2013 ALABAMA SHRM
STATE CONFERENCE

Creative Benefit SOLUTIONS

BENEFIT TRENDS AND BEST PRACTICES 2013 & BEYOND

PRESENTED BY MARK JOHNSON

Private Exchanges

Defined Contribution

HEALTH SAVINGS ACCOUNTS

OBAMACARE

Better Health Decisions

Health and Wellness

P.P.A.C.A

COBRA

CARROT

Member Engagement

CONSUMER DRIVEN HEALTHCARE

Outcomes

Penalties

STICK

Full Time Equivalents

High Deductible Health Plans

HIPAA

Defined Benefit

Dual Eligibles

Health Risk Assessment

Compliance

Safe Harbor Procedures

Rewards and Incentives

BEHAVIORS

USERRA

SPECIALTY DRUGS

Federally Facilitated Exchanges

SUBSIDIES

MENTAL HEALTH PARITY

Health Reimbursement Accounts

Temporary high risk insurance pool

Small Business Tax Credit

Qualified Health Plan

- Change ……and change is constant!
- Whether the impetus is legislation, cost containment, benefit additions or reductions, or flexible benefits, benefit plans are changing more than ever before.
- This trend is likely to continue due to increasing federal regulations and ongoing evolution in managed care arrangements

History of Health Care
How We Got To
Where We Are

1. **1939: Introduction of group health insurance as an employee benefit and (in the 1940s) exempting the employer/employee premium from federal taxes**. This set the stage for the development of the group health insurance market. The tax exempt status of health insurance premiums remains in effect today.

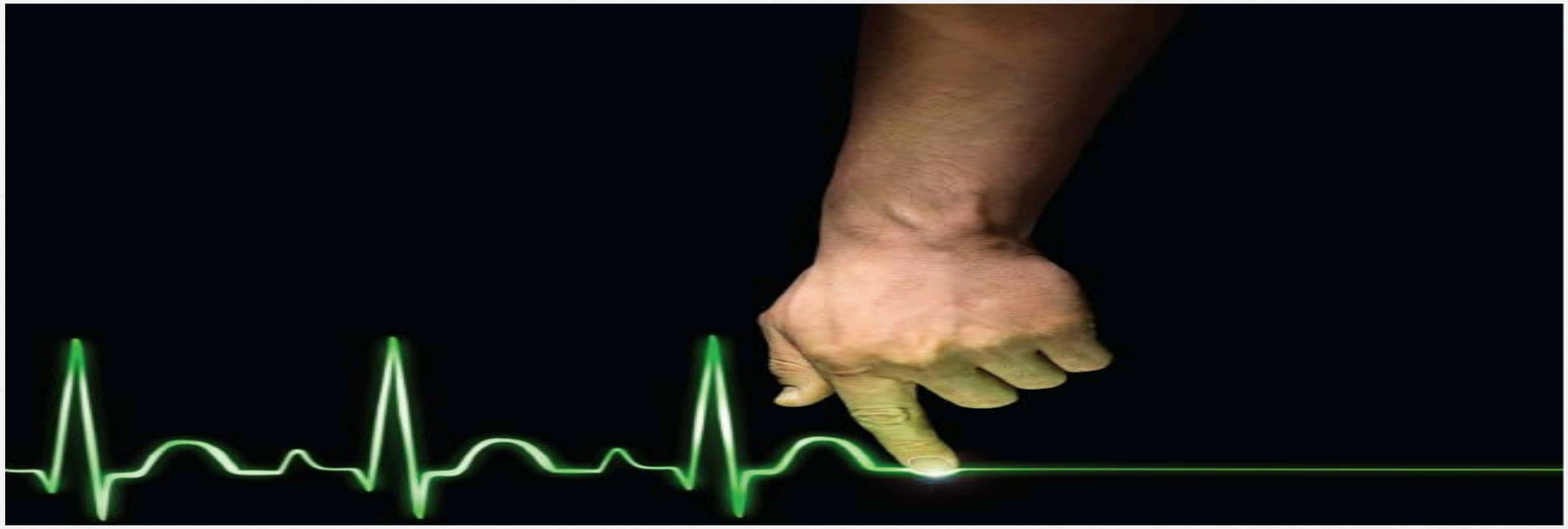
2. **1966: Introduction of Medicare and Medicaid**. The government was now in the health insurance business big-time and created the entitlement programs that now contribute significantly to our deficit.

3. **The HMO Act of 1974**. Managed care was introduced as the "savior" to address the rising health care costs in the country. It worked for awhile, but not so much any more.

4. **The Health Insurance Portability Accountability Act 1996**

5. **2010: The enactment of the Patient Protection and Affordable Care Act (PPACA)**; While we still don't know the final outcome- the legislation was a wake-up call for the country and an attempt to shake-up the unsustainable health care system we have in place today.

DO YOU HAVE YOUR FINGER ON THE PULSE



OR ARE HAVE YOU FLAT LINED?

5

BENEFIT TRENDS AND BEST PRACTICES TO WATCH IN 2013 & BEYOND

1. COST CONTAINMENT STRATEGIES

2. CONSUMER DRIVEN HEALTHCARE

3. HEALTH AND WELLNESS MANAGEMENT

4. HEALTH CARE REFORM

5. 2013 & BEYOND

COST CONTAINMENT STRATEGIES

- Engaging employees and promoting a culture specific to your organization
- Investing in a broad range of existing and emerging cost containment strategies (see chart)
- Rigorously measure and track both vendors and programs performance
- Develop action plans to bridge gaps and opportunities to achieve better outcomes
- Build a link between workforce health and business results.

