

Patient Protection and Affordable Care Act of 2010

Large Employer Perspective

Changes in Benefits

- No Lifetime Maximums and Very Limited Annual Maximums
 - Medical only – not dental or vision
- Preventive Care Covered at 100%
- Must Provide Essential Benefits
 - To be determined by HHS
- Result: Modest Upward Cost Pressure So Far
 - Still need to see essential benefits requirements

Changes in Covered Population

- Children of Employees Covered to Age 26
- Can not drop someone's coverage (except in case of fraud)
- No Exclusion for Pre-Existing Conditions
- Individual that Does Not Have Required Coverage is Subject to Penalty
 - Penalty is greater of \$695 or 2.5% of income
 - 1% of income in 2014 and 2% of income in 2015
- Result: More People Covered / Increased Demand on System

New Fees

- Annual Fee on Drug Manufacturers for Brand Drug Sales to Government Programs
 - Total annual fee of \$2.5 billion in 2011 grows to over \$4 billion
- Annual Fee on Medical Device Manufacturers Equal to 2.3% of Sales (starts 2013)
- Annual Fee on Health Insurance Providers Based on Premiums and Admin Fees (Total Annual Fee of \$8 Billion in 2014 Grows to \$14.3 Billion by 2018)
- Result: Higher Cost to Private Sector

Other Changes

- HHS will conduct many studies and make changes to Medicare payments to providers (mostly payment reductions)
- Result: Cost Shifting to Private Sector
- Dramatically increased administrative burden on health plans, providers and employers
- Result: Increased Cost

“Cadillac” Tax

- Tax for High-Value Plans (starts 2018)
 - 40% Tax on value of coverage in excess of \$10,200 for single coverage and \$27,500 for family coverage
 - For retirees age 55-64 and certain high-risk occupations tax applies to coverage in excess of \$11,850 for single coverage and \$30,950 for family coverage
 - Coverage includes health care FSA
- Result: Employers Will Reduce Coverage if Necessary to Avoid Tax, or Perhaps Shift Some Cost to Retirees

Health Care Exchanges

- States Establish Exchanges (2014)
 - States purchase health plans
 - Bronze: 60% actuarial value
 - Silver: 70% actuarial value
 - Gold: 80% actuarial value
 - Platinum: 90% actuarial value
 - Benefits package determined by HHS
- If State Does Not Establish Exchange HHS Will Establish and Run an Exchange for that State
- Question: Should Employers Opt for Elimination of Plans and Send Employees to Exchanges?

Coverage for Pre-Age 65 Retirees

- Longer-Term Outlook
 - Upward pressure on costs from new fees in system, additional demand, cost shifting, additional administrative requirements
 - If there is cap on company subsidy then that could eventually lead to selection, and ultimately death spiral
 - Cadillac tax will limit plan coverage, incent caps on company subsidy
 - Exchanges offer vehicle for employers to move away from providing retiree coverage
 - Many large employers currently giving strong consideration to moving pre-65 retirees to exchange
 - Possibly provide cash to help with cost

Coverage for Post-Age 65 Retirees

- Longer-Term Outlook
 - Similar cost pressures as pre-65
 - Tax advantage for Retiree Drug Subsidy changes in 2013
 - Many companies took accounting adjustment in 2010
 - Medicare Part D donut hole being phased in
- Some Options Under Consideration
 - Eliminate coverage and provide cash to help with Medicare premiums or purchase of Medigap insurance
 - Also provide tool to assist with making consumer choices
 - Offer Employer Group Waiver Plan (less common right now)

Coverage for Active Employees

- Employer Medical Plan Needs to Cover All Full-Time Employees (30 Hours per Week)
 - Must at least provide essential benefits
 - Determined by HHS
 - Minimum 60% actuarial value of utilized services
 - No annual limits on benefits
 - No exclusions for pre-existing conditions
 - Employee contribution (payroll deduction) must be less than 9.5% of taxpayer's household income

Coverage for Active Employees

- If Employer Plan Requirements Not Met
 - Penalty of \$2,000 per employee (\$3,000 for employees enrolled in another plan where they are receiving federal subsidy)
 - First 30 employees excluded from headcount
- Individual that Does Not Have Required Coverage is Subject to Penalty
 - Penalty is greater of \$695 or 2.5% of income
 - 1% of income in 2014 and 2% of income in 2015

Coverage for Active Employees

- Most Companies would Prefer to Continue to Offer Health Care Coverage
- High Priority is to Maintain Competitive Position in Marketplace
- Factors / Expectations Under Consideration
 - More fees / taxes in system
 - More demand on providers
 - Lower payments to Medicare providers
 - Increased administrative burden
 - Benefits could become taxable to employees
 - No opt-outs (must get required coverage somewhere)
 - Higher costs for private-sector plans

Coverage for Active Employees

- Anticipated Outcome
 - Employer plans will gravitate toward “bronze” level of coverage
 - Employees will be asked to contribute more
 - Pay more for less coverage
 - More incentives for dependents to consider or pursue other options
- Some Companies Have Already Indicated it is Highly Likely they will Terminate Coverage and Send Employees to Exchanges
 - Around 10% based on informal surveys
 - Many others giving some consideration
 - Is some concern Congress could increase penalty

Future Landscape

- Possible Consolidation of Health Plans
 - Increasing competitive pressures
 - Controlled profits for health plans
 - If loss ratio is less than 85% for large group plan or less than 80% for small group or individual plan then there must be premium rebates
 - HHS can review and approve (or deny) premium increases
- Possible Evolution to Single Payer System
 - HHS will establish Community Health Option to be offered through state exchanges
 - HHS negotiates reimbursements with providers and sets premium rates (could be national pooling)

Future Landscape

- Government Becomes Significant Provider
 - HHS will establish community “health teams”
 - Consist of health care professionals and social workers
 - Provide support to primary care providers
 - Health Care Workforce Commission will be established to educate, train and supply workforce of health care professionals
 - HHS will establish school based health centers

Future Landscape

- Government Provides Education
 - HHS will award grants to develop and implement curricula to educate and train medical professionals
 - HHS will oversee United States Public Health Sciences Track
 - Government developed curriculum for medical students, dental students, nursing students, public health students, mental health students, physician assistant and nurse practitioner students, and pharmacy students

Future Landscape

- Government Influence Over Health Care Practice
 - HHS will establish national strategy for improvements in health care and establish priorities for research
 - HHS will establish Shared Decision Making Centers
 - Will train providers in shared decision making
 - Helps patients understand their beliefs and preferences related to treatment options, including age appropriate care
 - Patient Centered Outcomes Research Institute (2012)
 - \$1 per participant fee for comparative effectiveness research
 - \$2 per participant for years 2013 – 20019 (adjusted for annual increases in health care spending)
 - Other countries with national health care systems have “comparative effectiveness” initiatives
 - In those countries comparative effectiveness generally = rationing

Still to Come?

- Just What Benefits Will be Mandated
- Taxation of Health Care Benefits
- Extent of Government Control Over Education and Delivery
- Comparative Effectiveness / Rationing
- No Tort Reform
- Single Payer System vs. Survival of Private Sector Sponsors

That's All Folks !

