The Early Retiree Reinsurance Program

Interim Final Rule with Comment Period
What is it?

- The Early Retiree Reinsurance Program (ERRP) provides reimbursement to participating employment-based plans for a portion of the costs of health benefits for early retirees and early retirees’ spouses, surviving spouses, and dependents. The program was authorized in the Affordable Care Act.

- The temporary program begins June 1, 2010.

- Funding is limited to $5 billion.
Who May Apply to Participate?

- Employers and unions that maintain, whether directly or through an insurer, an employment-based plan that provides health benefits to early retirees or the spouses, surviving spouses and dependents of early retirees.
An “early retiree” is a plan participant who:

- Is age 55 or older;
- Not eligible for coverage under Medicare; and
- Is not an active employee of the employer maintaining, or contributing to the maintenance of, the plan.
- Is enrolled for health benefits in a certified employment-based plan.

In the regulation, spouses, surviving spouses, and dependents of such retirees are each considered “early retirees.”

For the full definition, please see 45 CFR 149.2
What is an employment-based plan?

- An employment-based plan is a group health plan that is maintained by:
  - One or more current or former employers (including any state or local government, or political subdivision),
  - An employee organization, such as a union or committee that administers a voluntary employees’ beneficiary association, or
  - A committee or board of individuals appointed to administer one of the plans above.

- An employment-based plan can also be a multi-employer plan.
- A plan sponsor must submit an application to the Secretary.

- Sponsor and plan(s) must be certified by the Secretary, and the application approved.
Application includes:

- Applicant’s Tax Identification Number,
- Applicant’s Name and Address,
- Contact name, telephone number and email address,
- Signed plan sponsor agreement,
A summary indicating how the applicant will use any program reimbursement to meet the requirements of the program, including how the reimbursement received will be used to reduce plan participant and/or the employer’s/union’s health benefit or health benefit premium costs.

An applicant will also have to provide a summary of:

- What procedures or programs the sponsor has in place that have generated or have the potential to generate cost savings with respect to plan participants with chronic and high-cost conditions; and

- How the sponsor will maintain its level of contribution to the applicable plan.
Application- cont’d

- Projected reimbursement amounts for the first two plan year cycles (with specific amounts for each of the first two cycles).

- A list of all benefit options within a plan under which the sponsor may receive reimbursement.
What is a plan sponsor agreement?

- The plan sponsor agreement is an agreement that is signed by an authorized representative of an applicant that includes provisions relating to:
  - Disclosing information;
  - Acknowledging that information is being provided to obtain Federal funds, which includes an acknowledgement that subcontractors are aware that the information they provide is for the purpose of obtaining Federal funds;
  - Attesting to fraud, waste, and abuse procedures;
  - Agreeing to comply with all applicable program requirements.
Processing of Applications

- Applications will be processed in the order in which they are received.
- An application that does not meet the requirements will be denied and the applicant will have to submit a new application.
- A separate application for each year for a given plan is not required. Just need the start and end month and day of the sponsor’s plan year.
- A separate application is required for different plans.
- Applications will be available in June.

- We are in the process of determining how, when, and where applications will be sent.
Reimbursement Requests

- Once the employer or union (sponsor) and its plan(s) are certified by the Secretary and the application is approved, the sponsor may make one or more requests for reimbursement (HHS to announce form and manner of making requests.)

- A reimbursement request includes:
  - A list of early retirees;
  - Documentation of actual costs for items and services;
  - Prima facie evidence that early retiree (or the early retiree’s spouse, surviving spouse or dependent) paid his or her share of the costs (if the sponsor is requesting credit or reimbursement for the amounts paid by these plan participants).
-80% of claims costs for each early retiree (or early retiree’s spouse, surviving spouse or dependent), for claims incurred for that individual between $15,000 and $90,000 during a plan year, and paid.

-A sponsor can receive credit/reimbursement for the portion of claims paid by the insurer or health plan, as applicable, and by the early retiree and early retiree’s spouse, surviving spouse, or dependent.
Claims incurred before June 1, 2010 up to $15,000 count towards the $15,000 threshold and $90,000 limit.

Claims incurred before June 1, 2010 that are above the $15,000 threshold do not count towards the $90,000 limit.

The Secretary will not reimburse for claims incurred before June 1, 2010.

The Secretary will reimburse claims incurred after June 1, 2010 between the $15,000 threshold and the $90,000 limit.
For what can the reimbursements be used?

