MILLS BENEFIT GROUP, LLC

801 BROADWAY NW, SUITE 203
GRAND RAPIDS, MI 49504
(616) 459-1069
OR (888) 823-0334

BENEFIT INFORMATION RELEASE
JAMIE R. MILLS, PRESIDENT
NOVEMBER 2009
WWW.MILLSBENEFITGROUP.COM

Health Care Reform

The House of Representatives (as everyone knows) passed their legislation for health care reform. Many of us in the industry, prefer to acknowledge this as "insurance reform", as we cannot find the way this is really changing how people take care of their "health".

This newsletter outlines some of the important features of the House Bill. Obviously, the bill now has to go to the Senate and then back to both chambers.

One issue you need clarification on is the COBRA subsidy that is about to expire December 31, 2009. To date we have not heard if there will be an extension. Some members of the Senate have introduced a bill that would extend the subsidy for an extra six months and increase the subsidy amount from 65% to 75%. As soon as we know- we will let you know.

If an extension does not take place, those who are terminated after December 30, 2009, will not qualify for the subsidy. Those who lose their jobs up through December 30, 2009, will get the 9 month subsidy. (If loss of job is 12/31/09 COBRA would start 01/01/2010, and there would be no subsidy.) For those who started the subsidy in March 2009, they will lose their subsidy as of December 1, 2009, and will have to pay the full premium.

I fully expect they will pass the extension, but the legislators are hoping it will be part of the final health care legislation. I do not think they want to extend it if they believe the full bill will be passed by December 31st. If the bill is not passed by December 31st there will likely be an extension. I would recommend holding off any communication for another month.

COBRA

What did the House Reform bill say about COBRA? For those in self-funded plans, this might be very expensive! The House healthcare bill would allow ***COBRA participants to keep their coverage until a government-regulated insurance exchange is up and running or*** *until affordable alternatives become available.*

We all know that the COBRA premiums paid never cover the cost of COBRA participants. Having COBRA participants remain on the self-funded plan on an indefinite basis, puts an added exposure on the overall plan.

TAX ON PLAN

One of the "quiet" parts of the bill is the requirement for employers with payrolls above $500,000 to ***either*** *provide health insurance or pay a 8% tax penalty. The tax is a bargain!*

For example*:*
Most health plans for 100 employees will cost $1 million dollars.
Assume: Average payroll of $45,000 per person = $4,500,000
Payroll tax of 8% = $360,000
Savings to terminate health insurance and pay the tax: $640,000.

However, if the actual cost of a self-funded plan is truly 90% claims and 10% administration,

Continued on Page 2

Pages	Table of Contents
1-2	Health Care Reform
2-4	Health Care Modernization News

then true claims of $900,000 actually exist. How will the same costs be paid with a $360,000 tax? I realize there is waste in the system, but do not believe it is that large.

For every employer, paying the 8% tax would be a financial gain to their corporations. What is not discussed is if the employer pays the tax, is that tax credited directly to those employees to purchase coverage in the "exchange". We would assume so, but it is not discussed.

MEDICARE ADVANTAGE PLANS

Under the House bill, they anticipate a 64% reduction in retirees enrolled in Medicare Advantage plans. That is really unfortunate. Medicare Advantage plans do receive a subsidy from the government, but it is to help " manage health". Medicare does not manage care. Medicare Advantage plans have only been available a few years and it is too early to declare they have not managed care any better than regular Medicare. However, both Houses of Congress support the removal of the subsidy to pay for the other aspects of the bill, so we know if any reform passes, this subsidy will be eliminated. We also know the insurance carriers will remove themselves from this market if the subsidy is eliminated.

It will continue to be an interesting discussion. We all agree, healthcare costs cannot continue to escalate at 130% every ten years. The answer to this problem is very complex. As the baby boomers retire and join the Medicare ranks, the reimbursement to providers has to increase. They cannot provide care with lower and lower reimbursements which results in more cost shifting to the private sector.

Interestingly, the State of Maryland, reimburses all providers the same. This includes private carriers, Medicare and Medicaid. It seems to be working there. We realize not all demographics are the same, but an even playing field for reimbursements, would certainly be a step in the right direction.

