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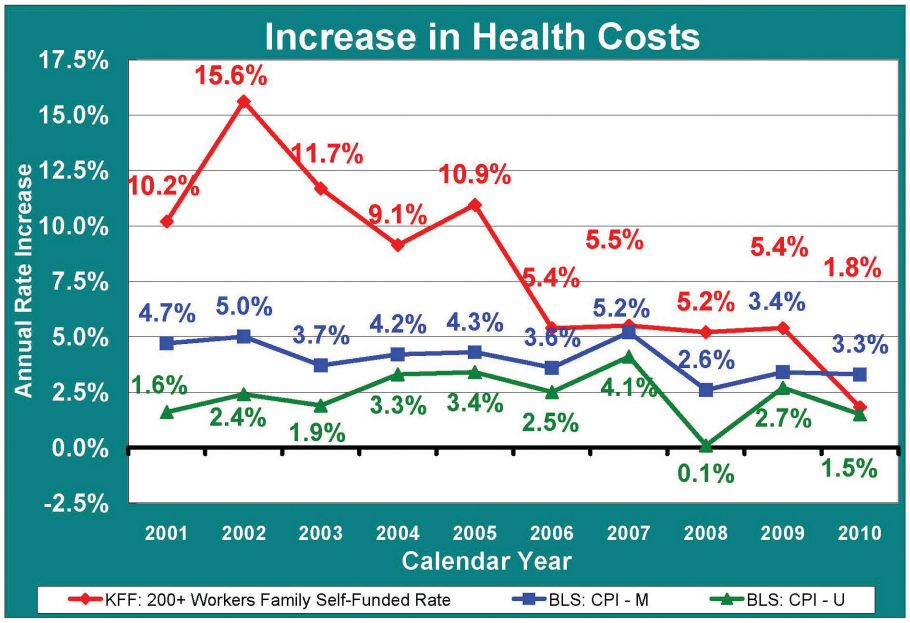
2010-11 Health Care Benefit Review and Outlook

This Advisory reviews health care cost trends, health program trends, medical innovations, key health care legislation, and the current political environment as it impacts health care benefits in the United States.

Health Care Cost Trends



Plan sponsored family average premium rates increased only by 1.8% in 2010 for self-funded groups with 200+ workers, according to the Kaiser Family Foundation (KFF). However, that number is impacted by changes in the structure of employers' health benefit plan designs and contributions. Conversely, benefit improvements are also implicit in the figure. Interestingly and most likely as a direct impact of the Great Recession, the trend was actually lower than the medical component of the Consumer Price Index (CPI). Generally the trend is higher than the medical CPI because of several factors: additional utilization, deductible / copay leveraging, different covered services (services covered by plan sponsors often have higher trend rates than in the entire market basket mix of health care services and products), and cost shifting from government programs and the uninsured. The lower trend indicates that for a typical large group (200+ workers), the health plan members saw a reduction in benefits during 2010. Most large groups would have set their 2010 covered benefits and member (employee) contributions prior to the enactment of the Patient Protection and Affordable Care Act (ACA) signed into law on March 23, 2010.

The unadjusted annualized CPI-U (i.e., the broad inflation measure for "all urban consumers") ending in December 2010 was 1.5%, compared to 2009's 2.7% and 2008's 0.1% inflation rate. The medical care component of the CPI (CPI-M) has stayed fairly constant at 3.3%, compared to 3.4% in 2009 and 2.6% in 2008. Consistent with the above trend, the respective medical associations reported that the nurse and primary care physician supply was adequate in 2010.

Richard Foster, the Chief Actuary for the Centers for Medicare and Medicaid Services (CMS) estimates that the ACA will increase trend slightly with percent of

GDP projected to be 21% in 2019 instead of 20.8% under the prior law. The increased accessibility and hence increased demand for health care services should put upward pressure on health care trends and, therefore, the portion of GDP. However, Foster notes that the ACA has many provisions to control trend both in the short and long-term: preventive care coverage, wellness program incentives, insurance reform, fee adjustments for conditions acquired in hospitals, physician quality reporting, teaching school financing for primary care physicians, quality reporting by plans, competitive pricing in the "exchanges," competitive research, administrative simplification, and augmented fraud and abuse enforcement.

