Impact of Health Care Reform on Program Pricing and Stop Loss

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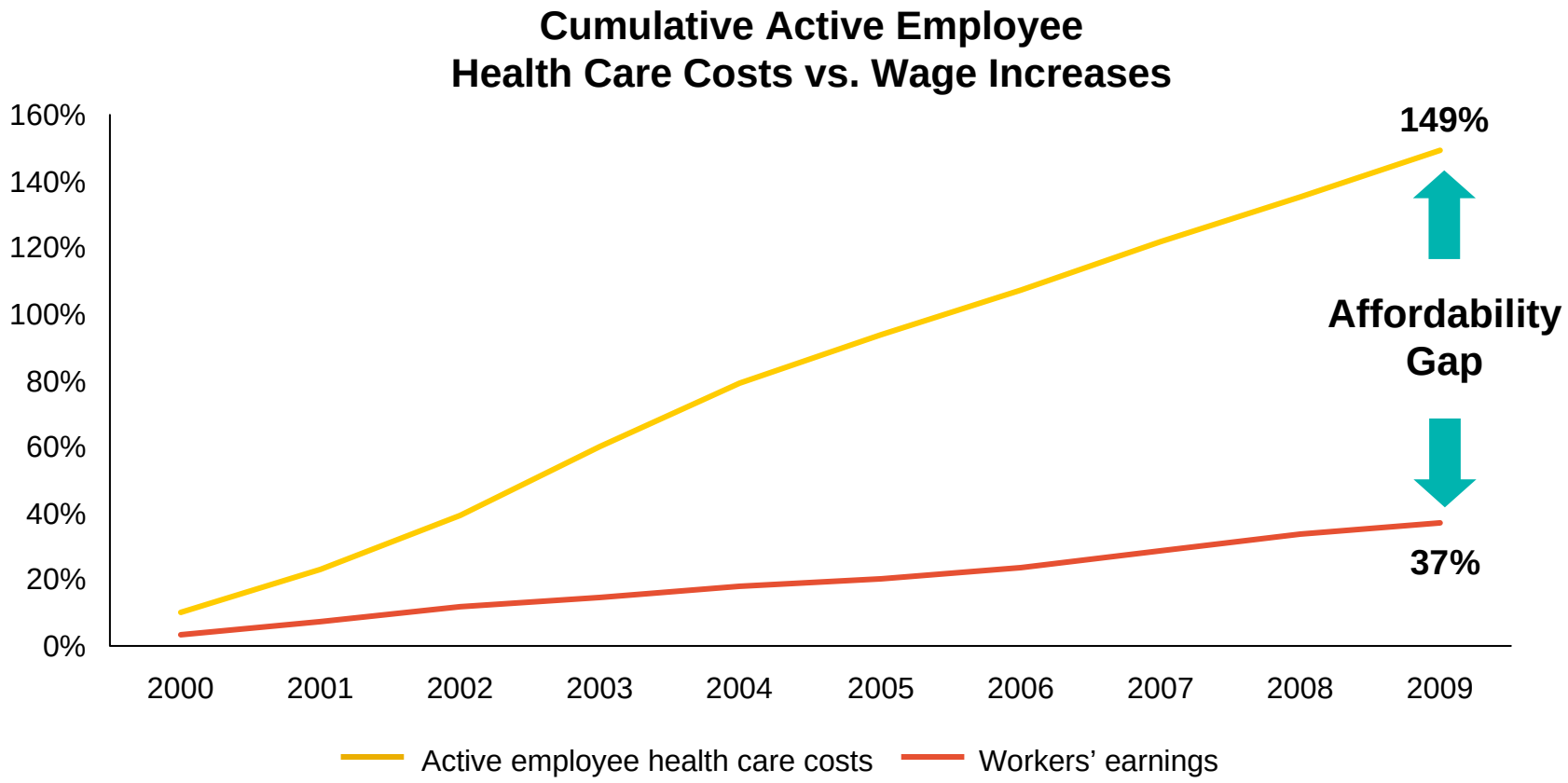
TOWERS WATSON

