



May 13, 2010

Health Service System

Overview of Health Reform and preliminary discussion of the potential impact on the HSS

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- Understanding the cost impact and implications of Health Reform



Background

Overview

- Patient Protection and Affordable Care Act (PPACA) with amendments made by the Health Care and Education Reconciliation Act (HCERA) has now become law
 - The approved measure holds significant implications for employers, but is short on many details
- Goals of reform are embedded in the law's voluminous provisions
- Various government agencies must develop regulations, and this is likely to be a long and staggered process taking many years
 - With long implementation timeline and intervening election years, it's possible that modifying legislation could be passed before some PPACA provisions are effective

How Health Reform was presented to Congress

- Focused on the upside
 - Increase access for the uninsured
 - Expand Medicaid
 - Expand dependent eligibility
 - Eliminate barriers to coverage
 - Make the price more affordable through subsidies and tax credits
 - Make coverage easier to purchase through Exchanges
 - Wellness incentives
 - Preventive care
- Give a face to why things must change
- Eliminate or soften the more contentious elements
- Stay on point – don't address what's missing



Anthem. 

Avenues to pay for Health Reform

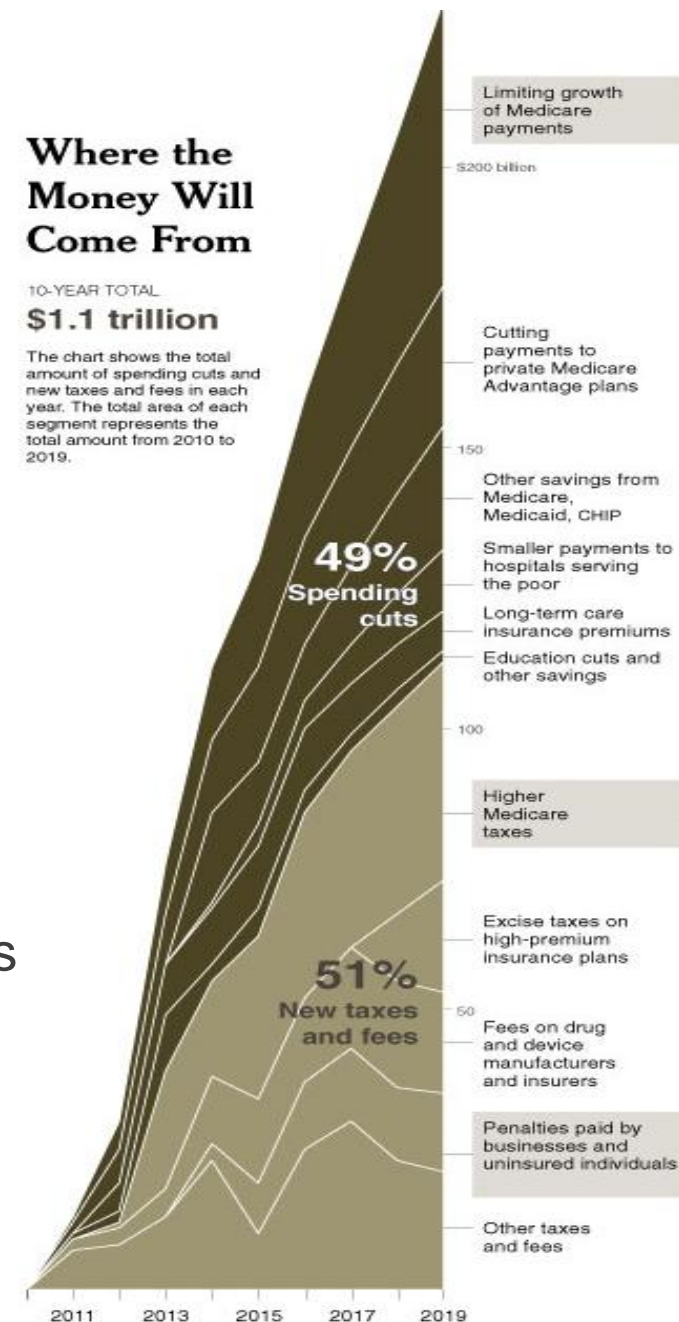
- Increase revenue through taxes and fees
 - Penalize people who don't buy coverage
 - Penalize employers
 - If they don't provide coverage
 - If coverage isn't affordable
 - If coverage costs too much
 - Increase taxes on upper income
 - Fees on employers, health plans, suppliers
 - Change tax treatment of Part D subsidy
- Reduce spending on Medicare Advantage plans
- Cut Medicare and Medicaid provider payments
- Implement stronger fraud and abuse controls
- Improve quality

Where the Money Will Come From

10-YEAR TOTAL

\$1.1 trillion

The chart shows the total amount of spending cuts and new taxes and fees in each year. The total area of each segment represents the total amount from 2010 to 2019.



