Executive Briefing – International Health & Wellness

Bienvenu! Willkommen! Bien Venido! Welkom! Valkommen! Failte! 'Powitaie!

Welcome!

- Introductions and Format Overview
- Advancing the health & well-being of your global population
- The impact of global health reform on international plans
- Assistance and security strategies
- Trends of multinational employers
- Q&A / Summary

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Agenda

- Global Wellbeing: Current trends and Drivers
- Definition and Model
- Cultural Attunement and Local Engagement
- Country Case Studies
- Questions

> Employers are increasingly seeing the value of developing global benefits policies in part, to ensure global consistency, internal equity, and consistent competitive positioning.
>
> *Source: National Business Group on Health, December 2012.*

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Wellbeing: History and Drivers

US Corporates

Drivers:
- Employer funded system
- Healthcare costs
- Employer Brand

Macro-Economic and Social Factors:
- State systems under cost pressure
- More onus placed on corporates
- Changes in lifestyle and work
- Increase in NCDS
- Increased reliance on international staff
- Changes in psychological contract
- Increased integration of wellbeing

Drivers:
- Benefits equity
- Health/Insurance Costs
- Risk Management
- Duty of Care

Non-US Corporates

Drivers:
- Reputation
- Absence
- Differentiation
- Duty of Care

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Global Trends

Stress is ranked as the top risk-driving wellness program in most parts of the world.

Rank	Africa	Asia	Australia	Canada	Europe	LatAm	US
1	STRESS	STRESS	STRESS	STRESS	STRESS	Physical Activity/ Exercise	PhysicalActivity/ Exercise
2	Physical Activity/ Exercise	Physical Activity/ Exercise	Physical Activity/ Exercise	Work / Life Issues	Physical Activity/ Exercise	Nutrition / Healthy Eating	Nutrition / Healthy Eating
3	Work / Life Issues	Nutrition / Healthy Eating	Work / Life Issues	Depression	Work / Life Issues	Stress	Chronic Disease

Stress alone is a major factor in exacerbating many health problems:

- 5× cancer
- 3× heart problems
- 3× back pain
- 2-3× mental health
- 2-3x infections
- 2-3× injuries
- 2× substance abuse

That Stress is the leading driver is not surprising given globalization, change in working patterns, and lack of job security over the past five years.

Exceptions are the U.S. and LatAm—where exercise and nutrition are of top concern.

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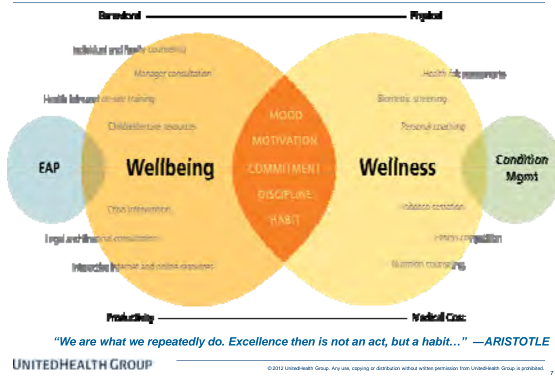
Buck Consultants 2010 Fifth Edition Global Survey of Health Promotion and Workplace Wellness Strategies



Wellbeing: Definition and Model
Manager consultation
Biometric screening
EAP
Wellbeing
MOOD
MOTIVATION
COMMITMENT
DISCIPLINE
HABIT
Wellness
Condition Mgmt
Crisis intervention
Nutrition counseling
"We are what we repeatedly do. Excellence then is not an act, but a habit…" —ARISTOTLE
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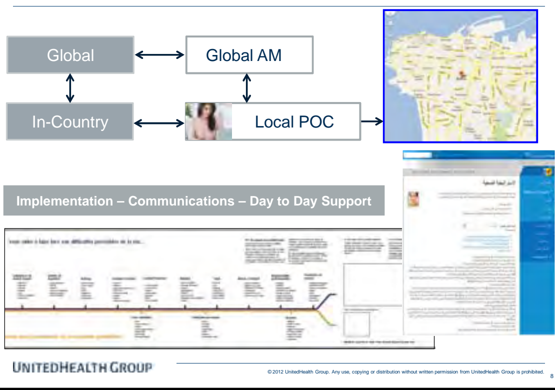

