

Health *Action* Network



*Building Better
Health Care*

Federal Health Care Reform

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September 18, 2009

Agenda:

- WellPoint's position on reform
- Key policies included in legislation and proposals
- Process and political outlook
- How you can engage

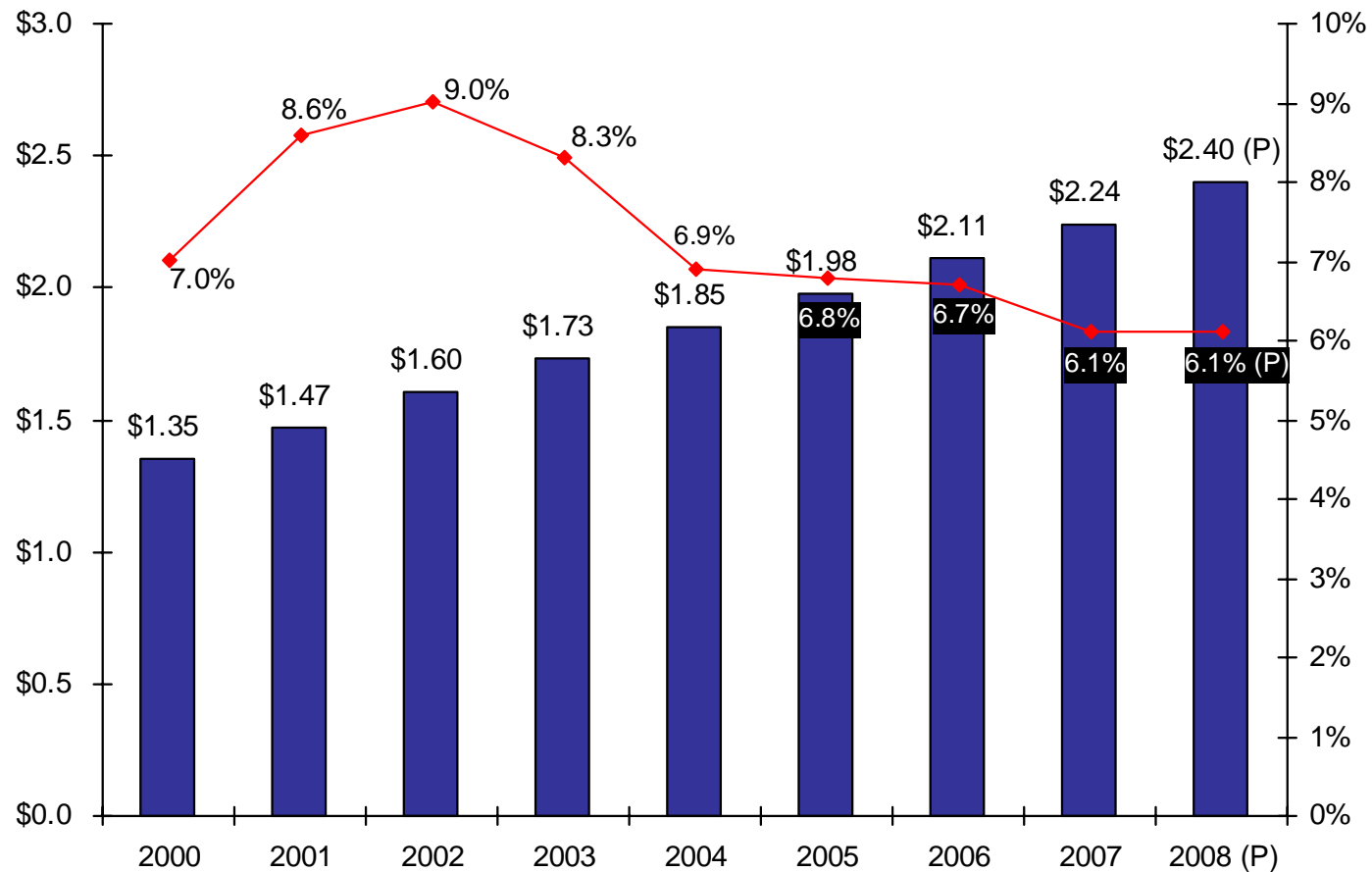


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U.S. National Health Expenditures (trillions)



Source: [National Health Expenditure Accounts](#), CMS

When it comes to health care reform, we should not just get it done, we should get it right.



