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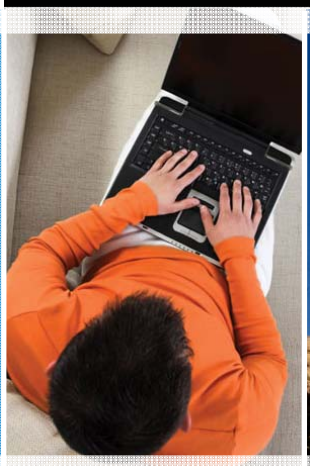
Federal Healthcare Reform:

Impacts on Employer-Sponsored Plans

June 3, 2010

Employee Benefits Planning Association

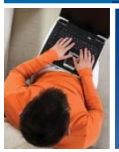


Jack McRae
SVP, Congressional and Legislative Affairs
Premera Blue Cross

Jim Grazko
VP and General Manager, Underwriting
Premera Blue Cross

Agenda

- **Overview** of Healthcare Reform
- **Early Provisions** – 2010 and 6 Months from Enactment
- **Later Provisions** – 2014 and Taxes

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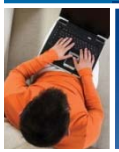
Overview of New Reform Law



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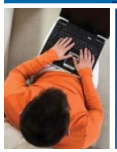
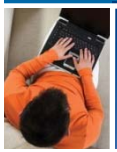
Federal Healthcare Reform Enacted

- *"Patient Protection and Affordable Care Act"* was enacted on March 23, 2010
- The reconciliation bill, which resolved final issues between House and Senate, was enacted on March 30, 2010




Overview of Reform

- Largely maintains employer-based system
- No new government-run public plan
- Requires individuals to have healthcare coverage
- Maintains state regulation under federal framework of rules for insured business



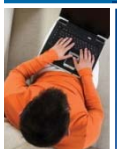

Broad Scope of Reform

The scope of reform impacts every segment of healthcare delivery and financing system

Insurers, Employers, and Individuals
Restrictive private insurance market rules
New taxes and fees
Mandates
Subsidies

Public Health Improvements
Studies to promote prevention and wellness
Incentives to train healthcare workforce
Increased public health spending

Providers and Federal/State Programs
Targeted payment reductions and quality improvements in Medicare
Medicaid expansion
Funding for Children's Health Insurance Program (CHIP)
Enhanced fraud and abuse measures



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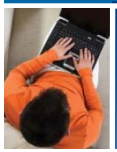
Next Steps

- Administration will issue rules and guidance on implementation over next several years
- State implementation and action
- Additional federal legislative fixes

> *One of the most common phrases in the health reform bill is, 'the Secretary shall.'*
> *– Politico*

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EARLY PROVISIONS

2010 and 6 Months

From Enactment

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Timeline of Reform

January 1, 2010
(Retroactive Date)

- Small business tax credits
- Medicare Part D "donut hole" rebates

March 23, 2010
(Enactment Date)

- Rate review for insured products
- Grandfathered plan status if in effect on enactment

90 Days Out

- National high risk pool
- Early retiree reinsurance program

July 1, 2010

- HHS internet portal for individuals and small group

Sept. 23, 2010

Plan Yrs. 6 Mos. Out – October 1

- Dependent coverage to 26
- Restrictions on rescissions
- No pre-existing exclusion period < age 19
- Preventive services with no cost sharing
- No lifetime limits; restricted annual limits
- Medical Loss Ratio reporting
- Patient protections

2011–2013

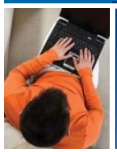
- Minimum Medical Loss Ratio requirements
- Wellness program grants for small employers
- Pharma Tax
- Summary of benefit requirements
- Reporting of quality of care activities
- Comparative Effectiveness Research Fee
- Medicare tax increase
- Medical device manufacturer tax

January 1, 2014

- Guaranteed issue, No pre-ex, modified community rating rules
- Individual mandate and employer responsibility
- State-based Exchanges
- Subsidies
- Medicaid expansion
- Phase II small employer tax credits
- Insurer fee

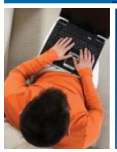
2015–2020

- **2016:** Healthcare Choice Compacts
- **2018:** 40% excise tax on "Cadillac Plans"
- **2020:** Completely close Medicare Part D "donut hole"



Grandfathering Provision — 2010

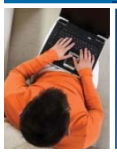
- Plans in effect on date of enactment (March 23, 2010) are “grandfathered”
- Many of the near-term requirements of the law apply to **all** plans, including grandfathered plans
- New employees and family members can enroll in “grandfathered plan” without impacting the plan’s status
- Open issue – What would cause a plan to lose grandfathered status?




