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Health Care Reform: What It Means for Employers and the Health Plans They Sponsor

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Agenda

- Welcome
- Overview of Patient Protection and Affordable Care Act ("PPACA")
- What You Need to Know As You Design Your Benefit Plans
- What You Need to Know As You Price and Shop Your Benefit Plans
- What You Need to Know to Coordinate the Implementation of Your Redesigned Benefit Plans
- Next Steps—What Do You Need to Do and By When?
- Questions?

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Overview of Patient Protection and Affordable Care Act ("PPACA")

- Three (3) Major Areas:
  - Expansion of coverage
  - Financing of expanded coverage
  - Reform of health care delivery system

Part I: What You Need to Know As You Design Your Benefit Plans

- Is your plan grandfathered?
- Coverage rules:
  - Coverage of individuals
  - Coverage of specific services
- Limits—financial and levels of care
- Flex plans
- Medicare changes

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Coverage

EXPANDED ADULT CHILD COVERAGE

- Plans providing dependent coverage must cover adult children up to age 26
- Non-grandfathered plans: effective as of January 1, 2011 for calendar year plans
- Grandfathered plans: effective as of January 1, 2014 for calendar year plans; prior to 2014 group health plans must only cover adult children who are not eligible for other employer-sponsored coverage
- Applies to fully-insured and self-insured plans

Coverage

WAITING PERIOD RESTRICTIONS

- Prohibits waiting periods of over 90 days for all plans (including grandfathered)
- Effective as of January 1, 2014 for calendar year plans
- Applies to fully-insured and self-insured plans

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Coverage

NONDISCRIMINATION RULES FOR INSURED PLANS

- IRC § 105(h) nondiscrimination rules for self-insured plans extended to non-grandfathered insured plans
- Prohibits discrimination in favor of highly compensated individuals
- Participants in insured executive-only plans subject to tax on benefits provided under discriminatory plans
- Effective as of January 1, 2011 for calendar year plans

Coverage

SELECTION OF PRIMARY CARE PROVIDERS

- Participants in non-grandfathered plans must be allowed to designate a primary care provider from any available participating provider
- Must permit designation of pediatrician for a child
- Effective as of January 1, 2011 for calendar year plans
- Applies to fully-insured and self-insured plans

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Coverage

CLINICAL TRIALS

- Non-grandfathered plans must cover clinical trials for cancer or life-threatening diseases
- Prohibits denying coverage of routine patient costs for items/services provided in connection with trial
- Prohibits discrimination against trial participants
- Effective as of January 1, 2014 for calendar year plans
- Applies to fully-insured and self-insured plans

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Limits

LIFETIME MAXIMUMS

- As of January 1, 2011 for calendar year plans, no lifetime dollar limits on essential health benefits
- Applies to fully-insured and self-insured group health plans
- Applies to grandfathered plans
- Does not eliminate lifetime dollar limits on non-essential health benefits

Limits

LIFETIME MAXIMUMS (CONT'D)

- Essential health benefits
  - Secretary of HHS to define, but to be equal in scope to benefits provided under a "typical" employer plan
  - To include at least the following general categories:
    - Ambulatory patient services
    - Emergency services and hospitalization
    - Maternity and newborn care
    - Mental health and substance use disorder
    - Rx
    - Rehabilitation
    - Laboratory services
    - Preventive and wellness services
    - Chronic disease management
    - Pediatric services, including oral and vision care

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Limits

ANNUAL MAXIMUMS

- As of January 1, 2011 for calendar year plans, annual limits on essential health benefits restricted
- For plan years prior to January 1, 2014, may only establish annual dollar limits on essential health benefits as determined by the Secretary of HHS
- As of January 1, 2014, no annual dollar limits on essential health benefits
- Applies to fully-insured and self-insured group health plans
- Applies to grandfathered plans
- Does not eliminate annual dollar limits on non-essential health benefits

Limits

ANNUAL COST-SHARING

- As of January 1, 2014 for calendar year plans, limits placed on annual cost-sharing
- Applies to fully-insured and self-insured group health plans
- Does not apply to grandfathered plans
- Limit on deductibles
  - For 2014:
    - Single coverage – $2,000
    - Other coverage – $4,000