What wasn't addressed in Health Reform

- Reform did not address major cost saving opportunities
 - Provider payment
 - Harmonization across payer programs
 - Tort reform
- May weaken some employer's commitment to providing benefits
- May increase some employer's interest in changing workforce strategy
- Risks to federal deficit
 - If savings assumptions are not realized
 - If Congress fails to cut Medicare payments
 - \$400 billion

Timeline for compliance

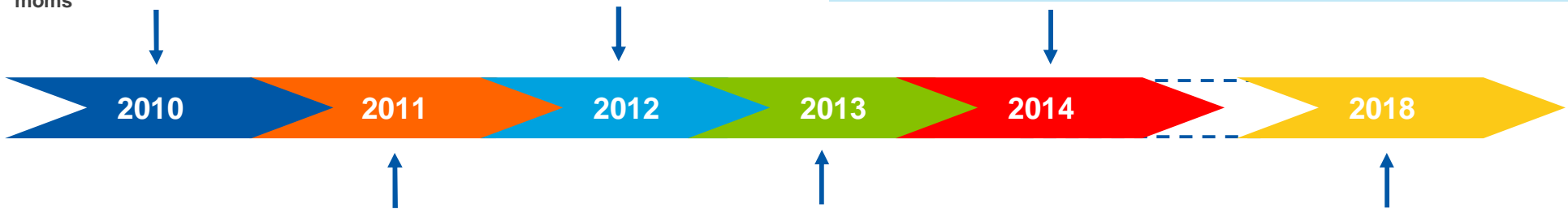
Key elements of health reform for employers

- 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 (TBD)
- Form W-2 reporting for 2011 health coverage

- Health insurance exchanges
- Individual coverage mandate
- Financial assistance for exchange coverage of low-income individuals
- Medicaid expansion
- New health plan regulations
- 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 (no other employer coverage available)**
- *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 Medicare tax on net investment income for taxpayers with incomes exceeding \$200,000/individual; \$250,000/couples
- Research fees begin
- 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). Collectively bargained plans may have a delayed effective date.*

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

The basics on health plan coverage and cost-sharing standards

- New health plan standards take effect in two phases
 - Plan years beginning on or after September 23, 2010
 - Plan years beginning on or after January 1, 2014
 - Special delayed effective date for certain collectively bargained plans
- New health plan standards apply to insured and self-insured medical plans, and likely to retiree medical plans, but not to separate dental and vision plans
- Some, but not all, standards apply to “grandfathered” plans that were in place before March 23, 2010
 - Important to determine how valuable grandfathering status is for a benefit plan or program