Small Employer Tax Credit - 2010

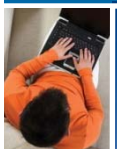
- Estimated value of $40B over 10 years
- Eligible Groups
  - Small employers (fewer than 25 FTE employees)
  - Less than $50k in average annual wages
  - Contribute at least 50% to total premium cost
- Eligible for Full Amount
  - 10 or fewer full-time equivalent employees (FTEs) and $25k or less in average annual wages

- **Phase I**
  - Effective Date: 2010-2013
  - Maximum Tax Credit:
    - Up to 35% of employer costs (25% if tax exempt)
- **Phase II**
  - Effective Date: 2014 and beyond
    - Exchange only
    - Only first two years of coverage
  - Maximum Tax Credit:
    - Up to 50% of employer costs (35% if tax exempt)




Early Retiree Reinsurance – 6/1/10

- New Program with $5B
- For groups with early retirees (age 55 & ineligible for Medicare)
- Plan sponsor applies to be certified by HHS
- Application requires documentation of procedures and ways to reduce participant or sponsor costs
- Eligible claims to file are those between $15,000 and $90,000 per retiree per plan year
- Reimbursed at 80% of health benefit cost
- First come, first served

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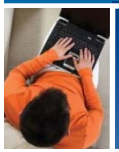
Temporary National High Risk Pool

- $5 billion in federal funding from July 1, 2010–2014
- States can operate program through existing high risk pool or non-profit entity; otherwise HHS will operate
- Eligible individuals:
  - Citizen, U.S. national, or lawfully present
  - Have a pre-existing condition
  - Not covered under creditable coverage for previous six months



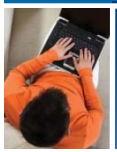

Near Term Requirements – 9/23/10

Benefit Plans

Key Provisions Effective Upon Renewal – Beginning Sept. 23, 2010

No Lifetime Maximums and Restricted Annual Dollar Limits on "Essential Health Benefits"*
Coverage for Preventive Services with No Cost Sharing
Extend Dependent Coverage up to age 26*
No Pre-Existing Conditions for Enrollees under age 19*
Coverage for Emergency Services
Access to Pediatrician as Primary Care Provider for Dependent Children
Direct Access to OB/GYN

* Applies to grandfathered plans - benefit plans in effect on enactment date , March 23, 2010



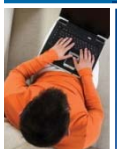

Near Term Requirements

Consumer Protections

Key Provisions Effective Upon Renewal –
Beginning Sept. 23, 2010

Restriction on Rescissions*
Appeals Process
Medical loss ratio reporting*
Transparency

* Applies to grandfathered plans - benefit plans in effect on enactment date , March 23, 2010

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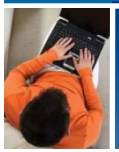
No Lifetime Limits on “Essential Health Benefits”

- Applies to all new plans beginning on or after Sept. 23, 2010
- Applies to all existing plans renewing on or after Sept. 23, 2010
- PPACA contains a lengthy list of benefits that are “essential”
- Open Issues
  - HHS required to further define “Essential Health Benefits”
  - HHS may approve annual dollar limits on certain “Essential Health Benefits”
  - What is a restricted annual limit?

Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Lab services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

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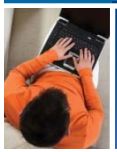
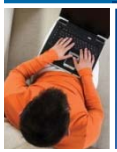
Coverage for Preventive Services

- Only “Restricted Annual Dollar Limits” allowed
  - Applies to all new plans beginning on or after Sept. 23, 2010
  - Applies to all existing plans renewing on or after Sept. 23, 2010
  - Preventive Services in PPACA list of “Essential Health Benefits”
- No Cost Sharing
  - Only applies to new plans beginning on or after Sept. 23, 2010, not grandfathered plans
- Open Issues
  - HHS required to further define “Essential Health Benefits”
  - HHS required to adopt recommendations on “Preventive Services”
  - Secretary may approve annual dollar limits on certain “Essential Health Benefits”
  - Would “office visit maximums” be considered “dollar limits”?



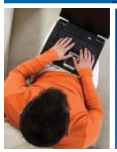

Extend Dependent Coverage up to Age 26

- Applies to all new plans beginning on or after Sept. 23, 2010
- Applies to all existing plans renewing on or after Sept. 23, 2010
- A married child can be a dependent
- Premera and other Blue plans extending this on June 1, 2010
- HHS Rules
  - Can no longer condition coverage on whether a child is tax dependent, a student, resides with or receive financial support from parent, or is married (not required to cover spouses of married dependents, nor children of dependent children)
  - Cannot vary rates or benefits for children based on age