- To reduce the sponsor’s health benefit premiums or health benefit costs;

- To reduce health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs for plan participants; or

- To reduce any combination of these costs.
Reimbursements cannot be used as general revenue.
Appeals

- A sponsor can appeal the partial or complete denial of a reimbursement request.

- Must appeal within 15 calendar days of receiving an adverse reimbursement determination.

- It is a one-step appeal, directly to the Secretary.

- Can not appeal denials based on the unavailability of funding.
Disclosure of Data Inaccuracies

- Not an appeal.
- Used when information that was submitted for reimbursement becomes inaccurate after reimbursement has been made.
- For example, if a sponsor collects post-point-of-sale price concessions after a reimbursement request has been paid, sponsor must report the price concession.
- The reporting process to be announced.
- The Secretary can reopen and revise a reimbursement determination on her own motion.
Change of Ownership Requirements

- Change of ownership consists of:
  - Certain changes in the members of a partnership.
  - Certain asset sales.
  - Corporate mergers resulting in a new corporate body.
Change of Ownership Requirements- cont’d

- Sponsor must give 60 days advance notice of a change in ownership.
- If there is a change in ownership that transfers liability for health benefits, the existing sponsor agreement is automatically assigned to the new owner.
- The new owner is then subject to the requirements of this program.
Questions?
Further Questions

Contact:

- James Slade at 410-786-1073 or James.Slade@cms.hhs.gov

- Dave Mlawsky at 410-786-6851 or David.Mlawsky@cms.hhs.gov

- David Gardner at 410-786-7791 or David.Gardner@cms.hhs.gov

- The Office of Consumer Information and Insurance Oversight’s website: http://www.hhs.gov/ociio/
HEALTH CARE REFORM:
Practical Implications for Public Sector Plans

June 17, 2010

National Association of Counties

Presented by:
J. Richard Johnson    Kaye Pestainia

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What We Will Discuss

- What are the key issues for the public sector?
- How will these changes affect your health benefit programs?
- What items need to be on your “critical follow up” list?
- What steps can public employers take going forward?
# Health Care Reform Timeline

## Key Health Care Reforms

<table>
<thead>
<tr>
<th>Year</th>
<th>Provisions Directly Affecting Existing Group Health Plans</th>
<th>Medicare Reforms</th>
<th>Other Health Reforms</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Retiree reinsurance program</td>
<td>$250 reimbursement in Part D coverage gap (“doughnut hole”)</td>
<td>Temporary high-risk pool</td>
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<tr>
<td></td>
<td>Tax-free coverage for children through end of year child turns 26</td>
<td></td>
<td>DOL to require Multiple Employer Welfare Arrangements (MEWAs) to register with DOL</td>
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<tr>
<td></td>
<td>Small business tax credits</td>
<td></td>
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<tr>
<td>2011</td>
<td>No lifetime dollar limits on essential benefits</td>
<td>Additional Prescription Drug Plan (PDP)/Medicare Advantage plan with prescription drug coverage (MA-PD) discounts for brand and generic</td>
<td></td>
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<tr>
<td></td>
<td>Only permitted annual dollar limits</td>
<td>PDP/MA-PD may waive copayments for first fills of generic</td>
<td></td>
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<tr>
<td></td>
<td>Extension of coverage for adult children until age 26</td>
<td>Medicare Advantage payments frozen at 2010 levels</td>
<td></td>
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<tr>
<td></td>
<td>No preexisting condition exclusion for children under 19</td>
<td>Medicare Part D premiums increased for high-income beneficiaries</td>
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<tr>
<td></td>
<td>Ban on rescinding coverage</td>
<td>New Medicare wellness benefits</td>
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<tr>
<td></td>
<td>Flexible Spending Arrangements/Health Reimbursement Arrangements/Health Savings Accounts: over-the-counter medications reimbursable only with prescription</td>
<td></td>
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</tr>
<tr>
<td>2012</td>
<td>Employer W-2 reporting on 2011 coverage</td>
<td>Medicare Advantage payments decreased</td>
<td>Higher penalty for Health Savings Account withdrawals for non-qualified expenses</td>
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<tr>
<td></td>
<td>Standardized information disclosure (with notice of modifications 60 days in advance)</td>
<td></td>
<td>Medical loss ratio requirements for insurers (85% for large groups)</td>
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<tr>
<td></td>
<td>Comparative effectiveness research fee paid by insurers and self-insured plans, beginning plan year ending after September 30, 2012 ($2 per covered life; $1 in first year)</td>
<td></td>
<td>CLASS program (voluntary, public long-term care program)</td>
</tr>
<tr>
<td>2013</td>
<td>FSA contributions capped at $2,500 (indexed)</td>
<td>Corporate health plans lose tax deduction for Part D Retiree Drug Subsidy reimbursements</td>
<td>Increases in Medicare Hospital Insurance tax for high-income individuals</td>
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<td></td>
<td>Employer notice to employees about the Health Insurance Exchange</td>
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<td>Annual fee on medical device manufacturers and importers</td>
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<tr>
<td></td>
<td>Plans to certify compliance with certain Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) standards</td>
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*Most of the law's provisions take effect at the start of a plan year. Plans that are not calendar-year plans would have different effective dates. For example, for a plan with a July 1 plan year, all but the last item listed in the left column for 2011 would take effect on July 1, 2011.*

