



Central Iowa Compensation and Benefits Network Meeting

Health Care Benefits Post Reform: Realities, Opportunities, and Predictions

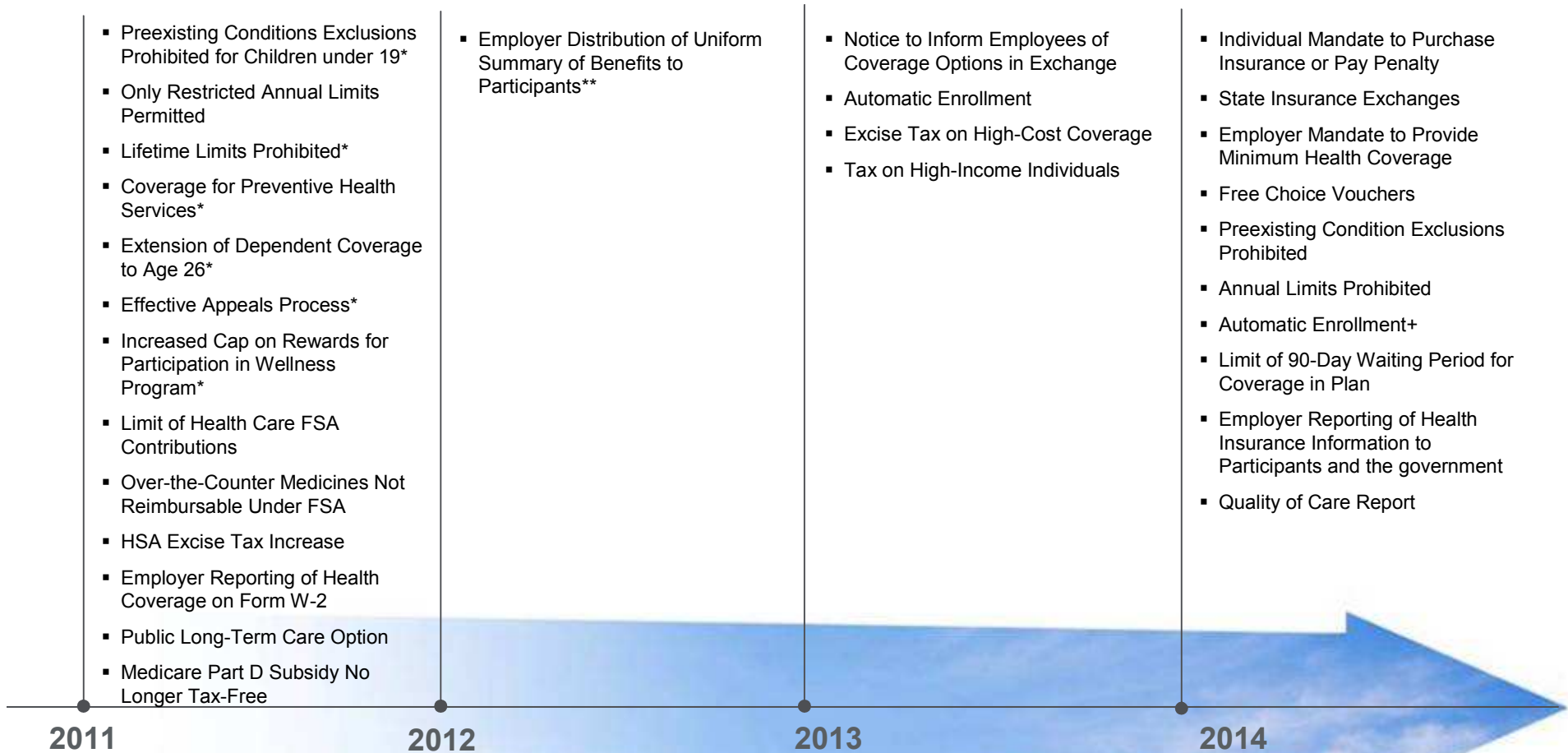
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Agenda

- Health Care Reform Overview
- The Burning Health Care Platform
- A Vision for the Future

Timing of Key Provisions



*Effective for plan years beginning 6 months after enactment

**Effective within 24 months of enactment

+Effective date unclear

Health Reform Will Impact Employers Differently

High Impact

- Limited employer contribution for benefits
- Health plans with less than 60% actuarial value
- Low paid employees
- Employees working 31-39 hours that are not benefits eligible
- Waiting periods of 90 days or longer
- Plans with annual or lifetime limits
- Employee demographic that drives up total cost
 - Pre-65 retirees
 - Older workforce
 - High risk industries

Low Impact

- Significant employer contribution for benefits
- Health plans with actuarial value of 60% or more
- Salaried workforce
- Few low paid employees
- Few part-time employees
- No waiting periods
- No annual or lifetime limits
- Employees demographic that keeps costs low
 - Young workforce
 - Few retirees
 - Low risk industries

What Is a Grandfathered Health Plan?



*“If you like your health care plan,
you can keep it.”*

President Barack Obama

Health Care Compliance—2010 and Beyond

What is a grandfathered health plan?

- Coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under the grandfather rules)
- In general, the grandfather rules apply separately to each benefit package made available under a group health plan or health insurance coverage
- A grandfathered health plan must comply with—
 - The pre-PPACA federal rules on health care
 - *Some* of the post-PPACA group market reforms

Advantages of a Grandfathered Health Plan

Grandfathered health plans do **not** have to comply with the following PPACA group market reforms:

- **2011:** 100% coverage of preventive health services
- **2011:** Nondiscrimination rules (fully insured plans)
- **2011:** Changes to appeals process (external review)
- **2011:** Various patient protections, including coverage of emergency services, access to pediatric care, obstetrical, and gynecological care
- **2011:** File financial data reports with HHS and state insurance departments
- **2012:** File quality of care reports with HHS
- **2014:** Coverage for individuals participating in approved clinical trials
- **2014:** Cost-sharing limits not exceeding HSA maximums—currently \$5,950 (individual) and \$11,900 (family)
- **2014:** No discrimination against licensed health care providers
- **2014:** Updated rules on no discrimination based on health status (wellness reward threshold increased to 30%)

But All Group Health Plans, Including Grandfathered Health Plans, Do Have to Follow...

...the following PPACA *group market reforms*:

- Extension of coverage for adult children to age 26 (2011)
 - Applies to grandfathered health plan before 2014 only if adult child not eligible for other employer coverage
- No lifetime limits on the dollar value of “essential health benefits” (2011)
- No annual limits on the dollar value of “essential health benefits” (2011)
 - Special rule before January 1, 2014
- No preexisting conditions exclusion for children under age 19 (2011)
 - No preexisting condition exclusion for all other participants (2014)
- Prohibition on waiting periods of no more than 90 days (2014)
- Uniform explanation of coverage (12 point font, 4 pages in length) (2011)
- Prohibition on rescissions (2011)
- Rules on minimum loss ratios (insured plans only) (2011)

Health Care Compliance—2010 and Beyond

What causes a grandfathered health plan to lose grandfathered status?