Cultural Attunement
Global
Global AM
In-Country
Local POC
Implementation – Communications – Day to Day Support
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THE IMPACT OF GLOBAL HEALTH
REFORM ON INTERNATIONAL PLANS

AGENDA

Impact of Global Health Reform on International Plans

I. United States – PPACA

II. International

- Middle East (Saudi Arabia, UAE, Kuwait)
- Australia
- Africa

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I. United States - PPACA

- **Patient Protection and Affordable Care Act ("PPACA")**
  - Signed into law on March 23, 2010
  - Broad federal legislation affecting entire healthcare sector
- **Main Goals of PPACA Include:**
  - Implementing immediate individual and group market reform requirements
  - Establishing new federal standards applicable to private health insurance coverage
  - Creating a new insurance marketplace, resulting in expanding access to coverage and the formation of state based Exchanges
    - ✓ October 1 - enrollment for the health insurance exchanges begins; also the deadline for employers to notify their employees of the availability of the health insurance exchanges.
  - Health IT, and prevention and wellness initiatives
- **International Plans:**
  - Expatriate plans & Foreign plans

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United States - PPACA

PPACA's U.S.-Centric Approach

- Cost containment measures using domestic plans as benchmarks (e.g., MLR calculation)
- Efforts to improve and unify the standards for electronic information exchange
- Reporting and disclosure standards and requirements (e.g., SBC requirement)
- Measures to provide more individuals with access to quality health care coverage (e.g., guaranteed issue)
- Measures to prevent discrimination in favor of highly compensated employees (e.g., sec. 105(h) non-discrimination test, excise tax on high value plans)

Expatriate Plans' Unique Features

- Administrative costs are much higher than domestic plans
- Family members sometimes in multiple jurisdictions
- Deal primarily with providers outside the U.S.
- Mainly cover employees working outside the U.S. (and their dependents)
- Expats' compensation tends to be higher
- A broader range of benefits with higher premium value
- Many members are not U.S. citizens or residents
- Compliance requirements in the U.S. and overseas

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United States – PPACA and the Transitional Relief

Expatriate plans – Transitional Relief Granted on March 8, 2013

- **Definition of Expatriate Plan: a fully-insured group health plan with respect to which:**
  - enrollment is limited to primary insureds
  - who reside outside of their home country
  - for at least six (6) months of the plan year and
  - any covered dependents, and its associated group health insurance coverage
- **Transitional Period: Apply to plans with plan years ending on or before 12/31/2015**
- **Conditions:** Must comply with Title 27 of the pre-PPACA PHS Act, and other applicable laws under ERISA and the Internal Revenue Code.
  - Benefits for mothers and newborns
  - Mental health parity
  - HIPAA Non-Discrimination Rules (no discrimination based on health factors)
  - Written claims procedure for all ERISA plans and other reporting and disclosure obligations under ERISA Part 1.
- **Exemptions:**
  - Subtitles A and C of Title I of PPACA
  - Deemed as having met the minimum essential coverage requirements
- **Any exceptions for assignees on a shorter assignment or coverage of a small number of local nationals? Unclear at this point**

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Health Reform Timeline

2010
- Adult child coverage until age 26
- Annual dollar limits restricted
- Early retiree reinsurance program (ERRP)
- ER coverage as in-network, no prior authorization [G]
- Initial appeals review standards [G]
- Lifetime dollar limits prohibited
- Medicare Part D rebate for beneficiaries in the gap
- No pre-existing conditions for kids until age 19
- Online consumer information at healthcare.gov
- Pediatricians as PCPs, direct access to OB/GYNs [G]
- Preventive services with no cost sharing [G]
- Rescissions prohibited except for fraud or non-payment
- Small business tax credit
- Temporary high risk pool

2011
- Annual fee on pharmaceutical manufacturers begins
- Annual rate review process
- Appeals ombudsmen and process documentation [G]
- Auto-enrollment for groups with 200+ FTEs (implementation delayed until regulations released)
- Discounts in Medicare Part D "donut hole"
- HSAs/HRAs/FSAs: limitations for OTC medications
- Increase penalty for non-qualified HSA withdrawals
- Minimum medical loss ratio (MLR): 85% for large group; 80% for small group and individual
- Non-discrimination rules apply to insured plans (implementation delayed) [G]
- Small business wellness grants (implementation delayed)