COST CONTAINMENT STRATEGIES

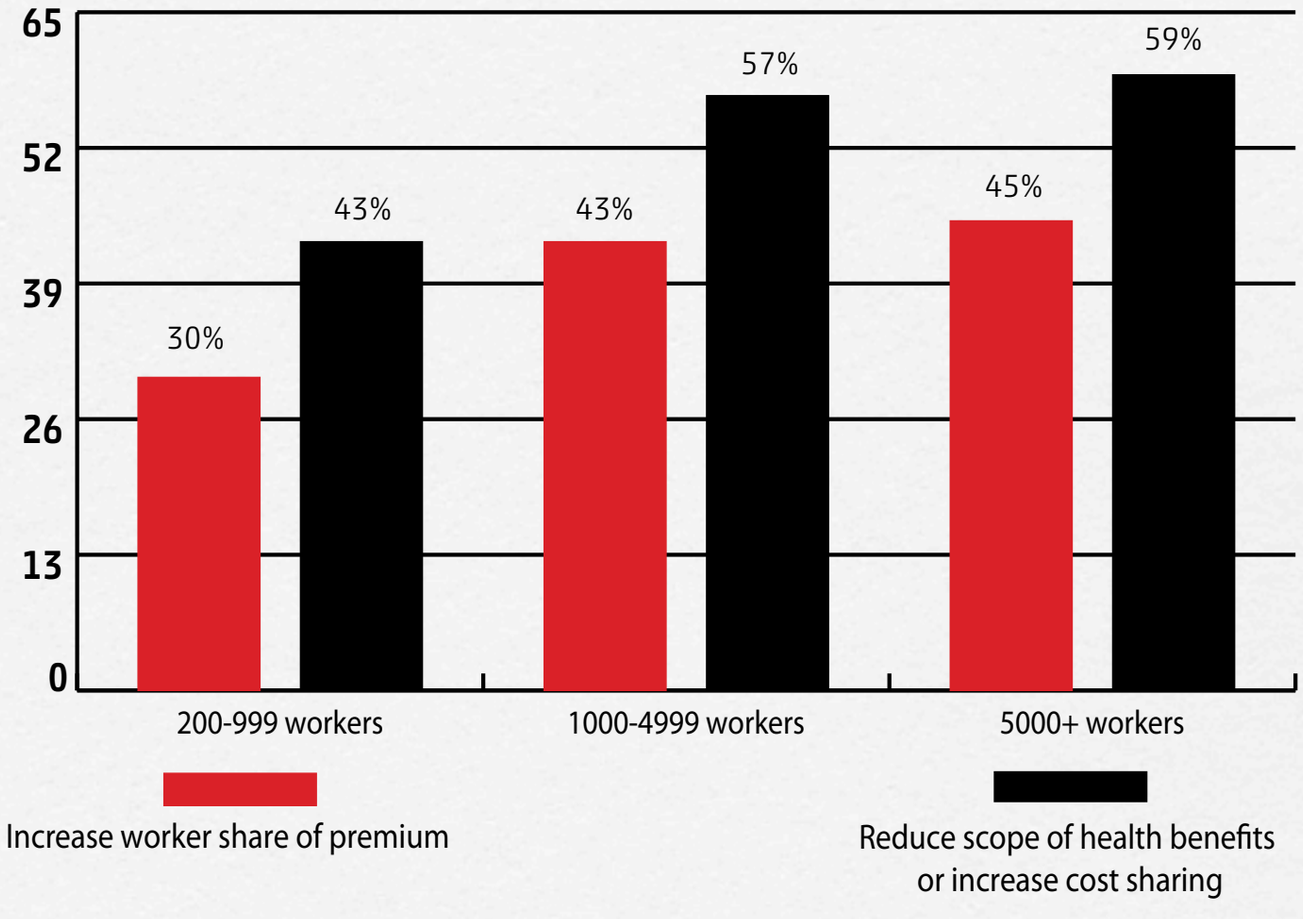
- PLAN SPONSORS ARE BEGINNING TO UTILIZE MORE VOLUNTARY BENEFITS VERUS EMPLOYER PAID CORE BENEFITS
- PLAN SPONSORS LOOK TO ONLINE TOOLS AND MOBILE APPS TO LOWER COSTS
- PLAN MEMBER HEALH DECISIONS ARE BECOMING #1 COST ISSUE
- HEALTHCARE REFORM RAISES QUESTIONS ABOUT FUTURE COVERAGE COST AND OPTIONS
- COMPREHENSIVE DISEASE MANAGEMENT IS BECOMING KEY TO MITIGATE RISING HEALTHCARE COST TRENDS

Cost Control Strategies

Wellness initiatives (onsite clinics, Coaching programs, incentives and penalties)	Carve - out Strategies (Pharmacy, Mental Health)	High Deductible Health Plans (HDHP)
Defined Benefits VS Defined Contribution	Disease Management Programs	Cost shifting (copays, deductibles coinsurance)
Exchanges (Federal, State & Private)	ELIGIBILITY MANAGEMENT Dependent Audits, Spousal Carve - outs	Consumerism (Account Based Strategies HSAs/ HRAs)