Limits

ANNUAL COST-SHARING (Cont'd)

- Limit on aggregate out-of-pocket maximum
  - Includes deductible, co-insurance, and co-pays
  - Excludes premiums, balance billing by out-of-network providers, and charges for non-covered services
  - For 2014, based on maximum applicable to HDHP
  - For context, the 2010 out-of-pocket HDHP maximum:
    - Single coverage – $5,950
    - Other coverage – $11,900

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Limits

PRE-EXISTING CONDITION EXCLUSIONS

- As of January 1, 2011 for calendar year plans, no pre-existing condition exclusions imposed on children under age 19
- As of January 1, 2014 for calendar year plans, no pre-existing condition exclusions on anyone
- Applies to fully-insured and self-insured group health plans
- Applies to grandfathered plans

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Limits

CERTAIN PREVENTIVE CARE

- As of January 1, 2011 for calendar year plans, must provide 1st dollar coverage (*i.e.,* no cost-sharing) for:
  - Certain evidence-based care
  - Certain immunizations
  - Child well visits
  - Women's preventive care and screenings
- Applies to fully-insured and self-insured group health plans
- Does not apply to grandfathered plans

Limits

EMERGENCY CARE

- As of January 1, 2011 for calendar year plans, if any hospital emergency room benefits offered, then must cover such benefits without:
  - pre-authorization
  - regard to whether participating provider
  - imposing requirements or costs different than those imposed on in-network participating providers
- Applies to fully-insured and self-insured group health plans
- Does not apply to grandfathered plans
- Waiting period and cost-sharing limits permissible

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Flex Plans

HEALTH FSA DOLLAR LIMITS

- Health FSA contributions capped at $2,500 for all plans (including grandfathered)
- Beginning in 2014, cap increased annually (indexed to CPI)
- Effective as of January 1, 2013

OTC DRUG REIMBURSEMENT

- Expenses for over-the-counter drugs are not eligible for reimbursement, unless prescribed by a doctor
- Applies to reimbursements from all health FSAs, HSAs, HRAs (including grandfathered)
- Effective as of January 1, 2011

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Flex Plans

SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES

- Allows employers with 100 or fewer employees to establish cafeteria plans covering qualified employees
- Provides nondiscrimination safe harbor
- Minimum required employer contribution
- Retain small employer status for future years until reaching 200+ employees
- Effective as of January 1, 2011

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Retiree Programs

KEY MEDICARE CHANGES

- Medicare Advantage Health Plans:
  - Many new restrictions applicable
  - Practical results:
    - Cut back of additional services
    - Plans are discontinued by issuers
- MediGap Health Plans:
  - Revisions to Standard “C” and “F” plans to include nominal cost sharing for certain physician services

Retiree Programs

KEY MEDICARE CHANGES (CONT'D)

- Items that may decrease employer retiree medical expense:
  - Medicare increased coverage:
    - No charge for annual wellness visit
    - Elimination of Deductibles and Copayments For Certain Preventative Care
- Items that may increase employer expense:
  - Increased monitoring by subcontractors of Medicare payments to providers
  - Independent Medicare Payment Advisory Board to be established
    - Authority to reduce Medicare payments
  - Transition to value-based payment modifier for physician services
  - Cuts to physician and hospital reimbursements

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Part II: What You Need to Know As You Price and Shop Your Benefit Plans

- Tax credits
- Evaluation of “play or pay”
- Wellness programs and discounts
- Access to insurance exchanges
- Medicare Part D subsidy
- Retiree reinsurance program

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Small Employer Tax Credits

- Effective now
- For-profits and tax-exempts with fewer than 25 FTEs eligible
- Designed to encourage small employers to continue (or newly offer) health coverage
- To qualify, the small employer must pay at least half the cost of single coverage and pay wages averaging less than $50,000 per employee per year

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Small Employer Tax Credits (Cont'd)