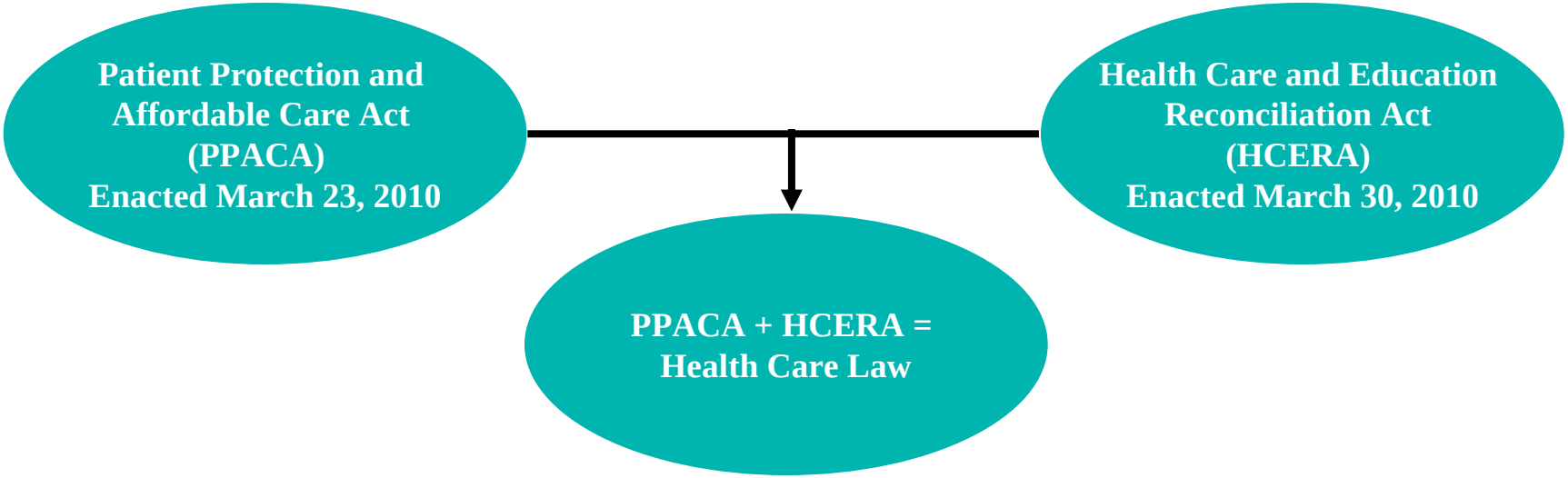
Background to Health Care Reform

The Growing Affordability Gap



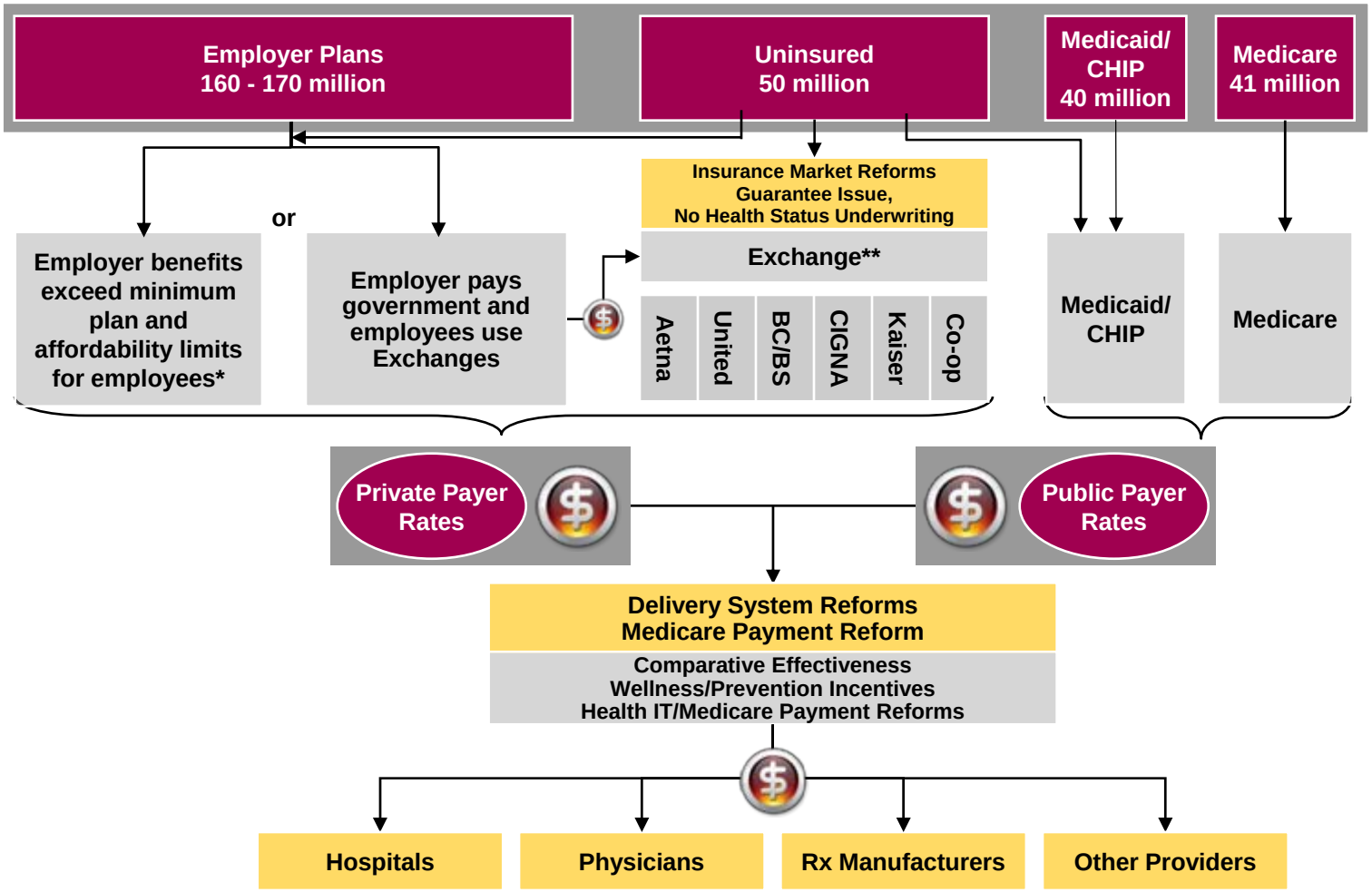
Note: Towers Watson Health Care Cost Survey 2010 (active employee data) and Bureau of Labor Statistics, seasonally adjusted data from the Current Employment Statistics Survey August to August, 2000 – 2009.

Health Care Reform is here — and brings significant short and long-term challenges for employers



- Reform has significant implications for employers, employees/individuals, insurers, health care providers and others
- Impact starts immediately for employers
  - Major changes continue for years to come
- Employers face short-term and long-term challenges
  - *Short-term* challenges include understanding the new law and its implications and implementing immediate provisions
  - *Long-term* challenges include managing compensation and benefit strategy in a new environment

The new health care insurance market



Source: U.S. Census Bureau. Does not depict 15 million now with individual insurance expected to move to Exchange or other sources.

* Employees may decline employer's plan in favor of Exchange-based coverage, but they may obtain federal premium subsidies for Exchange-based coverage only if employer coverage does not meet minimum requirements or, is 'unaffordable'.

** Low- and middle-income premium and out-of-pocket cost subsidies available up to 400% of federal poverty level.

Implementation begins right away …..

2010	• President signed PPACA and HCERA into law* • Reinsurance program for early retiree medical coverage • Accounting recognition of change in taxability of RDS payments • $250 rebate for seniors who hit Medicare Part D coverage gap • Some immediate coverage and consumer protection requirements (non-calendar year plans)
2011	• W-2 reporting of aggregate value of employees' health coverage • Extended dependent coverage, no lifetime dollar limits, restricted annual dollar limits, no preexisting condition exclusions for those under age 19, other immediate consumer protections (calendar year plans) • HSA withdrawal penalty increased • No reimbursement of over-the-counter (OTC) medicines from account-based health plans • CLASS** Act long-term care benefit enrollment
2012	• Presidential election

*PPACA — Patient Protection and Affordable Care Act; HCERA — Health Care and Education Reconciliation Act.
**CLASS: Community Living Assistance Services and Support Act.