- Change in insurance carriers (for non-union plans)
- “Anti-abuse rule”
 - Mergers and acquisitions
 - Change in plan eligibility
- Elimination of benefits
- Increase in percentage cost-sharing requirement
- Increase in a fixed-amount cost-sharing requirement other than a copayment
- Increase in a fixed-amount copayment
- Decrease in contribution rate by employer
- Changes in annual limits

Health Care Compliance—2010 and Beyond

An employer sponsoring a grandfathered health plan must—

- Include a statement in any plan materials describing plan benefits that the plan or coverage believes it is a grandfathered health plan
- Provide contact information for questions and complaints
- Maintain records documenting the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify grandfathered status, and
- Make such records available for examination upon request

Sample Employer Financial Summary

The following table summarizes the potential additional costs due to PPACA

Provision	Expected Impact	Year Cost Will Initially be Incurred
Removal of Lifetime Maximums	Increased claim exposure/risk	2011
Removal of Annual Benefit Maximum	Increased claims and risk	2011
100% Preventive Care Benefits	Increased utilization and lower cost-share	2011 if Grandfathered Status is Lost
ER Visit Parity	Loss of negotiated discounts for some ER visits	
Clinical Trial and Broader Definition of PCP	Likely to have little to no impact	
Expansion of Dependent Coverage	Increased enrollment/risk	2011
Reporting Requirements	Additional administrative expense	Varies with initial costs in 2011
Comparative Effectiveness Research	Fee increase	2012
Individual Mandate	Increased enrollment/risk	2014
“Pay or Play”	Increased enrollment/risk	2014



The Burning Health Care Platform

Plan sponsors are battling many environmental issues that are accelerating the trend curve.



Poor Diet

+



Bad Habits

+



Lack of Exercise

=

Higher Morbidity



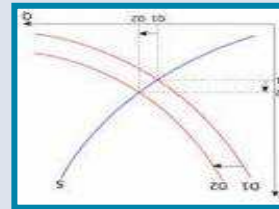
Technology

+



Brand Drugs

+



Inverted Supply/Demand Curve

=

Higher Cost/Unit



Under-funded Government Programs

+



Hospital Over-Capacity

+



Bad Debt

=

Cost Shifting

Aging Population

State Mandates

Malpractice Costs

Medicare Reimbursements



Quality Inconsistencies

Health Care Reform

Primary Care Delivery

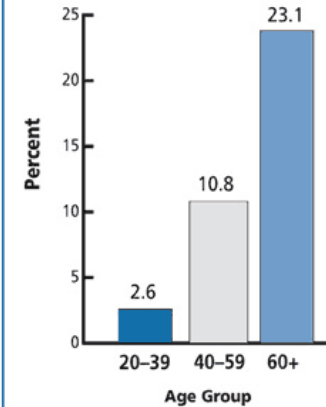
Physical Inactivity

Uninsured & Underinsured Populations

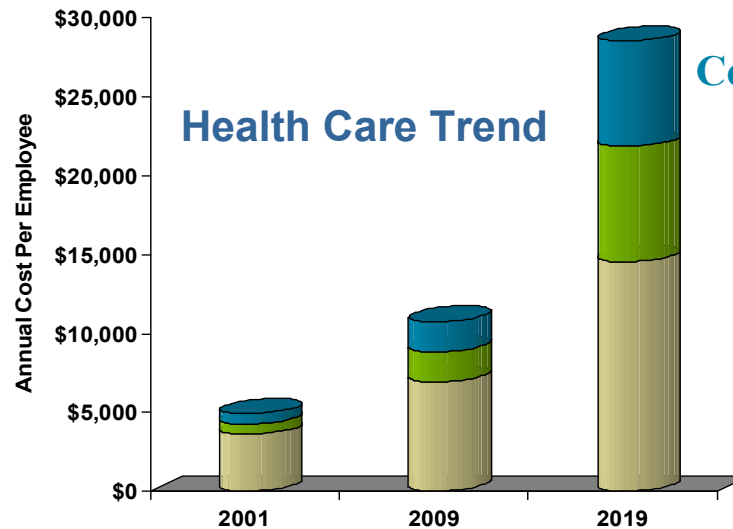


Lifestyle Risks

Estimated prevalence of diagnosed and undiagnosed diabetes in people ages 20 years or older, by age group, United States, 2007



