

Post-Game Summary of the Healthcare Reform Bill

**Presenter: Ken Ambos
Senior Managing Director, Employee Benefits
Equity Risk Partners
May 11, 2010**

Ken Ambos: Dr. Obama tells us our agenda for today will be, first, to look at a timeline of target effective dates for the various components of the reform bill as it is now documented. We will take a quick look at that and then move on to a review on a more deep dive basis of the key elements contained therein, again with a focus on those provisions that employers should care most about. Finally, we will look at some of the potential challenges ahead in the process of the reform regulations going into practice.

From a timeline standpoint, you will note that 2010, 2011, 2013, 2014, and 2018 are the critical years coming up during the decade ahead in which the majority of the reform regulations are slated to take place. 2010, 2011, and 2013 have a moderate number of provisions with varying degrees of severity kicking in, but we've highlighted 2014 in red as the mother of all reform years and when most of the heavy duty stuff starts to come into play. Slated to begin in 2018 is one of the final components - a "Cadillac" plan tax that we will talk more about later.

Before we get into the next section on the details of a number of these provisions, I will ask you to recognize that there is a grandfathering provision in the reform regulations for health plans that existed before the bill was promulgated. It is still relatively ill-defined as to whether those grandfathered plans have to comply with all, some, or none of these provisions; I'll do my best to key in on the ones that we're pretty sure are applicable to all plans

regardless of grandfather status, but there are quite a few that it's just not clearly defined as yet.

Let's move on to our first year, 2010. As we speak, there are some immediately effective provisions in the healthcare regulations that are now to be complied with. First off, for small businesses, which the law defines as those groups with less than 25 employees with an average wage of less than \$50,000 per year, a tax credit of up to 35 percent of the employer's group health plan spend is available provided the employer picks up at least half of the health plan premiums. Our friend with the interesting eyewear indicates that another immediate provision in the law is a new 10 percent tax on indoor tanning services. This is the first revenue-producing, tax-based funding element that the bill brings to bear to start paying for some of the reform obligations; though by most rational accounts, the amount of revenue associated with this has been vastly overestimated. We will see...

Later in 2010, the next set of provisions comes into effect, and they are slated to begin six months after the date the bill was signed, which was March 23. These provisions are then applicable as of the first plan year beginning after September 23, 2010. For example, if you're on a calendar year anniversary date for your health program, January 1, 2011 is when these provisions would be required to take effect in your program.

First, there's a coverage extension to dependents up to age 26. This access to extended coverage is available to the extent that dependents are not able to avail themselves of coverage through another group source, e.g., if the child is covered by or has access to coverage from their own employer, they can't be covered under their parents' plan. If they are living at home playing "Wii," then they can be added to the parents' program. In the last couple of weeks, media attention has been focused on both the initial pressure from the Secretary of Health and Human Services and the response from the insurance industry to make this provision available immediately. For the most part, the industry has complied and is offering that option to each employer group plan sponsor to make this extension immediately available. What is not clear is whether that coverage extension would be retro-available to people who weren't extended previously, or just to those reaching an age limit post the

date that this change is made. That's one of the elements that will be clarified in the weeks ahead.

The next provision is the prohibition of pre-existing condition exclusions and limitations for dependent children less than age 19. We will revisit this as we move forward to 2014, when it expands to a permanent and completely excluded option across the board regardless of age.

Another provision for 2010 will be that lifetime maximums on what the law defines as “essential benefits” will be prohibited, though it didn't really define essential benefits. I think it's safe to say that what they're referring to are overall benefit plan maximums, and for major categories such as hospitalization, surgery, or mental/nervous type conditions, that any kind of lifetime maximum for these categories would be disallowed.

Moving on to 2011, the first item we will address here is really more of an insurance industry regulation change, but it has clear implications for employer plan sponsors who pay the premiums. Carriers will be held accountable for adhering to at least the loss ratios identified here, meaning that they will need to be, for individual and small group plans, spending at minimum 80 cents on the dollar for payment of claims, and for larger groups – defined as 100 employees or more – 85 cents on the dollar at minimum would need to be allocated toward claim expense. Thus, only 15 percent or less is allowable or allocable to operating the program from an administrative and margin profitability standpoint.