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<td>2014</td>
<td>- No waiting periods longer than 90 days&lt;br&gt;- No annual dollar limits on essential benefits&lt;br&gt;- Employer free-rider penalty&lt;br&gt;- Free-choice vouchers&lt;br&gt;- Wellness program rules&lt;br&gt;- Employers to report to IRS on plan features (and provide statements to employees by January 31, 2015)</td>
<td></td>
<td>- Health Insurance Exchanges&lt;br&gt;- Individual mandate with federal subsidies&lt;br&gt;- Medicaid expansion to 133% of Federal Poverty Level&lt;br&gt;- Annual fee on health insurance providers</td>
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<tr>
<td>2015</td>
<td>- Plans to certify compliance with other HIPAA EDI standards</td>
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<tr>
<td>2018</td>
<td>- Excise tax on high-cost health plans</td>
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<tr>
<td></td>
<td>- Automatic enrollment by large employers (200 or more full-time employees)</td>
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Key Issues

Immediate and Longer Term

**Immediate**

1. Group Health Plan Mandates
2. Eligibility Rules
3. Administrative Requirements
4. Account-Based Health Plans
5. New Fees
6. Retiree Health Plans
7. CLASS Act

**Longer Term**

8. More Administrative Requirements
9. Medicaid Expansion/Subsidies
10. Free-Rider Penalty
11. Free-Choice Voucher
12. Exchanges and Subsidies
13. Excise Tax
14. Tax Changes
New Group Health Plans (not in existence on March 23, 2010) will face extensive new mandates, including the following:

- Rules on deductible maximums and out-of-pocket maximums
- Required coverage of preventive services with no cost-sharing
- Internal and external appeal process rules
- No prior authorization for ob-gyn visits
- Emergency care must have same payment in and out of network, and no prior authorization
- Nondiscrimination in both insured and self-insured plans under IRC 105(h)
- Coverage of treatment for those in clinical trials

These mandates will not apply to any plan that is “grandfathered,” unless plan loses its grandfathered status.
Group Health Plan Mandates for **Existing** Plans

- Plans in existence on March 23, 2010 are grandfathered from many new mandates

- Grandfathering applies for:
  - Employees who are in the plan on March 23, 2010,
  - New hires, and
  - Family members

- No delayed effective date for collectively bargained plans
Group Health Plan Mandates for **Existing** Plans

**What:**
- No annual or lifetime benefit maximums on essential benefits (with limited exceptions for certain annual limits)
- Coverage extension of children to age 26 for those without other employer-sponsored coverage
- Prohibits rescission except in case of fraud
- Prohibits preexisting condition exclusions for children under age 19

**When:**
- First plan year beginning six months after date of enactment (September 23; September 30)

<table>
<thead>
<tr>
<th>Plan Year Beginning</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1</td>
<td>October 1, 2010</td>
</tr>
<tr>
<td>January 1</td>
<td>January 1, 2011</td>
</tr>
<tr>
<td>April 1</td>
<td>April 1, 2011</td>
</tr>
<tr>
<td>July 1</td>
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</table>
## Dependent Coverage: Two Separate Provisions

### Age-26 Mandate
- Plans not required to cover children, but plans that do cover children must cover them until they reach age 26
- Regulations published on May 13, 2010
- Effective date: plan year beginning on or after September 23, 2010