Cheiron consultants saw moderate trends in 2010 as demand was dampened due to the focus on economic recovery from the Great Recession. A lot of plan sponsor energy went into understanding the impact of the Affordable Care Act. In 2011, we anticipate the health care industry to continue to reposition for the anticipated 2014 changes. In the short-term, we anticipate lower trends for insured products and slightly higher trends for prescription drugs.

Health Benefit Plan Trends

The percentage of firms **offering active employees health benefits** increased dramatically in 2010 from 60% to 69% of employers. KFF theorized that stronger firms were able to survive the Great Recession, and that resulted in the figure increasing since the increase was dramatic in the 3 – 9 employee marketplace. The number of full-time workers with access increased only 2%, from 91% to 93%. We note that the Bureau of Labor Statistics' (BLS's) National Compensation Survey (NCS) showed accessibility holding constant at 88% for full-time workers and slightly dropping for all workers 73% vs. 74% in 2009. The discrepancy between firms with at least some union workers vs. those without any union workers continues to remain large with ***94% of firms with some union workers offering health benefits*** compared to only 67% of those firms that had no union workers. NCS shows consistent figures with 93% and 70%, respectively. The health care industry consensus seems to be that the ACA will increase accessibility to health care coverage. CMS predicts the Employer (Plan) Sponsored marketplace will cover 1.5 million fewer persons in 2019 than had the ACA not been passed. RAND's COMPARE microsimulation model predicts a large increase in the number of employer (plan) sponsored plans with 60% of all firms providing coverage through the Exchanges.

The percentage of surveyed "large" plans (defined as those with 200 or more employees) **offering retiree health benefits** continued to drop in 2010 to 28% from 30% in 2009, 31% in 2008, 34% in 2007, and 66% in 1988, according to the KFF.

- **Wellness program** offerings stayed about the same in large plans at 92%-93% but increased dramatically in small plans from 58% to 74%.
- **Wellness incentives** were offered in 23% of large plan sponsors' plans versus 27% in 2009.
- **Disease Management** for at least diabetes was offered in almost all plans.
- **Retail clinic visits** were covered in 43% of all plans, but only 16% of large plans give a financial incentive to use this low cost alternative care.
- **High Performance Networks** were offered in 16% of plans.
- **Performance Indicators** (hospital outcomes, NCQA accreditation, URAC accreditation, and HEDIS) measures are reviewed by 34% of the large plans; of those, 54% are influenced by the measures.
- **Increased Mental Health and Substance Abuse limits** occurred in 75% of large plans in response to the Mental Health Parity and Addiction Equity Act of 2008 with only 2% dropping coverage. Seven percent of plans covering 51 to 200 persons dropped mental health and substance abuse benefits.
- **Prescription drug copays** remain relatively constant for generic and preferred drugs but increased on average between $3 to $4 for non-preferred and specialty drug scripts.
- **High deductible health plan offered by 15%** of plan sponsors; up slightly from 2009.
- **Portion of cost sharing increased** for members at 23% of the plan sponsors surveyed.
- **Benefits decreased** in 30% of the plans.

For 2011, we anticipate fewer benefit reductions and smaller increases in the portion of cost sharing as a result of so many occurring for 2009, slightly better economic times, and the new restrictions on cost sharing changes to maintain grandfathered status under ACA.

Medical Advances

We compared the top ten 2010 medical advancements from Time Magazine, Cleveland Clinic, and Herald Sun and picked the top ten that we thought would most impact our clients:

1. **Cardiopulmonary resuscitation (CPR) is having the "R" taken out.** New American Heart Association (AHA) guidelines reversed the procedure and begin with the 30 chest compressions instead of the breaths. AHA notes that the chest compressions can be done alone.

2. A new blood test is 80% accurate in diagnosing **Alzheimer's disease.** The new test offers hope for slowing the disease because of earlier potential diagnoses.

3. A new **blood test** looking for blood proteins can provide early diagnosis for **heart disease** even if previous tests show low LDL (bad cholesterol). This can allow for possible prevention of heart disease via either diet and lifestyle or early prescription of statins.

4. **Capsule endoscopy** procedure allows gastroenterologists to take 50,000 high definition pictures over 6 to 8 hours in children to diagnose **GI disorders** painlessly.

