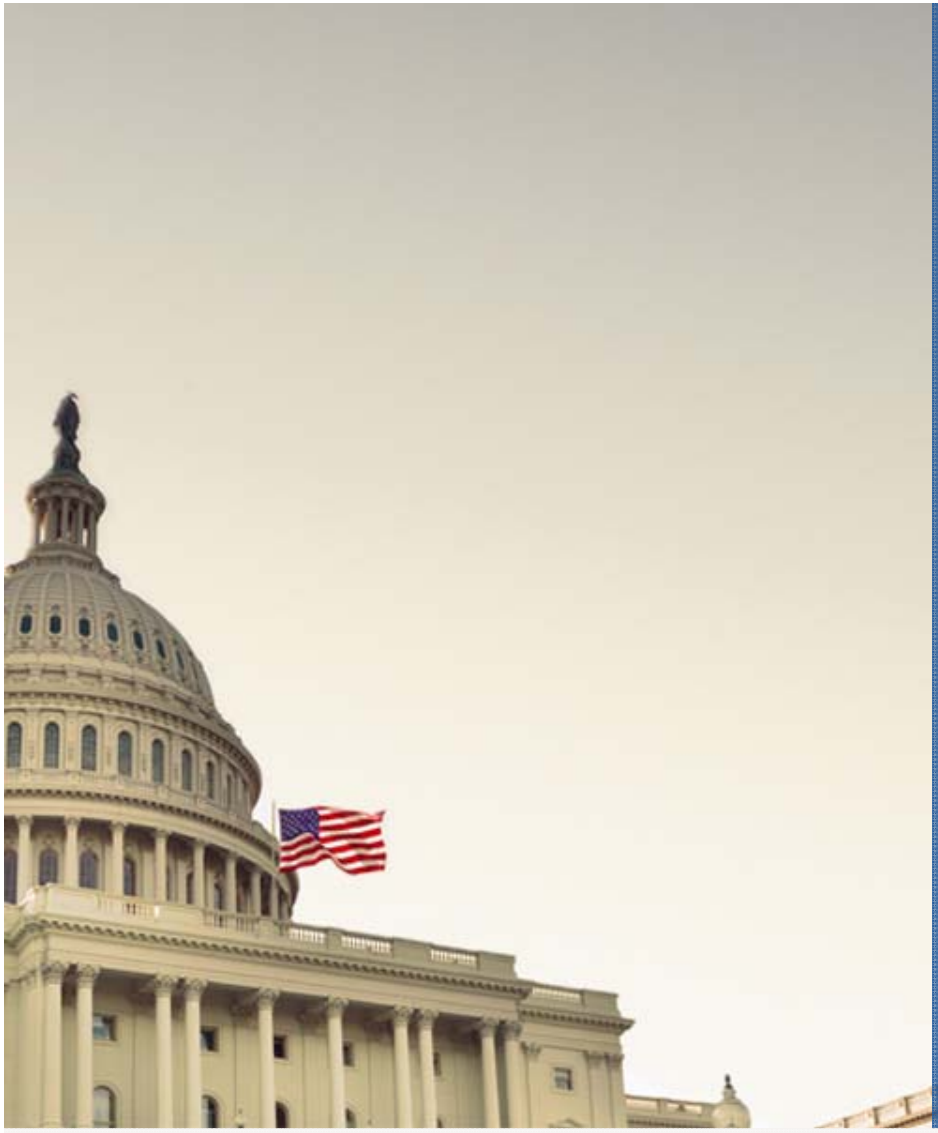


Health Care Reform Update

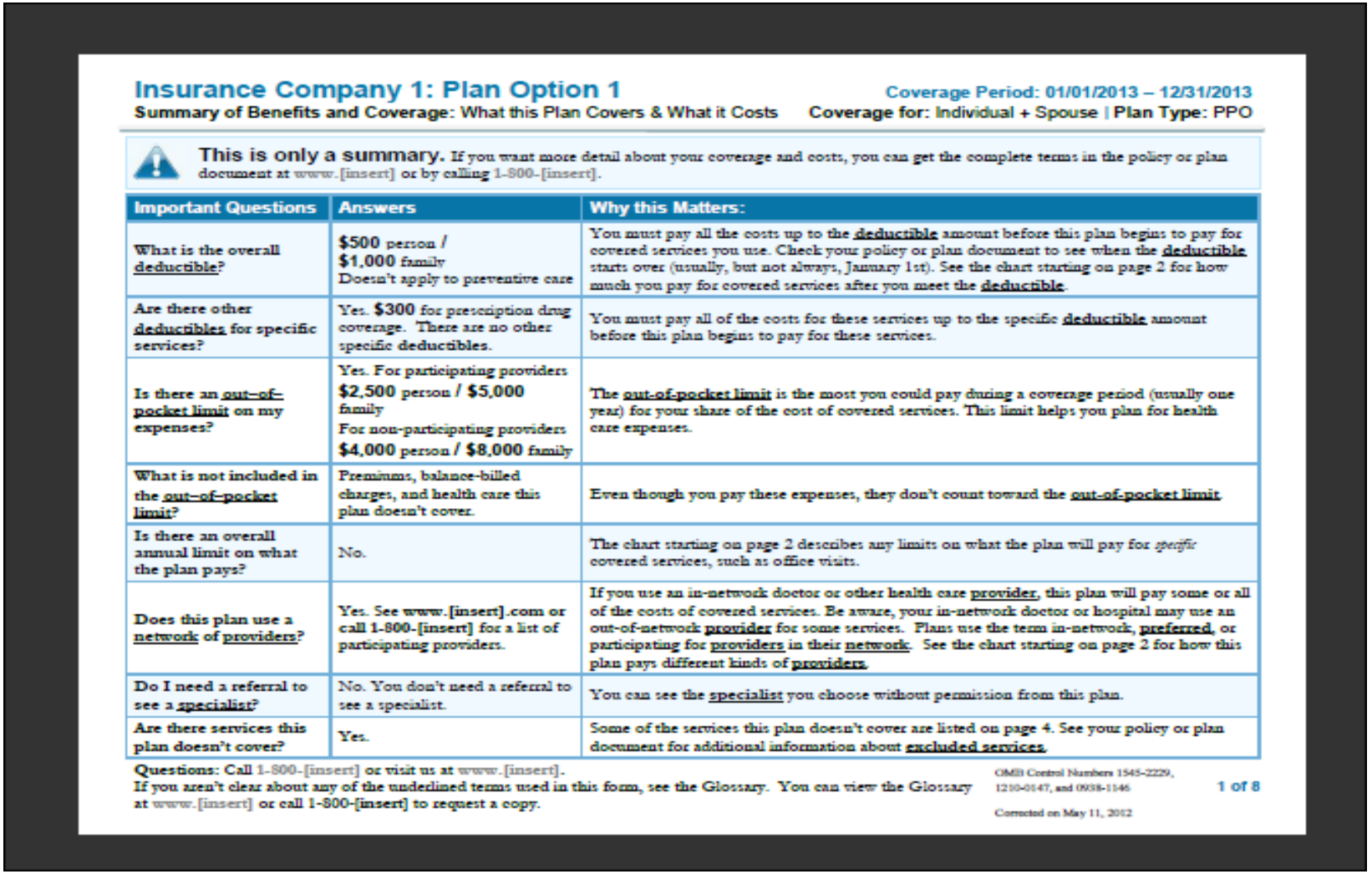
April 2013

2013 Compliance Issues

Summary of Benefits and Coverage

- Simple explanation of benefits and costs
  - 4 double sided pages, 12 point or larger font
  - Can provide in paper or electronic form
- Applies to:
  - Issuers and health plans (plan sponsors)
  - No duplication required: if issuer provides to enrollees, plan doesn't have to
- Deadlines
  - Issuers to health plans: **Sept. 23, 2012**
  - Health plans to enrollees: 1st day of **1st open enrollment period** on or after Sept. 23, 2012 or **1st day of the 1st plan year** on or after Sept. 23, 2012 (for other enrollment)

SBC Sample Template



Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013
Coverage for: Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 person / $1,000 family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers $2,500 person / $5,000 family For non-participating providers $4,000 person / $8,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.[insert].com or call 1-800-[insert] for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

Providing the SBC

- Issuers to health plans:
  - Upon application
  - Before the first day of coverage (if there have been changes to the SBC)
  - When a policy is renewed or reissued
  - Upon request
- Issuers (or employers) to individuals:
  - For each benefit package offered or which they are eligible
  - Annually at renewal (or 30 days before new plan year if automatic renewal)
  - With enrollment application materials (if no written enrollment materials, when the participant is first eligible to enroll)
  - Before the first day of coverage (if there have been changes to the SBC)
  - To special enrollees within SPD timeframe (within 90 days of enrollment)
  - Upon request

60-Day Notice Rule

- Effective once SBC rule is effective for a plan
- Material modifications **not in connection with renewal** must be described in a summary of material modifications (SMM) or an updated SBC
  - Must be provided at least **60 days BEFORE** modification becomes effective
- Material modification:
  - Enhancement of covered benefits or services
  - Material reduction in covered benefits or services
  - More stringent requirements for receipt of benefits