On behalf of the Mills Benefit Group Team, we wish you and your families a Happy Thanksgiving.

Jamie R. Mills, GBA
President
Mills Benefit Group, LLC

Health Care Modernization News

HOUSE RELEASES MERGED HEALTH REFORM BILL

On October 29th , leadership in the House of Representatives released a bill entitled the "Affordable Health Care for America Act" that merges legislation passed in July by the three House committees (Education and Labor, Energy and Commerce, and Ways and Means) with jurisdiction over health reform. The CBO estimates that this bill will cost $894 billion over ten years and cover 36 million of the 54 million uninsured. To pay for the cost of the bill, the Committee places a 5.4% surcharge on adjusted gross income above $1 million for married couples and $500,000 for singles, reduces provider payment rates under Medicare, reduces spending for the Medicare Advantage program, obtains prescription drug rebates and discounts for Medicaid and Medicare Part D from pharmaceutical companies, places a 2.5% sales tax on medical devices, and makes changes to HSA and FSA rules reducing the allowable limits:

Insurance Market Rules Effective in 2010: Several insurance market rules would take effect in 2010, including government review of health plan premiums and a requirement that 85% of premiums be spent on medical care, prohibition of lifetime benefit limits for individual and group plans, a requirement that health plans cover children as dependents through the age of 26, and prohibition of coverage cancellation or rescission except in cases of fraud. Prior to the implementation of new market rules and the Exchange in 2013, the House bill also establishes interim provisions between 2010 and 2013 that extend COBRA eligibility, shorten the pre-existing

Continued on Page 3

condition "look back" period to one month and the benefit exclusion period to three months, and establish high risk pool provisions for individuals who can not obtain coverage due to health status or a pre-existing condition.

Insurance Market Rules Effective in 2013: Beginning in 2013, the House bill makes additional insurance market changes that require guarantee issue and renewal of coverage, prohibits pre-existing condition exclusions and premium variation based on health status, and allow premium variation only for age, family size, and geographic area. The new market rules apply to all health plans inside and outside the Exchange. Starting in 2015, states could pass legislation to form "Health Care Choice Compacts" to allow the purchase of individual insurance across state lines.

Public Plan and CO-OPs: The House bill establishes a national public plan in 2013 to compete with private insurers in the Exchange.

Provider rates for the public plan would be negotiated and providers are presumed to participate unless they opt- out. The House bill also provides start-up funding to states to establish not-for-profit member-governed cooperative health plans (CO-OPs) to compete with private insurers and the public plan in the Exchange. CO-OPs and the public plan must comply with the same rules as other plans in the Exchange. States are not required to establish CO-OPs.

Exchange: A national health insurance "Exchange" is established in 2013 and would be operated by a new federal agency, the "Health Choices Administration (HCA)." The Exchange is designed to serve as a facilitator of comparison shopping, enrollment, and subsidy administration, a regulator of plan standards and rules, and a negotiator of premiums and contracts with health plans. All individuals who purchase coverage outside the group market or whose premiums are more than 12% of income (and are not eligible for Medicare or Medicaid) are eligible to purchase coverage through the Exchange. **Participation in the Exchange is voluntary, but no individual market exists outside the Exchange except for grandfathered plans.**" Employers can purchase coverage through the Exchange if they have up to 25 employees in 2013, up to 50 employees in 2014, and up to 100 in 2015).

Benefit Plans: In 2013, individuals have a choice of four plan types including Basic" (70% actuarial value), Standard" (85% actuarial value), Premium" (95% actuarial value), and "Premium Plus" (value over 95%). A new independent "Benefits Advisory Committee" is created to define and update the requirements for the minimum benefit plan or "Basic Plan." Plans are prohibited from having annual or lifetime benefit limits or establishing cost sharing above $5,000 individual/$10,000 family. Plans are required to cover a list of specified mandated benefits, but states may establish additional benefit rules. Individuals may keep their current coverage ("grandfathered plans") instead of enrolling in one of the four new plans, as long as no change is made in cost-sharing, contract terms, or benefit levels. Employers are required to at least meet the requirements of the "Basic Plan" by 2018.