5. **Transoral gastroplasty, or TOGA**, is a new experimental "scar-less" procedure allowing **obese** patients to lose 40 percent of their excess body weight within a year.

6. Two **drugs** await FDA approval **to treat hepatitis C** using protease inhibitors. The cure rates are higher and the side effects fewer in the clinical trials than current medications. Hepatitis C is a liver disease impacting 3.9 million Americans.

7. **Anti-CTLA-4 drug (ipilimumab)** is more effective in treating patients with advanced melanoma **(skin cancer)**. 23% were still alive after two years compared to 14% receiving the standard treatment.

8. FDA approved the first **therapeutic cancer vaccine** used in patients with advanced **prostate cancer**. It coaxes their own immune system into attacking and removing the cancer, reducing the risk of death by 24%.

9. FDA approved **Botox for migraines** after two large studies proved high success rate.

10. Stem-cell research created a new procedure, **induced pluripotent stem (iPS)**, that reduces viruses and cancers by using RNA genes to produce new healthy cells to replace those in humans that have been destroyed by disease.

Implementation of the Affordable Care Act

2010 was a landmark year for health care with the passage of health care reform or the Affordable Care Act (ACA) as it is called. The ACA has already had an impact on group health plans, health insurance issuers, and the health care marketplace. However, the biggest impact is anticipated to occur between 2014 to 2016, as that is when the exchanges are supposed to begin, expansion of Medicaid to 133% of the federal poverty level is effective, and many of Medicare's new provider incentive payments begin.

Group Health Plans – 2010 Highlights

In the six months after passage of the ACA, interim regulations were issued that directly impact group health plans, affecting the cost, procedure, and administration of group health plans. The interim regulations addressed topics such as:

1. coverage of **adult children below age 26**,

2. **early retirement reimbursement program** (ERRP),

3. **grandfathered** health plans definition,

4. **preventive** care required benefits,

5. rules for external and internal **appeals** processes, and

6. the removal of lifetime limits and allowance of **annual limits** in association with waiver programs prior to 2014.

See the Cheiron Health Alerts found on our website.

Aside from regulations, the Internal Revenue Service (IRS) issued guidance with respect to the tax changes made by the ACA with respect to **health care savings accounts, debit cards, and reporting the cost of health coverage on Form W-2**. Postponement of nondiscrimination rules to insured health plans occurred with a request for comments on proposed regulation. The Department of Health and Human Services (HHS) proposed regulations that would define what could be included in the 85% large plan and 80% small plan **medical loss ratios (MLR)**. Regulations were also issued on the ability of states and/or HHS to review **premium increases** for the appropriateness of the increase.

ACA Impact on 2011

Absent changes in the law, 2011 will be the year in which many of the regulations issued in 2010 will need to be implemented and/or finalized which may require additional modifications to group health plans. Additional interim or proposed regulations that will directly affect group health plans are likely. For example, it is likely that regulations will be issued to define essential health benefits, provide for information reporting for group health plans, and specify uniform explanations of coverage and standardized definitions.

Regulation on health insurance exchanges are anticipated as the ACA provides for the establishment within states on January 1, 2014. The idea is that an individual purchasing insurance through an exchange would be assured of receiving essential health benefits at a fair price. Employers may be able to allow individuals to opt out of their plan. However, there are a number of rules and definitions that need to be issued before the exchanges can be up and running.

Under the ACA and the Internal Revenue Code (IRC), there is a complex inter-related set of provisions that pertain to the purchase of coverage by an employee, the cost-sharing between an employer and the employee, the provision by the employer of affordable health coverage, the provision by the employer of a voucher to purchase health coverage, and the availability of tax credits to the employee to purchase coverage. These provisions are effective on January 1, 2014, but require regulations to define key terms and reporting. It is possible that proposed regulations will be issued in 2011.

Below are 21 provisions of the ACA scheduled to be implemented in 2011. The first three have the greatest impact on our clients:

1. Rebates from issuers if **medical loss ratios** are below 85% for the large group market or 80% for the small group and individual markets, respectively, for 2011.

2. **Medicare Advantage** payment changes freeze 2011 payments at 2010 levels and prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.

3. Changes to tax-free savings accounts (e.g., **FSA, HRA, HSA** or **MSA**) only allows reimbursement for **over-the-counter drugs** prescribed by a doctor.