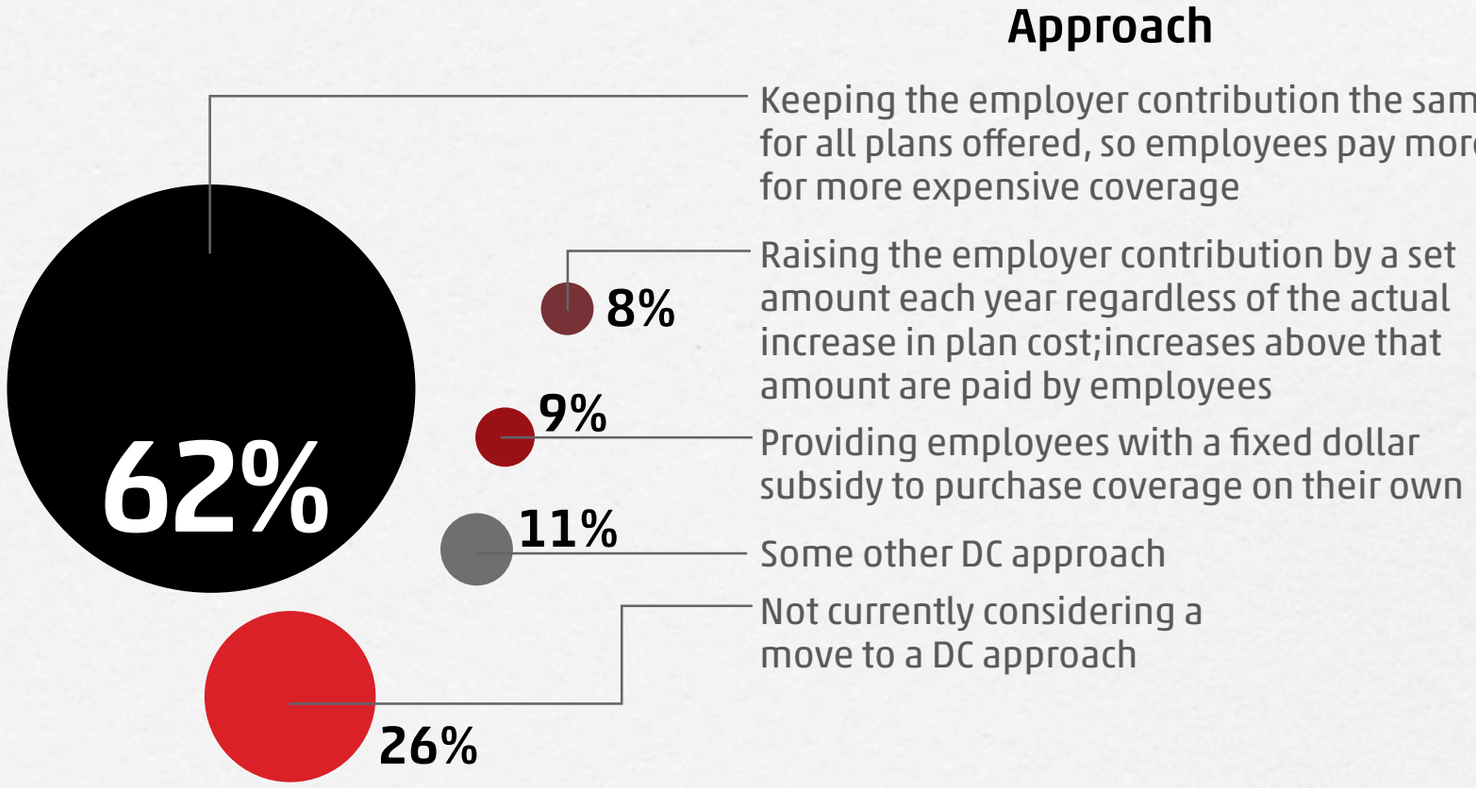
BENEFIT COST HIGHLIGHTS

Strategies to curtail rising costs (percentage of firms adopting the following methods)



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011

Managing cost of health coverage with a “defined contribution” approach



Source: Mercer’s National Survey of Employer-Sponsored Health Plans, 2011

In Order to Decrease Care Cost

Member Touches

Member Treatment Compliance

Change Behavior

Facilitate Timely Interventions

TeleHealth/TeleMedicine

Positive Outcomes of Remote Care Management programs include

- **Billions of Dollars Savings Over Next 25 years.**
- **Double Digit Medication Adherence**
- **Reduction In Hospital Readmission Rates**
- **Increase Member Engagement**

Remote Care Management

1. Keeps members connected and allows them to actively manage their care.

2. Engages members regularly outside a healthcare facility.

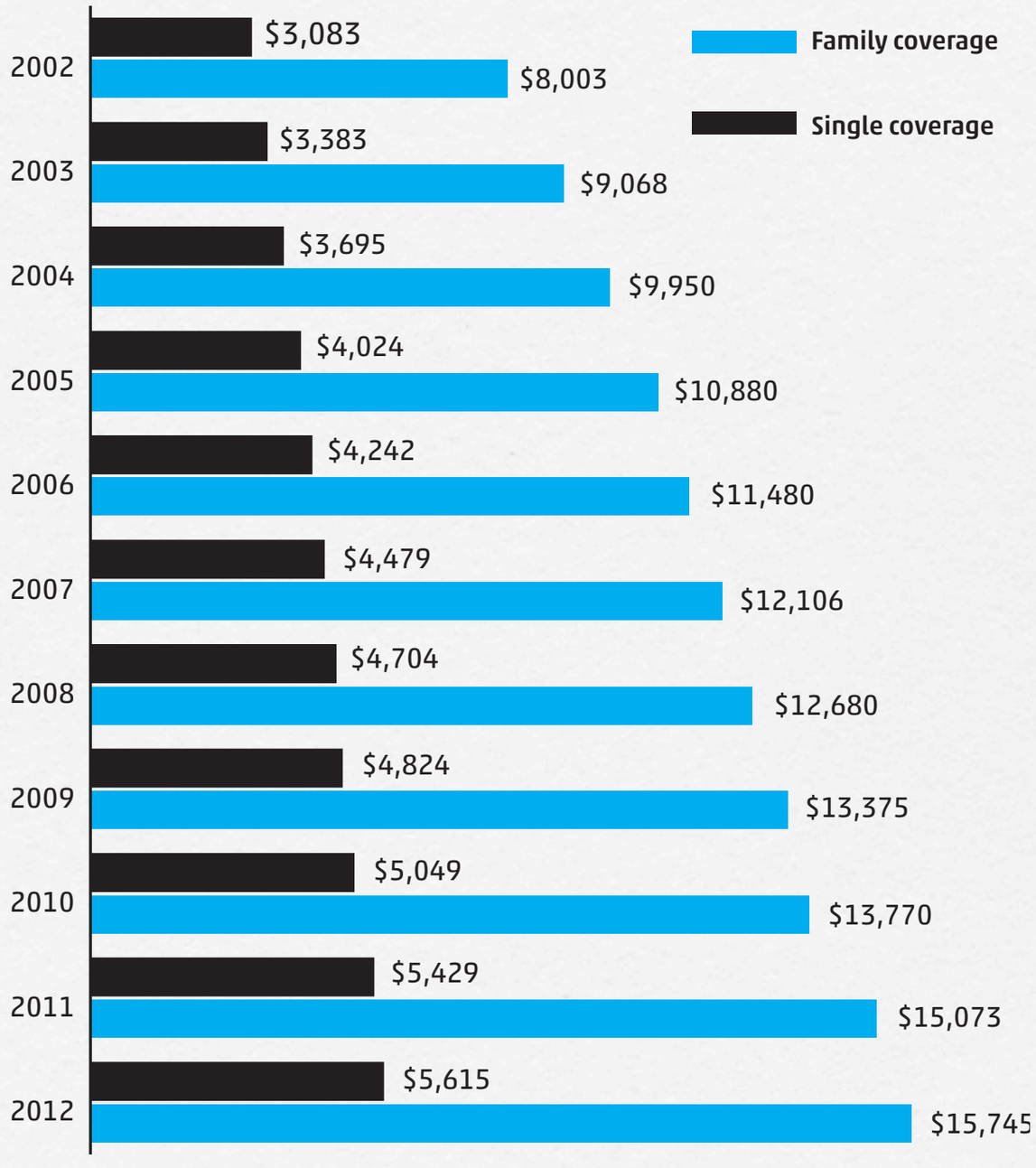
3. Educates members and gives their care team near real - time information.