The regulations are broadly defined to require that insurers refund surpluses to plan enrollees in the event the loss ratio is below the target levels. How will that actually be done? Your guess is as good as mine. We'll see how that plays out. In all likelihood, this is going to work on an insurer's-book-of-business-wide basis versus a client-specific or a policy-specific loss ratio basis. To illustrate, 100-employee groups can have wild swings in loss ratio outcomes year-to-year, so it would be impractical for a carrier to administer such a thing. In the event that any given carrier's pool was in excess of the profit thresholds defined here, it is unclear whether the return of those surpluses would go directly to the enrollees or through their employer

sponsor. Again, it seems impractical to suggest that individual checks of what I would imagine to be relatively small amounts would be going out to individual plan participants.

One last item relative to the medical loss ratio issue - there is already some jockeying going on between the regulators and the insurance industry about what constitutes "claims" vs. "health-related expenses" in determining this ratio. The insurance industry is making the case that expenses they incur toward improving the health of individuals covered under their plans should count toward the larger number and not the smaller - e.g., investment in wellness programs or the like not landing on the expense side but the claims side of the equation. That's another bump in the road to overcome, but I think you can see the argument on either side of that debate, and it'll be interesting to see how it plays out.

Another 2011 element that will come to bear is that employers will need to start reporting on the W-2s the value of the health plans provided to employees. We note that the COBRA rates or the billable monthly rates for your plan annualized are likely to be an acceptable proxy for that calculation. Self-insured employers have a bit more work to do to comply and figure out exactly how they're going to post that, but again, COBRA rates might be the shortcut way to get it done. The reason this is being done is presumably a precursor to the "Cadillac" tax reporting we'll touch on a little bit later, where plan values in excess of certain thresholds are going to get socked with an add-on tax. So this is a mechanism to start getting people ready for the prospect of that tax filtering through.

2011 also brings a change to Flexible Spending Accounts and Health Reimbursement Arrangements, which are typically considered part of the "consumer-directed healthcare" movement. Over-the-counter medications will no longer be eligible for reimbursement under these programs. It's another revenue-producing provision, an avenue for the government to help fund some of the expanded access that reform is putting into play, but on a practical level we would expect this to have a notable negative impact skewing on enrollment in FSAs. As that will drive lower pre-tax contributions, employer payroll taxes will proportionately rise as a function.

On a semi-related note, the tax penalty for non-qualified disbursements from Health Savings Accounts, the most prevalent consumer-directed health plan vehicle out there, will be increasing. At present, the regulations related to HSAs require a 10 percent excise tax on use of those deferred funds for non-qualified purposes. In 2011, that number will double to a 20 percent penalty. Again, a revenue source for the funding needed to finance the expansion of healthcare access, but the partisan nature of this provision is hard to miss to the extent that HSAs came to life during a staunchly Republican administration, and it's being painted here as largely a construct for wealthy people to dodge taxes. It was unsurprising that the Democratic-led movement to reform healthcare would contain a provision like this that might minimize or slow the growth of HSA programs to a certain extent.

Moving on to 2013, for you "Atlas Shrugged" fans out there, higher earners will be subjected to a significant increase in their taxation relative to Medicare. A good chunk of these dollars is going to be rerouted from Medicare to help fund healthcare reform elements. Just to put it in perspective, aside from the Medicare funding cuts themselves, and certain healthcare-related industry taxes and rebates from industries like pharmaceuticals, health device manufacturers, and even the health insurers themselves, this Medicare tax increase is amongst the primary sources of funding for reform. You can do the math to see what the potential implication is at your individual organizations, but do note that there are some accounting, HR, admin, and payroll gymnastics to do to take account of these changes, particularly as it applies to recognizing its tax on unearned income, such things as dividends, and other stock option recognition-related elements. There's some complication that needs to be dealt with in that regard.

Another 2013 element coming to bear, another chip away at the value of FSAs, is that a cap of \$2,500 per year in pretax deferrals will be imposed. The vast majority of folks who use FSAs do not put aside money at this level, but several do, particularly in years when children are getting braces and things like that.