Understanding the cost impact and implications of Health Reform

Health care reform issues for employer-sponsored plans

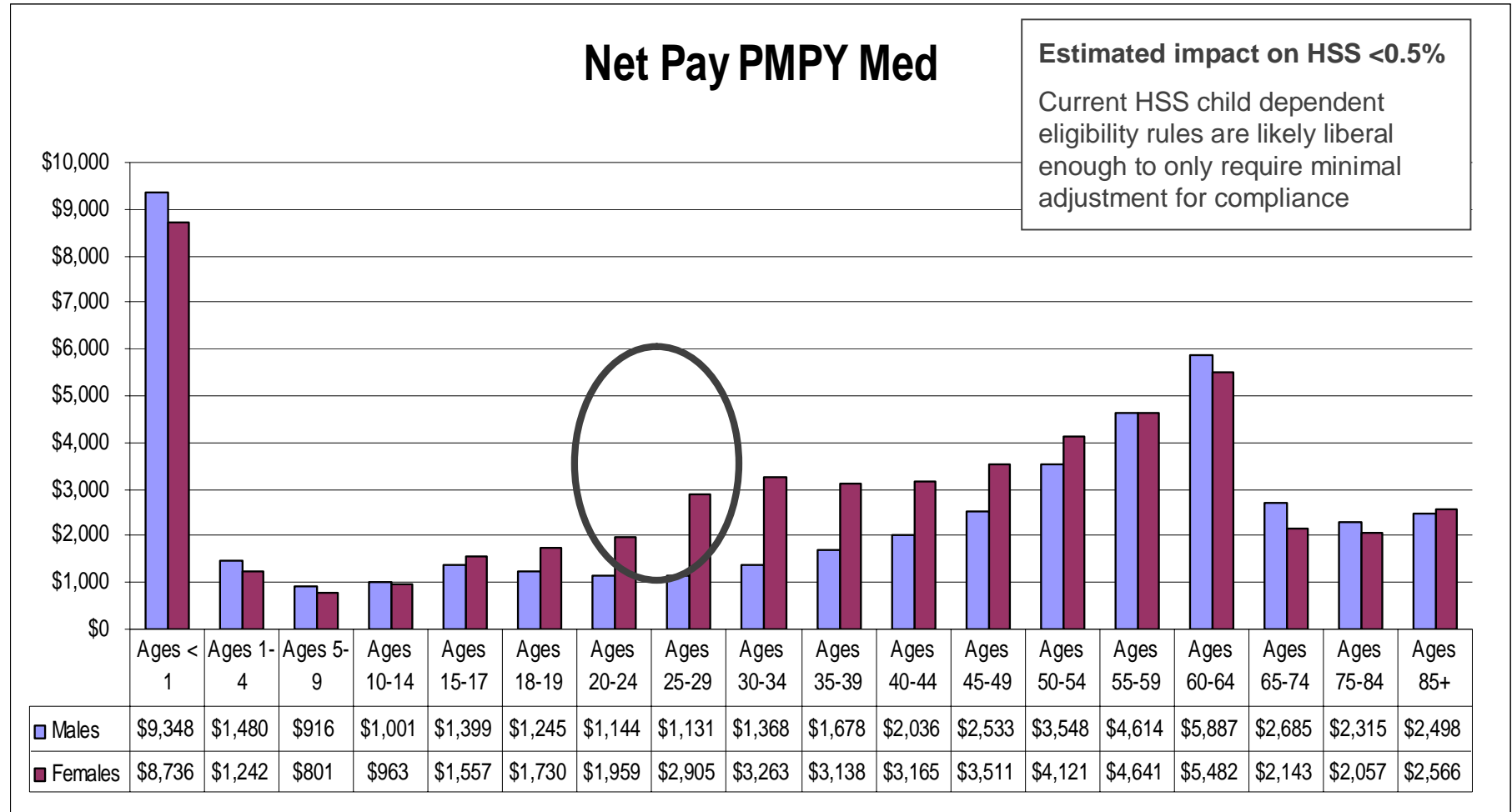
Beginning in 2010: July 1, 2011 for HSS

Issue	Patient Protection and Affordable Care Act, as amended
<p>Health plan standards – all plans Effective for plan years beginning on or after Sept. 23, 2010; delayed for certain collectively bargained plans*</p>	<p>Insured and self-insured plans</p> <ul style="list-style-type: none"> ■ Offer extended dependent coverage to age 26 for covered employee’s child (without access to other employer coverage) <ul style="list-style-type: none"> – Effective March 30, 2010, extend tax-free treatment for employer-provided health care to an employee’s child until the end of the year in which the child turns age 26 ■ Generally, no lifetime dollar limits ■ Restricted annual dollar limits on essential health benefits ■ No pre-existing condition exclusions for children under age 19 ■ No rescissions ■ All insured (but not self-insured) group health plans must meet minimum medical loss ratios <ul style="list-style-type: none"> – 85% if employer has more than 100 employees – 80% if employer has 100 or fewer employees

****“Collectively bargained coverage”** For health coverage under collective bargaining agreements (CBAs) ratified *before* March 23, 2010, PPACA’s coverage and cost-sharing mandates will apply on the termination date of the last CBA relating to the coverage. Any CBA amendment to comply with these new mandates will not be treated as terminating the CBA. Thus, while collectively bargained plans may get a postponement, they don’t have a permanent exemption from the new standards.