4. Empowers members to self - manage their health.

5. Facilitates timely intervention if condition worsens.

HEALTH PLANS

Average annual premiums for single and family coverage, 2002-2012



Source: Kaiser Family Foundation and Health Research & Educational Trust, 2012

Employers raising contributions for dependent coverage in 2012

36%
Raise contribution for dependent coverage

33%
Raise contribution for employee-only coverage

7%
Increase cost-sharing some other way

39%
Will not ask employees to pay a greater share of cost

33%
Raise deductibles, copays/coinsurance, or out-of-pocket maximum

Source: Mercer's National Survey of Employer - Sponsored Health Plans 2012

CONSUMER DRIVEN HEALTHCARE

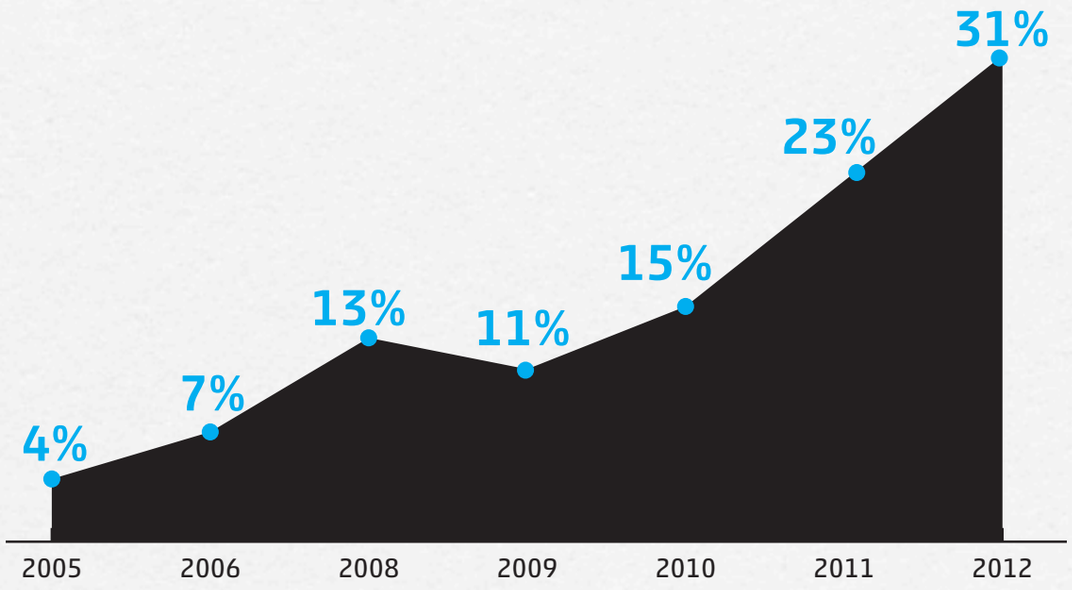
- Health care consumerism is about transforming health benefit plans by putting economic purchasing power and decision - making in the hands of employees.
- The most popular form of consumerism today has included the use of Insurance with some form of personal Account.
- Types of Personal Account: Health Saving Account (HSA), Health Reimbursement Arrangement(HRAs) and Flexible Spending Account (FSA).
- Consumer Driven Healthcare always includes a High Deductible Health plan (HDHP)
- In some instances, Health Care Consumerism benefits have lowered first year claims by 12 - 20%.
- Future Cost trends decrease between 3 - 5%

The Growth of Health Care Consumerism

What is it All about?

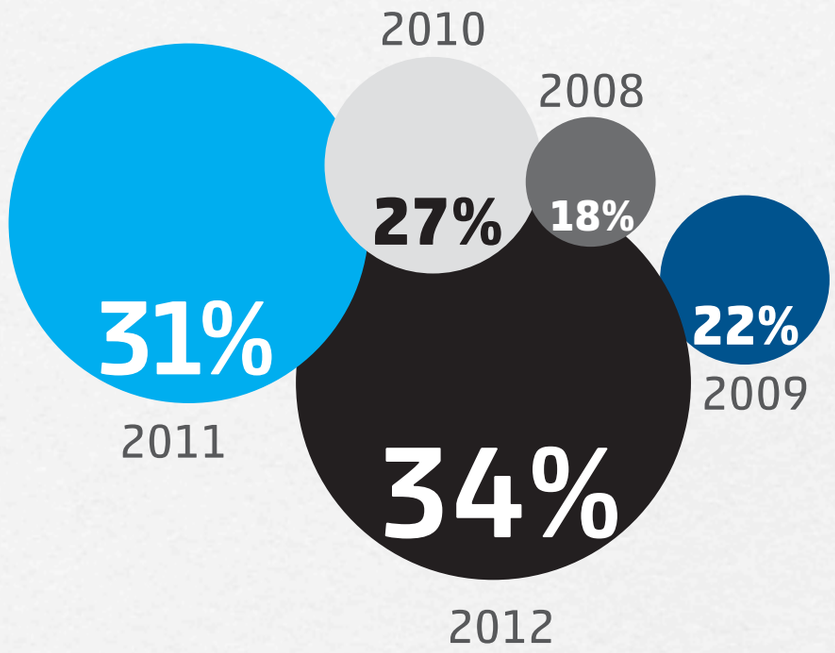
Purchasing Power → **Participant Engagement** → **Decision - making** → **Better Choices**