Also in 2013, employers will be required to provide simplified plan summaries. So the typical plan descriptions, SPDs (Summary Plan Descriptions), contracts, or whatever else that is typically now provided to make folks aware of the coverage that they have available to them, will be augmented by a standardized template form that's not supposed to exceed four pages, to be developed by HHS (Health & Human Services). Employers would be obliged to make it available to new enrollees and any entrants to the plan during subsequent open enrollments. This shouldn't be a tremendous burden to the extent that it follows a standard format, and in all likelihood the insurance provider will assist in the preparation and delivery of such documents, but it is a new requirement worth noting.

To wrap up 2013, another element that has caught some significant attention in the news media of recent vintage relates to prescription drug coverage under Medicare Part D. The deductibility for government subsidies associated with employers maintaining retiree prescription plans will be ending. When Medicare Part D was put into effect, as an inducement to keep employers who provided private plans to continue doing so, regulations were written for Part D to not only provide a subsidy to the employers continuing their post-retirement prescription drug plans, but to allow them to write-off and deduct the subsidy as though they had spent it themselves. That deductibility will end in 2013. To be clear, the subsidy will continue, but the deductibility of it will not.

There was quite a bit of hubbub when firms like AT&T, Caterpillar, and other large companies with significant spend in this area, publicly announced their need to recognize as much as billion dollar effects of these changes to their future liability for providing the retiree coverage.

FASB 106, for those of you who are familiar with the accounting board regulations surrounding post-retirement coverage, obliged them to do so. It was interesting to see how members of Congress, who thought this was sort of a business attempt to rain on their parade about having passed healthcare reform, were quickly brought back to the reality that another set of regulations obliged these employers to do so.

2014 is the big one, the year when most of the major stuff, apparatus, and systems that healthcare reform creates take effect. The first item we'll note here is that an individual coverage mandate will begin in 2014. Effectively, that would require all American citizens to secure health insurance coverage; or, if they fail to do so, pay a tax penalty or fine. Take a look at these numbers and scratch your head a bit. A \$95 per year penalty would apply in 2014 when this kicks off. It will graduate up to \$695 by 2016, and the maximum will be the greater of three times per family or 2½ percent of household income.

From an ERP opinion alert standpoint (and we're probably stating the obvious here), in our view the penalties are likely to be insufficient to drive universal compliance. It is a heck of a lot cheaper to spend \$95 in penalties than it is to pay for the premiums. The concern is that it would undermine the risk-sharing foundation of the insurance exchanges that the commercial insurance industry will be the risk-bearers for. This could easily lead to situations where "adverse selection" and related rapid-rate escalation would apply. Coupling a low cost to avoid the mandate, i.e., this \$95 to \$695 fine, with liberalization of the insurance regulations relative to pre-existing condition limitations, you have all the conditions necessary to generate an adverse selection-driven "death spiral", if anyone has heard that expression in the healthcare space. It suggests that to the extent people can come and go from the health plan as they need relative to their diagnosed health conditions, the loss experience can only continue to deteriorate and drive escalating premiums that force more and more healthier participants out. This is something to keep an eye on.

Also taking effect in 2014 for employers with 50 or more employees (any smaller groups would not be subject to this whole provision), is a requirement that would require them to either provide mandate-compliant coverage to their full-time employees or pay penalties into a government fund. If an employer provides group coverage, should even one of their full-time employees opt out and receive government assistance to purchase coverage through the insurance exchanges, the employer is on the hook for penalties.

Now, I would ask you not to shoot the messenger, as we talk about how this compliance penalty calculation works. I'll be darned if I can explain to you

the convoluted nature of its derivation but I'll do my best. The maximum annual noncompliance penalty would be \$3,000 per such full-time employee – meaning someone who opted out of the group plan, who then secured coverage through the insurance exchange as an individual, but took the government up on its subsidy offers. The employer's penalty would be \$3,000 for such individuals, but it would be capped for the group at no more than \$2,000, times the total number of full-time employees excluding the first 30.