Notice of Exchange

- Employers must notify new and current employees of Exchange information
- Current status of rule
  - Was to be effective March 1, 2013
  - More guidance and possibly **model notice** to be issued
  - **Delayed indefinitely – expected to be late summer or fall 2013**
- Notice must include information about 2014 changes:
  - Existence of health benefit exchange and services provided
  - Potential eligibility for subsidy under exchange
  - Risk of losing employer contribution if employee buys coverage through an exchange

Preventive Care Services

- Non-GF plans must provide coverage for preventive health services without any cost-sharing
- New guidelines for preventive care for women effective for **plan years on or after Aug. 1, 2012**
- Includes contraceptives and contraceptive counseling
  - Legal challenges by some religious institutions and private employers
  - Proposed compromise for religious organizations

Health FSA Limits

- Before health care reform
  - No limit on salary reductions
  - Many employers imposed limit
- Beginning with 2013 plan year, limit is **$2500/year**
  - Limit is indexed for inflation for later years
- Does not apply to dependent care FSAs

Increased Medicare Tax

- Medicare tax rate to increase for high-earners for **2013 tax year**
  - 0.9 percent increase (from 1.45 percent to 2.35 percent)
- Individual liability for tax depends on filing status and income
- Employer responsibilities
  - Withhold additional amounts from wages in excess of $200,000
  - No requirement to match additional tax
  - No requirement to notify employees

PCORI Fees

- Apply to plan years ending on or after **Oct. 1, 2012**
  - End with the 2018 plan year – do not apply for plan years ending on or after Oct. 1, 2019
  - Paid annually on Form 720 by July 31 each year
- Amount of fees
  - 2012 plan year: $1 x average number of covered lives
  - 2013 plan year: $2 x average number of covered lives
  - 2014 and beyond: increase based on National Health Expenditures
- Who pays?
  - Insurance carriers and self-funded plan sponsors
  - Special rule for HRAs and health FSAs

Whistleblower Protections

- OSHA final rule clarifies protections for employees under ACA
- Employers may not retaliate against employees for:
  - Providing information or filing a complaint regarding ACA violations
  - Objecting to or refusing to participate in violations of the ACA
  - Receiving a premium credit or subsidy for coverage though an Exchange
- Employees can file complaints with OSHA if they experience retaliation
  - Discharge, demotion, discipline, etc.

2014 Compliance Issues

Waiting Period Limitations

- Waiting periods limited to 90 days beginning with 2014 plan year
  - Proposed rule issued on March 18, 2013 (may rely on proposed rule through 2014)
  - First of the month following 90 days **not** permissible
- Other eligibility conditions are permissible (unless designed to avoid compliance with 90-day limit)
  - Cumulative hours of service requirement cannot exceed 1200 hours and must be one-time only (not each year)
- Employers can use up to a 12-month measurement period to determine FT status for variable hour employees
  - Coverage must be effective by 13 months from start date (plus remaining days in the month)

Limits on Out-of-Pocket Expenses and Cost-Sharing

- Non-GF group health plans subject to limits on cost-sharing and out-of-pocket costs
- Out-of-pocket expenses may not exceed HDHP limits
  - 2012: $6,050/$12,100
  - 2013: $6,250/$12,500
  - **Apply to all non-GF group health plans**
- Deductibles may not exceed $2,000 (single coverage) or $4,000 (family coverage)
  - **Apply only to insured small group non-GF plans**
- Limits indexed for inflation

Plan Changes

- Annual limits eliminated
  - Prohibited on essential health benefits with 2014 plan year
  - Essential health benefits to be determined according to state benchmark plan
- Preexisting condition exclusions prohibited
  - Currently prohibited for children under age 19
  - Prohibited for everyone beginning with 2014 plan year
- Small group and individual policies (non-GF plans)
  - Must provide essential health benefits package
  - Premium rating restrictions apply

Wellness Program Changes

- Current rules for wellness program rewards:
  - Reward must be no more than 20% of the cost of coverage
  - Program must be designed to promote health/prevent disease
  - Opportunity to qualify for those with health issues (and notice)

- **2014** health care reform changes:
  - Reward increased to 30%
  - Reward up to 50% for programs to reduce/prevent tobacco use (proposed)
  - Small business grants to establish new wellness programs (on hold)

Reinsurance Fees

- Transitional reinsurance program to operate **2014-2016**
  - Fees imposed on health insurance issuers and self-funded plan sponsors of major medical plans (with some exceptions)
- Fees based on annual national contribution rate
  - 2014 proposed rate: $5.25/month ($63/year) x average number of covered lives
- Payment of fees
  - Issuers and sponsors to submit annual enrollment count to HHS by Nov. 15
  - HHS to notify issuer or sponsor of amount due within 15 days or by Dec. 15
  - Payment due within 30 days of notification

