CHEIRON CLIENT ADVISORY

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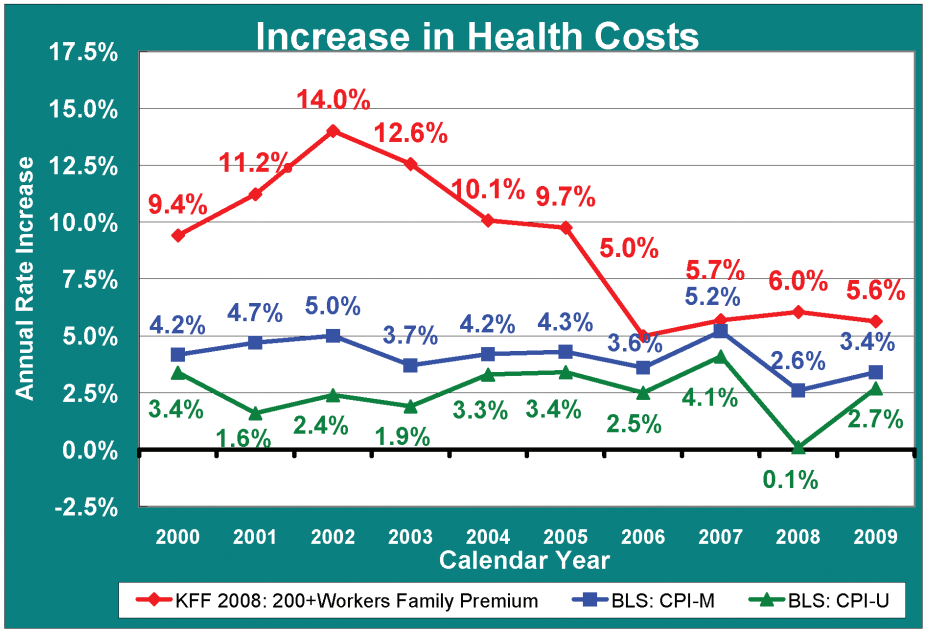
2009-10 Health Care Benefit Review and Outlook

This Advisory reviews important developments in the health care legislative, regulatory and plan design arenas, as well as some notable medical innovations.

Health Care Cost Trends

Employer-sponsored family average premium rates increased by 5.6% in 2009 for 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. Thus, the relatively low (by historic standards) increase may reflect benefit reductions and/or increased cost-sharing with employees. Conversely, benefit improvements are also implicit in the figure.



The unadjusted annualized CPI-U (i.e., the broad inflation measure for "all urban consumers") ending in December 2009 was 2.7%, compared to 2008's 0.1% and 2007's 4.1% inflation rate. The medical care component of the CPI (CPI-M) was 3.4% compared to 2.6% in 2008 and 5.2% in 2007. However, those numbers do not reflect cost-shifting to insured groups from the uninsured and government programs. In addition, the CPI-M does not reflect the leveraging impact of deductibles and out-of-pocket maximums. It is also moderated by its inclusion of a large number of medical services that are rarely covered by group health plans. The health care industry has added 631,000 job positions since the recession began in December 2007.

Cheiron consultants saw some increase in prescription drug costs in 2009 partially in reaction to the First DataBank settlement and partially as a result of some participants fearing loss of coverage. However, in 2010, negotiations with PBMs may result in getting back the gains from the First DataBank transition through more favorable contractual terms. We also saw large discrepancies in trend rates between clients, with some seeing increases in their health care utilization because of fear of future job layoffs, while others experienced low trends.

Health Benefit Plan Trends

The percentage of firms **offering active employees health benefits** dropped from 63% to 60% of employers. The discrepancy between firms with at least some union workers vs. those without any union workers remained large with ***97% of firms with some union workers offering health benefits*** compared to only 57% of those firms that had no union workers.

The percentage of surveyed "large" firms (defined as those with 200 or more employees) **offering retiree health benefits** continued to drop in 2009, down to 29% from 31% in 2008, 33% in 2007, and 66% in 1988, according to the KFF.

- **High deductible health plan offered by 12%** of all plan sponsors is consistent with 2008.
- **High deductible health plan offered by 28%** of largest plan sponsors (1000+ employees) up from 22% in 2008.
- **Wellness programs** exist in 93% of large plan sponsors compared to 88% in 2008.
- **Wellness incentives** were offered in 27% of large plan sponsors' plans versus only 20% in 2008.
- **On-site clinics** were available at 20% of the large employers' worksites.
- **Prescription drug copays** remain constant on average except for plans with specialty drug copays, and those increase $10 per script on average.
- **Cost sharing increased** at 15% of the plan sponsors surveyed.
- **Benefits decreased** in 21% of the plans.

