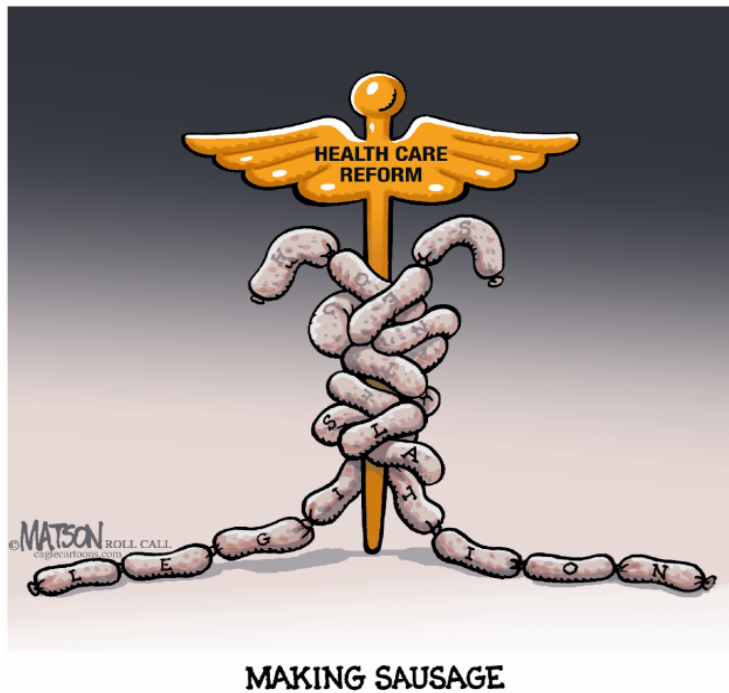


Laying Down the Law – A Post-Game Summary of the Healthcare Reform Bill Process

Way back in January of this year, we dropped the inaugural edition of Equity Risk Partners' **Viewpoint: Healthcare Reform** ([http://equityrisk.com/active/Healthcare Reform.asp](http://equityrisk.com/active/Healthcare_Reform.asp)) on our unsuspecting audience – those valued clients and trusted partners interested in a fresh perspective on the federal healthcare reform process. ERP's intent since has been to offer Viewpoint updates as frequently as events required, while not lapsing our readers into a coma with the same type of blather and minutia widely available elsewhere. We boldly set out instead to create our own special brand of blather and minutia.



The original Viewpoint analysis took a look back at the gathering political turmoil, commented on critical stages of the reform bill development process, and included a grid highlighting ERP's perspectives on some of the key elements of the debate. Now that the bill(s) have become law (the original reform bill was signed by the President first, and was then conjoined with the reconciliation measure Mr. Obama inked last week), let's take a closer look at what's come out the other end of Washington's often messy, always entertaining legislative sausage factory.

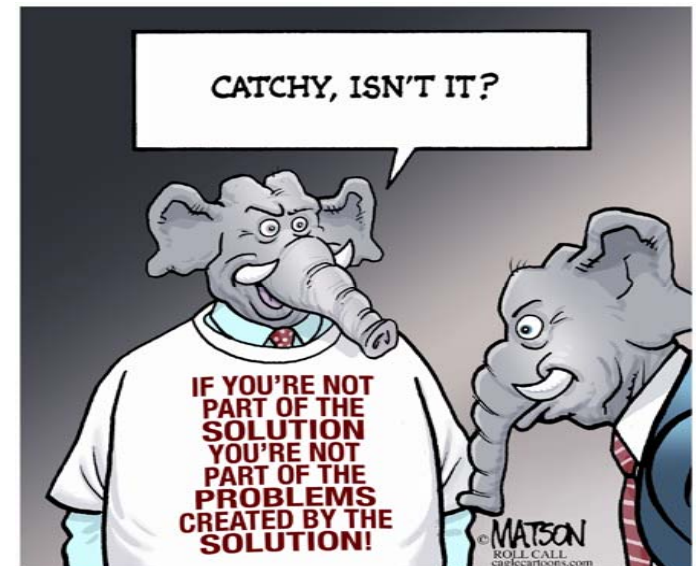
Following some framing commentary below is our shiny new graphical analysis of key provisions contained in the reform package, laid out chronologically for your viewing pleasure. Given the enormity of the underlying legislation, we've focused mainly on those elements we believe our clients and partners should care most about on the employer-sponsored health coverage front.