- Maximum credit for 2010 – 2013:
  - For-profit – 35% of premiums paid by employer
  - Tax-exempt – 25% of premiums paid by employer
- In 2014, the maximum credit increases:
  - For-profit – 50% of premiums paid by employer
  - Tax-exempt – 35% of premiums paid by employer
- For-profit corporations claim credit on tax return
  - Cannot claim deduction to extent credit received
- Tax-exempts can claim credit against payroll taxes
  - Guidance to be issued

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Large Employer Play or Pay

NO COVERAGE PENALTY

- As of January 1, 2014, large employers (50 or more FTEs) must offer full-time employees health coverage or pay a monthly penalty for each full-time employee if
  - Any one full-time employee obtains an income-based tax credit for coverage in a state insurance exchange for that month
- Monthly penalty equals 1/12 of $2,000 (*i.e.*, $166.67) per FTE
- First 30 FTEs disregarded

Large Employer Play or Pay (Cont'd)

NO COVERAGE PENALTY

- Example: 65 FTEs and one FTE is eligible for the income based tax credit and secures coverage on a state insurance exchange for the month
- Calculation of monthly premium
  - 1/12 of $2,000 x 35 = $5,833.30
- Remember the first 30 FTEs excluded

Large Employer Play or Pay (Cont'd)

NO COVERAGE PENALTY

- FTE means on average at least 30 hours per week
- A full-time employee with a household income ranging from 133% to 400% of the Federal Poverty Level is eligible for a subsidy in the form of a premium tax credit:
  - 2010 FPL for family of four (except for Alaska and D.C.)
    - 133% = $29,326
    - 400% = $88,200

Large Employer Play or Pay (Cont'd)

OPT-OUT PENALTY

- Even if a large employer offers coverage, may still be subject to a penalty if coverage "unaffordable"
  - Employee's share of premium would exceed 9.5% of employee's household income or employer does not pay at least 60% of allowed costs under plan **and**
  - Employee's household income does not exceed 400% of FPL
- Monthly penalty equals 1/12 of $3,000 (*i.e.*, $250) per FTE who is eligible for premium tax credit, capped at penalty that would be applicable if employer offered no coverage

FREE CHOICE VOUCHER

- Available to certain FTEs who opt out of employer coverage
  - Employee's share of premium would be between 8% to 9.8% of the employee's household income **and**
  - Employee's household income does not exceed 400% of FPL
- Used to purchase coverage on a state insurance exchange

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Wellness Programs

- Existing programs can continue, so long as regulations remain in effect
- Beginning January 1, 2014, new calendar year programs must meet one of two new sets of requirements
- One set for programs that condition rewards on satisfaction of a standard related to a health status factor, one set for programs that do not

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Wellness Programs (Cont'd)

- Health status factors include:
  - Health status
  - Medical conditions
  - Claims experience
  - Receipt of health care
  - Medical history
  - Genetic information
  - Evidence of insurability
  - Disability
  - Other factors as determined by HHS

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Wellness Programs (Cont'd)

- Programs without health status factor conditions or rewards:
  - Available to all similarly situated individuals?
  - If so, deemed to comply:
    - Fitness center membership
    - Diagnostic testing program
    - No cost preventative care
    - Smoking cessation program
    - Periodic health education seminars

Wellness Programs (Cont'd)

- Programs with health status factor conditions:
  - Reward can be increased to 30%, possibly 50% of coverage cost
  - Cost equals employer and employee contributions
  - Cost or benefit based rewards
  - Program must meet certain criteria
- Programs with health status factor conditions must:
  - Have a reasonable chance of improving the health or preventing disease
  - Not be overly burdensome
  - Not be a subterfuge for health status factor discrimination
  - Not use a highly suspect method
  - Allow individual to qualify for reward at least once a year
  - Provide a reasonable alternative or waiver

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Wellness Programs (Cont'd)

- Grants available for new small employer wellness programs in 2011
- New programs must include:
  - Health awareness initiatives
  - Efforts to maximize employee engagement
  - Initiatives to change unhealthy behaviors and lifestyle choices
  - Supportive environmental efforts

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Access to Insurance Exchanges