2012
- 60-day advance notice of material modifications
- Accountable Care Organization requirements
- Appeals provision fully implemented [G]
- First medical loss ratio rebates to be paid by August
- New women's preventive services with no cost sharing[G]
- **Patient-centered Outcomes Research Institute (PCORI) fee ($1 per member/year)**
- Quality bonus begins for Medicare Advantage plans
- Quality of care reporting Requirements (implementation delayed)[G]
- Summary of Benefits and Coverage (SBC) and the Uniform Glossary[G]

2013
- Administrative simplification begins
- Annual fee on medical device sales begins
- Deduction for expenses allocable to the Part D subsidy for "qualified prescription drug plans" eliminated
- Employee notification of access to Exchanges
- FSA contributions limited to $2,500
- High earner tax begins
- **PCORI fee increases to $2 per member/year**
- W-2 reporting on the value of employer-sponsored health benefits

2014
- Coverage for all adult children until age 26 including those that have employer coverage (formerly not covered for grandfathered plans)
- Deductible caps cannot exceed $2K for individual and $4K for family [G]
- Guarantee issue and renewal rules [G]
- Health Benefit Exchanges
- ICD-10 code adoption
- Insurance fee -- permanent
- Individual & employer mandates
- Mandatory coverage for clinical trials [G]
- No annual dollar limits
- No pre-existing condition exclusions
- OOP limits must comply with OOP limits for HSA qualified plans [G]
- Rating restrictions / Adjusted community rating [G]
- Essential health benefits required for small employers[G]
- Tax credits and subsidies for individuals and small employers
- **Transitional reinsurance fee**
- Waiting period limits
- Wellness programs

2015 & beyond
- High-value plan excise tax begins (2018)
- Medicare Part D "donut hole" closed by 2020
- States can open Exchanges to CHIP eligibles (2015) and all employers (2017)

[G] Grandfatherable provision

Note: some provisions apply only to fully insured business (e.g., MLR, insurer fee and guaranteed issue) .

- Red items do not apply to Expatriate Plans based on March, 2013 Transitional Relief.
- Green items do not apply to Expatriate Plans based on relief previously granted.

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Other Special Relief under PPACA

Special relief still applicable to expatriate plans

- **Transitional Reinsurance Program -- 2014 to 2016**
  - Requirements: U.S. health plans and issuers are required to make reinsurance contributions to fund the premium stabilization programs
  - Relief for Expatriate Plans: Fully-insured expatriate plans that qualify for the transitional relief are exempt.
  - **Comparative Effectiveness Research Fee (the PCORI Fee) -- 2012 to 2019**
  - Requirement: Payment of Comparative Effective Research Fees ($1 per covered life for the 2012 plan year, $2 for the 2013 plan year, and the dollar amount will be further adjusted after 2013)
  - Relief for Expatriate Plans (both fully insured and self-funded): Exemption for plans covering primarily expatriate employees working and residing outside the U.S. (including trailing dependents in the U.S.)

Special relief that is less relevant due to the Transitional Relief

- **Medical Loss Ratio ("MLR") standards effective for the 2012 reporting year**
  - Relief for Expat Plans: Qualified Expat Plans may apply a special circumstances adjustment to the numerator of their MLR -- by multiplying the total of the incurred claims plus expenditure for activities that improve health care quality by a factor of 2.0
- **Uniform Summary of Benefits and Coverage ("SBC") effective September 23, 2012**
  - Content Requirements: must provide applicants and enrollees with a four-page (double-sided) SBC in clear language, using prescribed uniform format
  - Relief for Expat Plans: Only need to provide SBCs for the coverage provided within the U.S. and an Internet address for the information regarding coverage outside of the U.S.