A group might choose not to provide coverage to any of its full-time employees, which some of you may be, as you think about this stuff, saying “Gosh, it's becoming so crazy. Why don't we consider getting out of the provision of health coverage business?” This is actually what the government's doing to try to induce you not to, among more practical concerns like your industry competition may keep you from taking such draconian actions – but, if you don't cover any of your full-time employees, you would be subject to the \$2,000 per total employees excluding the first 30.

Let's look at a quick example of that calculation, just to put some idea of what kind of magnitude this impact could have. An employer has 230 full-time employees, 30 of whom are benefits-eligible, salaried folks. In this example, the other 200 hourly employees are not afforded access to the group health plan and are all earning below the threshold where they could purchase coverage in the insurance exchanges on a subsidized basis. The gross tax or penalty would be the 200 who aren't provided coverage times \$3,000, or \$600 grand. The cap calculation would generate a lower number, but you're still looking at a \$400,000 hit. What we see from this is the premise that there are a number of business models out there that are going to have to think real hard about how they're going to deal with this. If there's a tremendous amount of uncovered (or covered, but at coverage levels below what the law will require) lower-income folks, the revenue in that business model is going to need to be adjusted somewhere to account for the fact that there's either going to be a need to expand coverage to those people or pay these fines.

I've referred to the state-level insurance exchanges a number of times, so let's talk a little bit about what that looks like. They'll be going live in 2014 as

federally mandated constructs, but are intended to be operated at the state level. This represents a new marketplace; think of it as sort of a Web-based market for individuals and small groups (initially defined as less than 100 employees) to seek purchase of health plans in a government-managed private market environment.

Now, among the general rules of the exchanges as they're presently defined (this is clearly one of the areas where a tremendous amount of haggling and negotiation has yet to happen), will be standardized benefit sets. At present, I believe there are four different tiers of coverage expected, but even the lowest tier of coverage is a fairly extensive and robust package of elements that certainly go beyond programs that many employers presently provide. There will be a requirement that any coverage afforded in that exchange vehicle needs to be issued on a guaranteed basis and renewed on a guaranteed basis, meaning there are no ways for insurance companies to rescind coverage or prohibit a particular group from taking them up on the coverage offer. The only ratings adjustments that insurers who participate in these exchange pools can make beyond what their published community rates are will be modest amounts of variance for age, area, family composition, and tobacco usage of the population to be insured.

A couple more 2014 elements... We talked earlier about how preexisting condition limitations for dependent children are being eliminated in 2010. That preexisting condition limitation exclusion premise goes bye-bye across the board in 2014 - it will no longer be a possible plan feature in a health policy. The scary part of this is, relative to the health insurance exchanges, if there are a ton of people who are more than happy to pay the small fine for choosing not to participate in the insurance pools, the absence of a preexisting condition limitation would allow them to jump back into the insurance waters when they become sick or injured. This is not a workable situation for an insurance risk pool under any circumstances, with such conflicting elements coming to bear.

We also talked about a provision that would limit and restrict lifetime maximums on essential benefits; annual limits on essential benefits will also be prohibited as of 2014. You can imagine that, if adhered to explicitly, this

could have a material impact on insurance premiums in certain categories. What remains to be seen is whether the ability to, in effect, game this provision by using other forms of limitations like maximum number of days or units of services, will end around the intent of this provision. If there's a mass movement in that direction, you can imagine there being some further amendments and addenda to these regulations to try to clamp down on that.

The small business tax credit we talked about that became available immediately this March will move up to a 50 percent credit from 35 percent for small employers in 2014.

Just a couple more, if you can stand it. I told you it was a big year! Health plans will be required, if covering a group of more than 200 employees, to auto-enroll all new hires; they would have to take the proactive initiative to opt out of coverage. It's sort of "Big Brother-ish" to the extent that it's making the decision for people who aren't thinking enough about healthcare coverage, but if they really want to opt out then they're going to have to take action to do so.

Another interesting feature that will have a material impact on a good sector of the economy is that health plan eligibility waiting periods will no longer be allowed to exceed 90 days. If you're in an industry with significant turnover, with a high rate of people coming and going within 90, let alone 180 days for example, you can imagine that having to cover these transient populations is going to ramp up the average number of people covered on the plan in any given period, and, of course, add to the administrative burden that HR and other departments have to deal with in terms of these people constantly going on and off coverage as well as the COBRA-related responsibilities, etc.