4. **Medicare premiums** are higher for beneficiaries with incomes above $85,000/individual and $170,000/couple.

5. Closing of the **Medicare Drug coverage gap** by forcing (via removing drugs off of the Part D formulary) pharmacy manufacturers to provide 50% rebates if individuals are in the doughnut hole and have no other coverage. (This can have an indirect impact to our clients.)

6. Medicare 10% bonus payments to **Primary Care** providers.

7. **Preventive care benefits** are covered in full under Medicare.

8. Creation of the **Center for Medicare and Medicaid Innovation** for the purpose of developing and testing new delivery payment models while maintaining or improving quality.

9. **Medicaid health homes** creates a state option to permit certain Medicaid enrollees to designate a provider as a health home and provides states taking up the option with 90% federal matching payments for two years for health home-related services.

10. **CLASS** Program establishes a national, voluntary insurance program for purchasing community living assistance services and support (CLASS program).

11. HHS is to have a **National Quality Strategy** that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.

12. Provide **grants to small employers** for establishing **wellness programs.**

13. **Chronic disease prevention grants** provided to states for their **Medicaid enrollees** with incentives to participate in comprehensive health lifestyle programs and meet certain health behavior targets.

14. Teaching Health Centers are given **payments for primary care residency** programs in community-based ambulatory patient care centers.

15. **Medical malpractice grants** up to $50 million for five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

16. **Health Insurance Exchanges grants** are being provided to states to begin planning for the establishment of American Health Benefit Exchanges and Small Business Health Options Program Exchanges.

17. **Nutritional labeling** is being required on standard menu items at chain restaurants and food sold from vending machines beginning March 23, 2011.

18. Prohibit federal payments to states for Medicaid services related to certain **hospital-acquired infections** beginning July 1, 2011.

19. Increase the number of **Graduate Medical Education (GME)** training positions by redistributing currently unused slots and promote training in outpatient settings beginning July 1, 2011.

20. **Medicare Independent Payment Advisory Board** is to be established, comprised of 15 members, to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds targeted growth rates. Funding available October 1, 2011; first recommendations due January 15, 2014.

21. **Medicaid Long-Term Care Services** created using the State Balancing Incentive Program to provide enhanced federal matching payments to increase non-institutionally based long-term care services and establishes the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities. **Implementation:** October 1, 2011.

The Political Environment

The ACA was passed in March 2010 with a Democratic majority in both the House and the Senate. While there was some bipartisan agreement on some of the provisions of the law, the Republicans were loud in their general opposition after enactment. Repeal of the ACA became a centerpiece of many campaigns during the Congressional elections held last fall. The new Republican majority in the House has vowed to pass a repeal of the ACA. As a practical matter, with the Senate remaining with a Democratic majority, repeal is unlikely and would be met with a Presidential veto. What is more possible is that the House will attempt to refuse to appropriate money for HHS to issue implementing regulations or to carry out certain provisions of the law. Note that items 12, 13, 14, 15 and 16 above under 2011 are direct grant money.

The true test for the ACA will be with the 2012 election. If the Democrats win enough votes to maintain control, then the ACA will likely be implemented close to its current form. Repeal would then be difficult once the full implementation has begun on January 1, 2014. However, if the Democrats lose control in 2012, then health care reform could become substantially different.

Florida filed a lawsuit against HHS stating that it is unconstitutional to require an individual to purchase health insurance (or face a tax penalty). As of January

18, 2011, 26 states have joined Florida. The states that have joined Florida are Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming. Separately, Virginia filed a lawsuit, and a district court ruled that the requirement to purchase insurance is unconstitutional. That decision has been appealed to the 4th Circuit. Two district courts (Michigan and Pennsylvania) have rejected that view. Most recently, the Florida lawsuit resulted in a district court ruling that the entire law, not just the requirement to purchase insurance, is unconstitutional. We expect that the litigation will continue throughout 2011 and go to the Supreme Court at some point.

Cheiron is a full-service actuarial consulting firm assisting Taft-Hartley, public sector and corporate plan sponsors manage their benefit plans proactively to achieve strategic objectives and satisfy the interests of plan participants and beneficiaries. To discuss how Cheiron can help you meet your technical and strategic needs, please contact your Cheiron consultant, or request to speak to one by emailing your request to ***info@cheiron.us****.*

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