Access to Coverage

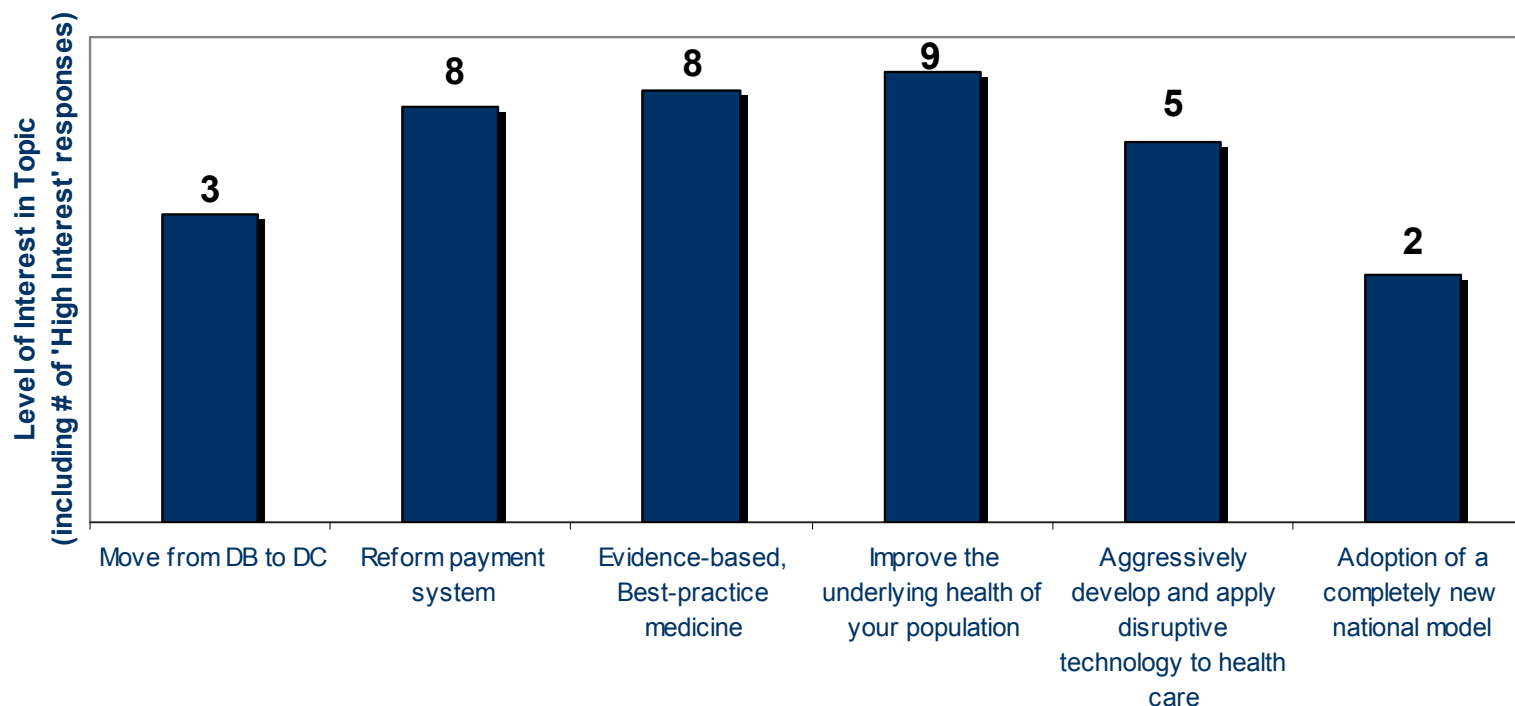


Cost of Care and Coverage

- Employee Out-of-Pocket Expenses
- Employee Payroll Contributions
- Employer Cost

Which Concepts are Promising When it Comes to Health Care Transformation?

Aggregate Survey Answers



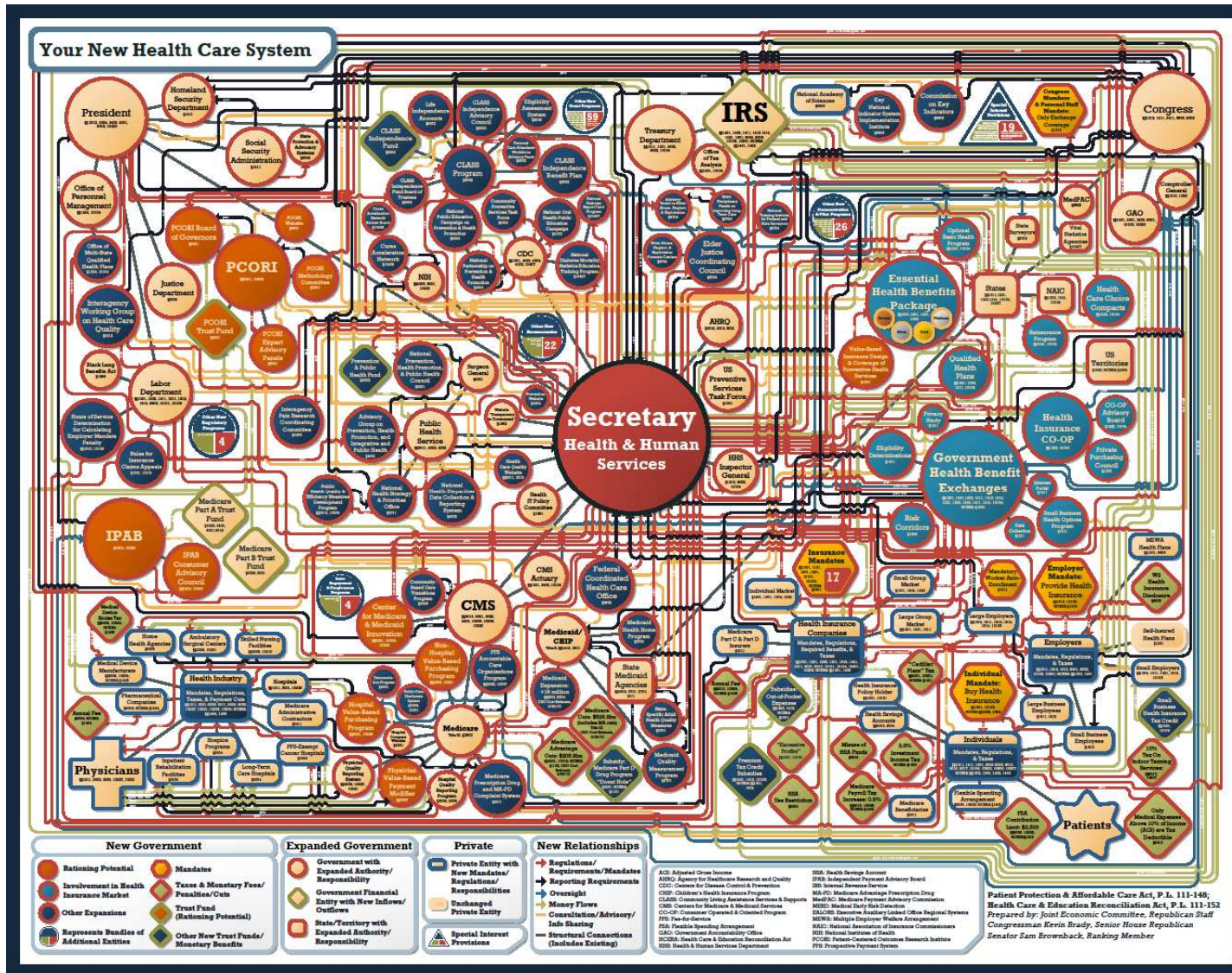
Transformation Concepts

- The height of each bar represents the overall level of interest in each concept, taking into account all responses
- The number at the top of each bar represents number of survey responses indicating highest level of interest for each concept (e.g., "High Level of Interest in Exploring")



A Vision for the Future

Assembly completed!