Growth in high-deductible health plans*



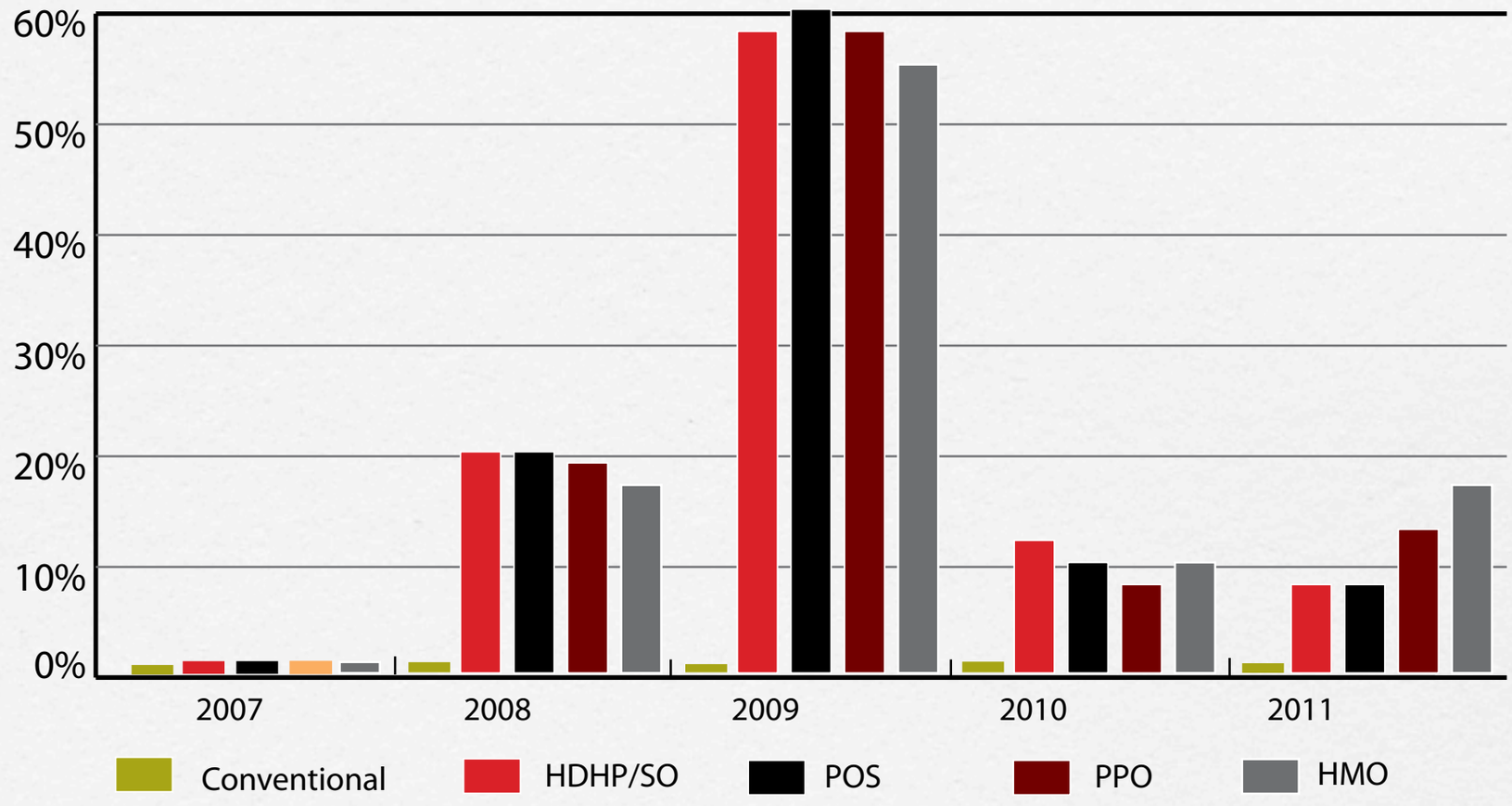
**Among firms offering health benefits, percentage that offer an HDHP/savings option*
Source: Kaiser Family Foundation and Health Research & Educational Trust, 2012

Percentage of covered workers enrolled in a plan with an annual deductible of $1,000 or more for single coverage



Source: Kaiser Family Foundation and Health Research & Educational Trust, 2012

Distribution of health plan enrollment for covered workers by plan type



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011

HEALTH AND WELLNESS MANAGEMENT

There are at least five areas that can be changed to implement financial incentives:

- **Premium - allows employee and employer to share any savings based on the split in how each contributes to the overall cost of the plan.**
- **Employee Contribution Rate - This allows greater flexibility to award employees more or less than would occur by using the "change in premium" approach.**
- **Deductible - Increase of decrease the plan deductible based on compliance standards set in the plan.**
- **Cost - sharing - This would expand on the "change deductible" approach and impact any combination of deductible, coinsurance, maximum out of pocket costs and copayments.**
- **Personal Care Accounts - This would allow direct increases to health savings accounts (HSAs) or Health Reimbursement Arrangements (HRAs)**

HEALTH AND WELLNESS MANAGEMENT

The strategy of linking employee incentives to health and wellness results must follow Federal rules. When an incentive (or penalty) is contingent upon the satisfaction of health status, a plan must:

- ❑ **Be designed to promote health and wellness**
- ❑ **2013 can not exceed 20 percent (2014: 30% to 50% under PPACA) of the total cost of coverage offered**
- ❑ **Be available to all "similarly situated individuals"**
- ❑ **Offer an appeals process**
- ❑ **Provide "reasonable alternatives" when appropriate**
- ❑ **Offer re - assessment at least once per year**