Medical Advances

We compared top ten 2009 medical advancements from Time Magazine, Cleveland Clinic, and Quality Health and picked the top ten that we thought would most impact our clients:

1. **H1N1 Vaccine** was created, tested, and distributed in record time. H1N1 first appeared in Spring 2009, and the vaccine was being mass distributed by October 2009.

2. New **mammography guidelines** of the U.S. Preventive Services Tasks Force were issued in November, recommending mammograms begin at age 50 instead of 40 and be done biennially instead of annually. This was met with significant opposition from advocacy groups. The Senate voted in December to include preventive services in their Health Care Reform bills to calm fears.

3. New **prostate cancer guidelines** of the U.S. Preventive Services recommended against prostate cancer screening in men over 75 based on the study result of 76,000 men over 7 years. The task force concluded the harms from the screening of prostate-specific antigen were greater than the benefits. The results were unclear for men ages 50 to 75.

4. **Stem-cell produced mice that can reproduce** were created from iPS cells (usually adult skin cells) in two separate Chinese labs. This is potentially a significant advancement for treatment of many diseases.

5. Increased research on **autism**, as it now affects 1 in 100 American children up from 1 in 150, indicates that variation in chromosome 5 could play a role.

6. A new set of genes that may contribute to the cause of **Alzheimer's** was discovered in September. It's been 15 years since a discovery of this kind has been made, giving hope for more effective treatment.

7. **Fibroid tumors** occur in 40% of women older than 35. A new non-invasive treatment called Doppler-Guided Uterine Artery Occlusion was introduced in 2009.

8. Circulating tumor cell technology is a new blood test that measures circulating tumor cells in order to detect **recurrent cancer** and to predict how well **cancer treatment** is working.

9. The invention of a **warm organ perfusion** device increases the time for a heart transplant to occur from 4 hours to 12 hours.

10. New research by Swedish scientists found lean adults tend to have more **brown fat** than obese adults. Brown fat actively breaks down sugar into heat and consumes a lot more energy than white fat. Babies and rodents have brown fat to keep warm. It was previously thought that brown fat virtually disappears as people age. Swedish scientists discovered that it remains in our necks.

Access to Affordable Health Care

Over 15% (or 45.7 of 262.8 million) of the nonelderly population in the United States were uninsured in 2008 according to the Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of the March 2009 CPS. Of the 45.7 million uninsured, 8.1 million are children and 27.8 million

work, of which over 11 million made more than 2 times the federal poverty level (for a family of four, the federal poverty level was $22,025 in 2008). Another statistic that has been published frequently in 2009 is that over 7 million of the 37.6 million uninsured adults are not US citizens, but most of those are legal residents.

The Political Environment

Health care reform remained on the front burner for all of 2009. It began with the Children's Health Insurance Program (CHIP), which expands the number of children covered by an estimated four million and was signed into law by President Obama on February 4th, 2009. The American Recovery and Reinvestment Act signed into law by President Obama on February 17, 2009 provided a ***65% subsidy for nine months of COBRA continuation premiums*** to involuntarily terminated workers and their families between September 1, 2008 and December 31, 2009. The subsidy began as early as March 1, 2009. On December 23rd, Congress extended eligibility for the subsidy program to workers terminated on or before February 28, 2010, and extended the period of the subsidy six more months for a total of 15 months. Congress also delayed the scheduled 21.2% decrease in Medicare physician reimbursements.

Different and complex **health care reform bills** passed. The House bill passed on November 7th without a public option and the Senate bill passed on December 24th with a public option. Each bill is around 2,000 pages. As the reconciliation process between the two bills was occurring, a political upset occurred on January 21, 2010, with the election of Republican Scott Brown taking the late Senator Ted Kennedy's seat from Massachusetts. Brown won on the platform of opposing the current health care reform legislation. This resulted in the pollsters immediately polling the public to find out, according to KFF, that the public is split on supporting health care reform and that most do not understand what the bills contain. At the time this publication is going to print, it appears that there is a political re-trenching taking place as the various parties / players revise their strategies.