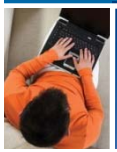

Appeals Process

- Applies to new plans beginning on or after Sept. 23, 2010
- Does not apply to grandfathered plans
- Must have appeals process
- Must provide notice to enrollees, in a “culturally and linguistically appropriate manner” about the process and the availability of an ombudsman to assist with appeal
- Must allow enrollee to review file, present evidence and testimony, and continue coverage pending appeal outcome
- External review is binding and must comply with minimum protections of NAIC Model Act
- Open Issue – Rule-making impacts from DOL and HHS



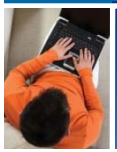

No Pre-Ex Conditions for Enrollees Under 19

- Applies to:
  - All new plans beginning on or after Sept. 23, 2010
  - All existing plans renewing on or after Sept. 23, 2010
- No denial of coverage or exclusion of treatment for enrollees under 19 for pre-existing conditions
- HHS Informal Guidance
  - No exclusion of treatment for pre-existing conditions
  - No denial of coverage based on health condition (guarantee issue required for children under age 19)



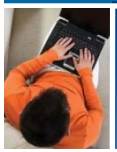

Coverage for Emergency Services

- No prior authorization and prudent lay person standard
  - Only applies to new plans beginning on or after Sept. 23, 2010, not grandfathered plans
- Requires equivalent cost sharing coverage for network and non-network providers



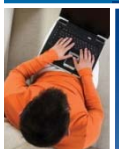

Pediatricians as Primary Care Provider

- Must permit designation of pediatric specialty physician (allopathic or osteopathic) as dependent child's primary care physician, if such provider participates in the network
- Only applies to new plans beginning on or after Sept. 23, 2010, not grandfathered plans, that require or provide for a member to designate a PCP for the child
- Open Issue – What are the practical implications for this requirement for a plan that does not require the designation but allows members to designate a PCP?



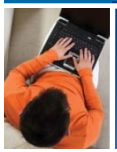

Direct Access to OB/GYN

- May not require preauthorization or referral for OB/GYN care provided by participating OB/GYN specialist healthcare professional who agrees otherwise to adhere to polices and procedures, including those regarding authorization and treatment plans approved by the plan or issuer
- Only applies to new plans beginning on or after Sept. 23, 2010, not grandfathered plans, that require a member to designate a PCP
- Open Issue – What types of providers can be OB/GYN specialists?




Rescissions

- Applies to all new plans beginning on or after Sept. 23, 2010 and renewing plans on or after Sept. 23, 2010
- Prohibits rescissions unless individual has "performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact" as prohibited by the plan

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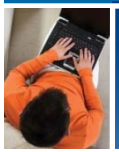
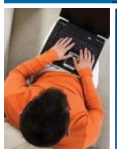
Medical Loss Ratio (MLR) Requirements

- Plan year reporting starting 6 months after enactment
- Makes required reports available on HHS website
- Applicable to insured Individual, Small & Large Group, Grandfathered & Non-grandfathered Plans
- Requires rebates for MLRs below required levels starting in 2011
  - 80% for individual and small group, 85% for large group
  - Permits states to set higher percentages
  - Allows HHS some flexibility to adjust
- Open issues
  - Calculation of MLR to be defined
  - Rebates for employer unclear




Transparency

- Only applies to new plans beginning on or after Sept. 23, 2010, not grandfathered plans
- Must submit detailed information to HHS and applicable state insurance commissioner and make available to the public
- Information includes:
  - Claims payment policies and practices
  - Data on enrollment/disenrollment
  - Rating practices
  - Cost-sharing and payments for out-of-network coverage
  - Financial disclosures
  - Other information as determined by HHS
- Open issues – content, format, and process of data submission




LATER PROVISIONS

2014 and Taxes

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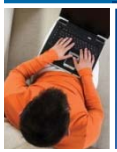
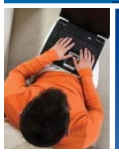
Major Reforms – Effective 2014

- Guaranteed issue, no pre-existing condition exclusions, new rating rules, small group size
- Mandated benefit designs
- State-based Exchange
- Subsidies for individuals up to 400% FPL
- Individual mandate and employer responsibility
- Medicaid expansion



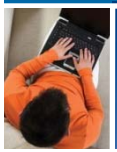

Individual Mandate – 2014

- Requires legal residents to maintain "minimum essential coverage"
- Imposes annual penalty for not having insurance at the greater of flat dollar amount or percent of taxable income:
  - $95 or 1% of income (2014)
  - $325 or 2% of income (2015)
  - $695 or 2.5% of income (2016)
  - Penalty is capped at national average premium for Bronze plan in Exchange
- Exemptions for affordability, gap of less than 3 months, hardship, religious exemption, unauthorized immigrants, incomes below tax filing threshold