HEALTH AND WELLNESS MANAGEMENT

Testing and Screenings

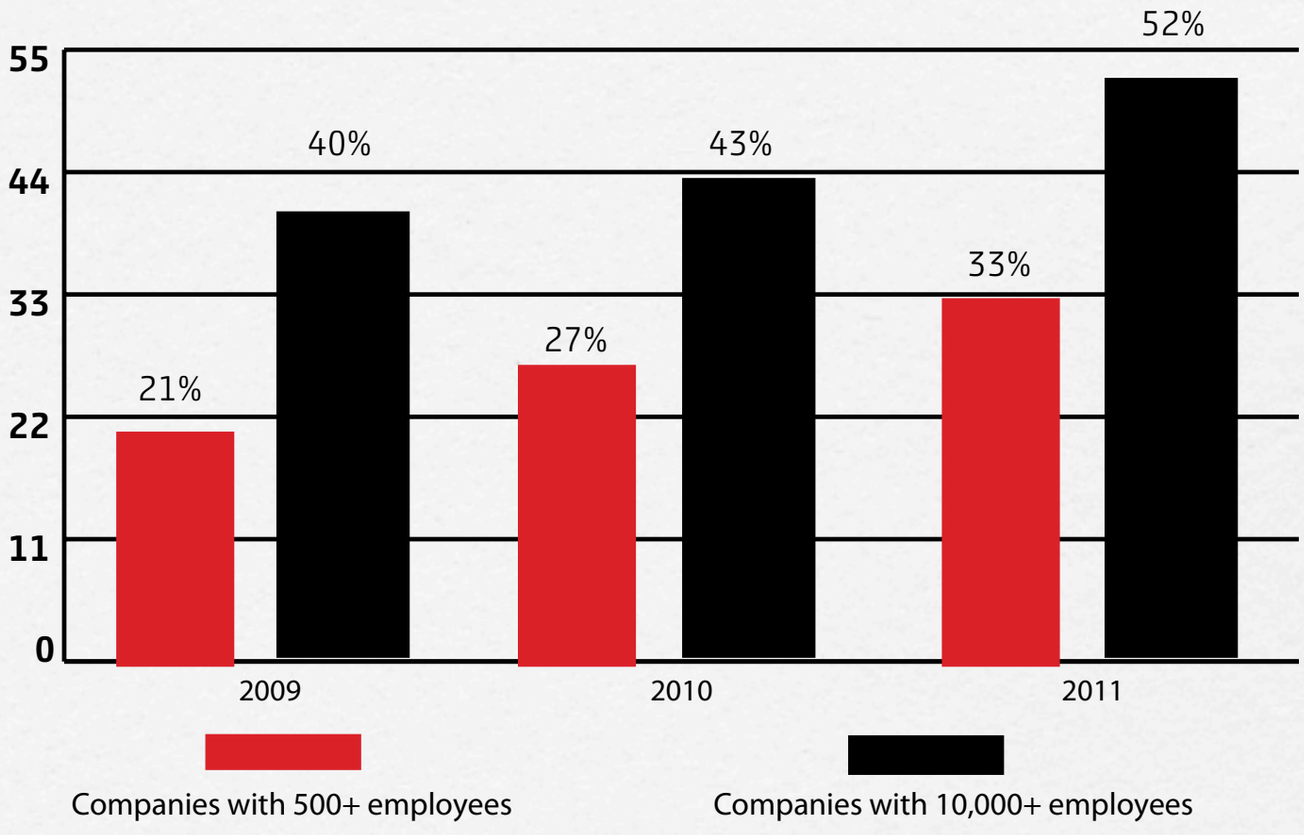
- ☐ **Body Mass Index (BMI)**
- ☐ **Blood Pressure (BP)**
- ☐ **Cholesterol**
- ☐ **Fasting Blood Sugar (FBS)**
- ☐ **HgbA1C**
- ☐ **Urine Protein**
- ☐ **Creatinine**
- ☐ **Pulmonary Function**

HEALTH AND WELLNESS PLAN BASED INCENTIVES

Goal of incentive	Decision Timing	Health Status	Examples
Select optional health plans or provider networks that meet the cost and coverage needs of the member	During Open Enrollment	Distribution between the healthy and ill reflecting underlying enrollee population	Premium tiered health plans
Select a low - cost, high - quality provider	Varies, usually at the point of care	Patient is usually ill or needing service	Point of care tiered health plans
Select a low cost, high quality treatment option	At the point of care	Usually when the patient becomes ill, sometimes before	*Tiered drug benefits * Incentives for following evidenced - based care
Reduce health risks by engaging members to seek care	Ongoing	Varies - the patient has a high risk or chronic condition	Incentives to comply with recommended care (e.g. prenatal care)
Reduce health risk by engaging members to change lifestyle	Ongoing	Varies - the patient has a lifestyle factor that increases health risks	Incentives based on outcomes using biometrics