The Patient Protection and Affordable Health Care Act was signed into law by President Obama on March 23, 2010; one week later on March 30th the President also signed the Health Care and Education Affordability Reconciliation Bill. Together, they form arguably the most significant piece of socio-economic legislation our country has launched since the advent of Medicare.

The path to this momentous outcome was serpentine, exhibiting as many plot twists as a Hollywood screenplay. Relentless pursuit of this signature issue by Mr. Obama and his fellow Democrats, whatever the political cost will be, overcame unanimous, strenuous Republican objections to the approach and scope of the road ultimately taken.

In addition to the massive logistical challenges of implementing the myriad provisions outlined in the bill itself, which we address in the analysis below, a minefield of tangential pitfalls looms immediately ahead. Just a sampling:

- Attorneys General of 15 states and counting have initiated a constitutional challenge to the crucial “individual mandate” contained in the federal reform legislation. The overt basis for this action is to set aside as unconstitutional the federal government’s attempt to require citizens of any state to purchase a commercially sold product, since no such power is explicitly reserved for federal authorities. The broader crux of this action may be more accurately characterized as an attempt to preserve states’ rights as the Constitution intends, rather than allowing the balance of governing power to continue tipping further in the federal direction. Regardless, while the chances of this maneuver derailing the reform law are generally considered minimal, a prolonged legal debate could cause delays that sap strength and resources from the effort to build the infrastructure needed to press forward.
- Democrats must fend off a rejuvenated GOP, driven to regain control of Congress in midterm elections this fall. The Republicans’ call to “repeal and replace” the healthcare reform law will permeate most contested election districts, leveraging their core message that this 100% partisan endeavor was perpetrated by an out of touch Democratic majority via a series of ugly back-room deals.



- Most public opinion surveys continue to suggest a majority of Americans do not support the Democratic vision of reform framed by the law. While it's difficult to assess how much of this is due to ignorance or irrational fear of the changes to come,



or even anger over the way in which the bill was rammed through, the expectation remains that incumbent Democrats will be faced with defending their ye votes, in many cases counter to the mood of their constituencies. An inherent perception of Democratic arrogance that “we know what’s best” must be replaced with digestible explanations voters can recognize as tangible positives in the new law themselves. If Democrats can make that leap, their re-election prospects improve dramatically and along with that the ability for reform implementation to stay on track.

A final word before delving into the important provisions contained in the reform package. As ambitious as this law is, its biggest vulnerability lies in its treatment mainly of the symptoms without aggressively attacking the root cause – hyperinflationary health care delivery costs. Most elements of the law are centered on health **insurance** reform and/or healthcare **access** reform, as you’ll see vividly in the summary grid to follow. These are without question laudable goals, but in and of themselves insufficient to achieve the long term bend in the cost curve this grand undertaking must generate to be deemed a success.

The President is far too smart to have missed this essential point; he appears to have realized the only way to get a system reform stake in the ground was to narrow the scope of the Democrats’ messaging, paint a bulls-eye on a common enemy (the insurance dog everyone loves to kick), and pound away with his gift for oratory. Already, with the security of the signed bill in his pocket, Mr. Obama has publicly acknowledged this is the beginning of a journey and not the ultimate destination. One can only hope that the hardest challenges of reining in underlying health care costs will be tackled with the same zeal in the years to come.