At the **state level**, last year marked the second full year in which **Massachusetts** residents were mandated to have health insurance coverage. While the mandate has been successful in decreasing the number of uninsured in Massachusetts from 7% to 3%, the costs of the program have been significantly higher than expected. The estimated budget of $1.3 billion for 2009 is nearly double the 2007 budget. For some low income people, it is less affordable, as the premiums are high for some families that were previously covered at no cost but are now paying premiums. The state is nearly bankrupt, and hospitals are suing the state for additional payments.

In **California**, in December legislation was signed into law that prevents insurers from using gender as a variation for premium rates and from rescinding, canceling, limiting or increasing rates for any reason for 24 months after issue.

In **Utah**, legislation was enacted allowing for electronic swipe card technology that allows patients and providers to access information on eligibility and coverage amounts. A plan called "NetCare" was created that costs one half to one third the average cost of average large-group health insurance for insurers to offer coverage and removes some state mandates and includes wellness incentives, high deductibles, and caps on preventive care. All employers are allowed to offer NetCare instead of COBRA. Small employers can give employees the choice between their coverage and purchasing their own coverage. Insurers must cover all workers regardless of pre-existing conditions but are eligible for assistance through the Utah Health Re-Insurance Pool.

Maryland estimates that if federal health care reform passes with the expansion of Medicaid to 133% of the federal poverty level, it will cost Maryland $283 million in 2014. **Florida** estimated that it would cost them $700 million in 2016. In 2009, state fiscal crises slowed down legislation that had occurred in 26 states between 2006 and 2008 with six states actually cutting their Medicaid budgets: **Maryland, New Hampshire, New York, South Carolina, Utah, and Vermont**.

At the **local level**, the so called **"play-or-pay" legislation** enacted by **San Francisco** requiring large employers to provide their workers health coverage, or else pay an excise tax, was determined not to be preempted by ERISA (i.e., such laws do not violate federal law), according to an October,

2008 ruling by the U.S. Court of Appeals for the 9th Circuit. The United States Supreme Court has agreed to review the case and requested comments from the Obama administration in October 2009.

Legislation and Regulation

Below is a quick summary of legislation that may impact your health plan this year:

1. The American Recovery and Reinvestment Act (ARRA) signed into law by President Obama on February 17, 2009 with its December 23rd Congressional extension provides a ***65% subsidy for up to 15 months of COBRA continuation premiums*** to workers (and their families) that are involuntarily terminated between September 1, 2008 and February 28, 2010.

2. ARRA also included funding for technology to improve the efficiency and availability of health care information. With that came stricter requirements for complying with the Health Information Portability and Accountability Act (**HIPAA**) and protecting Private Health Information (**PHI**). Enforcement begins February 17, 2010 with more significant penalties for non-compliance.

3. The **Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008** requires group health plans with 50 or more members to provide the same level of benefits for mental health coverage as for regular medical services. Mental health and substance abuse coverage is still not a required covered benefit. The Act is effective the first plan year beginning one year after the October 3, 2008 enactment date. For most plans, that was **January 1, 2010**. The law makes an exception for collectively bargained plans that defer compliance until after the latest current collective bargaining agreement terminates. Any plan changes made to comply with this law will need a summary of material modification **(SMM) to be distributed** to plan participants. If the plan improved benefits to comply, it has 210 days after the end of the plan year or *July 29, 2011* for a January 1, 2010 implementation. If the plan reduced benefits, e.g., eliminated mental health and substance abuse coverage, the plan has 60 days after the benefit reduction to provide notice; for a January 1, 2010 implementation date that would be *March 1, 2010*.

4. **Michelle's Law** prohibits group health plans that offer coverage to students from terminating coverage when a student takes a medical leave of absence. This was effective for the plan year beginning after October 9, 2009, or **January 1, 2010** for many calendar year plan years. The participant notification (SMMs) requirements would be the same as for the MHPAEA above.

5. Implementation of the **First DataBank / MediSpan** settlement occurred on September 26, 2009 as the average wholesale price (AWP) was required to change on over 1,400 drugs. This went fairly smoothly for most Pharmacy Benefit Managers (PBMs). However, there is still not a clear consensus on what alternative measure will be used since First DataBank and MediSpan will no longer be publishing AWPs after March 2011.

6. **Genetic Information Nondiscrimination (GINA)** Act of 2008's final regulations were issued on October 7, 2009 and require implementation by 2010. In general it prevents insurers or employers from using genetic information in developing rates. Most notably, it prohibits asking family history questions in a health risk assessment form.

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****.*

The issues presented in this advisory do not constitute legal advice. Please consult with your own tax and legal counsel when evaluating their impact on your situation.