WellPoint's principles for improving quality and managing costs

- Promote evidence-based medicine; determine real-world outcomes
- Advance health care quality by disseminating information throughout the system
- Focus on prevention and manage chronic illness
- Improve effective use of drug therapies to prevent and manage illness
- Promote strategies to reduce medical errors and adverse drug events
- Reduce costs through eliminating fraud, reducing costs related to litigation, and improving administration



The **Member Health Index** measures performance against targets we've established in four areas where we believe we can make a difference.

Screening and Prevention

- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening
- High cholesterol screening
- Childhood immunizations

Clinical Outcomes

- Diabetes ER visits
- Congestive heart failure ER visits
- Asthma ER visits
- Select hospital admissions
- Select 30-day readmissions

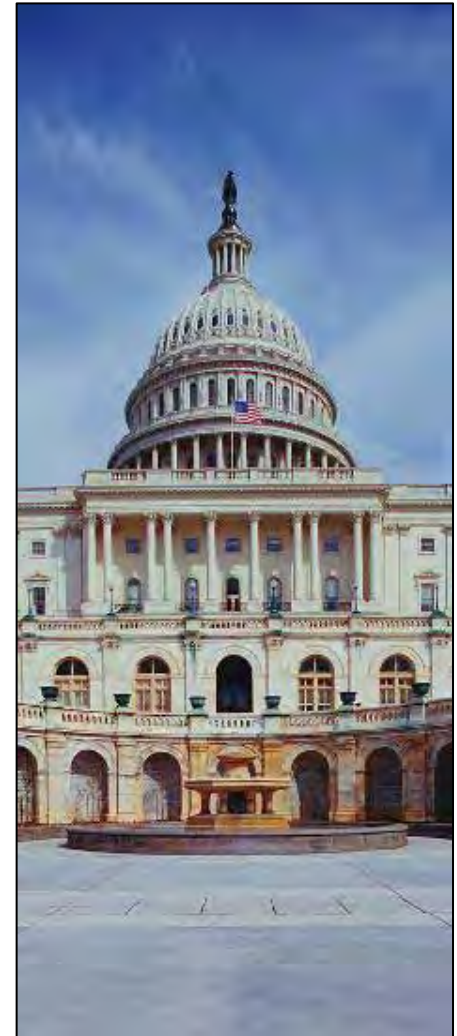
Care Management

- Diabetes compliance
- Hypertension compliance
- Behavioral health follow up
- Controller medications for asthma
- Appropriate treatment for upper respiratory infection
- Participation in disease management programs
- Blood pressure knowledge and control

Patient Safety

- Patient safety hospital structural index
- Patient safety outcome index
- Persistent medication monitoring

- Enforceable, effective individual mandate
- Premium assistance
- “Guaranteed-issue”
- Rating flexibility for age, geography, family size and benefit design
- Premium discounts for healthy behavior such as not smoking
- Protect currently insured individuals from premium increases
- Tax equity between individual and employer-sponsored coverage

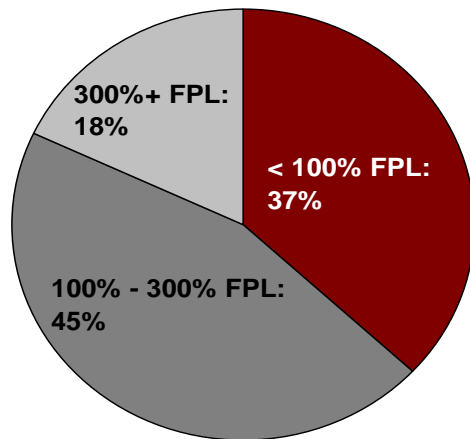


WellPoint's solutions to enact financing strategies to place America on a sustainable path towards covering all of the uninsured:

- Improve and expand programs for the most needy
- Provide a bridge to self-sufficiency through premium assistance
- Expand the employer-based system
- Equalize tax treatment for individuals purchasing coverage on their own
- Increase funding for public-private partnerships



How Does WellPoint's Plan Address the 46 Million Uninsured?



Element	Eligible
Extend outreach to those already eligible for programs	12 M
Kids expansion to 300% FPL	6.5 M
Parents expansion to 200% FPL	9.3 M
Childless adults to 100% FPL	5.1 M
Premium assistance	4.6 M
Total	37.5 M

For the remaining 18% of uninsured who make over 300% FPL (\$67k for family of 4), focus on expanding the employer-based system and designing attractive products

Source: Internal analysis of U.S. Census Bureau Current Population Survey statistics. (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html). September 2008.