Healthcare Reform Law Implementation Timeline: Key Provisions for Employers (as of April 2010)

TARGET DATE	PROVISION	ERP VIEWPOINT
		PLEASE NOTE: EXTENT TO WHICH “GRANDFATHERED” PLANS (those existing as of 3/23/2010) WILL BE EXEMPT FROM VARIOUS REFORM PROVISIONS IS SUBJECT TO FURTHER REGULATORY CLARIFICATION...
2010	<p><u>Within 90 days of law’s enactment:</u> Small business (<25 EEs, average wage <\$50K) tax credit for providing group health coverage</p> <p>10% tax on indoor tanning services (really???)</p> <p><u>6 months from enactment:</u></p> <p>Health plans must extend Dependent coverage eligibility to age 26, regardless of student/marital status</p> <p>Prohibition of pre-existing condition (Pre-X) limitations for dependent children (< age 19)</p> <p>Elimination of lifetime maximums on “essential health benefits” (definition TBD)</p> <p>Specified preventive care services to be covered in full</p>	<p>Up to 35% of employer costs, provided employer pays at least 50% of premium</p> <p><i>Next best thing, since the sun can’t be taxed...</i></p> <p>For plans years beginning after 9/23/2010 (i.e. 1/1/2011 for calendar year plans)</p> <p>Prior to 2014 plan must cover such dependents only if they have no access to other employer coverage (this will be considered irrelevant after 2014)</p> <p>Most group health plans post-HIPAA do not effectively impose Pre-X exclusions</p> <p>Permissible annual limits to be prescribed by HHS; limits on “non-essential” benefits unaffected</p> <p>Grandfathered plans may be exempt (TBD)</p>
2011	<p>Minimum “medical loss ratios” mandated for insured health plans – 80% for individual/small group, 85% for large group (100 EEs+)</p> <p>Employer to report health coverage value on employee W2s</p>	<p>Insurers are to refund “surplus” to enrollees; unclear how this will be determined (carrier’s book of business results or employer-specific?) and distributed (direct to individuals or through employer?). Insurers are likely to escalate overall premium to ensure 15% (20%) expense factor [including profit margin] can be secured within billed rates.</p> <p>COBRA rates may be deemed a reasonable proxy for this calculation</p>

2011 (cont.)

Over-the counter medications no longer to be eligible for reimbursement under FSAs, HRAs

May cause **reduction in pre-tax FSA contributions**, increasing employer payroll taxes

HSA tax penalty for non-qualified disbursements increases from 10% to 20%

Could have a **negative impact on enrollment in “consumer directed”** HSA/HDHP plan options

2013

Personal taxation changes:

- > **Medicare payroll taxes to increase significantly for higher incomes** – those with earned (wages) and unearned (investment returns) income above \$200K for individuals/\$250K for couples will pay a **new 2.9% tax** on interest, dividends, royalties, and other unearned income
- > Existing 1.45% Medicare payroll tax on earned income will increase to 2.35% on amounts above \$200K per individual/\$250K per couple
- > Threshold for claiming **itemized medical cost tax deduction** to rise from 7.5% to 10% of income

\$2,500/year maximum imposed on Healthcare FSA contributions

Elimination of deduction for Medicare Part D subsidy afforded employers maintaining Prescription Drug plans for retirees

New simplified Plan Summary requirement – all health plan sponsors must supply participants (paper or electronic) a max 4 page summary of benefits, exclusions, cost-sharing, etc.

Example - individual earning \$225K in salary and \$75K in investments would pay the following Medicare taxes:

- > 1.45% on first \$200K of wages (\$2,900)
- > 2.35% of \$25K wages above \$200K threshold (\$588)
- > 2.9% on all \$75K of investment income (\$2,175)

Total Medicare taxes post-reform: \$5,663

Pre-reform Medicare taxes: \$3,263 (1.45% of \$225K)

NOTE: Employer Medicare payroll tax rate would remain at 1.45%

...Financial planners are already hard at work devising strategies to keep reported executive incomes below these thresholds...

May cause **reduction in pre-tax FSA contributions**, increasing employer payroll taxes

This provision triggered huge write-downs recently announced by jumbo employers (AT&T, Caterpillar, etc) to adjust their FAS 106 post-retirement medical cost liability projections...

To be made available upon initial eligibility and at subsequent open enrollments

2014

Individual coverage mandate takes effect – requirement that all citizens be covered by health insurance or pay a fine (\$95/year for 2014, graduating up to \$695 by 2016 – maximum greater of 3x per family or 2.5% of household income)

Penalties may be insufficient to drive universal compliance; could undermine risk-sharing foundation of **Insurance Exchanges (see below)**, leading to **adverse selection** and rapid rate escalation

2014 (cont.)