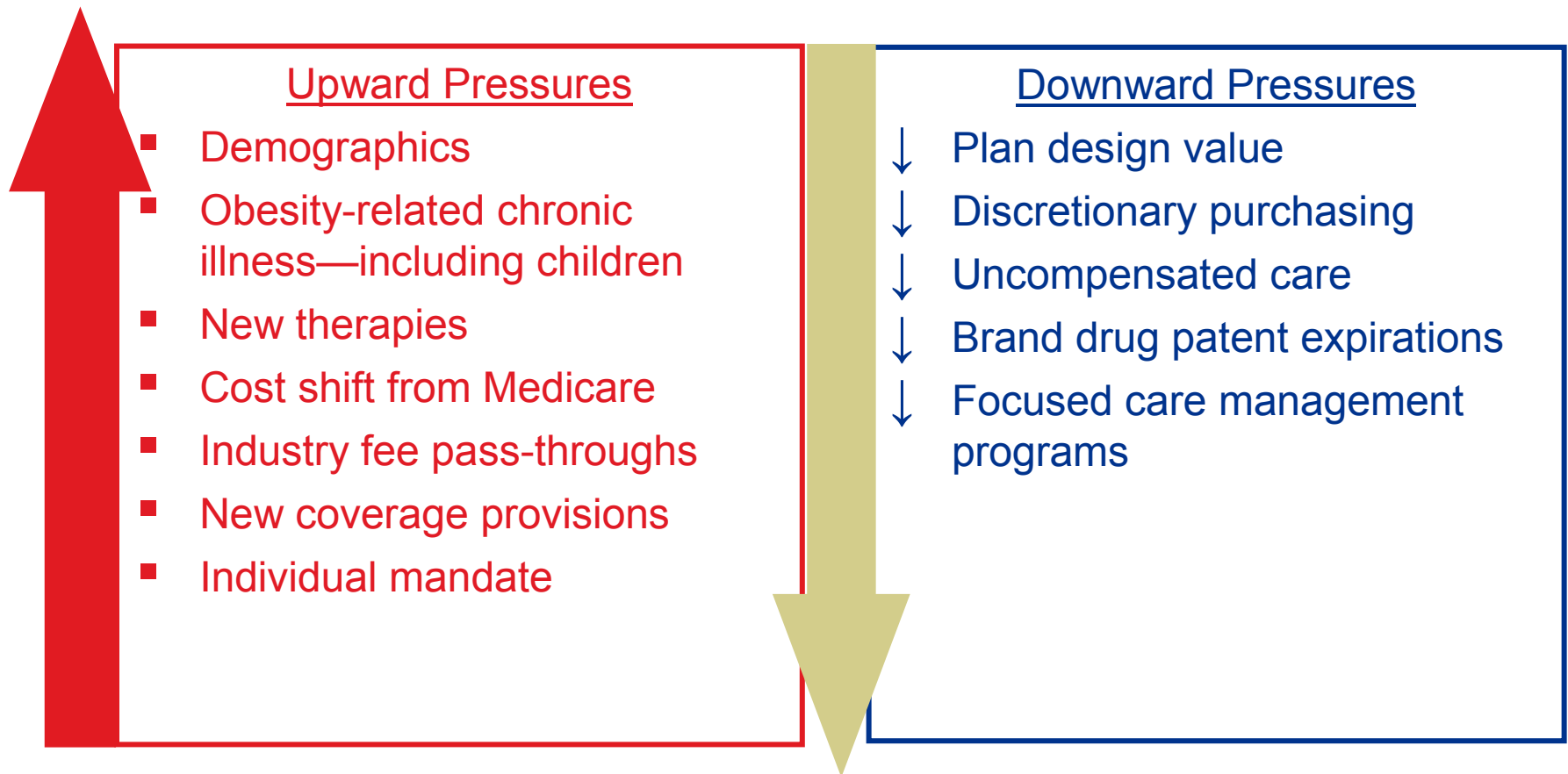


Five Realities by 2015

1. Employer health care cost will rise over 60% on a “stand still” basis; employer actions will mitigate this increase to 40%.
2. Very few, if any, large employers will exit health care benefits, but the market trend to move from DB to DC will have begun.
3. Plan designs will be leaner and meaner.
4. The explosion of technology-enabled information will (finally) trickle down to our world, but will not lower employer cost.
5. Employer-sponsored retiree medical benefits will cease to exist, except for collectively bargained and some grandfathered plans.

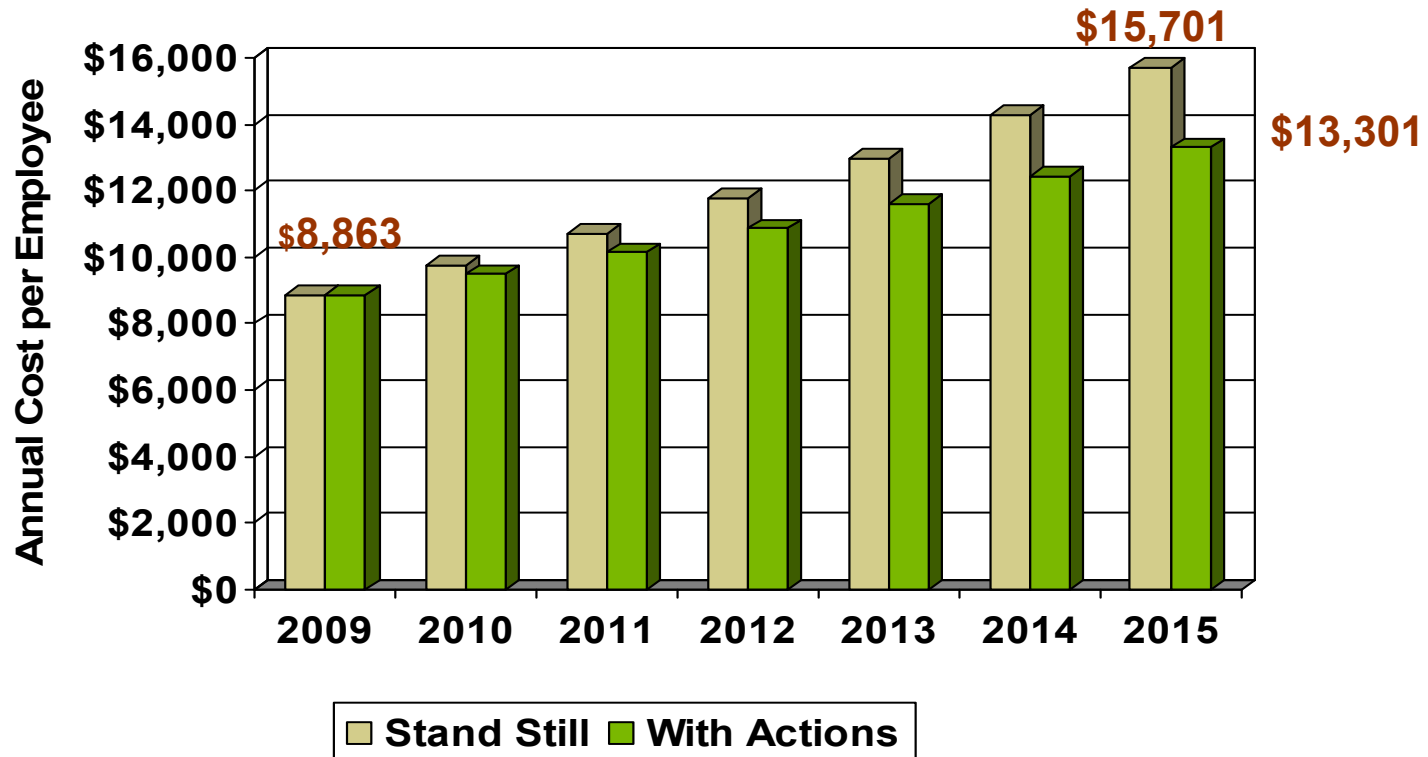
Employer costs will rise 60% on a “stand still” basis

Annual gross trend of 10% per year; net trend of 7% per year



Employer costs will rise 60% on a “stand still” basis

Annual gross trend of 10% per year; net trend of 7% per year



Even a 7% CAGR in unsustainable long-term; there needs to be a “new normal”

Very few large employer exits...