Coverage Mandates, Penalties, and Subsidies: Beginning in 2013, individuals are required to have health insurance coverage that is either a "grandfathered plan," a government plan (Medicaid, Medicare, and the like), an employer-based plan (until 2018), or an individual or group plan that meets or exceeds the qualifications of the federally-defined minimum benefit plan ("Basic Plan"), or pay a 2.5% of income tax penalty. Waivers are allowed for Native Americans, those with religious objections, dependents, and individuals with a financial hardship defined as premiums over 12% of income. Individuals up to 400% of the federal poverty level ($88,000 for a family of four) are eligible for sliding scale premium and cost-sharing subsidies. **In 2013, employers with an annual payroll over $500,000 are**

Continued on Page 4

required to offer health insurance coverage to their employees or pay an 8% of payroll tax penalty. Employers must pay 72.5% for single and 65% for family coverage of the lowest cost qualified plan to avoid the penalty. Employers are also subject to the penalty for employees in the Exchange obtaining subsidies if the cost of employer-based coverage is higher than 12% of the employee's income. Employers with an average wage below $40,000 and 25 or fewer employees are eligible for up to a 50% premium credit for two years.

Medicaid and the Children's Health Insurance Program (CHIP): Medicaid eligibility is expanded to 150% of the federal poverty level for all individuals in 2013 with full federal funding of the expansion in 2013 and 2014 and 91% federal funding to states starting in 2015. States are required to maintain existing Medicaid eligibility; states are also required to maintain CHIP eligibility, but only until 2013 when CHIP beneficiaries will get coverage through the Exchange. The bill also extends enhanced federal Medicaid funding from the stimulus bill (ARRA) to states until June 2011.

Medicare: The House bill reduces payments for Medicare Advantage to 100% of Medicare fee-for-service spending by 2013 and establishes quality bonuses for plans with high quality scores in markets with low Medicare fee-for-service spending and high Medicare Advantage enrollment. By 2019, the "donut hole" or coverage gap under Part D is eliminated. Pharmaceutical manufacturers are to provide a 50% discount for brand name drugs purchased in the "donut hole" and HHS is required to negotiate directly with manufacturers for Part D drug pricing. The income subsidy exclusion for employers who maintain prescription drug plans for Part D eligible retirees is eliminated. The House bill also creates pilot programs for coordinated care delivery models, establishes a new "Center for Medicare and Medicaid Innovation" to test and implement new provider payment methods, and changes payment incentives to reduce hospital readmissions. Annual provider payment updates are reduced for Medicare Part A and Part B and the Institute of Medicine is instructed to study geographic variation in payment rates and recommend changes.

CMS ACTUARY ESTIMATES COST AND COVERAGE IMPACT OF HOUSE HEALTH REFORM LEGISLATION

In late October, the Chief Actuary for the Centers for Medicare and Medicaid Services (CMS) released a report analyzing the cost and coverage impacts of health reform legislation debated in July by the three House committees with jurisdiction over health reform. The report states that total national health expenditures will increase under the House language and that "demand for health services could be difficult to meet initially with existing health provider resources and could lead to price increases, cost-shifting, and/or changes in providers' willingness to treat patients with low-reimbursement health coverage." The CMS Actuary also states that the language does little to contain health care cost growth, "With the exception of the proposed reductions in Medicare payment updates for institutional providers, the provisions of H.R. 3200 would not have a significant impact on future health care cost growth rates." In addition to analyzing the impact of the House legislation on costs, the CMS actuary estimates the impact on coverage for Medicare beneficiaries, stating that the reduction in Medicare Advantage rates to 100% of Medicare fee-for-service would result in less generous benefit packages and enrollment in Medicare Advantage plans would decrease by 64%.

Source:
UnitedHealth Group
Health Care Modernization News
Volume I, Issue 12 (November 5)
Retrieved from
http://www.uhc.com/news-room/health_care_policy//policy_update/nov._5_2009.htm