Individual Mandate and Exchanges

Individual Mandate

- Effective Jan. 1, 2014
- Individuals must have "minimum essential coverage" or pay a penalty
- Exceptions
  - Low income or hardship
  - Coverage is unaffordable
  - Religious exemption
  - Incarcerated
  - Member of Indian tribe or health care sharing ministry
  - Short gap in coverage
  - Not lawfully present

Minimum Essential Coverage

- Employer sponsored coverage
  - Including COBRA and retiree coverage
- Individual coverage
- Medicare
- Medicaid
- Children's Health Insurance Program (CHIP) coverage
- Some veterans' health coverage
- TRICARE

Individual Penalty Amounts

- Flat dollar amount or a % of income → whichever is greater
- Penalty amounts
  - 2014 = $95 or 1%
  - 2015 = $325 or 2%
  - 2016 = $695 or 2.5%
- Family penalty limit:
  - 300% of the adult flat dollar penalty or
  - Bronze level Exchange premium

Health Insurance Exchanges

- State options:
  - Establish state Exchange
  - Establish Partnership Exchange with HHS
  - Do nothing (HHS will set up federally-facilitated Exchange)
- State action:
  - 17 (and D.C.) declared state-based Exchange
  - 7 planning Partnership Exchange
  - 26 default to federal Exchange
- Deadlines
  - Open enrollment: 10/1/13
  - Fully operational: 1/1/14