Getting Out—The Simplified Math

Total Health Care Premium		\$8,863
Employer Subsidy		<u>\$6,917</u>
Employee Contributions		\$1,946

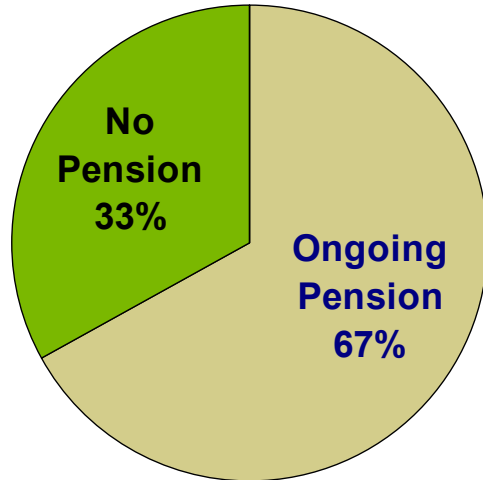
Free Rider Penalty (non-deductible)	\$2,000	
Loss of Deduction (40%)		<u>\$ 800</u>
Net Expense of Penalty		<u>\$2,800</u>
Employee Comp. Increase (50% of Subsidy)	\$3,458	
Tax Gross-up (30%)	<u>\$1,482</u>	
Total Comp. Expense		\$4,940
Total Employer Cost After Exit		<u>\$7,740</u>

Where are the Savings?

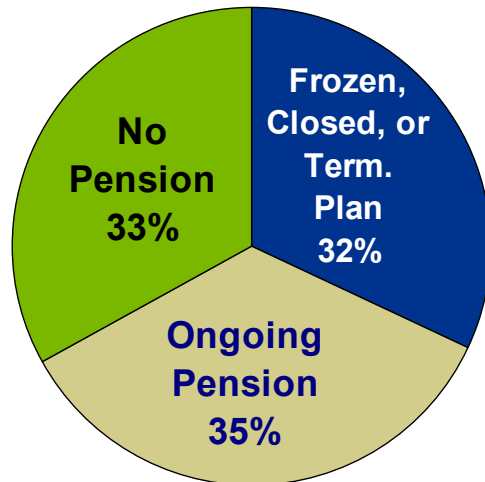
...but the DB to DC trend begins

Fortune 500 Pension Plan Prevalence (Common Group of Companies)