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Government-Run Plan

**Changes to
Medicare
Advantage**

**Insurance
market
rules /
Strength
of coverage
obligation**

**Impact on
employer-
sponsored
coverage**

**Exchange /
Gateway/
Regulatory
structure**

Proposed Federal Reform – Comparison of Key Elements

	Senate Finance*	Senate HELP	House “Tri Committee”*
Government-Run Plan	Nonprofit co-ops with grants and loans awarded by the federal government. No insurer involvement.	New federally-sponsored plan independent of Medicare operating in the exchange. HHS contracts directly with providers.	New federally-sponsored plan based on Medicare fee-for-service operating in the exchange that allows Medicare providers to opt-out
Individual mandate	Yes, enforced through tax filing process with various exemptions. Penalty amount increases to \$950 per year	Yes, enforced through tax filing process with various exemptions. Penalty amount set at \$750 per person per year	Yes, enforced through tax filing process with various exemptions. Maximum penalty 2.5% of income
Market reforms	IND: Beginning in 2013 guaranteed issue, 5:1 age rate band, global rate band at 7.5:1 SG: Phase-in over five years to conform to IND requirements, Includes risk adjustment, reinsurance, and risk corridors	Market reforms apply to individual market and small group markets, pooled separately Guaranteed issue, 2:1 age rate band, product rating only by “actuarial value”	Market reforms apply to individual market and group market regardless of groups size. Guaranteed issue, 2:1 age rate band IND products cannot be sold outside of the exchange
Insurance Exchange	States would establish exchanges in 2010 to present products available in market – separately for IND and SG. Subsidies only available in exchange	Provides states grants to establish “gateways” alongside reformed market. Gateways must make available “qualified health plans”. Subsidies only available in exchange	Establishes new federal insurance commissioner that establishes a federal exchange that uses a bidding process for contracting with health plans Subsidies only available in exchange

Proposed Federal Reform – Comparison of Key Elements

	Senate Finance*	Senate HELP	House “Tri Committee”*
Product Framework (actuarial value)	Four tiers: 65%, 70%, 80%, 90%. Separate policies for “young invincibles”.	Three tiers: 76%, 84%, 93%	Three tiers: 70%, 85%, 95%, but products must also not be less rich than the “average employer plan”
MLR Requirements	MLR reporting required	Must report MLR by product	Secretary of HHS to establish MLR requirement “as high as possible”
Subsidies, Coverage Expansions	Subsidies only in exchange, to 400% FPL. Medicaid to 133% FPL	Subsidies only in exchange, to 400% FPL. Medicaid to 150% FPL for all	Subsidies only in exchange, to 400% FPL. Medicaid up to 133% FPL for all
New Regulatory Entity	States would be required to establish ombudsman offices by 2010.	None	New federal insurance commissioner that has authority that significantly overlaps with state insurance commissioners
Medicare Advantage	Set benchmarks based on plan bids	None	Set payments equal to 100% of local FFS
Other Major Financing	35% “Cadillac benefit” tax \$6 billion annual insurer tax, allocated by market share.	None	New income tax surcharge: 1% for \$350k-\$500; 1.5% up to \$1 million, and 5.4% over \$1 million.

- Rating Rule Reform for Group Coverage
- Employer Mandates and Penalties
- Tax Law Changes
- ERISA Changes

- **Senate Finance Committee**
 - Employer requirement to pay portion of costs for any employees who receive government assistance
 - Applies to employers with more than 50 FTEs
- **Senate HELP Committee**
 - Pay-or-play set at \$750 per year, includes prorated amount for part-time employees
 - Employers must subsidize at least 60% of employee premiums
 - Applies to employers with 25 or more employees and waives the penalty on the first 25 employees
- **House Legislation**
 - Pay-or-play phases-in to 8% of payroll and includes prorated amount for part-time employees
 - Employers must subsidize at least 72.5% of the premium for individual coverage and 65% of the premium for family coverage for the lowest cost plan offered by the employer
 - Phased in for employers with between \$250,000 and \$400,000 in annual payroll*

Tax Law Changes – Senate Finance Committee Proposal*

- **Fees on Health Care Companies**
- **“Cadillac Tax”**
 - A 35 percent excise tax on health insurance coverage above \$8,000 for individuals and \$21,000 for family coverage, applied to amounts above the thresholds, which would be adjusted for inflation
 - Tax would apply to both fully-insured and self-insured group coverage, but it would not apply to coverage in the individual insurance market
 - Tax would apply to the total of all health related coverage above the threshold level, including contributions to HSAs, HRAs, FSAs, dental and vision services and other supplemental benefits
- **W-2 Reporting –**
 - Requires employers to report on the full value of employee health coverage on the W-2
- **FSAs**
 - Limit annual contributions to FSAs to \$2,000
- **Part D Employer Subsidy**
 - Requires employers to include the Medicare Part D subsidy for corporate income tax purposes