- State insurance exchanges must offer qualified plans by January 1, 2014
- Qualified plan defined:
  - Health plan
  - Licensed health insurance issuer
  - Provides essential benefits package or offers catastrophic coverage
- Essential benefits packages:
  - Benefits specified by HHS
  - Equal to a typical employer plan
  - Satisfies cost-sharing and minimum actuarial value requirements
  - Qualifies as bronze, silver, gold, or platinum level coverage

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Access to Insurance Exchanges (Cont'd)

- Provide a Small Business Health Options Program (a SHOP Exchange)
- Small vs. large employers defined (1-100)
- Cover all of a small employer's full-time employees
- Access continues for a small employer that grows too large
- A new employer's access based on its reasonable expectation
- Large employers and 2017
- Regional exchanges possible
- State fails to, HHS sets up exchange

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Retiree Programs

MEDICARE PART D EMPLOYER SUBSIDY

- Taxable
  - Amount received in subsidy cannot be deducted as an expense - 2013
  - Under accounting rules, may require an immediate adjustment to financial statements
- Qualification
  - Reducing the “Doughnut Hole”
    - Brand-name drugs
    - Generic drugs
  - Actuarial Equivalence Test

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Retiree Programs

TEMPORARY RETIREE REINSURANCE PROGRAM

- Who is covered
  - Both fully and self-insured qualified plans
    - Cost savings programs
    - Certified by Secretary of HHS
  - Age 55 to 65 and not eligible for Medicare
    - And their eligible dependents/surviving spouse
- What is covered
  - Each high-dollar claim
    - Between $15,000 and $90,000
    - Reimbursement of 80%
- How to get the reinsurance
  - Apply to HHS
  - Implement cost saving measures for high-cost chronic conditions
  - HHS certifies your plan
  - Document the cost of the medical claims and submit

Retiree Programs

TEMPORARY RETIREE REINSURANCE PROGRAM (Cont'd)

- Payments
  - Must be used to lower plan costs
    - Premium costs
    - Premium contributions, co-payments, deductibles, co-insurance or out-of-pocket costs
  - Will not be considered income
- Timing
  - To be established June 2010
  - Ends January 1, 2014 or $5 billion has been spent

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Part III: What You Need to Know to Coordinate the Implementation of Your Redesigned Benefit Plans

- Auto enrollment
- Payroll reporting & additional taxes
- Access to “CLASS” program
- Appeals processes
- Standardized disclosures
- Transparency reporting
- More government reporting

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Enrollment Processes

AUTOMATIC ENROLLMENT

- Non-grandfathered plans must automatically enroll new full-time employees and continue enrollment of current participants, unless either opt-out
- Applies to employers with over 200 full-time employees
- Notice and opt-out opportunity required
- Effective date is unclear; Labor Department regulations forthcoming

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Increased Medicare Taxes

NEW MEDICARE TAXES EFFECTIVE JANUARY 1, 2013

EARNED INCOME

- Current employee tax rate -1.45%
- An additional 0.9% Medicare tax on wages in excess of:
  - $200,000 for individuals
  - $250,000 for married couples filing jointly
- Applies only to employee-paid portion of Medicare tax, but employers must withhold and report

UNEARNED INCOME

- 3.8% Medicare tax on the lesser of:
  - Net investment income for tax year **or**
  - Excess modified adjusted gross income for tax year over
    - $200,000 for individuals
    - $250,000 for married couples filing jointly
- Net investment income includes gross income from
  - interest
  - annuities
  - rents
  - dividends
  - royalties
  - other passive activities
- Employers are not required to withhold or report

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Tax on Cadillac Plans

- Latest effective date – January 1, 2018
- Tax imposed on provider (not participant)
- Tax equal to 40% of "excess benefit"
  - For 2018, annual amount of coverage that costs more than:
    - $10,200 for single coverage
    - $27,500 for family coverage
- Includes:
  - Major medical
  - Health care FSAs
  - HSAs
  - Certain onsite wellness centers
- Excludes:
  - Stand alone dental and vision
  - Voluntary specific disease and hospital indemnity policies
  - Long-term care