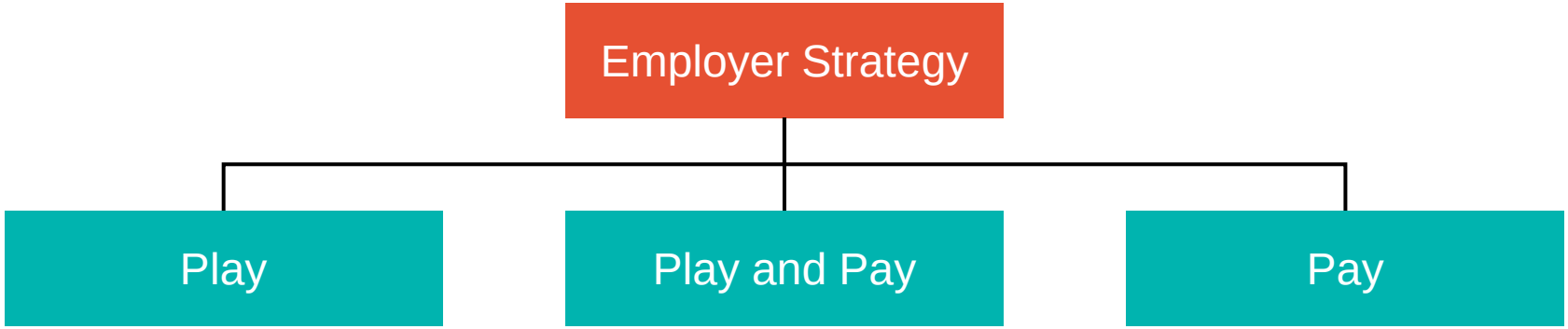
….. and will take years

2013	• Medicare payroll tax increased for high-wage employees and new tax on unearned income • Cap on salary-reduction contributions to health FSAs • Change employer tax treatment for Medicare Part D retiree drug subsidy (RDS)
2014	• Individual health coverage mandate • Employer mandates: play-or-pay, automatic enrollment, free-choice vouchers • Health Benefit Exchanges operational • Premium and cost-sharing subsidies for low- and middle-income individuals • Medicaid eligibility expanded in all states to 133% of FPL • Additional consumer protection standards, such as prohibition on excessive waiting periods
2016	• Sales of health insurance across state borders permitted
2018	• 40% nondeductible excise tax on high-cost group health plans

The EMPLOYER building blocks of the health care reform law

Key Element	Congressional Direction
Individual mandate	• All individuals required to enroll in basic health coverage, with limited exemptions
Individual and small group market reform	• Insurers required to offer guaranteed issue coverage, no health status underwriting, four standard plan designs • Limits on maximum premium differentials; permitted only for certain factors (e.g., tobacco use, age, residence, family size)
Subsidies to low- and middle-income individuals	• Federal premium subsidies provided to individuals earning up to 400% of the federal poverty level (FPL) unless they have access to affordable employer coverage • Federal premium subsidies only for health coverage obtained through insurance Exchanges, not through employer-sponsored plans
Health insurance Exchanges	• State-based insurance Exchanges established to structure a market for individual and small group health insurance
Employer pay-or-play mandate	• Employer required to offer health plan that meets minimum requirements to those employed on average 30 or more hours per week, or pay a per-employee assessment to the government
Excise tax on "high-cost" employer health coverage	• Excise tax on carriers (insured plan) or administrators/employers (self-insured) plan when employer-offered health coverage exceeds specified value per year (e.g., $10,200 single coverage/$27,500 family coverage)

Health Reform creates new strategies and new financial dynamics (2014 – 2018)



- Meet minimum requirements
- Manage plan cost
- Mitigate rate and cost trend
- Avoid hitting excise tax cap
- Balance cost-sharing strategy with free choice voucher requirements and subsidy penalties
- Implement required administrative rules

- $3,000 non-deductible penalty for lower wage full-time employees eligible for subsidies who apply to an Exchange when employee's required self-only contribution exceeds 9.5% of household income
- Deductible free choice voucher for a lower wage employee if offered subsidized coverage and employee's required contribution for self-only is between 8 – 9.8% of household income