Increasing eligibility to age 26

1015 HSS dependents turn 25 in the next 12 months. HSS will save 2.2 million \$ in City and County premium costs (moving employees to EE only or EE1) over the next 12 months



Source: Thompson-Reuters Market Scan Q12009 data

Near-term impact to Medicare plans

- Medicare Advantage plan cuts will impact future premium rates and service areas
 - Law cuts \$136 billion in Medicare Advantage program by 2019
 - Current MA Plans paid 14% more than Medicare
 - Likely outcomes – less generous benefits, higher premiums or fewer plans
- Other changes will not directly impact HSS plans
 - Loss of employer tax deduction equal to Retiree Drug Subsidy payments from 2013
 - Part D “donut hole” begins to close
 - \$250 rebate to individuals reaching the coverage gap in 2010
 - Gradual closing of the coverage gap by 2020
 - Part D income based surcharges applies to beneficiaries from 2011

Early retiree reinsurance

- Temporary reinsurance program reimburses some early retiree costs
 - \$5 billion total government fund available (6/1/2010)
 - 80% of per-person claims between \$15,000 and \$90,000
 - HHS interim final regulations released last week
- Applications and claims processed in order received
- Sponsors must maintain their level of effort in supporting the plan
 - Use payments to defray sponsor's premium increases, increases in other health benefit costs; reduce participants' costs
 - Applications must explain how payments will be used to satisfy maintenance of effort requirements
- Plans must have procedures to save costs for high-cost conditions
 - Likely to generate \$15,000 per year for participant
 - Applications must explain the procedures/programs in place

Early retiree reinsurance

- Process similar to Retiree Drug Subsidy program under Medicare
- Incomplete applications will be denied
 - Sponsor will have to re-initiate process; go to the back of the line
- Claims incurred during current plan year but before 6/1/2010 will count towards \$15,000 threshold but not be reimbursable
- Getting payments will be process-heavy
 - Applications will require narrative text, representations and data
 - Payment requests will require documentation of actual costs
 - Sponsors will weigh projected payments against burden - efficiencies gained by lining up resources involved in Retiree Drug Subsidy activities

Time Period Reviewed (Data from respective Dashboards)	Number of Claims Exceeding \$50k	Average Size of Claims	Potential Reimbursements
12-months ending December 31, 2009	259	\$130k	\$15.5M+
12-months ending December 31, 2008	210	\$128k	\$12.6M+

Health care reform issues for employer-sponsored plans

Beginning in 2010: July 1, 2011 for HSS

Issue	Patient Protection and Affordable Care Act, as amended
<p>Health plan standards – new and nongrandfathered plans** Effective for plan years beginning on or after Sept. 23, 2010; delayed for certain collectively bargained plans*</p>	<p>Insured and self-insured plans</p> <ul style="list-style-type: none"> ■ Provide mandated preventive services with no cost-sharing ■ Establish and provide notice of internal and external appeals procedure ■ Emergency services coverage <ul style="list-style-type: none"> – Cannot be limited to in-network providers – Include higher cost-sharing for out-of-network providers – Cannot require preauthorization ■ Plans requiring or providing for primary care physician designation <ul style="list-style-type: none"> – Must allow designation of any participating primary care physician or pediatrician – May not require preauthorization or referral for OB/GYN services ■ Insured plans cannot discriminate in favor of highly compensated individuals (significant implications for insured executive medical plans)

****"Grandfathered plans"** A grandfathered plan is one in place *before* March 23, 2010. The law doesn't say how a plan's grandfathered protection can terminate or be lost. The PPACA does permit a grandfathered plan to enroll new hires and their family members, as well as the family members of any employee covered before March 23, without affecting its status. However, the law doesn't say whether a plan can enroll employees who weren't covered before March 23 or make cost-sharing, benefit or other changes – including PPACA-required changes – without losing grandfathered status. Just how long a plan will enjoy grandfathered status will be difficult to know until regulatory guidance is issued.

Health care reform issues for employer-sponsored plans

Effective date is unclear

Issue	Patient Protection and Affordable Care Act, as amended
<p>Auto-enrollment requirement for employers with more than 200 full-time employees Effective date is unclear</p>	<ul style="list-style-type: none">■ Unclear when it applies; may be effective<ul style="list-style-type: none">– March 23, 2010– Once Department of Labor issues regulations– 2013 or 2014■ Must automatically enroll new full-time employees in employer-sponsored plan■ Must automatically continue plan enrollment for current employees■ Required notice and opt-out opportunity
<p>60-day advance notice of plan design changes Effective date is unclear</p>	<ul style="list-style-type: none">■ Unclear when it applies; may be effective<ul style="list-style-type: none">– Plan years starting on or after March 23, 2010– Plan years beginning on or after March 23, 2012■ Must give 60-days prior notice before any material modifications can be made to the plan