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W-2 Reporting

- Effective for 2011
- First applicable to W-2 issued in January 2012
- Same inclusions/exclusions as for Cadillac plans, except includes stand alone dental and vision and excludes:
  - HSAs
  - Employee contributions to medical flexible spending account
- Purpose is to track fulfillment of individual mandate and tax on Cadillac plans

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CLASS Act - Long-Term Care

- Effective as of January 1, 2011
- New, voluntary, self-funded public long-term care plan to provide community living assistance services and supports community residence
- Working adults auto enrolled, with opt out
- Funded by monthly payroll deductions
- 5-year vesting schedule

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Appeals Processes

- Internal and external reviews
- Effective appeals process minimum requirements
  - Notice to participants and beneficiaries:
    - About internal and external appeals processes
    - Availability of any ombudsman or health insurance consumer assistance
    - Culturally and linguistically appropriate language
- Effective appeals process minimum requirements
  - Allow participants and beneficiaries:
    - To review their files
    - To present evidence and testimony during an appeal
    - To receive continued coverage during an appeal
- Internal review process:
  - Now meet the current claims regulation requirements
  - Later meet updated DOL requirements
- External review process:
  - Self-insured plans: new minimum DOL standards
  - Insured plans:
    - Applicable State external review processes
    - Or minimum DOL standards
- Effective January 1, 2011 for calendar year plans

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Standardized Disclosures

- Summaries of benefits required
- Four pages; 12 point font; culturally and linguistically appropriate language; and understandable by the average plan participant or beneficiary
- Summary must include:
  - HHS definitions of insurance and medical terms
  - Coverage descriptions
  - Cost-sharing descriptions; renewability and continuation of coverage descriptions
  - Examples
  - Minimum essential benefit statement
  - Contact number for questions and WEB address for plan document

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Standardized Disclosures (Cont'd)

- Precise summary standards by HHS, NAIC and working group due March 23, 2011
- Summaries distributed by non-grandfathered plans by March 23, 2012; possibly by March 23, 2010 for grandfathered plans
- Notification of material changes 60 days before changes effective
- Sets a preemption floor
- $1,000 fine for each willful failure
- Employers must provide information to participants about insurance exchanges including:
  - Availability of tax credits
  - Availability of cost sharing
  - Availability of free choice voucher
- By March 1, 2013 for existing employees

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Required Transparency Disclosures

- Beginning in 2011, accurate and timely disclosures required to HHS and the public:
  - Claims payment policies and practices
  - Periodic financial disclosures
  - Data on:
    - Enrollment and disenrollment
    - The number of claims denied
    - Rating practices
  - Information on:
    - Cost sharing and payments for out-of-network charges
    - Rights under the act
    - Any other information required
- As updated and harmonized by DOL
- Must use plain language
  - Intended audience can readily understand
  - Concise, well-organized, and follows best practices
  - HHS and DOL to issue best practices guidance
- Must respond to individuals' questions about coverage for a specific service

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More Government Reporting

MEDICAL LOSS RATIOS REPORTING TO HHS

- Effective as of January 1, 2011
- Applicable to fully-insured plans only
- Applies to grandfathered plans
- Report % of premium revenue expended on medical care as opposed to administrative costs
- If ratio is not at least 85% for large group market (80% for small group market), then rebate

QUALITY OF CARE REPORTING TO HHS

- HHS to issue regulations by March 2012 requiring plan reporting on measures that improve quality of care
- Applies to self-insured and group health plans
- Does not apply to grandfathered plans

COVERAGE REPORTING TO IRS

- Effective January 1, 2014 for large employers (50 or more FTEs)
- Whether employee coverage offered
- Length of waiting periods
- Lowest cost option
- Plan's actuarial value

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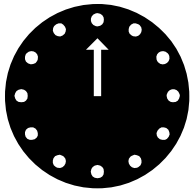
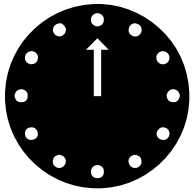
Timeline for Next Steps