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United States – Applicable Fees and Charges under PPACA

Insurer Fees (Proposed Rule) – effective 2014

- **Requirement: Health insurance companies must pay an annual, permanent fee beginning in 2014 (Section 9010 of the Internal Revenue Code)**
  - Based on an insurance company's net premiums written with respect to health insurance for any United States health risk (including U.S. citizens / residents no matter where they're located and foreigners located in the U.S.)
  - Amount is determined by the market share of the health insurance issuer (net premiums of $50M+ will be fully taxed; net premiums less than $25M will be exempt)
- **The proposed rule did not grant any relief for expatriate plans and HHS is seeking public comments**

Excise Tax on Cadillac Plans – effective 2018

- **Cadillac Plans: Group health plans with aggregate benefits value exceeding certain threshold (estimated at $10,200 for individual and $27,500 for family)**
- **Excise Tax: 40% of the excess benefits – the amount of the benefits above the applicable threshold**
- **Challenges: Expatriate plans provide high value benefits (e.g., 24/7 multilingual call center, medical evacuation) and have higher administration costs**

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Employer Mandate – Play or Pay

Who It Applies To

- Mandate applies to **employers with 50+ FTEs** (based on avg. count full- and part-time in prior calendar year) – foreign employers with employees in the U.S. might be subject to the Mandate
- Uses **IRS aggregation rules** to determine if subsidiaries and jointly owned companies treated as one
- Applies to **both fully insured and self-funded** groups
- Applies to **grandfathered** groups
- Must offer coverage to dependents up to 26, but NOT to spouses
- Effective on **January 1, 2015**

Minimum Essential Coverage

- Must **provide "minimum essential coverage"**
  - NOT a limited benefit or mini-med plan, disability, accident, critical illness, indemnity plan
  - "Foreign" plans are NOT recognized as MEC and requires certification under the PPACA regulations
- **Offer must include 95% of full-time employees, and be available to dependents**

Penalty Assessment A

If employer not offering MEC → $2,000 penalty per full-time employee per year (minus 30-employee buffer).

Minimum Value & Affordable

- Must be **affordable**
  - Single employee contribution for lowest cost plan must not exceed 9.5% of household income
  - 3 safe harbors to use as proxies for household income:
    - W2 income, Box 1
    - 130 times hourly wage monthly
    - Poverty level
- Must provide **minimum value**
  - Plan pays 60% or more of medical costs across a typical population

Penalty Assessment B

If coverage fails these tests → Penalty is $3,000 per employee per year receiving subsidy in Exchange.

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Individual Mandate

In 2014, Individuals (for themselves and dependents) MUST…

Qualify for an exemption based on income, religion or status (native American, undocumented immigrant, or incarceration) **OR** Obtain coverage through government program/Exchange, employer or individual insurance market **OR** Pay a penalty

- **The Mandate applies to all applicable U.S. residents, including inpatriate employees residing in the U.S. and considered "resident aliens"**
- **Individual Exchange subsidies are available if no other available coverage is affordable or meets minimum value requirement**
- **Penalties phase in beginning in 2014 as part of tax return:**
  - **2014: Greater of $95 (adult)/$47.50 (child) or 1.0% of family income**
  - **2015: Greater of $325/$162.50 or 2.0% of family income**
  - **2016: Greater of $695/$347.50 or 2.5% of family income**
- **IRS cannot use normal enforcement mechanisms to force people to pay**

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Taxes and Fees Overview

	Description	Effective Date	Timing / Duration	Payment Cycle	Segment Impact	Basis of Assessment
PCORI Research Fee	• Help fund Patient-Centered Outcomes Research Institute • Will assist patients, clinicians, purchasers and policy-makers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings • Expatriate plans for coverage of primarily employees residing outside of the U.S. and their dependents are exempt	10/1/12	Begins 2012 Phases out 2019	July 31 (calendar year following end of plan year)	FI and ASO (ASO paid and remitted by customer) Groups and Individuals	$1 pmpy in year 1 $2 pmpy in year 2
Insurer Fee	• Annual fee on health insurance sector, allocated by market share, to fund health insurance exchange subsidies • Fees assessed on net written health insurance premiums, with certain exclusions. • Might apply to foreign plans covering U.S. health risks; proposed rule contains no exemption for expatriate plans	1/1/14	Permanent	No later than September 30 of calendar year	FI Only Groups and Individuals	Industry wide targets $8B – 2014 $11.3B – 2015 $11.3B – 2016 $13.9B – 2017 $14.3B – 2018 ~ 2.5% of premium
Transitional Reinsurance Fee	• Transitional fees to stabilize individual market; assessed on a per capita basis for both fully insured and ASO members • Fee funds reinsurance for high claimants in non-grandfathered individual market plans, on and off Exchange • Fully-insured expatriate plans that qualify for the transitional relief are exempt	1/1/14	3 Years (2014-2016)	Annual basis for state and federal First payment to be remitted by 1/15/15 for 2014 calendar year	FI and ASO Groups and Individuals	Industry-wide federal targets, to which states may add: $12B – 2014 $8B – 2015 $5B – 2016 ~ $5.25 1st year
Risk Adjustment Fee	• Administrative expenses for the risk adjustment program will be supported by a user fee, estimated to be no more than $1.00 per enrollee per year • This user fee will be collected from issuers of risk adjusted plans in June of the year following the benefit year	1/1/14	Permanent	June (calendar year following end of plan year)	Individual and small group plans in and out of Exchange	Zero sum redistribution of premiums from plans with healthier populations to plans with unhealthier populations Administrative costs is ~$1 pmpy in year 1