Employer coverage mandate takes effect – **employers with 50+ employees** required to either provide mandate-compliant coverage to full-time employees (FTEs) or pay penalties into government fund. **If employer provides group coverage**, should even one FTE opt out and receive government assistance to purchase coverage through Insurance Exchanges (see below) employer must pay penalties (“Free Rider Surcharge”). Maximum (annual) non-compliance penalty of \$3,000 per such FTE, capped at \$2,000 x total number of FTEs (excluding first 30 FTEs). **If employer does not offer coverage to any FTEs**, max penalty is \$2,000 x total FTEs, excluding first 30. These penalties are to be calculated on a monthly basis (1/12).

Individual affordability tax credits to be afforded lower income employees preferring to purchase coverage through Insurance Exchanges (see below) vs. employer’s plan

State-level **“Insurance Exchanges”** to be rolled out; intended to establish new marketplace for individuals and small groups (<100 EEs) to seek purchase of health plans in a government-managed, private market environment

Pre-X limitations/exclusions prohibited

Potentially **business model paradigm-changing impact on employers** that do not provide health coverage to categories of full-time employees; paying fines would in most cases be less costly than providing adequate coverage to meet mandate, but would still require a substantial new expense for such employers....

Penalty Calculation Example #1: Employer with 4,500 FTEs; 500 are benefits-eligible corporate staff, 4,000 are ineligible field staff who purchase subsidized coverage through Insurance Exchange
Gross penalty: 4,000 x \$3,000 = \$12,000,000
Penalty cap: (4,500 – 30) x \$2,000 = **\$8,940,000**

Penalty Calculation Example #2: Employer with 230 FTEs; 30 are benefits-eligible salaried, 200 are hourly employees not eligible for group sponsored health plans, thus purchase subsidized coverage through Insurance Exchange
Gross penalty: 200 x \$3,000 = \$600,000
Penalty cap: (230 – 30) x \$2,000 = **\$400,000**

Penalty Calculation Example #3: Employer with 55 FTEs does not provide group health coverage
Penalty cap: (55 – 30) x \$2,000 = **\$50,000**

Employers would be required to provide lower income employees with **vouchers equal to amount of employer contribution** to corporate health plan; employees buying less expensive coverage through Exchange keep the differential

Exchange rules to include:

- > Establishment of standardized set of plans (each meeting “essential benefits” minimum requirements)
- > Insurers must offer coverage on guaranteed issue/renewability basis
- > Modified “community rating” – rates can be adjusted only for group variance in age, area, family composition, tobacco usage

Expands 2010 Pre-X prohibition for children to virtually **all potential plan participants**

2014 (cont.)

Annual limits on “essential” benefits prohibited

Small business (<25 EEs, average wage <\$50K) tax credit for providing group health coverage increases

Auto-enrollment in health plans required for groups of 200+ employees

Health plan eligibility **waiting periods** greater than 90 days prohibited

Dependent coverage to age 26 to be provided regardless of access to employer coverage elsewhere

Participation in HIPAA-compliant **Wellness programs** can be incented with discounts to employee health plan costs of up to 30% (previously 20% under HIPAA)

Expands 2010 prohibition on **lifetime** maximums

Up to 50% of employer costs, provided employer pays at least 50% of premium

Employees can elect to opt out, but are to be enrolled upon eligibility

Graduating financial penalties for waiting periods <90 days contained in the original reform law were eliminated by the reconciliation bill

Expands 2010 dependents to age 26 eligibility requirement by **disallowing alternative employer coverage availability exception**

Eventual regulations may **escalate differential to up to 50%** to encourage further growth in wellness programs uptake

2018

“Cadillac Plans” tax - 40% levy on excess value of high cost health plan coverage above indexed annual thresholds (initially \$10,200/individual, \$27,500/family)

To be imposed on “coverage provider” (insurer, TPA, or employer); **ultimately to be funded by plan sponsor**. Extent to which demographics, location, other cost-impacting characteristics of the covered group can be factored is TBD



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