Part D “Donut Hole” closes
- Reduced payment for hospital-acquired conditions

Source: PricewaterhouseCoopers LLP
Reform requires action

<table>
<thead>
<tr>
<th>Providers</th>
<th>Pharmaceutical Companies</th>
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<tbody>
<tr>
<td>• Accelerate physician alignment and employment.</td>
<td>• Manage 4.3% drug spending reduction.</td>
</tr>
<tr>
<td>• Mitigate quality penalties and reputational cost.</td>
<td>• Plan around biologic pathway to “generics.”</td>
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<tr>
<td>• Adjust to movement of uninsured to Medicaid.</td>
<td>• Provide products based on payment for health outcomes.</td>
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<table>
<thead>
<tr>
<th>Payers</th>
<th>Employers</th>
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<tr>
<td>• Lower administrative expenses to meet the new medical loss ratios (MLR).</td>
<td>• Assess short-term impact on health benefit plans.</td>
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<tr>
<td>• Shift attention from group to individual plans.</td>
<td>• Assess short and long-term cost impact of reform.</td>
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<tr>
<td>• Differentiate on price, service, quality, and provider network in the insurance exchanges.</td>
<td>• Develop longer term strategy for health benefits.</td>
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</table>
Federal budgetary pressures will require attention in coming years, which could affect reform provisions.

**Federal Budget Deficit as a Share of GDP**

- **Current Law**
- **Current Policy**

40-Yr Historical Average = -2.6%

Assumes expiration of 2001-3 and business tax cuts, low discretionary spending growth.

Assumes extension of 2001-3 and business tax cuts, historic discretionary spending growth, phasedown of Iraq/Afghan spending.

Source: Congressional Budget Office, January and March 2010, PricewaterhouseCoopers calculations.
How Health Reform Moves the Status Quo to Customized Care

**Status quo**
- Spending flows to acute care
- Industry needs IT standards, infrastructure
- Reimbursement incentivizes siloed care

**Reform**
- Funding goes to prevention, medical homes, primary care, individual health plans
- Government funds, and standardizes EMR systems
- Bundling, coordinated care models funded

**Customized Care**
- Identify individual’s genetic, medical and behavioral markers to focus on wellness and prevention
- EMRs provide exchange of information among clinicians, individuals
- Teams share responsibility and savings for patient care
Section 2
Employer Strategic Considerations
Timeline of major provisions affecting employers

New rules for employer-sponsored insurance and plans

Begin:

- Providing coverage to children up to age 26
- Covering children regardless of pre-existing conditions
- Considering participation in pre-65 retiree reinsurance program

Reporting value of worker health benefits on W-2

Providing uniform statement of benefits to employees

Providing 1099 for participation in pre-65 retiree reinsurance program

Notifying workers about the state insurance exchanges that will start in 2014

If available, considering whether to join state health insurance exchanges (small employers)

Covering all full-time workers or pay the “free-rider” penalty

Getting subsidies for providing coverage to their workers (small employers only)

Considering offering 30% wellness incentives to workers

If available, considering whether to join state health insurance exchanges (large employers)

Stop:

2010
- Setting lifetime limits on benefits
- Implementing annual benefit limits that do not meet HHS standards
- Allowing OTC drugs as qualified medical expenses
- Allowing FSA contributions of more than $2,500
- Deducting federal subsidies for retiree drug coverage
- Setting out-of-pocket limits that are greater than health savings account plan limits
- Making workers wait more than 90 days to enroll
- Setting annual plan limits
- Excluding benefits for pre-existing conditions
- Offering “high-cost” benefit plans or face 40% excise tax

2011

2012

2013

2014

2017-2018

First plan year after Sept. 23, 2010

The health reform laws require companies to...