Effective Date		Action Items	Applies to Grandfathered Plans?
Now	✓	**If you have 25 or fewer FTEs**, work with your Finance Department to evaluate whether you are eligible for the small employer tax credit and if so, apply for credit	
	✓	**If you offer retiree coverage and apply for the Medicare Part D subsidy**, work with your Finance Department and auditors to evaluate the current impact on your financial statements under the FASB rules because the Medicare Part D subsidy will effectively become taxable in 2013	
6/23/2010	✓	**If you offer retiree coverage for retirees ages 55-65 who are not eligible for Medicare**, apply for the retiree reinsurance program, work with your Finance Department and obtain claims data from your insurance company/TPA and consider appropriate plan design changes	

Timeline for Next Steps



Effective Date		Action Items	Applies to Grandfathered Plans?
1/1/2011 for calendar year plans	✓	**Evaluate what plans you are going to offer, and determine whether any plans need to be restructured**	
		• Determine what grandfathered plans you have	
		• Determine whether you have any dental and vision coverage that you want to convert to "stand-alone" plans so that they are exempt from the new rules on annual and lifetime limits	
		• Determine whether you have any fully-insured plans that need to be restructured to comply with the nondiscrimination coverage rules, such as executive-only plans	
		• CLASS Act (voluntary long-term care program)	
		• New wellness programs (grants available for small employers)	

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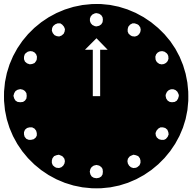
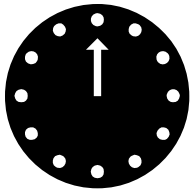
Timeline for Next Steps



Effective Date		Action Items	Applies to Grandfathered Plans?
1/1/2011 for calendar year plans	✓	**Amend medical plan documents**	
		• Remove lifetime maximum limits for essential health benefits (and define what those are)	
		• Revise annual limits for essential health benefits to reflect HHS standards	
		• Remove pre-existing condition limits for children under age 19	
		• Limit right to rescind coverage only to fraud or intentional misrepresentation of a material fact	
		• Expand dependent eligibility to cover adult children up to age 26 (applicable to grandfathered plans only if the dependents are not eligible for coverage under another employment-based plan)	
		• Remove cost sharing, and implement first-dollar coverage, for preventive care (deductibles, copays, and co-insurance can't apply)	
		• Permit designation of any participating primary care provider	
		• Remove restrictions on emergency care	
		• Update internal and external appeals procedures	

Timeline for Next Steps



Effective Date		Action Items	Applies to Grandfathered Plans?
1/1/2011 for calendar year plans		**Amend medical plan documents (cont'd)** • Any additional design changes that may be made to offset some of the anticipated increases in costs due to limits on annual and lifetime maximums, removal of pre-existing conditions, etc.	
	✓	**Amend medical FSA plan documents**	
		• Eliminate reimbursement for OTC drugs	
		• If small employer, consider establishing "Simple" cafeteria plan	
	✓	**Provide notice of changes to participants (by 11/1/2010)**	
		• Give at least 60 days' advance notice of changes (SMMs or new SPDs)	
	✓	**Negotiate insurance costs or stop-loss coverage, as applicable**	
		• Removal of annual, lifetime, and pre-existing condition limits, and cost sharing, the addition of other restrictions, and expansion of dependent eligibility could create more expense to employers, in terms of premiums for fully-insured plans and stop-loss	

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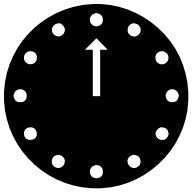
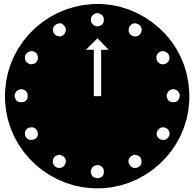
Timeline for Next Steps



Effective Date		Action Items	Applies to Grandfathered Plans?
1/1/2011 for calendar year plans	✓	**Update contracts with TPAs/claims administrators**	
		• Compliance with new internal and external claims processes	
		• Determine who will handle transparency disclosures	
		• Determine who will prepare HHS reporting on medical loss ratios	
	✓	**Implement auto enrollment (depending on effective date)**	
	✓	**Work with payroll to implement changes**	
		• Payroll withholding to implement any "Simple" employer cafeteria plan; voluntary CLASS Act plan	
		• W-2 reporting of employer-provided health coverage	