Preview of health plan standards for 2014

- All insured and self-insured plans
 - Offer coverage to dependent children to age 26 (regardless of access to other employer coverage)
 - No preexisting condition exclusions
 - No waiting periods over 90 days
 - No annual dollar limits
- New and non-grandfathered insured and self-insured plans
 - Cost-sharing limited to high deductible plan limits (out-of-pocket limits and, possibly, deductibles)
 - Mandated coverage of routine patient costs in connection with clinical trial participation
 - Provider nondiscrimination

Health care reform issues for employer-sponsored plans

Some reforms beginning in 2014

Issue	Patient Protection and Affordable Care Act, as amended
Employer shared responsibility penalties	<ul style="list-style-type: none"> ■ Employers with 50 or more full-time equivalent employees may be subject to shared responsibility penalties if at least one full-time* employee obtains exchange-based coverage and is eligible for financial assistance to better afford it
Employers <i>offering</i> coverage to full-time* employees and their dependents	<ul style="list-style-type: none"> ■ Subject to penalties if either <ul style="list-style-type: none"> – The plan’s share of total allowed benefit costs is less than 60%, or – An employee’s contribution represents more than 9.5% of household income ■ Penalty is the lesser of: (1) up to \$3,000 for each full-time employee eligible for income-based assistance, or (2) up to \$2,000 for every full-time employee (minus the first thirty)
Employers <i>not offering</i> coverage to full-time* employees and their dependents	<ul style="list-style-type: none"> ■ Subject to penalty of up to \$2,000 for each full-time employee (minus the first thirty)
No penalties for certain employees	<ul style="list-style-type: none"> ■ No penalties for employees enrolled in Medicaid or receiving free choice vouchers

*Full-time employee is one who works, with respect to any month, an average of at least 30 hours a week

Health care reform issues for employer-sponsored plans

Some reforms beginning in 2014

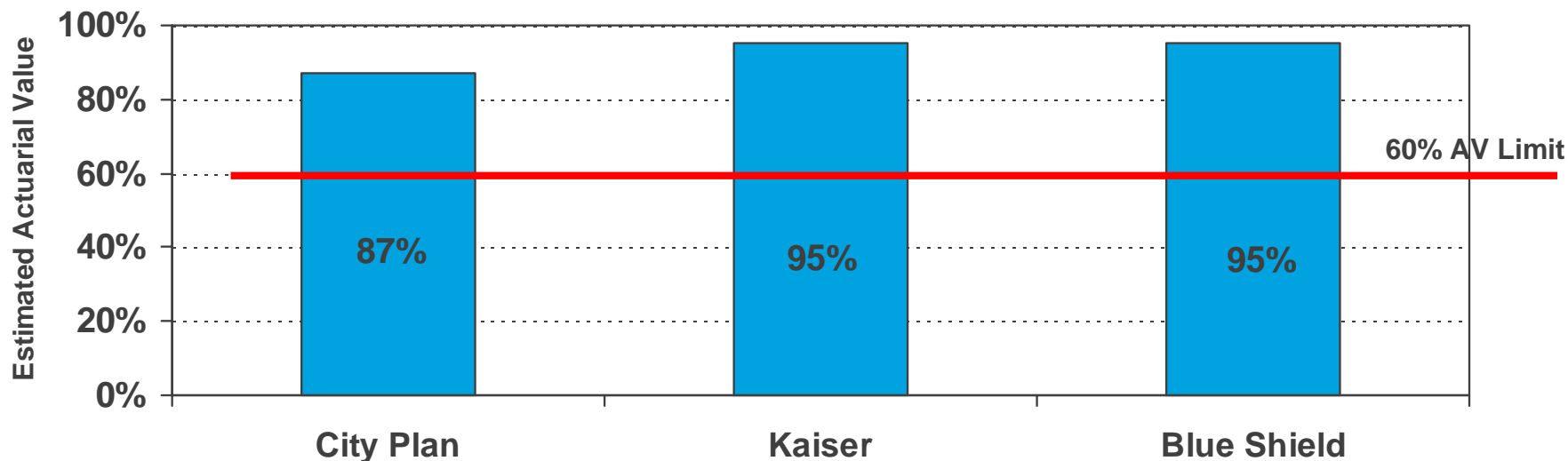
Issue	Patient Protection and Affordable Care Act, as amended
Employee free choice vouchers	<ul style="list-style-type: none">■ Any employer offering health coverage and making plan contributions must provide “free choice vouchers” to eligible employees
Eligible employees	<ul style="list-style-type: none">■ Any employee - whether full- or part-time – offered employer coverage and who<ul style="list-style-type: none">– opts out of the employer coverage,– has household income at or below 400% of federal poverty level,– faces a required contribution representing 8%-9.8% of household income,– buys coverage through a health insurance exchange
Voucher payments	<ul style="list-style-type: none">■ Amount will equal what employer’s cost would have been had employee enrolled in option with largest employer-paid share of the contribution■ Amount will vary on whether employee buys individual or family coverage on an exchange.■ Employer to pay exchange for the cost of the employee’s coverage, and to pay any excess to the employee■ Voucher payments will be deductible by employers