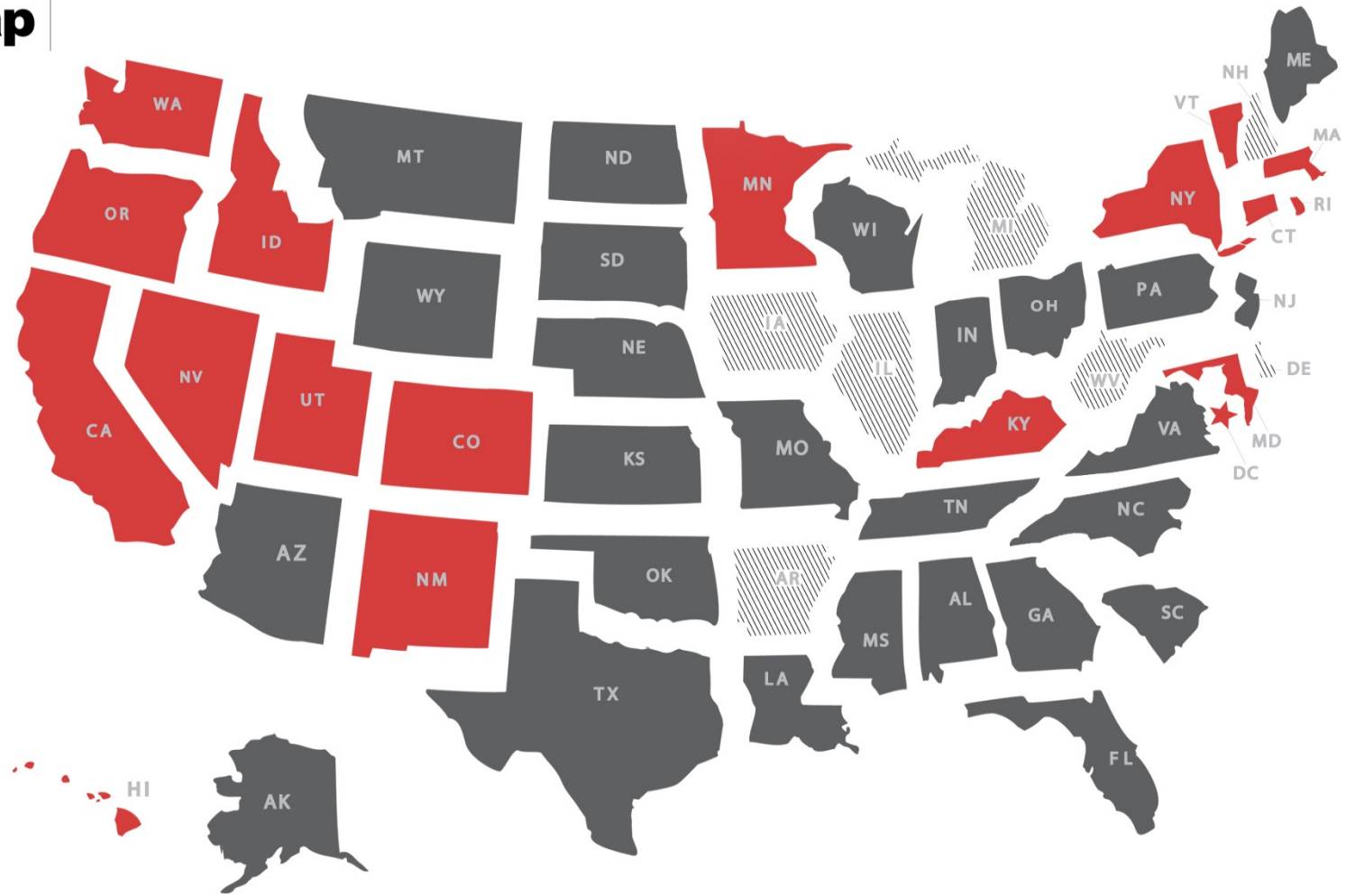
State Health Insurance Exchange Map

Declared State-based Exchange

Planning for Partnership Exchange

Default to Federal Exchange

Updated: 2/25/13



Health Insurance Exchanges

- Individuals and small employers can purchase coverage through an Exchange
- Small Business Health Option Program (SHOP)
  - Small employers = up to 100 employees
  - Before 2016, states can define small employers as having up to 50 employees
- In 2017, states can allow employers of any size to purchase coverage through exchange
- Individuals and small employers can be eligible for tax credits/subsidized coverage

Proposal to Delay Exchange Employee-Choice Feature

- HHS has proposed a one-year delay for employee choice
  - Delay planned for federally-facilitated Exchanges
  - Optional for state Exchanges
  - Some states still plan to offer employee choice
- Exchanges still planned to be operational
  - Employers will have to choose a plan
  - Will not be able to let employees choose from all plans right away

Qualified Health Plans

- Must offer essential health benefits package
  - Provide essential benefits
  - Limit cost-sharing
  - Provides bronze, silver, gold or platinum coverage or catastrophic plan
- Metal levels
  - 60-90% of benefits
  - Allow consumers to compare plans

Exchange Eligibility

- Individual eligibility for QHP enrollment:
  - Citizen or legal resident for period of coverage
  - Not incarcerated
  - Resides in state covered by Exchange
- Employer eligibility for SHOP Exchange:
  - Qualify as small employer based on size (up to 100 or 50 employees, depending on state)
  - Offer at least all FT employees coverage in a QHP
  - Have primary office in Exchange service area and offer coverage through that SHOP OR offer coverage through SHOP in area of employee's primary worksite

Exchange Enrollment

Type of Enrollment Period	Dates	Rules
Initial enrollment period	Oct. 1, 2013-March 31, 2014	Dec. 15 deadline for Jan. 1 coverage
Annual enrollment period (for 2015 and later years)	Oct. 15-Dec. 7 each year (for coverage for the next year)	Advance written notice to enrollees in Sept. each year
Special enrollment period	60 days from date of triggering event	Available under certain circumstances (like marriage or birth of a child)
Employer Enrollment	Any time for new enrollment	After enrollment, will have to use an annual election period

Exchange Subsidies and Tax Credits

- Individuals who are **not offered employer coverage**
  - Not eligible for government programs (like Medicaid)
  - Meet income requirements (less than 400% of FPL) – For 2013, 400% of FPL is **$45,960** for 1 person, **$94,200** for a family of 4
- Individuals who are **offered employer coverage**
  - Not enrolled in employer's plan
  - Not eligible for government programs (like Medicaid)
  - Meet income requirements (less than 400% of FPL)
  - **Employer's coverage is unaffordable (greater than 9.5% of income for single coverage) or not of minimum value (covers less than 60% of cost of benefits)**

Determining Large Employer Status for Pay or Play Penalties

Large Employers

- Large employer:
  - Average 50 or more full-time/full-time equivalent employees in prior calendar year
  - For 2014, can look back at any **six consecutive months** in 2013
- Common ownership rules
  - Controlled group rules apply
  - All employees taken into account
  - Liability and penalties apply separately to each controlled group member