Timeline for Next Steps



Effective Date		Action Items	Applies to Grandfathered Plans?
1/1/2011 for calendar year plans	✓	**Provide required notices to HHS**	
		• Reporting to HHS on medical loss ratios	
		• Reporting to HHS (and public) to comply with transparency provisions	
	✓	**Apply for available grants for small employer wellness program**	
1/1/2012 for calendar year plans	✓	**Amend medical plan documents**	
		• Coordination with Medicare	
	✓	**Provide new required (uniform) plan summaries**	
	✓	**Update contracts with TPAs/claims administrators**	
		• Put systems in place to enable quality of care reports to HHS	

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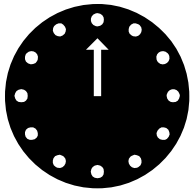
Timeline for Next Steps



Effective Date		Action Items	Applies to Grandfathered Plans?
1/1/2013 for calendar year plans	✓	**Amend Medical FSA plan documents**	
		• Impose cap on contributions	
	✓	**Work with payroll to implement changes**	
		• Medical FSA caps	
		• Increased Medicare taxes on earned income	
	✓	**Work with Finance**	
		• Taxation of Medicare Part D subsidy	
		• Payment of per-participant fee (premium tax)	
	✓	**Provide required notices by 3/1/2013 to employees regarding availability of insurance exchanges**	

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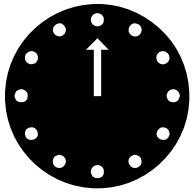
Timeline for Next Steps



Effective Date		Action Items	Applies to Grandfathered Plans?
1/1/2014 for calendar year plans	✓	**Evaluate what plans you are going to offer**	
		• Small employers have access to state insurance exchanges	
		• Large employers are subject to play or pay penalties, opt-out penalties, and "free choice" vouchers	
		• Wellness plans have to meet certain standards, so existing wellness programs may need modification	
	✓	**Amend medical plan documents**	
		• Grandfathered plans must expand dependent eligibility for adult children, even if eligible for other employer-provided coverage	

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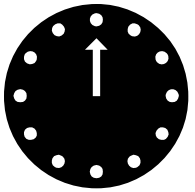

Effective Date		Action Items	Applies to Grandfathered Plans?
1/1/2014 for calendar year plans		**Amend medical plan documents (cont'd)** • Remove waiting periods exceeding 90 days	
		• Remove all annual limits on essential benefits	
		• Remove all pre-existing conditions (can no longer impose on individuals age 19 and over)	
		• Mandated cost-sharing limits	
		• Add coverage for clinical trials for cancer or life threatening diseases	
		• Any additional design changes that may be made to offset some of the anticipated increases in costs due to changes on annual limits, removal of pre-existing conditions, and limits on cost-sharing	
	✓	**Negotiate insurance costs or stop-loss coverage, as applicable**	
		• Removal of annual and pre-existing condition limits, cost sharing and other restrictions, and expansion of dependent eligibility could create more expense to employers, in terms of premiums for fully-insured plan and stop-loss	
	✓	**Reporting to IRS on employer-provided coverage**	

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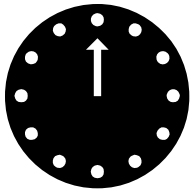

Effective Date		Action Items	Applies to Grandfathered Plans?
1/1/2014 for calendar year plans	✓	**Provide required notices regarding employer-provided coverage and wellness programs**	
1/1/2017 for calendar year plans	✓	**Evaluate what plans you are going to offer**	
		• Large employers have access to state insurance exchanges	
1/1/2018 for calendar year plans	✓	**Evaluate what plans you are going to offer**	
		• Work with Finance and with insurance company or actuarial firm to determine if you offer a "Cadillac" plan subject to penalty tax, or whether you can restructure your plans to minimize or avoid penalty	

Contact Information

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