Red flags: Areas that could lead to increased cost for HSS

Specific Circumstances	Situation for HSS
<p>What percent of employees are not participating in the plan?</p> <ul style="list-style-type: none"> ▪ The contributions may not be affordable ▪ They may have access to another employer's plan 	<p>Approximately 1,400 (4%) employees currently waive coverage. Given the current contribution structure (c.f. the "Single employee pick-up"), the majority are unlikely to be single and are likely to be enrolled in partner's health plan.</p>
<p>What percent of employees are not covering their dependents?</p> <ul style="list-style-type: none"> ▪ The contributions may be unaffordable 	<p>56% are enrolled in Single+Dependent or Family tiers. This is not an unusually low percentage.</p> <p><i>If the individual mandate prompts a proportionally greater non-Single tier enrollment this could lead to increased costs to the employers. For example, a 10% increase in # of employees covering dependents would increase CCSF costs by an estimated 3%</i></p>
<p>What percent of employees are considered low income?</p> <ul style="list-style-type: none"> ▪ Their current contributions may exceed 9.5% of their household income 	<p>TBD</p> <p>Data collected for latest GASB analysis may provide necessary data for analysis</p>

All of the HSS plans exceed the required 60% “actuarial value” limit

Estimated Actuarial Values: 2010/11 Plan Designs



- “Actuarial Value” represents an estimate of the average cost sharing between the plan and associated enrollees. For example
 - The estimated actuarial value for the City plan in the 2010/11 plan year is 87%
 - On average, therefore, the City Plan meets 87% of all claims costs and the member meets 13% of the claims cost via deductibles/coinsurance/copays

What percent of the workforce is eligible for Medicaid or a voucher?

Family Size	Federal Poverty Level	Eligible for Medicaid (133% FPL)	Eligible for Exchange (400% FPL)
Single	\$10,836	\$14,412	\$ 43,344
Family of 2	\$14,580	\$19,391	\$ 58,320
Family of 3	\$18,312	\$24,355	\$ 73,248
Family of 4	\$22,056	\$29,334	\$ 88,224
Family of 5	\$25,800	\$34,314	\$ 103,200
Family of 6	\$29,532	\$39,278	\$ 118,128
Family of 7	\$33,276	\$44,257	\$ 133,104
Family of 8	\$37,020	\$49,237	\$ 148,080

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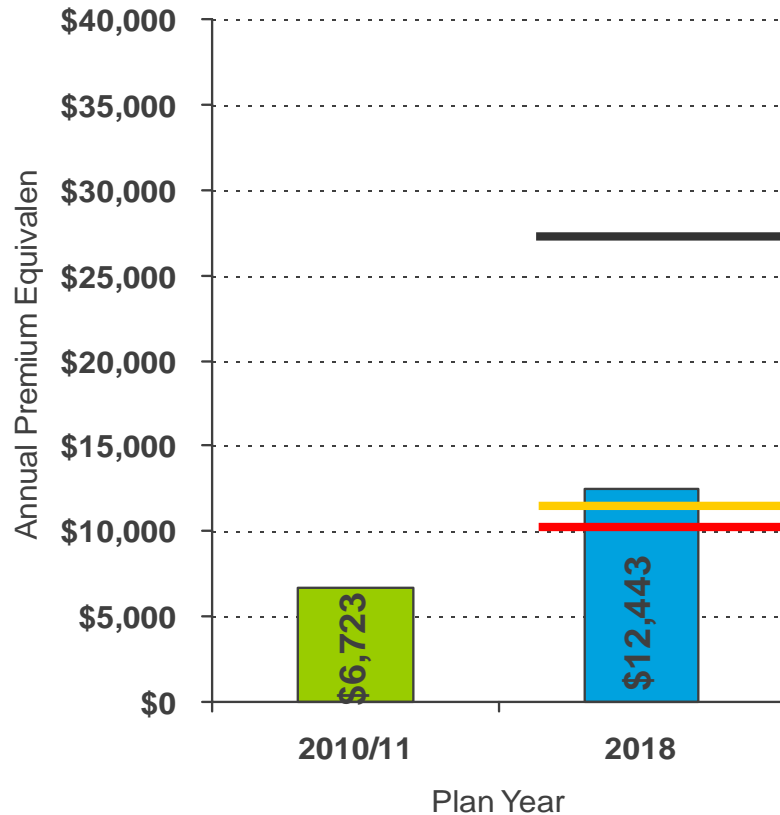
Some reforms beginning in 2018