1996

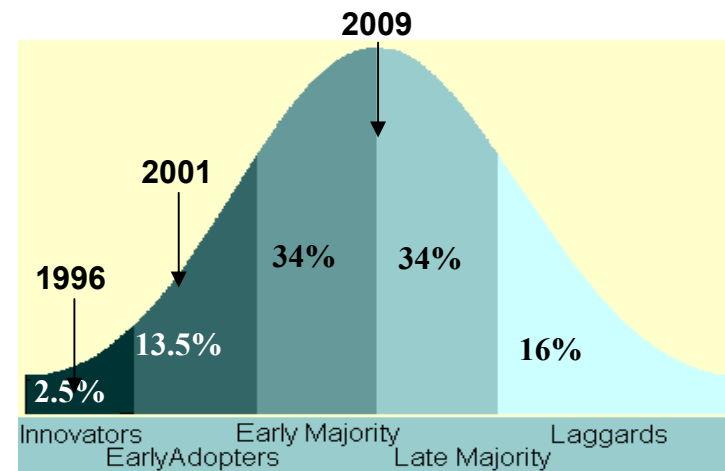


2009

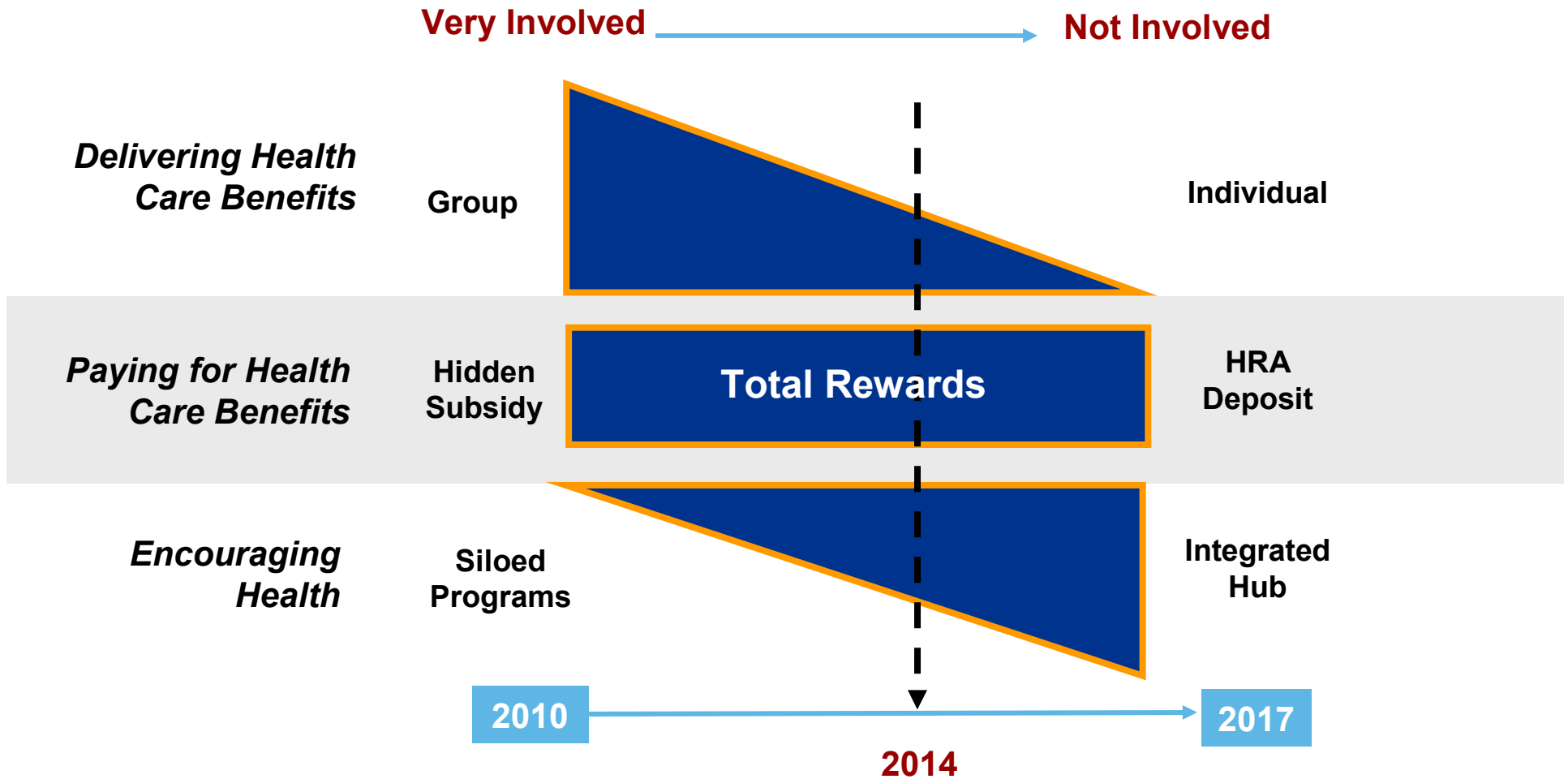


SOURCE: Hewitt Benefit SpecSelect, Rogers (1995)

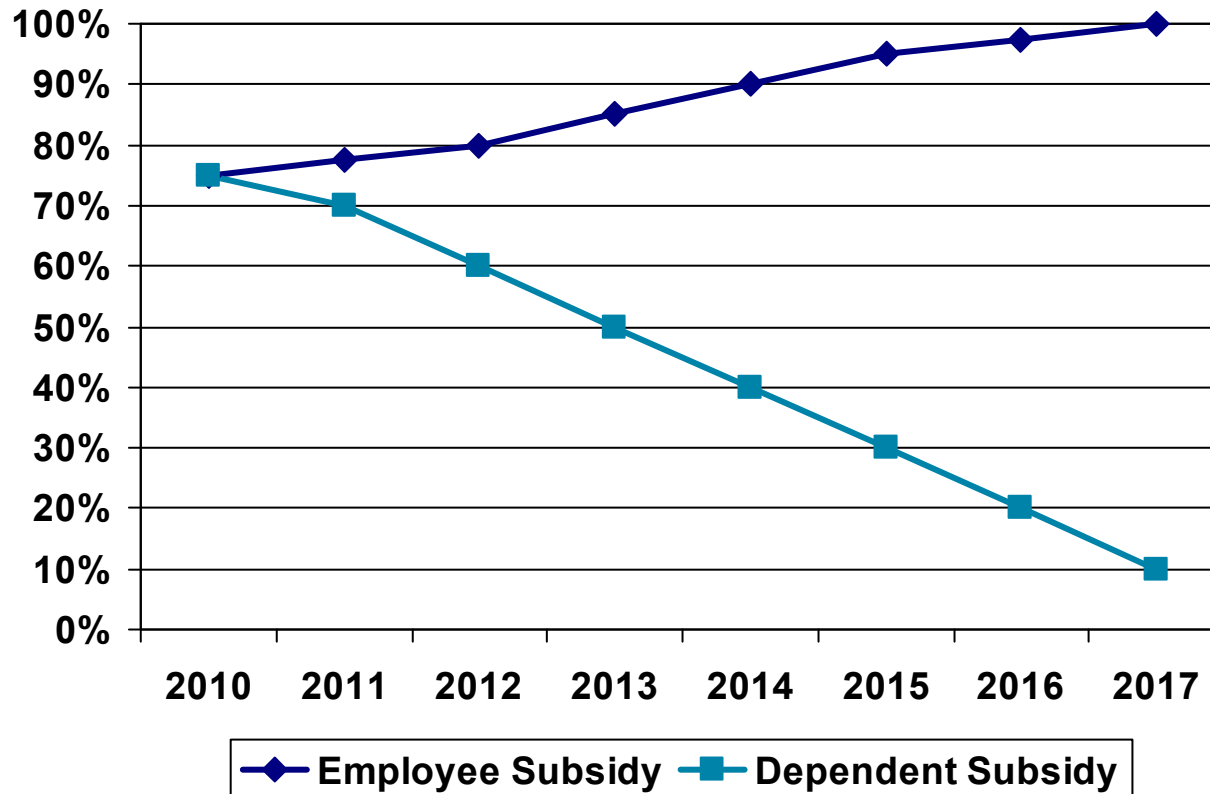
- Started with market mover (IBM)
- Driven by desire to reduce complexity, volatility, and annual cost increases
- Followed typical innovation curve
- Federal government didn't stand in the way; replacement alternatives existed
- Companies didn't seek to make employees whole



A potential solution—the Large Employer Exchange



Total Rewards structure allows for re-prioritization of commitments...