Projections based on analysis of study by Oliver Wyman & AHIP 2012

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II. International – Middle East

- **Saudi Arabia**
  - Locally licensed insurance coverage is required for any expatriate employee to obtain work permit
  - Coverage must be provided by insurers licensed by the Saudi Arabian Monetary Agency ("SAMA") (Article 1 of the Executive Regulation of the CHIL sanctioned by Ministerial Decision Number (6131/30/1/S) dated 8/6/1430 H(2/6/2009))
  - Contracting with local providers by non-local insurers is restricted
- **UAE**
  - Abu Dhabi: Compulsory health insurance scheme implemented in accordance with Abu Dhabi Health Insurance Law No. 23 of 2005
    - All nationals must be covered by the public health insurance scheme – Thiqa
    - All expatriate employees must have insurance from an insurer registered with the Health Authority of Abu Dhabi ("HAAD")
    - New regulations – Healthcare Insurers Policy Manual enacted in 2012 provides a framework for the regulation of the health insurance sector
  - Dubai: In the process of implementing a similar mandatory insurance scheme

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International – Middle East

- **Kuwait**
  - Highly subsidized health care system with free public facilities for local nationals
  - Law no. 1 of 1999 – Medical Insurance of Foreigners
    - Residency granted only upon satisfaction of mandatory health insurance
    - Previously private insurance was acceptable to satisfy the requirement
    - Currently the health insurance for expatriates must be provided through the government health insurance scheme
    - Private insurance still common
- **Regional Trends**
  - Health care costs rising
  - Expatriates ability to participate in social schemes no longer free
  - Push towards expatriate participation ($), local licensing requirements and Regional schemes

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Australia & Africa

- **Australia**
  - Australian citizens, legal residents and individuals from reciprocal countries (i.e., Finland, Ireland, Italy, Malta, Netherlands, New Zealand, Norway, Sweden, and the UK) are required to be covered by the Medicare program
  - The Medicare program can only be provided by locally licensed insurers
  - Foreign insurers may cover other overseas visitors (also known as "457 visa holders")
- **Africa**
  - South Africa:
    - Insurers/Intermediaries not licensed as a medical scheme are prohibited from contracting with local providers under the Medical Schemes Act 131 of 1998
  - Kenya:
    - Trend towards requiring foreign insurers to sell insurance products through a registered medical insurance provider

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ASSISTANCE
AND
SECURITY STRATEGIES

Examples of Complacency (1)

Israel / Lebanon Conflict - 2006

- **12 July:** Israel initiates airstrikes on Lebanese border in response to Hezbollah rocket attacks that same day.
- **13 July:** Israel expands airstrikes across Lebanon, including Beirut and the main international airport – closing it until September.
- **20 July:** Sea-borne evacuations by USN/USMC begin.

Many senior level executives on vacation were caught with no way out.

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Examples of Complacency (2)

Arab Spring – 2011

- Latent public sentiment erupts, overturning governments and initiating civil wars in the region.
- Unexpected catalyst was self-immolation of a fruit vendor in Tunisia in Dec. 2010.

Many companies, individuals and schools were unprepared to move when calls came to evacuate.

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Examples of Complacency (3)

Japan - Earthquake & Tsunami of 2011

- Multiple coinciding occurrences from quake, tsunami waves and radiation exposure all within a matter of hours.
- Corporations scrambled to determine risk tolerance, responsibility for dependents and business continuity.