### Tax Provision
- Plans may provide health coverage (defined broadly) to certain children on a tax-free basis until the end of the calendar year in which the child turns 26
- Guidance released April 27, 2010
- Effective date: March 30, 2010

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The age-26 mandate applies until the child’s 26th birthday, but the tax provision allows tax-free coverage to continue through the end of the calendar year.
Eligibility Rules Will be Affected by Age 26 Mandate

- Can only set criteria for coverage of children based on:
  - relationship to the child
  - age

- Common eligibility requirements will be prohibited such as:
  - Tax dependency
  - Financial dependency on participant (or anyone else)
  - Student status
  - Residence with participant (or anyone else)
  - Being unmarried
  - Employment
  - Eligibility for other coverage (with one time-limited exception)

- Will need to reassess what groups of children the plan will cover going forward
Paying for the Coverage

- Cannot vary premium contributions or other plan terms based on a child’s age (unless child is 26 or older)

  *Example:* Plans with self-only and family coverage cannot impose an additional premium for a recent college grad or other child younger than 26

- May have multiple coverage tiers based on family size, but tiers cannot vary based on the age of children
Plan terms may not vary -- The terms of the plan or policy for dependent coverage cannot vary based on the age of a child, except for children age 26 or older.

**Example:** A group health plan offers two benefit packages—an HMO option and an indemnity option. The plan cannot limit children who are older than age 18 to the HMO option.

**Special enrollment**
- Must last at least 30 days
- Done by effective date
- Notice
Group Health Plan Mandates for **Existing** Plans

**What:**
- Uniform standards for certain benefits communications

**When:**
- 24 months after enactment

**Effective Date:**
- March 23, 2012
Group Health Plan Mandates for **Existing** Plans

**What:**
- No annual benefit maximums on essential benefits (without exceptions)
- Dependent coverage extension without regard to other coverage
- No preexisting condition exclusions
- Prohibits waiting periods longer than 90 days

**When:**
- Plan years beginning on or after January 1, 2014

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<td>October 1</td>
<td>October 1, 2014</td>
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</table>
Eligibility Rules Will be Affected

- Waiting periods of more than 90 days will be prohibited as of plan years beginning on or after January 1, 2014

- What is a waiting period?
  - A “waiting period” is, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.
  - Most governmental plans already allow participation within 90 days.
  - Check eligibility requirements for all health benefit plans.
  - May affect part-time employee requirements.
Losing grandfathered status may not be the worst option. Plans will need to compare losing grandfathering to having to meet these 7 rules.
No delayed effective date for collectively bargained plans (insured or self-insured)

*Insured* coverage provided under one or more collective bargaining agreement ratified by March 23, 2010 is grandfathered at least until the last of the agreements relating to the coverage terminates

- Before the last CBA terminates the insured coverage can be changed in any way without losing grandfathered status
- Once the last CBA terminates then the rules for when a plan loses its grandfathered status apply
New Administrative Requirements

- Employers will be required to disclose health benefit costs on the employee’s annual Form W-2 in 2012 (reflecting coverage in 2011)
- Uniform disclosure standards for benefits explanations—standards to be issued in one year with compliance a year later
- Change in taxation of dependent coverage

- Possible major issue for public sector to accommodate new line item on W-2.
- May involve actuarial calculations on a per-participant basis.
- Need guidance on reporting for retirees.
- Disclosure standards may require standardized language that requires complete revision of existing communications.
Impact on Account-Based Health Plans

- Health Flexible Spending Arrangements (FSAs)
  - Limited to $2,500 per year in 2013

- Health Savings Accounts (HSAs)
  - Penalty for withdrawals for non-medical expenses increases to 20% in 2011

- FSAs, HSAs and Health Reimbursement Arrangements (HRAs)
  - Starting in 2011, FSAs, HRAs and HSAs can only reimburse participants for over-the-counter drugs where the participant has a prescription.