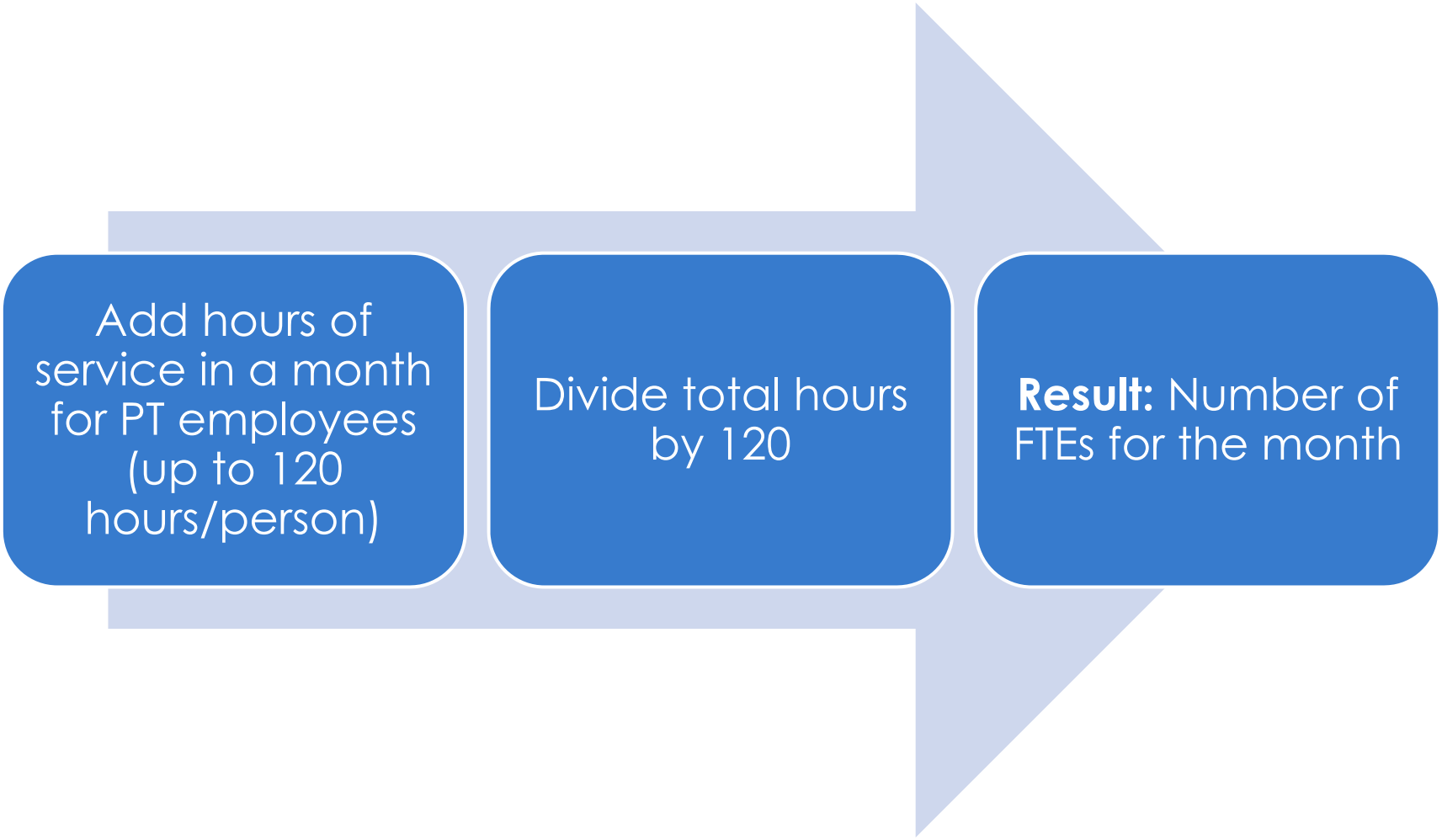
Full-Time Employee

With respect to a calendar month

An employee who is employed on average at least **30 hours of service per week**

130 hours of service in a calendar month = the monthly equivalent of 30 hours of service/week

Full-Time Equivalent Employees



Counting Employees

1. Add full-time employees (including seasonal) for each calendar month in prior calendar year
2. Add FTEs (including seasonal) for each calendar month in prior calendar year
3. Add full-time employees and FTES together for each month of prior calendar year
4. Add 12 monthly totals and divide by 12

* Special rule for 2014: can use 6 consecutive months in 2013

Special Rules

- Seasonal employees
  - An employer is not a large employer if (1) the employer's workforce exceeds 50 full-time employees for 120 days (4 months) or fewer during the calendar year and (2) the employees in excess of 50 employed during that period were seasonal workers
- New employers
  - Calculation based on the average number of full-time employees the employer is "reasonably expected to employ" on business days in the current calendar year

Providing Coverage to Full-Time Employees

Employer Shared Responsibility Penalties

- Large employers subject to "Pay or Play" rule
- Penalties may apply if the employer:
  - Fails to offer minimum essential coverage to all FT employees (and dependents)
  - Offers coverage that is not affordable or does not provide minimum value
- Penalties triggered if any FT employee gets subsidized coverage through Exchange

Penalty Potential

Not a large employer: Less than 50 full-time equivalent employees	Large employer: 50 or more full-time equivalent employees			
	Does not offer coverage		Offers coverage	
	Scenario A No full-time employees receive credits for exchange coverage	**Scenario B** 1or more full-time employees receive credits for exchange coverage	**Scenario C** No full-time employees receive credits for exchange coverage	**Scenario D** 1or more full-time employees receive credits for exchange coverage
No penalty	No penalty	Number of full-time employees minus 30 multiplied by $2,000	No penalty	Lesser of: Number of full-time employees minus 30, multiplied by $2,000. Number of full-time employees who receive credits for exchange coverage, multiplied by $3,000. (Penalty is $0 if employer has 30 or fewer full-time employees- because penalty is based on the lesser of the two calculations)