Source: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

Incentives, penalties for wellness program participation increase



Source: Mercer's National Survey of Employer-Sponsored Health Plans, 2011

Lower Cost

Cash for Action

Incentives

Merchandise

Healthier Habits

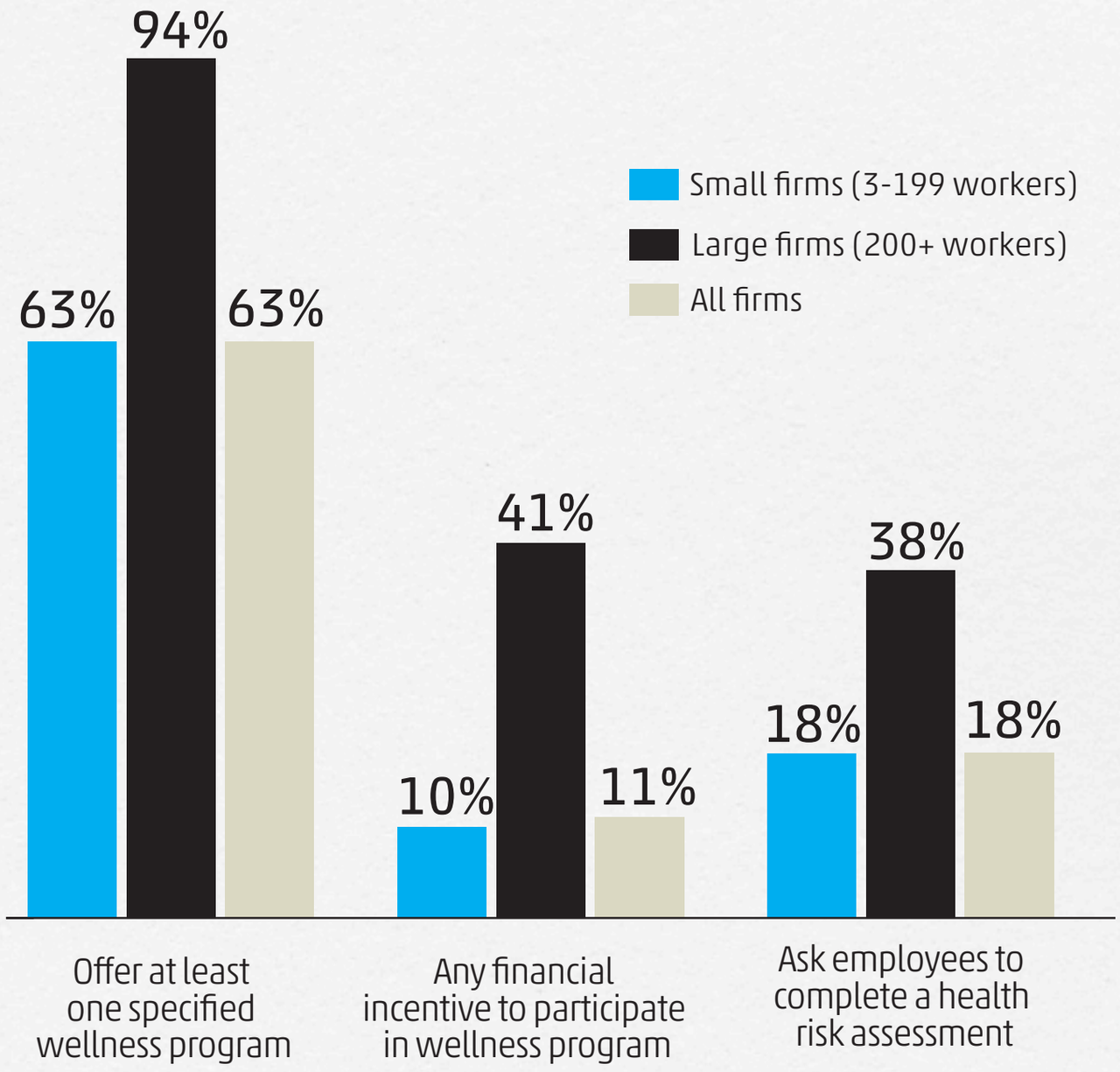
Voluntary Participation

Return on Investment

Premium Reduction

Gift Cards

Percentage of firms offering wellness programs and health risk assessment



Source: Kaiser Family Foundation and Health Research & Educational Trust, 2012

Do you feel like you are about to be consumed ?

Legislation

PPACA and its supplement have already passed, but technical corrections and follow-up legislation is likely to continue.

Regulation

Departments of labor and Health and Human Services have hired over 700 new staff due to the new legislation

Compliance

Consultants, Lawyers and CPA's are finding an expanded need for their services

Litigation

In the end, expect courts to decide what all of the language of the law mean. New laws require a period of adjustment that can take decades to sort out the meaning and conflicts of legal

HEALTH CARE REFORM
Where Are We now?

Employers struggling with compliance

Exchange Notices expected late summer 2013

Exchange Open Enrollment October 1, 2013

Exchange goes Live effective January 1, 2014

Individual Mandate goes into effect January 1, 2014

State of Alabama Action

Expect more Technical corrections or changes

HEALTH CARE REFORM
CHALLENGES & STRATEGIES

- Pay or Play
- Public Exchange versus Private Exchanges
- Four Levels of coverage on Public Exchanges (<u>Bronze, Silver, Gold & Platinum)</u>
- Public Exchanges are expected to offer competitive benefits to small businesses and individuals.
- Small businesses participating in the public exchange may be eligible for tax credit of up to 50 percent of their premium payments if they have 25 or fewer full-time employees whose average annual wages are no more than $50,000.
- Employees with household incomes between 100% and 400% of the Federal Poverty Level (FPL)could benefit from buying health insurance through the public exchange because they can receive either a subsidy or tax credit. In addition, employees at 100% to 200% of FPL will be eligible for reduced cost

HEALTH CARE REFORM
Exchange Eligibility

- All individuals eligible in 2014
- Only small employers (50 or less) eligible in 2014
- 2017 states may allow large employers to be eligible
- **Employers notice should:** Inform employees about the existence of the Exchange

  * Describe the services to be provided by the Exchange
  * Tell how to contact the Exchange to request assistance
  * Inform employees they may be eligible for premium tax credits or cost - sharing reductions through Exchange.
  * Inform employees that they may lose employer contributions toward the cost of employer - provided coverage.

- People eligible for public coverage (i.e. Medicaid) not eligible for premium assistance in Exchange.
- People offered coverage through an employer plan that does not have an actuarial value of at least 60% or the required employee contribution toward the cost of individual coverage exceeds 9.5% of income.

2013 Federal Poverty Level (FPL)
48 Contiguous States and DC

Household size	100%	133%	150%	200%	300%	400%
1	$11,490	$15,282	$17,235	$22,980	$34,470	$45,960
2	$15,510	$20,628	$23,265	$31,020	$46,530	$62,040
3	$19,530	$25,975	$29,295	$39,060	$58,590	$78,120
4	$23,550	$31,322	$35,325	$47,100	$70,650	$94,200
5	$27,570	$36,668	$41,355	$55,140	$82,710	$110,280
6	$31,590	$42,015	$47,385	$63,180	$94,770	$126,360
7	$35,610	$47,361	$53,415	$71,220	$106,830	$142,440
8	$39,630	$52,708	$59,445	$79,260	$118,890	$158,520
additional persons, add	$4,020	$5,347	$6,030	$8040	$12,060	$16080

Source: Federal Register Notice published January 24, 2013

HEALTH CARE REFORM
CHALLENGES & STRATEGIES

Challenges

When Is Employer subject to a potential penalty under the Pay or Play Mandate?

- **An employer has 50 or more full time employees and provide <u>NO COVERAGE</u> to a full -time employee (and dependents) AND**
- **A full time employee applies for coverage on a public exchange AND**
- **The employee receives a subsidy or premium tax credit to help pay for that coverage. 2012 Fed**

Penalty **$2,000 ($166.67 per month) times all employees (>30)**

HEALTH CARE REFORM
Timeline

2013 deadlines to watch:
January 1

*Secretary of HHS to notify states if criteria met to operate state-based health insurance exchanges.
*New sales tax on health insurance totaling $8 billion in 2014, increasing to $14.3 billion in 2018.
* 0.9% additional Medicare tax (from 1.45% to 2.35%) applies to wages exceeding $250,000 for married taxpayers who file jointly, $125,ooo for married taxpayers who file separately, and $200,000 for all other taxpayers.
*New 3.8% Medicare tax on net investment income. applies to modified gross income over $250,000 for married couples filing jointly, $125,000 for married filing separately or an unmarried individual.
*Limit of $2,500 on the amount employees can contribute to Flexible Spending Accounts (FSA)
* Threshold for itemized medical expenses rises from 7.5% to 10% of adjusted gross income for those under 65.
* W2 reporting requirement for value of employees coverage.