- Pay $2,000 per full-time employee (non-deductible)
- Change health care "deal" with employees
- Employees faced with buying through Exchanges
- Revisit total compensation
  - Provide "make up" to employees?
  - Gross up to address tax implications for employees
- Face competitive impact on recruiting/retention

Implications for Health Insurers

2011	Host of new insurance mandates (no pre-existing on children, no lifetime limit, restricted annual limits as determined by HHS) on *new* and existing policies; existing plans grandfathered from Wellcare mandates.
2014	• Influx of new individual/small group customers through subsidized policies sold on state exchanges • Exchanges bring increased regulatory oversight than insurers now typically face and may need to alter their business models drastically • Law places strict limits on premium bands among the people taking out the same policy, based on age, geography and tobacco use • Insurers concerned that young and healthy people will not enroll because new requirements will make their premiums higher to subsidize the sick people • The legislation requires insurers to cover people with costly preexisting conditions • Penalties may be too low to enforce mandated “minimum essential coverage”: 2014 — Greater of $95 or 1% of income 2015 — Greater of $325 or 2% of income 2016 — Greater of $695 or 2.5% of income

Implications for Health Insurers - Taxes

- New taxes are imposed on health insurers, allocated based on net written premiums; half-shares for non-profits:
  - 2010 — $8 billion
  - 2015 — $11.3 billion
  - 2016 — $11.3 billion
  - 2017 — $13.9 billion
  - 2018 — $14.3 billion; indexed thereafter
- Higher medical cost from pass-through excise taxes on medical device manufacturers and pharmaceutical companies, and other cost increases will put more pressure on premium rates

Stop Loss Market Overview

- Provides protection for self-funded employer plans
- Specific stop loss – provides protection against large individual claimants
- Aggregate stop loss – provides protection against a large excess of total claims (net of specific amounts)
- Employer plans are typically ppo plans
- Groups size in the 25 to 5000 range
- Coverage is heavily underwritten (lasers)
- Coverage issued by many carriers and health plans

Key Provisions Impacting Self-Funded Plans in 2010 and 2011

- Current self-funded plans are grandfathered
- Generally applies to plan years starting with October 2010 and later

Treatment of Coverage Options

Coverage Issue	Self Funded Plans		Stop Loss	
	Current	Post HCR	Current	Post HCR
Child Age	19/23 or 25	Until age 26 (Through age 25)	Follows s/f plan	Follow s/f plan. Will cause a modest increase in premium
Pre-existing Conditions	New hires and dependents w/ break in coverage	Apply to adults but waive for children under 19	Follow s/f plan	Follow s/f plan; cost impact is small

Treatment of Coverage Issues (continued)

Coverage Issue	Self Funded Plans		Stop Loss	
	Current	Post HCR	Current	Post HCR
Lifetime Maximum	$1 or $2 million	Unlimited	Follows s/f plan	Eliminates the notion and replaced by annual max
Annual Maximum	Not used	1 or 2 million (at least as high as prior lifetime max)	Not used	Follow s/f plan. Will cause a modest increase in premium
Well Care	Well care is expanded and copays eliminated (new plans only)		Follow s/f plan; will increase aggregate attachment points	
Rescissions	Does not impact large group self-funded plans			

Impact on Stop Loss Market

- Underwriting (lasers) is expected to be unchanged in the short-term
- The risk for elimination of lifetime maximum is passed back to the self - insured plan
- Modest premium increases (above trend etc.) as noted above
- Market space is not directly addressed in the HCR legislation so modest short-term changes

Considerations for Captives Providing Stop Loss

- Captives are not directly considered
- Specific stop loss coverages will still be available from carriers and health plans
- Consider additional cost/risk of no lifetime maximum
  - Single parent captive
  - Group captive
- Account for additional cost of:
  - Child age to 26
  - Annual maximum vs. lifetime
  - No pre-existing less than 19
  - Well care expansion (if applicable)
- Captive Stop Loss solutions may still be attractive
  - Cost
  - Control
  - Premium and claim transparency