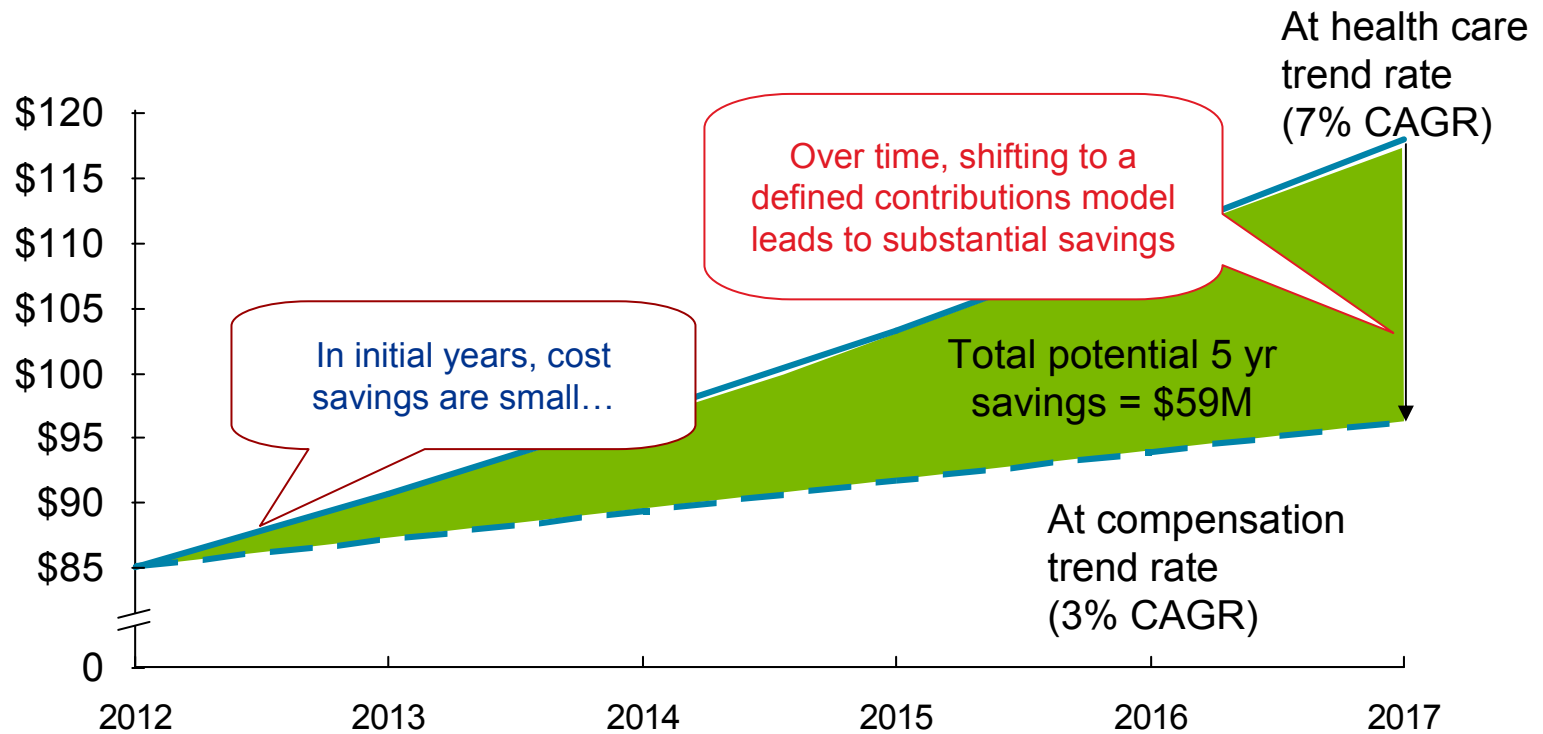


Focus on employees
(who drive company
performance)

Redirect dependent
subsidies to employee-
based programs

- Health improvement
- Productivity and absence management
- Retirement security
- Training and development
- Continuing education
- Time off with pay

...and allows employers to get off the health care trend curve in favor of a compensation-based rate of increase



Total estimated employer subsidy (current = \$7,000 PEPY), care costs and health for a typical employer with 10k lives at varying growth rates

Total shareholder value potential of \$315M at Yr 5 (2017)
Annual savings of \$21M at Yr 5 drops to bottom line
Equivalent to \$315M in shareholder value at PE of 15x

Plan Designs will be Leaner and Meaner ...

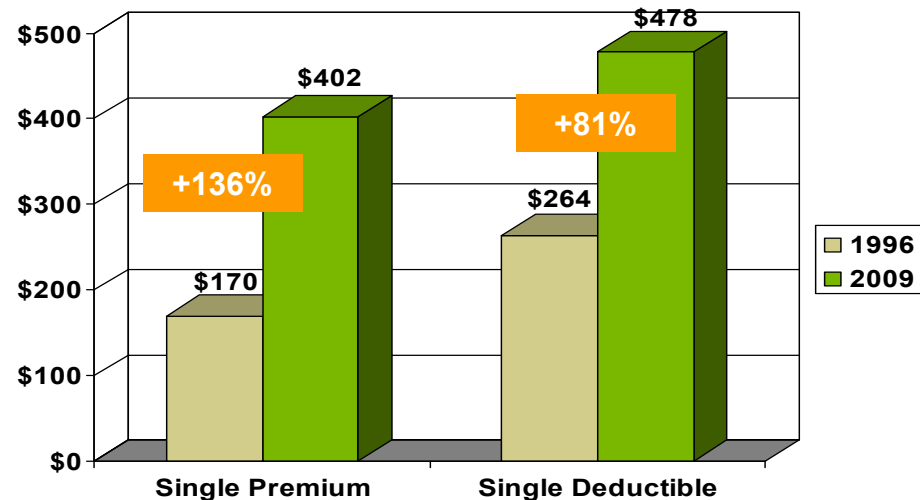
Leaner

- The era of the copay may be over; HMOs only in select markets
- Rational deductibles, coinsurance as the norm
- Greater CDHP acceptance and penetration
- Value-based incentive designs expand based on effectiveness

Source: Kaiser/HRET Annual Survey of Employer Health Benefits

Meaner

- From incentives to penalties
- More “gates” to access best coverage at lowest cost
 - Participation
 - Outcome



... and Choices Should be Meaningful

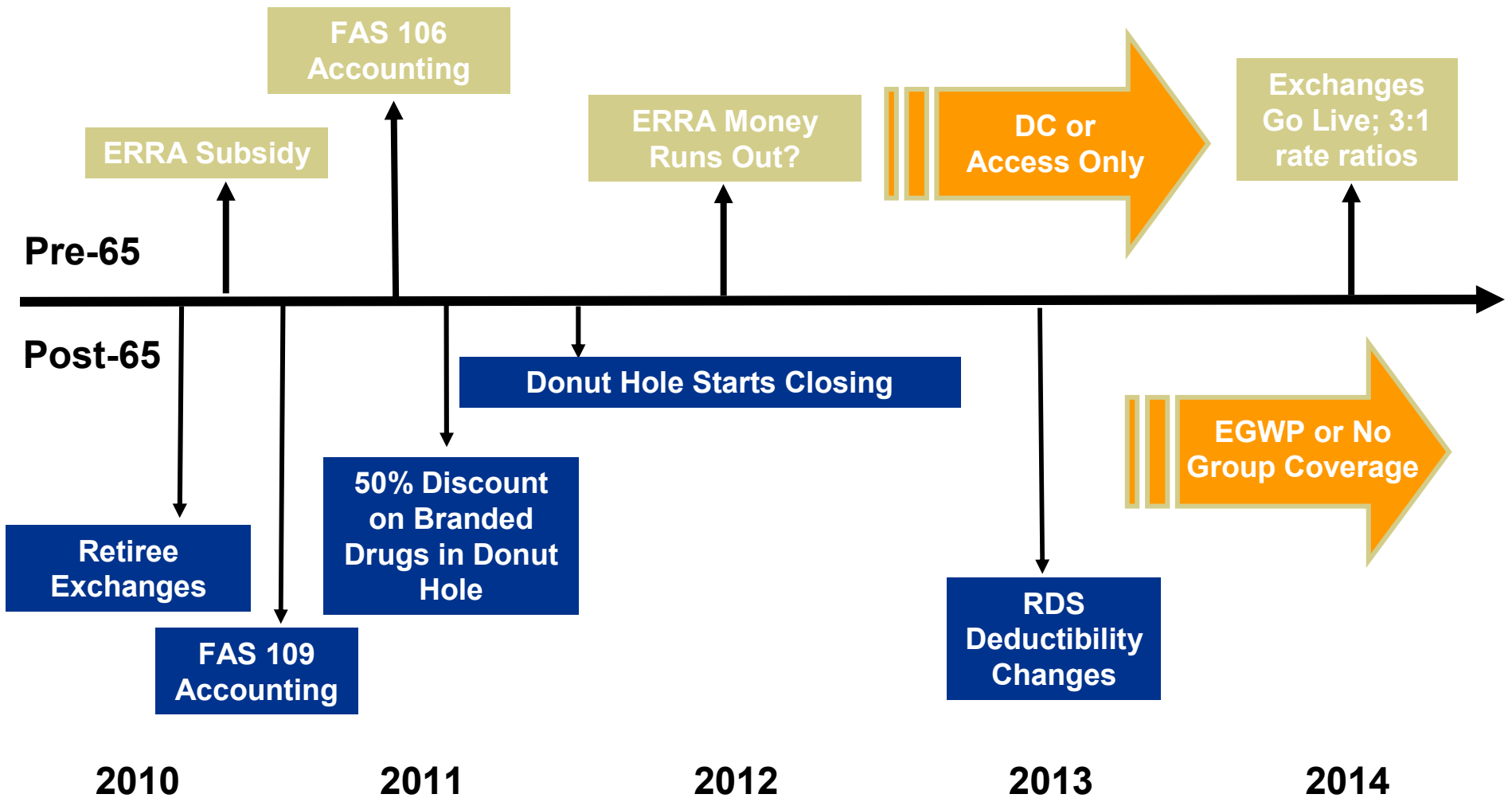
- Choice architecture is complex and needs to be guided by the needs of different segments of the employee population
 - Young and/or healthy employees may want to purchase the lowest cost plan to provide catastrophic protection
 - Yet, many catastrophic plans would cause a financial catastrophe for these enrollees if an unforeseen event occurred
 - Chronically ill members need a plan that provides affordable/budgetable coverage for their condition
 - They may cap out the benefit, but need to cap it out over time and not through a single event early in the year
 - Risk averse employees “need” a comprehensive plan (with an appropriate premium) to provide them the protection against unforeseen expenses or unexpected bills
 - These individuals are willing to pay a premium for peace of mind
 - High earners and Risk Takers/Evaluators may request a plan that helps them create and save through an HSA