2013 continued
January 1

*New limits on business expense deductions employers can take for providing health insurance.
*New 2.3% excise tax on medical devices.
*Patient Centered Outcomes Research Institute fees begin. ($1,2013 and $2 2014).
* Temporary Reinsurance fees begin $63 per covered lives on health plan.

Jan. 1, 2014

* All employers must report aggregate cost to provide group health plan on w-2s.
* States must have established exchanges or Federal government will establish for those not complying with law.
* Employers that have a group health plan must adopt external appeals processes pursuant to federal safe harbor procedures.
*Tax penalties will apply to employers not offereing minimum essential health care coverage.
*Tax penalties for individuals and their dependents if they do not have and maintain minimum essential health care coverage.
* Temporary high risk insurance pool program terminates.
*Early retiree reinsurance program terminates.
*Small employer tax credit increases.
*Employers and Insurers can no longer impose pre - existing condition exclusions.

2014 continued

* Wellness programs can include incentives or surcharges from 30% to 50%.
* Certain employers must file annual informational returns to certify whether they provide minimum essential coverage.

Jan. 1, 2015

*States offering exchanges must ensure they are self sustaining.

Jan. 1, 2017

* States can permit health insurers to offer health plans through exchanges to certain large employers.

Jan. 1. 2018

* Excise tax on high cost coverage applies to group health plans exceeding thresholds.

September 30, 2018

* fees for Patient Centered Outcomes Research Institute Expires.

BENEFITS MANAGEMENT

Cost management approaches to health care reform initiatives

37%
Reduce spending on dependent coverage in relation to employee-only coverage

29%
Add voluntary benefits to transition some non-medical, employer-paid benefits to voluntary

6%
Outsource benefits administration

12%
Move to salary-based employee contributions

22%
Eliminate coverage for early retirees (among those currently providing coverage)

92%
Add or strengthen programs or policies to encourage more health-conscious behavior

Source: Mercer's National Survey of Employer-Sponsored Health Plans, 2011


WHAT'S ON THE HORIZON?

2013 & BEYOND

- More plan sponsors will be adopting strategies to motivate plan member behavior changes.

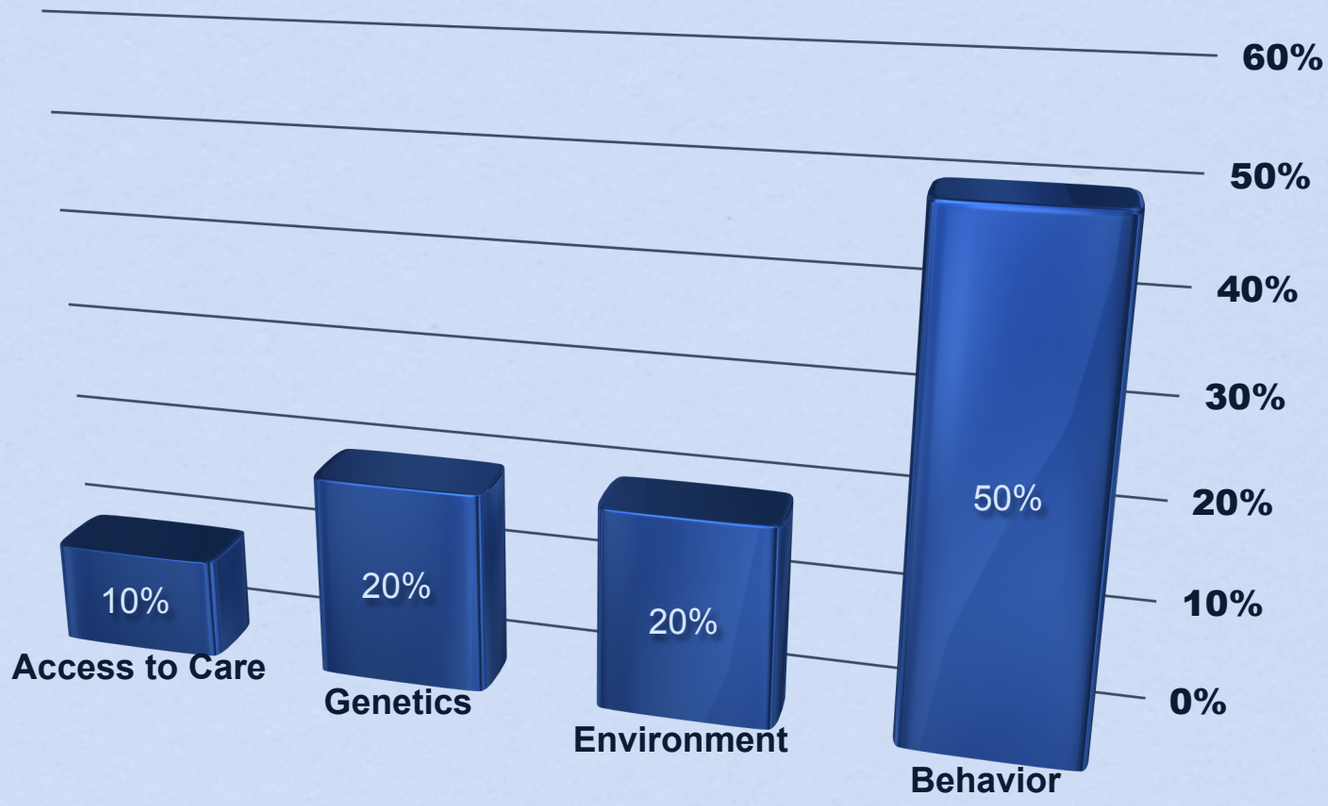
- Critical elements that must be included:
  (1) Education
  (2) Incentives
  (3) Better Decisions

- Plan sponsors will have to implement more creative Incentive strategies regardless if they seem like additional costs with an uncertain return.

- Motivating employees to make better health and health care choices will continue to be complicated.

Today's Health Care Environment and Trends

Determinants of Health



Source: Center of Disease Control and Prevention

2013 & BEYOND

- Prevailing issue for plan sponsors and members will be balancing cost with quality care.
- Nearly all cost control strategies discussed earlier will see increased usage.
- Healthcare reform will impact retiree coverage the most.
- Plan sponsors will continue to be concerned about rising Healthcare cost.
- Most plan sponsors will remain deeply committed to providing benefits to current plan members and retirees.
- Only a handful of organizations will consider moving current members Public Exchanges.

Questions

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