Sorting through the deluge of media reports proved exceptionally challenging for businesses and travelers.

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Being Prepared: Plan, Plan, Plan

Intelligence

- **Be sure that intelligence is real-time and comprehensive.**
  - Provides confidence of knowing that you will be informed – not just of the latest incidents, but also of when the situation itself has changed, which is critical.

> - *Media* only tells you "what"
> - *Intelligence* tells you "why"
> - A *trusted provider* answers the question "What does it mean for me?"

- **Know what the triggers are from your Intelligence Source** that warrant escalation of actions on your part.
- **Ensure that your Intelligence Source's products are aligned** in advance with your company's internal risk tolerance.
  - Every company's tolerance and coverage are different.

What does your company do?

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Being Prepared: Know Your Playbook

- **Withdrawal/Evacuation scenarios must be realistic and executable.**
  - Simpler always = better
  - Playbook should directly address communications and disruption contingencies.
  - Plan components need to be explained for the reader.
- **Remember to expect the unexpected and be flexible.**
  - Asking "what if" ahead of time and having options based on those answers can save a lot of time and trouble when the unexpected occurs.
- **Drill, Drill, Drill.**
  - Drills should be conducted annually, bi-annually or quarterly, depending on scale and exposure of international assets in high-risk locations.

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Being Prepared: Proactive Planning and Response

Advance Questions / Auditing are critical:

- **Where are my people?**
  - Tracking them ahead of a crisis allows for a much faster response.
- **Can I locate and communicate with them?**
- **What are my backup protocols?**
  - Lessons from Arab Spring
- **Who is my response provider in a crisis?**
  - Don't believe marketing slicks
  - Experience counts
  - Vet your providers before a crisis occurs
  - Backup support – if one is good, two are better

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Global Benefits Strategy & Integration

HIGH LEVEL TRENDS

- Vendor consolidation
- Shift to shorter term assignments
- Increased cost sharing in the U.S. and steerage to in-network access
- Continued interest to leverage international plans for in-bound expatriates (a.k.a. inpats).
- Progressive trend of women taking assignments abroad

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Managing Global Trend

PROVIDER DISCOUNTS

- Leveraging international discounts can and do manage costs
- The value of discounts is sometimes opaque due to multiple pricing tariffs
- Volume with providers is not usually as concentrated as in the U.S.
- Cheapest price does not always equal western standards of accommodation

BENEFIT DESIGN CHANGES

- Increased cost sharing can only affect the premiums to a limited degree
- International hospitals prefer/insist on 100% coverage for direct settlement
- PPACA and state mandates limit the reductions that can be made
- Employers historically provide comprehensive coverage to expatriates

CLINICAL PROGRAMS

- Manage chronic conditions cross borders
- Utilize predictive modeling technology to identify treatment gaps
- Support members through a international clinical care team of nurses
- Integration and linkage from wellness programs
- Leverage data and the power of analytics

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Global Benefits Strategy & Integration

- Spread of assignee locations is increasingly diverse
- Clients want & need to know the extent of their exposure
- Consider fines and/or penalties imposed on the plan sponsor, member/employee, broker/consultant or insurer
- Can this impact my ability to conduct business in this market/geography?
- Increasing number of countries with local regulations for expatriates
- Increasing use of state sitused plans for U.S. related assignments
- Onshore vs. offshore

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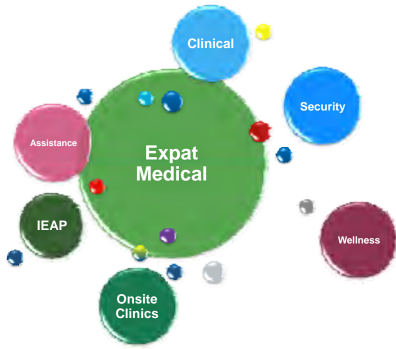
Decentralized Model



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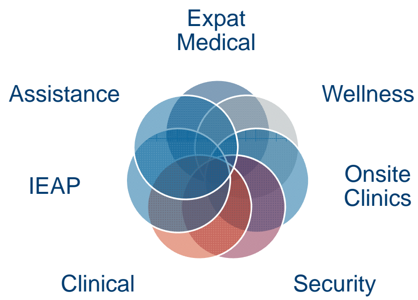
Integrated Single-Source Solution



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