- Hold to current Health FSA limit until 2013 or phase down?
- Retrain participants to plan for the new FSA limits.
- Adjust all plans to new OTC rules?
Comparative Effectiveness Fee

**What:**
- All plans (insured and self-insured) must pay a fee to fund comparative effectiveness research. (Patient-centered outcome research)

**When and Amount:**
- First plan year ending after September 30, 2012—$1.00 per participant per year
- 2012 – 2019—$2.00 indexed
- Sunsets in 2019

Comparative effectiveness is comparing two or more treatments for a given condition.
Early Retiree Insurance Program

What:
- Early retiree reinsurance program
- Covers pre-Medicare retirees age 55 – 64
- Reimburses 80% of claims per retiree between $15,000 – $90,000
- Plans must use the reinsurance funds to lower retiree costs
- $5 billion earmarked for this program to last until Exchanges begin operating in 2014

When:
- Effective 90 days from enactment (June 1, 2010)

- Early retirees are a significant portion of public sector retiree population.
- Jurisdictions need to move quickly on initial application to capture their share of the earmarked funding.
- Consider need to rate retirees separately from actives.
Medicare Part D Changes

- Medicare Part D coverage
  - $250 rebate for beneficiaries who reach doughnut hole in 2010
  - In 2011, discounts on brand-name and generic drugs in doughnut hole for retirees in a Prescription Drug Plan
  - Close doughnut hole by 2020

- 50% brand discount applies after plan payment. May force changes in current Part D plan design.
- May affect pass-through rebates on brand drugs.

- Part D Retiree Drug Subsidy (RDS) is taxable starting in 2013
  - For employer with a tax liability

- Most government entities are not taxable.
- Possible implications for plans that include for-profit business entities owned by government or higher education institution.
Medicare Part D Changes

Part D premium indexed based on income just like Part B (2011)

- This may force changes in longstanding premium sharing with retirees.
- Possible administrative implications to track low income retirees or to make adjustments required by CMS.
Medicare Advantage Plans

- Medicare Advantage reimbursements for 2011 are frozen at 2010 levels
- Medicare Advantage reimbursements will decrease over several years

- Freezing reimbursements to MCOs offering MA programs ultimately shifts costs to participating retirees.
- MCOs will be reassessing whether to continue offering MA plans.
- Phase out of MA-Private Fee for Service plans already scheduled for 12/31/2010 puts additional pressure on carriers.
- Potential disruption of care.
CLASS Act—2011

- National, voluntary insurance program for purchasing community living assistance services and supports (CLASS)
- Five-year vesting period
- Cash benefit of not less than an average of $50 per day
- Effective January 1, 2011
- Voluntary payroll deduction and employee opt-out process

- Requires another payroll deduction line.
- Also requires another employer administration process to keep up with the program.
- Confusion with existing Long-Term Care insurance programs?
What’s Coming after 2011?

- More Administrative Requirements
- Medicaid expansion/Exchange subsidies
- Employer Free-Rider Penalty
- Free-Choice Vouchers
- Health Insurance Exchanges
- Exchanges and Individual Subsidies/Penalty for failure to obtain insurance
- Excise Tax
Auto-enrollment

- Employers with more than 200 employees offering health coverage must automatically enroll employees in the plan
- The employees may opt-out

Wellness plans—incentives/penalties may be increased to 30% of cost
Free-Rider Penalty—2014

- Effective 2014
- Applies to employers with 50 or more employees, including public sector employers
  - Must aggregate hours of part-time employees to create total number of employees
  - Subtract first 30 workers when paying assessment
- If the employer does not offer coverage (and one employee receives a tax credit in the Exchange)
  - Penalty is $2,000 times the total # of full-time employees
  - Upward pressure on salaries—employees with family income >$88,000 might pay full cost of coverage
- If the employer does offer coverage but coverage is unaffordable or actuarial value is less than 60%
  - Penalty is $3,000 times # of full-time employees getting tax credit in Exchange (penalty max)
Employers offering health coverage must offer voucher to employees with incomes less than 400% of the Federal Poverty Level (FPL) if:

- Contributions for employer plan are between 8% and 9.8% of employee’s household income and
- Employee does not enroll in the employer plan

Vouchers are equal to:

- Amount employer would have provided toward employee’s coverage (self-only or family, depending on employee’s election)
- Under option for which employer paying largest cost

Employers pay vouchers to Exchange; if coverage through Exchange is less than voucher amount, Exchange pays difference to employee

- Eliminates plan’s “gain” for a lower-paid employee who elects coverage through an Exchange.
- Forces rethinking of employer’s subsidy approach.
- Employer will require calculations of amounts to apply per participant each year, plus administrative processes to make vouchers available and to monitor and audit.
The Health Insurance Exchange—2017