Issue	Patient Protection and Affordable Care Act, as amended																	
<p>40% excise tax on “high cost” employer coverage</p>	<ul style="list-style-type: none"> 40% excise tax on “high cost” coverage, including medical, employee and employer health FSA contributions, onsite medical clinics, and employer (but not employee) contributions to HSAs (but not insured stand-alone dental and vision coverage) <table border="1" data-bbox="465 586 1800 1189"> <thead> <tr> <th data-bbox="465 586 768 696"></th> <th colspan="2" data-bbox="772 586 1800 696"> Thresholds for excise tax (Indexed to CPI + 1% in 2019, CPI thereafter) </th> </tr> <tr> <th data-bbox="465 698 768 758"></th> <th data-bbox="772 698 1288 758">Self-only</th> <th data-bbox="1292 698 1800 758">Any other tier</th> </tr> </thead> <tbody> <tr> <td data-bbox="465 759 768 819">General</td> <td data-bbox="772 759 1288 819">\$ 10,200</td> <td data-bbox="1292 759 1800 819">\$ 27, 500</td> </tr> <tr> <td data-bbox="465 821 768 931">High-risk professions</td> <td colspan="2" data-bbox="772 821 1800 931" rowspan="2">\$ 11,850</td> </tr> <tr> <td data-bbox="465 932 768 1082">Retiree aged 55 through 64</td> </tr> <tr> <td data-bbox="465 1083 768 1189">Multiemployer plan</td> <td data-bbox="772 1083 1288 1189">\$ 27,500</td> <td data-bbox="1292 1083 1800 1189">\$ 27,500</td> </tr> </tbody> </table> <ul style="list-style-type: none"> Employers to determine aggregate cost, report to responsible entities 			Thresholds for excise tax (Indexed to CPI + 1% in 2019, CPI thereafter)			Self-only	Any other tier	General	\$ 10,200	\$ 27, 500	High-risk professions	\$ 11,850		Retiree aged 55 through 64	Multiemployer plan	\$ 27,500	\$ 27,500
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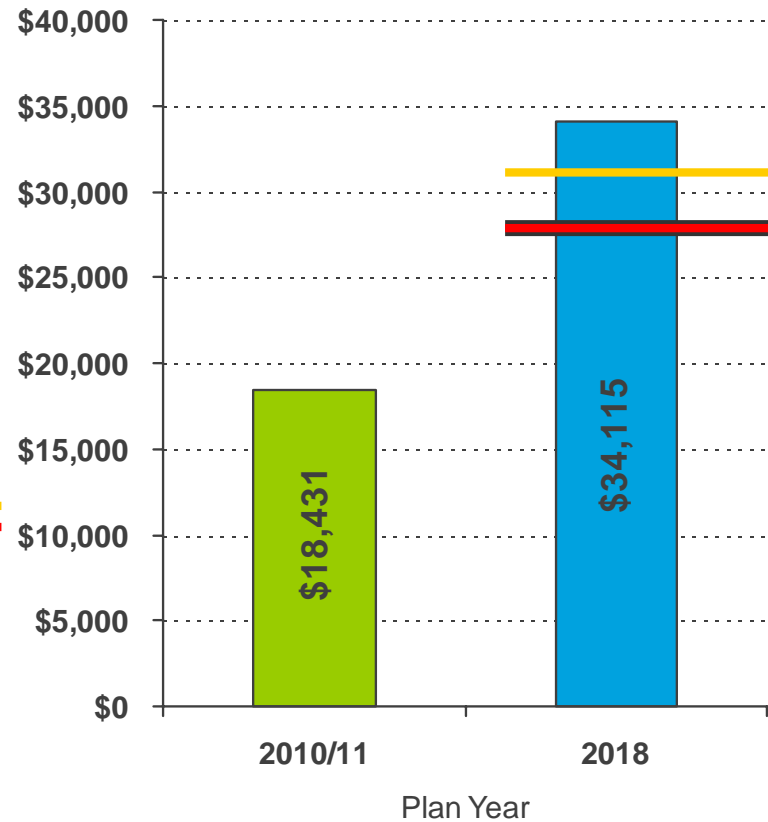
Health care reform issues for employer-sponsored plans