The dependent coverage eligibility extension to age 26 that we talked about earlier is going live pretty much as we speak. The one caveat that it was limited in situations where a dependent had access to coverage elsewhere will go by the boards in 2014. Effectively, if you want to cover your dependent up to age 26, you will be allowed, no further questions to be asked.

One last blurb on the 2014 front, just to show there was at least one area that we could find where the regulations are intending to actually help employers improve the underlying health of the populations they insure. There will be an adjustment to the HIPAA regulations that will improve employers' ability to offer incentives for employees to participate in qualified wellness programs. As you have seen through the balance of this presentation, the vast majority of regulations related to healthcare reform are on the front of health insurance and health plan access, not really at all focused on whether the underlying cost of healthcare is moving up, down or sideways. This is one area where the regulations do make at least a token attempt to address cost issues.

OK, let's wrap this up with 2018, when the "Cadillac" plans tax kicks in. What this refers to is a 40 percent levy on the excess value of high cost health plan coverage above indexed annual thresholds, which as of 2018 would be \$10,000 per individual and \$27,500 per family. Sounds like a lot, but I think those of you who manage the expenses of your health plan can see that if you take your run rate annual cost today, and hit it by fairly typical healthcare inflation factor, you're not going to be too far off from these numbers for even a relatively modest health plan offering.

What we see fairly likely to happen here – big surprise, right? – is that while the insurance companies or a TPA (Third-Party Administrator if you're in a self-insured environment) are going to be the parties responsible to make payment of these taxes to the taxing authorities, that money's going to come from the plan sponsor. It'll show up in the rates or some form of a pass-through levy. One footnote is that certain elements like the demographics of the population, the location of the business, and the risk level of the industry may ultimately be determined as adjustment factors to where the thresholds kick in. This is to some extent the function of union groups protesting this tax pretty heavily - one evidence being that the effective date was pushed off to 2018, another being that where unions exist, sometimes they're higher risk industries where the incidences of healthcare expense excess occur more frequently.

That is our summary of the provisions that employers, at least initially, should be most focused on. Before we wrap this up, I want to touch on a few things

from an environmental or a “mood” sense regarding the reform process. Many of you may be aware that there are a number of states - I believe 13 to 15 at this point - who have conjoined efforts to pose a Constitutional challenge to the individual mandate aspects of the reform law at the federal level. Ultimately, what this seems to turn on is more of a referendum on states' rights versus federal overarching control, but the specific feature that they're referring to is the federal government's imposition on citizens of their states to buy a commercial insurance product. It is unprecedented that a purchasable item, a private commerce item, would be forced upon the citizenry by a federal law. That's the ostensible issue afoot there. The likelihood is this gambit will not have any material impact ultimately, beyond perhaps draining some attention and resources from the reform movement's forward progress, slowing things down a bit.

On a generic basis, just about every public opinion poll, certainly right after the law was signed in and even now that several weeks have transpired, continues to suggest that the majority of Americans are not in support of the reform package as it's presently structured. And that leads directly to the last note about the Democratic majority that pushed this thing through on strictly partisan lines facing big challenges in the November elections, the so-called midterm elections. A rejuvenated Republican party has been beating the drum for a “repeal and replace” strategy relative to healthcare reform. It's a lot easier said than done. They have to win enough of the elections to regain control of Congress first, craft a repeal and replace measure that can pass both houses, then somehow get the President not to use his veto to stop it, which is highly unlikely given this is a signal issue of Obama's administration. If a veto comes, sufficient votes to override would be necessary to complete the change. All this remains to be seen, but there is certainly an interesting path ahead - to see how that process affects the reform measures that actually get put into place.

So, let's wrap things up with an opportunity to open the phone lines up. We'll handle this as a bit of a free-for-all open line, first-come-first-served basis, so whoever's loudest and I can hear you first, I'm more than happy to tackle your question and we'll take it from there.