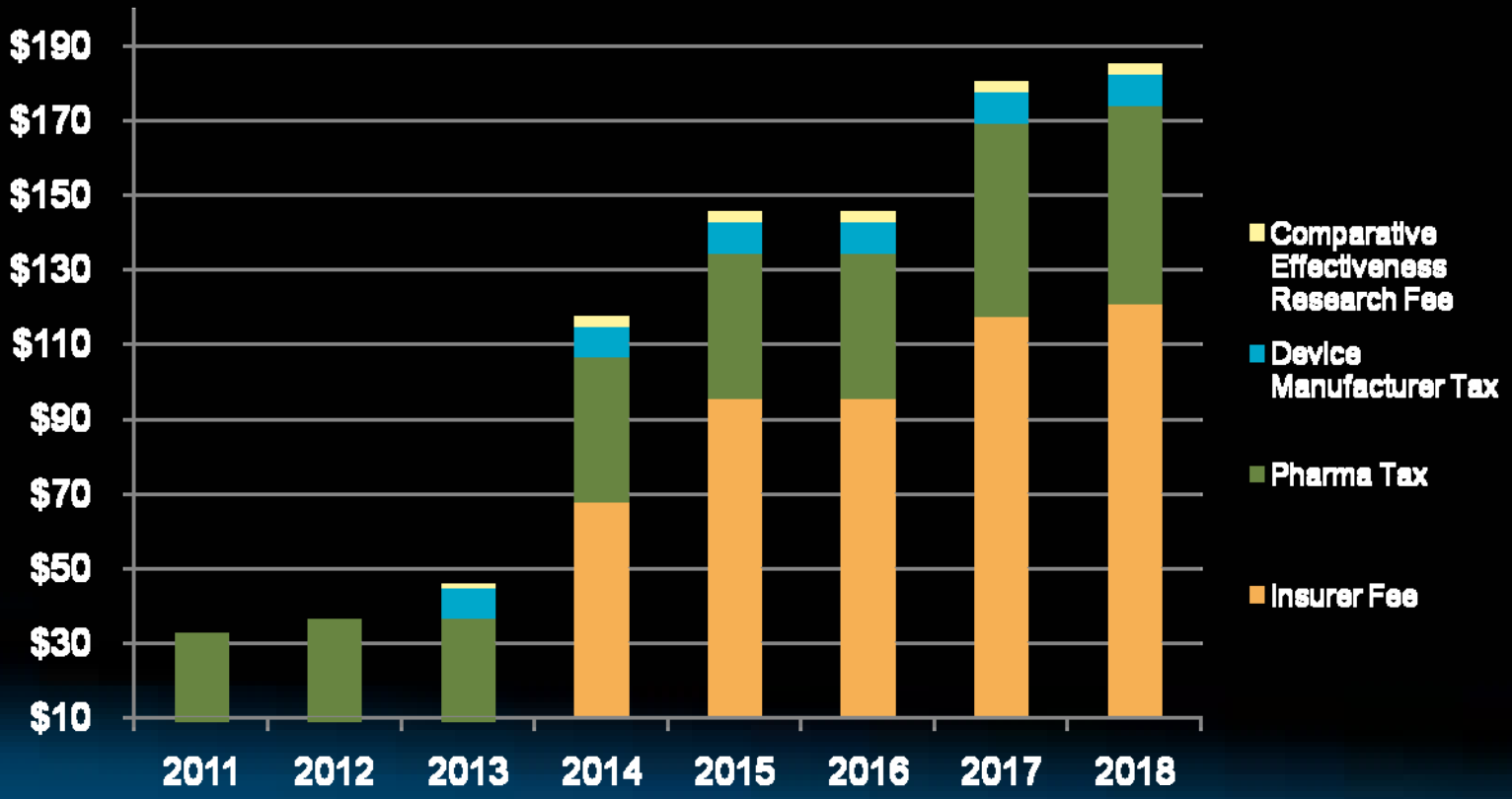

Employer Responsibility – 2014

- Applies to employers with average of at least 50 full-time employees
- Fee must be paid if coverage is NOT offered to full-time employees and one obtains a subsidy in the Exchange
  - $2,000 per full-time employee per year (subtract first 30 employees)
- Fee must be paid if coverage IS offered to full-time employees and one obtains a subsidy
  - Lesser of: $3,000 for each employee getting a subsidy per year OR $2,000 per full–time employee (subtract first 30 employees)
- An employee may be eligible for a subsidy in the Exchange if the employer coverage is below 60% actuarial value or if the employee's premium exceeds 9.5% of income
- Free Choice Vouchers



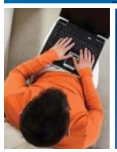

Estimated Impact of Taxes & Fees

($ in millions)



2011	2012	2013	2014	2015	2016	2017	2018	Aggregate
$32.4M	$36.3M	$45.8M	$117.4M	$145.3M	$145.3M	$180.2M	$184.9M	

Aggregate estimated impact to Premera and affiliates assumes pass through from providers

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Questions?