Illustration of how the excise tax penalty will work

Single Coverage



Family Coverage



— General Limit \$10,200/\$27,500
 — High Risk Profession Limit \$11,850/\$30,950
 — Multiemployer Limit \$27,500/\$27,500

Health care reform issues for employer-sponsored plans

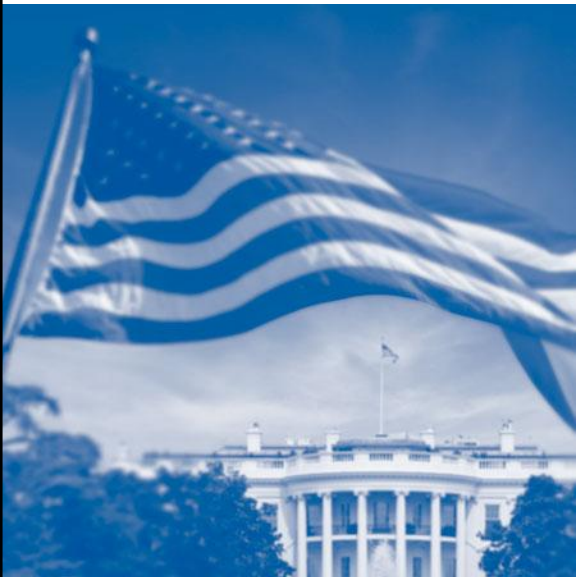
Illustration of how the excise tax penalty will work

	Employees	Under 65 Retirees	Over 65 Retirees	Total
Projected Costs in Excess of Limits	\$76M - \$114M	\$79M	\$0M	\$155M - \$193M
Estimated Excise Tax @40%	\$31M - \$46M	\$32M	\$0M	\$63M - \$78M
Projected Gross HSS Plan Costs	\$600M	\$161M	\$149M	\$910M
Excise Tax as a % of Plan Costs	5% - 8%	20%	0%	7% - 9%

- The excise tax calculation is very sensitive to the assumptions used to project costs
- Assumptions impacting the calculation include:
 - Projection trends: Medical 8%, Dental 6%
 - No material plan changes in the interim
 - Static program enrollment profile

Potential future implications on employer sponsored health care?

- What will be the extent/impact of the potential cost shifting on employer plans? Driven by
 - Government sponsored programs
 - Uncompensated care until individual market becomes viable
 - Insufficient rates for individual and small group coverage
- Will we see employers dropping 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
- Will insurers pull out of states that do not approve their rate requests?
 - If so, it opens the door for a public option
 - Or, will they develop more cost effective solutions to meet a targeted cost?



Appendix

Health care reform issues for employer-sponsored plans

Some additional reforms

Issue	Patient Protection and Affordable Care Act, as amended
Form W-2 reporting	<ul style="list-style-type: none"> ■ Employers must include the aggregate cost of an employee’s health coverage ■ “Aggregate cost” to be determined using methodology similar to that for determining COBRA premiums (excluding pre-tax health FSA contributions, employee HSA contributions) ■ 2011 actions will include valuation of aggregate cost to be reported on employee W-2 Forms issued in early 2012
No reimbursement for non-prescribed over-the-counter drugs (2011)	<ul style="list-style-type: none"> ■ No reimbursement for non-prescribed over-the-counter drugs from a health plan, health flexible spending account, health reimbursement arrangement, or health savings account <ul style="list-style-type: none"> – Reimbursements limited to physician-prescribed drugs and insulin
Health industry fees	<ul style="list-style-type: none"> ■ Pharmaceutical manufacturers and importers (2011) ■ Durable medical equipment (2013) ■ Health insurers (2014)
Health FSA contribution cap (2013)	<ul style="list-style-type: none"> ■ Annual contributions to health flexible spending accounts limited to \$2,500

New industry fees that impact plan cost

Fees	Initial year	Comments
Pharmaceutical manufacturer fee	2011	\$2.8 B (2012) to \$4.1 B (2018)
Medical device manufacturer fee	2013	2.9% of sales
Patient-centered outcomes research fee paid by employer	2013	\$1.00/employee (2012) to \$2.00/employee
Insurance industry fee	2014	\$8.0 B (2014) to \$14.3 B (2018)

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