Ken Ambos: I have a question that was keyed in on the Web line. Sonia asks about the 2014 change in the waiting period limit to 90 days - if there's clarity on it being actually 90 days, or can it be first of the month the following 90 days?

There is not clarity on that as yet. I would venture a guess that it's going to be the 90 days pure and simple, and that first of the month will just be seen as a legislative irritant that regulators won't want to bother adjusting for. While a first of the month provision would make life a bit more manageable for those who have to administer this stuff, that type of consideration has not been a high priority for those formulating these regulations.

Guest: Could you just repeat what the cap or the threshold is for the "Cadillac" tax and when that kicks in?

Ken Ambos: Sure. Starting in 2018, the "Cadillac" plan's tax would be 40 percent on the excess value of coverage costs that exceed \$10,200 per individual, \$27,500 per family per year. So as an example, if you took an average cost on a gross basis of a health plan, a national average today approaching \$10,000 – that's a combination of individuals at a lower level, families at a higher level – hit that by a 12 to 15 percent per year inflationary factor for the next eight and you're going to be right in this territory if not above.

Guest: And that tax is paid by the insurance company?

Ken Ambos: Paid by, yes - but funded by ...

Guest: Oh no, I hear you.

Ken Ambos: So at least at this point it's set up to be a funnel through – kind of like the way a carrier now pays premium taxes to various taxing entities at the state level. They collect it in their premium base and then forward it on.

Guest: Ok, thank you.

Ken Ambos: Sure. We've got a couple other things coming in on the written front. Nancy writes, "Would you restate when the first 2011 challenges, or changes would

take place? Our plan renews in July, so wouldn't all the 2011 changes need to be implemented at renewal?"

I think that is a fair and reasonable assumption, that any of the subsequent year changes whether it is 2011, 2013, *et cetera*, would kick off in concert with your renewal dates, but I can't say that with certainty. That hasn't been addressed specifically at this point.

Some of the big ticket stuff, for instance in 2014, I would guess would go in the other direction where there's going to be a date certain that everybody and everything will move to the new paradigm. But some of the smaller adjustments that we've talked about, whether it's FSA, benefit amount limits and things like that, to go through the process of having to communicate and make those changes off-cycle seem almost punitive to the employer. It doesn't mean it won't happen, but my guess is at this point that you're right in that it would hold off to the renewal date. As soon as we're aware of those types of details, we'll continue to advise and publish on these points to make it clearer.

I have another note, "Can you please turn back to the 2010 reform measures on the slides?" I can, and I also want you to know that these documents are going to be posted - in fact, this entire presentation will be on our website at www.equityrisk.com, and you'll be able to download it directly from there.

Just to run them down quickly, the 2010 elements are the small business tax credit, the indoor tanning services tax of 10 percent, and the others are – subject to your first renewal after September 23 – the dependent coverage extension to age 26, the prohibition of preexisting condition limitations/exclusions for dependent children less than age 19, and the prohibition of lifetime maximums on essential benefits.

OK, now one final question here from Tony. "Our business has a lot of teenagers here - part-time workers, which, if I understand it, will be included in their parents' plans."

Yes, they will be allowed to be. Even if they are full-time employed with your company, if you are not providing coverage to them they can cover themselves under their parents' plan. Since this depends under age 26 element, and some of the other regulations about you as an employer being obliged to provide coverage or pay a fine, don't kick in for a couple more years. During this window, such situations are more the parents' obligation to address vs. you having to deal with the teenagers working in your operation.

Guest: In the final legislation, was there or was there not something about the requirement to cover part-time employees?

Ken Ambos: Yes - the first version of this slide deck was probably enough to keep you on the phone for two hours. We tried to narrow it down to the key stuff, but you're right - there are provisions addressing part-timers. The aggregated number of hours worked by such employees will need to be measured against how many full-time people that would have represented, as the employer's tax penalty calculation will factor that in. The regulations do not oblige you to cover these individuals.

Guest: And when does that kick in?

Ken Ambos: That would also be a 2014 situation.

Guest: Thank you.

Ken Ambos: Sure.

Ken Ambos: Well, if there are no further questions, I greatly appreciate everyone's time and attention. Thank you for tuning in.

END