Health IT will trickle down, but not lower cost

- Evidence of investments in health IT
 - Proliferation of electronic medical records
 - Better cost and quality transparency
 - Increased process efficiency and patient safety
 - Health content moves to mobile devices; point-of-care available
 - Internet-enabled care (e-visits, e-second opinion, e-imaging)
- Investments will be funded by government and providers
- Benefit will accrue to payors, providers, and to some extent patients
- Lack of competitive market means efficiencies will increase margin, not lower prices
 - Employers are unlikely to see the direct benefit



Employer-sponsored retiree medical will cease to exist



What Needs to Change



Ideas on Transformation

“I have no idea, how do we move one sixth of the U.S. economy?”

Providers:

- Held accountable for value and clinical effectiveness
- Transparency of outcomes, quality and cost information
- Must participate in CM/DM
- Interoperable platforms for HIT
- Eliminate system waste
- Accountability overall
- Increase the supply of providers and allow for interactions to be done by non-doctors
- Allow Pharmacists to prescribe some medications

Pharmacy:

- Move to cost plus models
- Stop development of highly expensive, limited improvement medications



Employers:

- Focus on population health vs. sickness
- Use plan design to reward participants and providers
- Leverage models like Cleveland Clinic
- Exit strategy

Consumers:

- People must make a premium contribution AND a health and wellness contribution
- Pay more for bad health behaviors

Care Delivery:

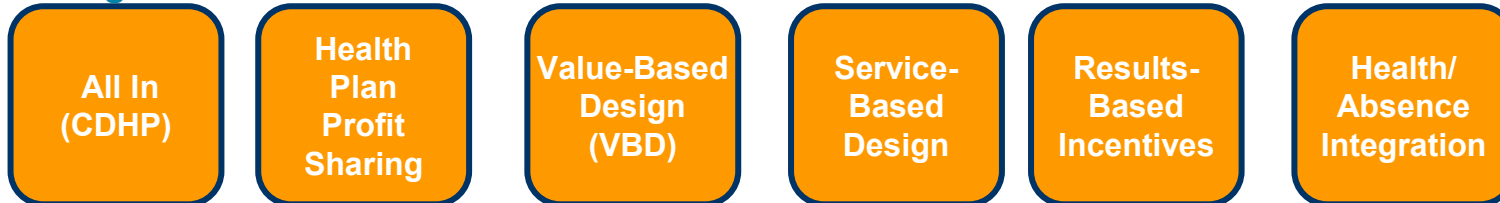
- Decentralize care, steer high volume procedures to lowest credentialed provider

Legal:

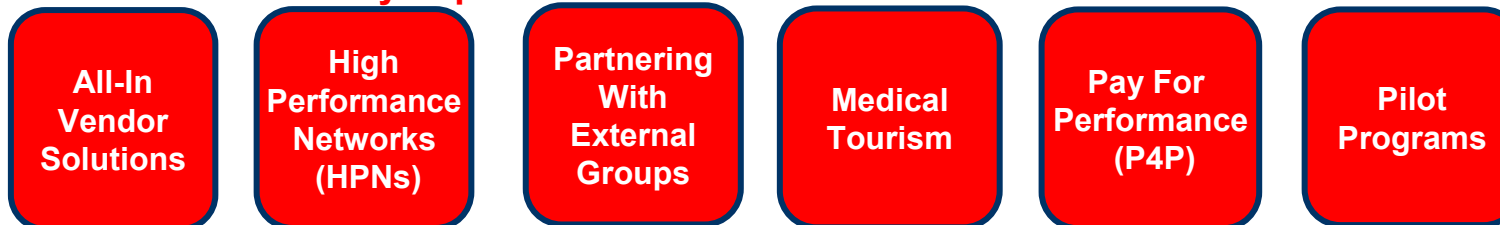
- Reform malpractice laws and cap damage awards

Potential Tactics to Adopt to Manage/Maintain Cost

Design



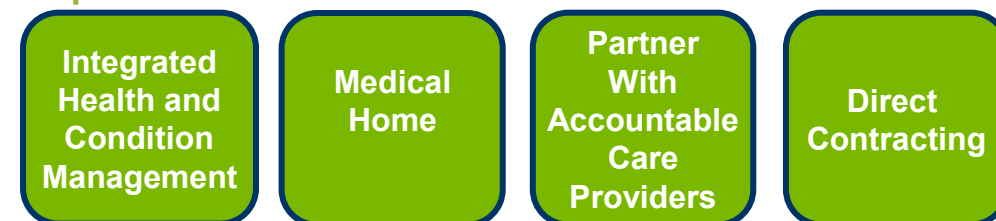
Reduce Unnecessary Expense



Engagement



Improved Health & Outcomes



Questions

Thank you for your time and attention.

For questions, please e-mail or call:

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