- A new marketplace where individuals and small groups can choose from a menu of insurance products
- Final Exchanges will be established by the states
- **2017:** State Exchanges may allow large groups in Exchange
Medicaid Expansion/Exchange Subsidies

- **Expansion of Medicaid to 133% of the Federal Poverty Level (FPL)**
  - More federal money toward Medicaid expansion to ease burden on states

- **Subsidies to individuals up to 400% of FPL**
  - More money to subsidize lower income individuals in the Exchange (in the form of a tax credit)
  - Subsidies on a sliding scale based on income
  - Subsidies will provide lower premiums and lower cost-sharing
Excise Tax—2018

40% Excise Tax on Health Plans that Cost Above a Certain Threshold

- Threshold $10,200/$27,500 indexed to the CPI-U
- Adjustments due to age/gender; increased thresholds for high-risk professions and retirees
- Effective date 2018
- Thresholds increased in 2018 if CBO projections incorrect
- Excludes dental and vision; includes health FSAs and HRAs
- Multiple employer plans treated as family coverage for all participants

- May discourage employers from offering coverage worth more than the market “norm,” particularly for jurisdictions where collective bargaining agreements are not in effect.
- Could trigger a longer-term trend of shaving down employer coverage levels to conform with the exchanges and the excise tax threshold.
Aspects that Impact Plan Costs
Tax Changes—Effective 2013

- Medicare Part A Hospital Insurance (HI) Tax
  - Wage taxes increases 0.9% from 1.45% to 2.35% for high income individuals
  - Single $200,000; couple $250,000

- In addition, a new 3.8% tax on investment income would apply to individuals whose modified adjusted gross income is higher than $200,000/$250,000 (would include interest, dividends, royalties, rents, etc., but not retirement plan distributions)

- Various other taxes on health insurance industry

- Likely won’t affect many public sector employees.
- Some university professors and specialty employees may be affected.
Some provisions may potentially reduce costs for plan sponsors indirectly and over the long term

The arguments:

- Reduced pool of uninsured may reduce cost shift from uncompensated care
- Pre-65 subsidy may help for a brief time
- New insurance marketplace will bring down costs throughout the system due to increased competition and reduced administrative costs
- Quality incentives/payment reforms will induce providers to coordinate care and redesign delivery systems around quality cost-effective care
- Comparative effectiveness research and health IT are additional tools
- Medicare Independent Payment Advisory Board will help control provider costs

These arguments are mostly untested and may not bring relief to plan sponsors.
How will Health Reform Affect Your Costs?

Other provisions will directly and indirectly *add to costs*:

- Direct cost of expanding coverage (no limits, shorter waiting periods)
- Direct add on fees such as the $2 PMPY fee to plans for comparative effectiveness research
- Taxation of RDS subsidies (for corporate plan sponsors)
- New taxes on devices and insurers that will be passed through to buyers in the form of higher premiums
- Additional administrative costs to plan sponsors to comply with new rules (legal; actuarial; administrative fees to prepare Health W-2s; voucher administration costs, including additional auditing and monitoring)
- A new round of medical price inflation from providers as they attempt to make up losses from lower reimbursement rates from Medicare and Medicaid

Initial assessment of the new law will also increase plan sponsor cost in the short term.
8 Things Public Employers Should Be Doing

1. Continue to apply short- and long-term strategies to manage expenses
2. Take advantage of the early retiree reinsurance
3. Revisit Medicare Advantage plan strategies
4. Reassess Medicare Prescription Drug Coverage
5. Assess and adjust current plan offerings to avoid penalties and perhaps preserve grandfathering
6. Stay focused on the longer-term strategy implications
7. Evaluate the impact on your collective bargaining agreements
8. Don’t underestimate the importance of communicating with employees and retirees
Stat! Health Reform Weekly
Segal’s Weekly Publication on Health Reform
http://www.segalco.com/publications-and-resources/stat/

And Other Resources:

- Health Care Reform Timeline  New!
- Issue Briefs  New!
- Bulletins
- NewsLetters

Can be found on:

- Segal’s Health Care Reform Guide page
  http://www.segalco.com/health-care-reform/
We can help you:

- Evaluate the impact of health reform on your plan
- Determine how changes may affect your employees’ total compensation
- Leverage subsidies available
- Examine coverage options
- Plan for future requirements under the law
- Strategize the best way to balance plan design, vendor relationships and employee health initiatives to reach your objectives

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