The

The

The

The

The
Growth in medical costs for 2011 is expected to be 9%, down 0.5% from 2010

- Pre-managed care benefit design with higher deductibles and more coinsurance
- Generics erode brand-name drug spending
- COBRA costs return to more normal levels

- Cost-shifting from Medicare
- Provider consolidation could increase their bargaining power
- Providers increase investment in electronic health records to get stimulus funding
Coinsurance is increasingly replacing co-pays

Percentage of employers using coinsurance for selected services

- Specialty care: 23% in 2010, 23% in 2008
- Brand name drugs: 26% in 2010, 26% in 2008
- Generic drugs: 12% in 2010, 19% in 2008
- Emergency department: 16% in 2010, 18% in 2008
- Specialty care: 12% in 2010, 12% in 2008
- Primary care: 12% in 2010, 18% in 2008

Source: PricewaterhouseCoopers Touchstone survey
Deductibles are high and rising

- 43% of employers have a deductible of $400 or greater, up from 25% in 2008
- 32% of employers offer high-deductible plan with a health savings account (HSA)
- 19% of employers offer high-deductible plan with a health reimbursement account (HRA)

Source: PricewaterhouseCoopers Touchstone survey
Most employers believe health reform will bring significant change…

- 94% of employers expect to have to make changes to their benefits to comply with PPACA while 74% expect to make additional changes to offset the costs of complying.
- 79% expect to re-evaluate their benefits strategy with the most common focus being to increase efforts related to health and wellness and with a substantial minority focusing on significant changes to company subsidies for employees or dependents, or considering coverage of employees through the state exchanges.

As a result of PPACA provisions, likelihood of employers to:

- Re-evaluate benefits strategy:
  - Very/Somewhat Likely: 19%
  - Not Certain: 79%
  - Very/Somewhat Unlikely: 2%

- Change company’s benefits to comply with PPACA:
  - Very/Somewhat Likely: 4%
  - Not Certain: 94%
  - Very/Somewhat Unlikely: 2%

- Change company’s benefits to offset costs:
  - Very/Somewhat Likely: 17%
  - Not Certain: 74%
  - Very/Somewhat Unlikely: 9%

- Cover employees through state-run health insurance exchange(s):
  - Very/Somewhat Likely: 11%
  - Not Certain: 63%
  - Very/Somewhat Unlikely: 22%

- Increase company’s efforts related to wellness and health management:
  - Very/Somewhat Likely: 6%
  - Not Certain: 83%
  - Very/Somewhat Unlikely: 15%

- Significantly change or eliminate company subsidies for employee medical coverage:
  - Very/Somewhat Likely: 55%
  - Not Certain: 30%
  - Very/Somewhat Unlikely: 15%

- Significantly change or eliminate company subsidies for dependant medical coverage:
  - Very/Somewhat Likely: 52%
  - Not Certain: 33%
  - Very/Somewhat Unlikely: 15%

PwC Health Reform Touchstone Survey Results – July 2010
… and some employers will relook at why and how they provide coverage

- While most employers will continue to offer health coverage even when access is guaranteed in the open market, 16% of employers are looking to eliminate company plans and subsidize health exchange programs in the future.
- If employers do provide subsidies to a health exchange in the future, most envision subsidies not varying by age or area but potentially varying based on other factors such as income.
- About half of employers are looking to significantly change or eliminate retiree medical benefits due to PPACA.

### Active Health

- Continue to offer Employer Plan(s)
- Subsidize Health Exchange(s)

16%  
84%

### Retiree Health

Likelihood of employers significantly changing or eliminating retiree medical benefits due to PPACA

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<thead>
<tr>
<th></th>
<th>Very Likely</th>
<th>Somewhat Likely</th>
<th>Unlikely</th>
<th>Very Unlikely</th>
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<tbody>
<tr>
<td>Pre-65</td>
<td>13%</td>
<td>35%</td>
<td>39%</td>
<td>13%</td>
</tr>
<tr>
<td>Post-65</td>
<td>15%</td>
<td>34%</td>
<td>37%</td>
<td>14%</td>
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PwC Health Reform Touchstone Survey Results – July 2010
... as well as New Market Dynamics
– State Exchanges, Guaranteed Issue, Federal Subsidies
  • State or region-based marketplaces for health insurance
  • Private health plans sell their products side-by-side
  • Health benefits standardized
  • Enrollment and information through website and phone hotline
  • Improved consumer choice and pricing transparency