Employer Penalties

- Penalties triggered if FT employee is certified to employer as enrolling in subsidized Exchange coverage for a month
- **Penalty A:** employer failed to offer substantially all FT employees (and dependents) opportunity to enroll in employer's plan for a month
- **Penalty B:** employer offered substantially all FT employees (and dependents) opportunity to enroll **but not all FT employees** OR coverage is **unaffordable** or **not minimum value**

Employer Penalty Amounts

- **Penalty A**: $2,000 per full-time employee (minus the first 30)
- **Penalty B**: $3,000 for each employee who receives subsidized coverage through an Exchange
  - If too expensive, not generous enough or not offered to enough employees
  - Cap: lesser of Penalty A or Penalty B will apply
- Amounts shown are annual penalties
  - Penalties will be calculated on a monthly basis

Offering Coverage

- Must be offered to substantially all FT employees and dependents
- Substantially all
  - 95% general rule
  - May fail to offer to up to 5% (or 5, if greater)
  - Does not have to be inadvertent
- Dependents must be offered coverage
  - Children up to age 26
  - Not spouses
  - Dependent coverage does not have to be affordable

Affordability Safe Harbors

- **W-2 Safe Harbor**
  - Measures employee's required contribution for single coverage against employees W-2 wages
  - Coverage is affordable if cost is 9.5 percent or less of W-2 income
- **Rate of Pay Safe Harbor**
  - Affordability based on employee's rate of pay.
  - Employee's monthly contribution for single coverage is affordable if 9.5 percent (or lower) monthly wages
- **Federal Poverty Level Safe Harbor**
  - Determines affordability based on FPL for single individual.
  - Coverage is affordable if the employee's contribution for single coverage is 9.5 percent of that FPL (or lower)

Minimum Value Coverage

- Minimum value measures cost-sharing (similar to metal levels for QHPs)
- To provide MV, plan's share of total allowed costs of benefits provided under the plan must be at least 60%
  - HRA/HSA amounts to be included
- Determining MV:
  - MV calculator
  - Design-based safe harbor checklists
  - Appropriate certification by actuary

Measuring Full-Time Status

Employees Expected to Work Full-Time

- Employer must offer coverage by the end of the first 3 full calendar months of employment
- Applies to an employee who is "reasonably expected at his or her start date to be a full-time employee (and is not a seasonal employee)"
- If coverage not offered by deadline, penalties can apply for:
  - The first 3 calendar months
  - Any subsequent months where coverage not offered

Safe Harbor for Variable Hour/Seasonal Employees

Measurement Period

Counting hours of service (3-12 months)

Administrative Period

Time for enrollment/disenrollment (Up to 90 days)

Stability Period

Coverage provided (or not) – length depends on type of employee and whether FT or not