ERISA Implications – House Legislation

- Automatic federal waivers to ERISA would be granted to states that enact single-payer health care plans
- Unlimited state law rights and remedies apply to employer-sponsored health coverage obtained in the Exchange. This will permit enrollees to sue health insurers and employers under state laws
- TRIPLE government enforcement for private plans in the Exchange by state regulators, state Exchanges (if any), and federal (via the Commissioner and the Special Inspector General)
- Self-funded employer sponsored health plans are given a 5-year "grace period," after which they must comply with the provisions in the House bill (including providing government-established minimum benefits in their benefit plans)

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Senate Finance Committee

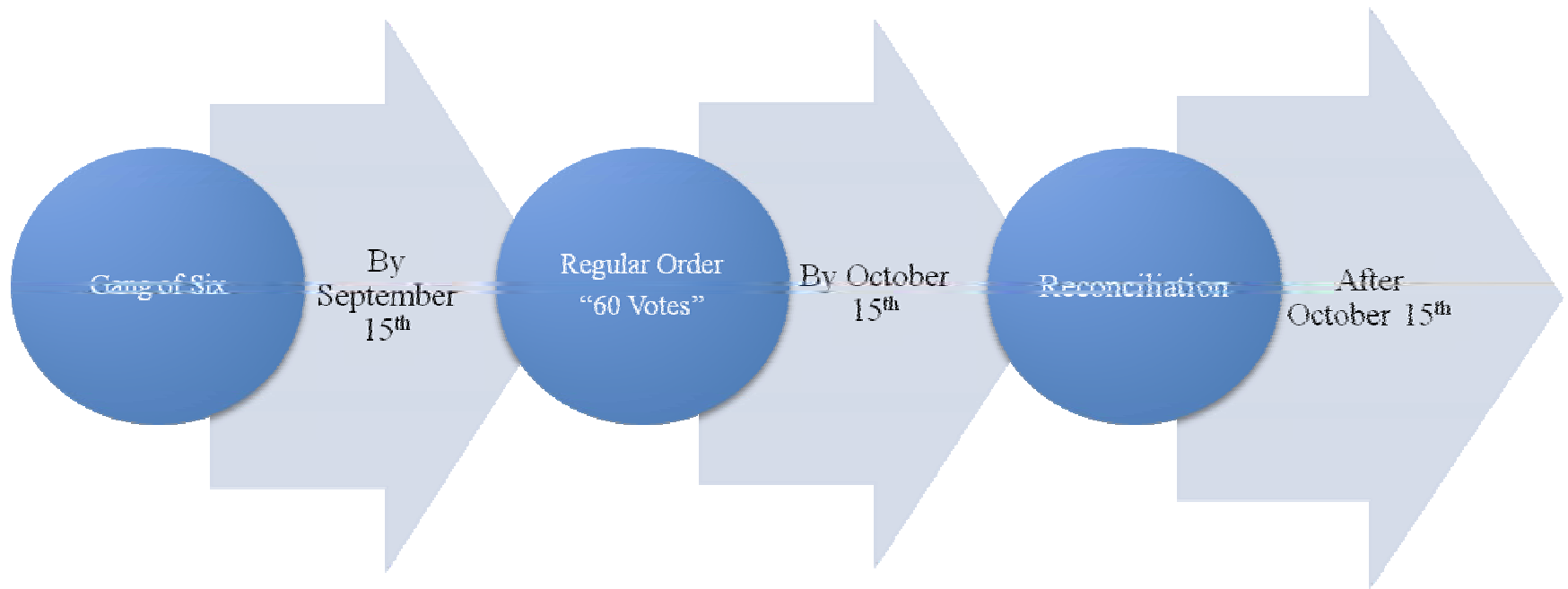
- Bipartisan “Gang of Six”?

Senate Health, Education, Labor and Pensions (HELP)* Committee

- Kennedy/Dodd Legislation*

Three House Committees (the “Tri-Committee”)

- Education & Labor
- Energy & Commerce
- Ways & Means



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- One-stop platform to follow and participate in the debate on health care reform
- Designed for internal and external audiences
- Contact Members of Congress
- Register to receive weekly news on health care reform
- Become a Facebook fan
- Tell others about the Health Action Network
 - Request printed materials via e-mail grassroots@wellpoint.com