* • Employers must provide Notices to Employees about the Exchanges (3/2013)
  • For plan years beginning before 1/2016, states may provide that only ≤ 50 employees can participate
  • States may open to large employers in 2017
## Impact of Healthcare Reform will vary

<table>
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<tr>
<th>Employer segment</th>
<th>High impact provisions</th>
<th>Key decisions</th>
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<tbody>
<tr>
<td>Retail industry: low-wage, high turnover workforce</td>
<td>• Coverage expansion&lt;br&gt;• Free rider penalty&lt;br&gt;• Free choice voucher</td>
<td>• Revise or drop employee coverage&lt;br&gt;• Consider funding access to the exchange (when available)</td>
</tr>
<tr>
<td>Mature industries with large retiree populations</td>
<td>• Retiree drug subsidy&lt;br&gt;• Temporary pre-65 reinsurance&lt;br&gt;• Close Part D “Doughnut Hole”&lt;br&gt;• Cutbacks in Medicare Advantage funding</td>
<td>• Assess retiree medical accounting impact&lt;br&gt;• Apply for ERRP&lt;br&gt;• Re-assess strategy on retiree medical benefits</td>
</tr>
<tr>
<td>Industries with high average wage (e.g., financial services)</td>
<td>• Additional 0.9% Medicare tax&lt;br&gt;• New 3.8% Medicare tax on unearned income&lt;br&gt;• Nondiscrimination requirements for new insured plans</td>
<td>• Communicate potential under-withholding to 2 wage-earner families&lt;br&gt;• Consider additional qualified plan options (distributions not subject to 3.8% tax) or shifting capital gains to earned income</td>
</tr>
</tbody>
</table>

Source: PricewaterhouseCoopers LLP
Section 3
Discussion: Strategic Implications
Eligibility

• What role should you play with respect to health benefits when access is guaranteed in the open market?
• How will employment policies (e.g. minimum work week) be influenced by “free rider” requirements?
• How does the perceived value of health benefits compare to other rewards?
• If employers elect not to offer coverage, will individual penalties under reform ensure coverage?
• How will health benefits policies be influenced by labor issues?
• Will there need to be specific solutions targeted for unique populations?
• Other?
Contribution & Funding Strategies

• How much should businesses subsidize dependent coverage?
• How will tax policies and tax subsidies influence contribution and funding strategies?
• Should you move toward a defined contribution medical plan design in the state exchanges?
• How should a defined contribution plan design take into account age, gender, area, and health status?
• How can aggregators be utilized to make state exchanges more accessible and viable for national employers?
• Other?
Cost Increases & Impact on Financial Statements

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

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

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

Anticipated Compliance and Administrative Burden

- Significant burden: 49%
- Moderate impact: 39%
- No Effect: 11%
- Too Early to tell: 1%

Health Research Institute
PricewaterhouseCoopers April 2010

PwC Health Reform Touchstone Survey Supplement - 2010
Implications for Employers

Short term implications

• Reassess impact on current consumerism and health management strategies
• Evaluate and react to health reform changes needed for 2011 compliance and value of grandfathered status. Consider value of offsets.
• Review “Free Rider Penalties” for potential tax liabilities and impact on labor strategy, benefits eligibility and coverage levels.

Longer term implications

• Reevaluate “total rewards” and “health and wellness” strategies
• Assess potential for health exchanges and federal subsidies to replace all or some of employer provided subsidized health benefits.
• Reconsider retiree health programs including potential early retiree subsidies, expanded Rx coverage and movement toward EGWPs and potential “wrap”.
• Re-examine the longer term risks and burdens of compliance in a post-reform environment.
• Consider potential outsourced solutions.
Section 4
Questions and Answers