Measurement and Stability Periods

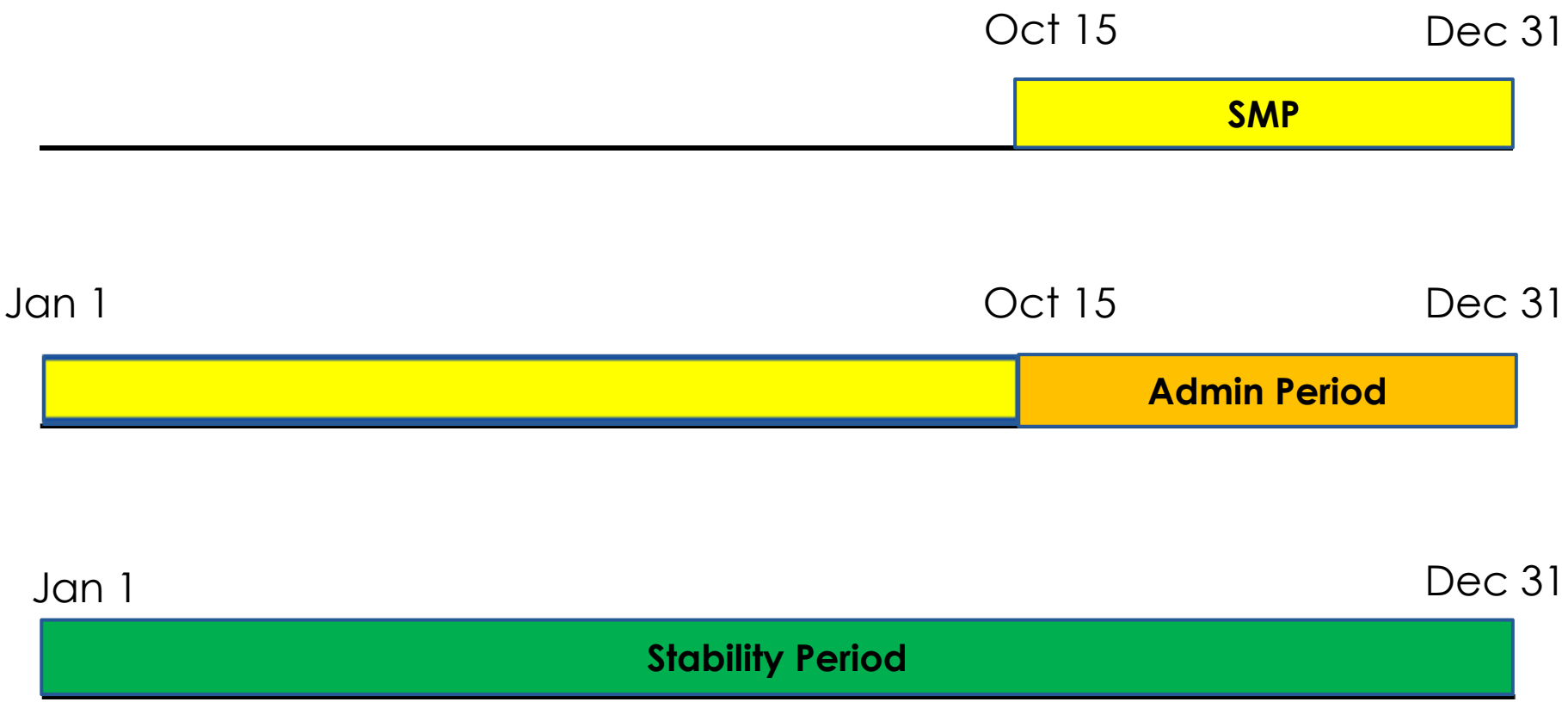
Ongoing Employees

- Measure for 3-12 months (Standard MP)
- Period chosen by employer
- Stability period = same length as SMP and at least 6 months long

New Employees

- Measure 3-12 months (Initial MP)
- IMP to start between start date and first day of the next month
- Stability period depends on whether FT or not in IMP
- Need to double measure during SMP and possibly offer coverage early

Ongoing Employees - Safe Harbor Illustration



Special Rules

- Measurement periods for 2014 stability periods
  - Employers that want to use 12 month measurement period can use 6-12 months for 2013
  - Must begin by July 1, 2013 and end no sooner than 90 days before 2014 plan year
- Terminated employees
  - Not treated as a new employee unless 26-week break in service
  - Shorter period may apply if short employment
- Averaging rules for hours of service in measurement period
  - For school employees and FMLA/USERRA/jury duty leave

Transition Rules

Non-Calendar Year Plan Years

- Penalties will not apply right away on Jan. 1, 2014 if:
  - Plan is changed to avoid penalties at renewal
  - Requirements are met
- No penalties for months of 2013 year that fall in 2014 for
  - Employees who would be eligible for coverage on 1st day of 2014 plan under eligibility terms of plan in effect on Dec. 27, 2012
  - Other employees if at least 1/4 of employees are covered under fiscal year plan as of Dec. 27, 2012 (or at least 1/3 of employees are offered coverage under the plan)
- Employees must be offered affordable, minimum value coverage by 1st day of 2014 plan year
  - Plans will not need to make mid-year or advanced changes

Non-Calendar Year Cafeteria Plans

- Employers may allow employees to change elections in 2013 plan year
  - Employees may want to enroll in employer's plan mid-year to avoid individual penalty
  - Employees may want to leave plan for an Exchange
- Plan must be amended by Dec. 31, 2014
  - Amendment can be retroactive to first day of 2013 plan year

Employer Reporting

New Information Return for Large Employers

Large employers must file information returns with IRS

First returns due in 2015

- About coverage offered in 2014
- On form issued by IRS

Written report provided to FT employees

Information Required

- Whether coverage offered to FT employees and dependents
- Number of FT employees for each month
- Length of any waiting period
- Cost of lowest cost plan option
- Employer's share of total allowed costs of benefits
- Identifying information of employees offered coverage

Still to Come

Upcoming Requirements

Nondiscrimination Rules

- Will apply to fully-insured non-GF plans
- Cannot discriminate in favor of highly compensated employees
- Effective after regulations issued

Automatic Enrollment

- Will apply to large employers (> 200 FT employees)
- Must automatically enroll/re-enroll employees in plan, provide notice and allow opt-out
- Effective after regulations issued