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HEALTH CARE REFORM: THE FACTS, THE TAXES AND THE OPPORTUNITIES

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Denise Angleman, CPIW
Regional Senior Vice President
Marsh & McLennan Agency LLC

Health Care Reform? What is it?

- **Patient Protection and Affordable Care Act ("PPACA") – signed on March 23, 2010**
- **Health Care and Education Reconciliation Act (Reconciliation Act) – signed on March 30, 2010**
- **The Health Care Reform law makes sweeping changes to our nation's health care system.**
- **Compliance with these reforms was required beginning the first plan year after September 23, 2010 or for plan years beginning October 1, 2010 going forward.**

Health Care Reform? What is it?

The Delay

- **July 2, 2013 the Internal Revenue Service announced:**
  - **Annual reporting requirements for the employer "Play or Pay" mandate are delayed until January 1, 2015**
  - **There will be no enforcement of the Play or Pay penalties for 2014**
- **Impacts two key provisions of ACA:**
  - **Employers' requirement to offer sufficient and affordable coverage**
  - **Any reporting requirements associated with the employer mandate**

The Taxes

The Taxes

- 3.8 % Medicare Contribution Tax
  - Beginning 2013, high-income individual taxpayers will be subject to a new 3.8% surtax to net investment income.
  - Single filers with income above $200,000
    Married filers, joint filer with income above $250,000
  - Definition: Net Investment Income
    - Interest
    - Capital Gains
    - Dividends
    - Other Passive Income*

    ** to be better defined by IRS*
- Medicare Payroll
  - Tax increases from 1.45% to 2.35% on the wages and self-employment income in excess of $200,000 for single filers and $250,000 for joint filers, married.

The Taxes (Continued)

- Indoor Tanning Excise Tax at 10%
- Medical Device Excise Tax at 2.3%
- Taxes that will affect your plans directly
  - Patient Centered Outcomes Research Institute (PCORI)
  - Transitional Reinsurance Assessment
  - Health Insurance Providers Fee
  - 2018 High Cost Health Plan Excise Tax (Cadillac Tax)

A New Fee Called Patient-Centered Outcomes Research Institute ("PCORI") Fee formerly Called Effectiveness Research Fee:

- This new fee will apply to plan sponsors and insurers of individual and group medical policies, as well as some HRA's and some Health FSA's. Excludes dental and vision plans.
- The fees are to be contributed toward the Patient-Centered Outcomes Research Trust Fund. The research will evaluate and compare health outcomes and clinical effectiveness, risks and benefits of two or more medical treatments and services.
- The fee is $1 per member per year for policies/plan years ending after September 30, 2012. The fee adjusts to $2 per member for policies/plan years ending 2012 through 2014. After September 30, 2014, the dollar amount will be adjusted by HHS. The first set of taxes were due on July 31, 2013.
- There is a suggested methodology to calculate number of lives.
- Fully insured insurers will file reports and pay fees.
- This tax is Tax Deductible.
- Self insured plan sponsors must do these tasks themselves and will need to file IRS Form 720 to report fees and make annual payments. (Includes HRA plans.)
- The research fee ends after 2019.

Transitional Reinsurance Program

- Intended to help offset the losses health insurance companies are expected to incur for providing coverage to high risk individuals buying coverage in State Insurance Exchanges. Excludes dental and vision plans.
- Financial assessments from 2014 through 2016 totaling $25 billion to be imposed on health insurers and TPA's.
- This tax is not tax deductible
- $5.25 per member per month or $63.00 per member per year (approximately 1.5% of premium). Reducing in 2015 and 2016.
- Pass-through tax.
- HMS will collect annually (November 15 to December 15).
- Fully Insured Plans – collected and paid by carrier.
- Self Insured Plans – employer must calculate and pay own fee.

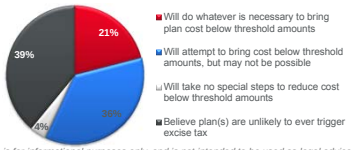
Federal Insurer Annual Fee (Premium Tax)

- Designed to help fund the PPACA, this fee places an additional premium tax on insurers: $8 billion in 2014 rising to $14.3 billion by 2018. After that, the fee will increase in an amount proportional to overall premium growth. This fee is only applicable to fully insured business and applies to medical, dental and vision plans. The assessment is based on all premiums collected in 2014 and includes plans that begin in 2013 and extend into 2014.
- Estimated revenue generation is $8 billion in 2014 to $14.3 billion in 2019.
- The insurer fee is estimated to be 2.3% of earned premium, 3% - 4% in later years.
- Fully Insured Plans Only: Since the assessment is based on all premiums collected in 2014, and we have policy years that begin in 2013 and extend into 2014, insurers have already added the fee to premiums for most plans beginning February 2013.

ACA High Value ("Cadillac") Plan Excise Tax

- Includes medical/Rx, individual reimbursement accounts, EAP, and onsite medical clinics
- 2018 thresholds are $10,200 for single coverage and $27,500 for family coverage – will be indexed annually thereafter based on CPI
- 40% excise tax on the coverage value that exceeds these thresholds
- Threshold adjustments permitted for pre-65 retirees, high-risk professions, significant age/gender factors, and multi-employer plans

Most Likely Employer Actions Regarding Excise Tax



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Not a Tax Yet – But a Reporting Requirement

Form W-2 Reporting for Value of Health Coverage (Issued after 1/1/13)

- Employers that file 250 or more W-2's (prior calendar year) will be required to report the cost of employees' health benefit coverage on their 2012 W-2 forms that are distributed) in January 2013. (Ongoing requirement annually)
- Total number of W-2's, not total employees.
- Counted on entity basis not controlled group
- This requirement is informational only and does not mean that employees will be taxed on these dollars.
- The coverage costs that must be reported include:
  - Medical and Prescription Drug plans
  - Dental and Vision plans, unless they're 'stand alone' plans (i.e. an employee may elect only dental or only vision and is not required to also enroll in medical coverage)
  - Executive physicals
  - On site clinics (providing full-scale medical treatment)
  - Medicare supplemental policies
  - Employee Assistance Programs (EAP's)
  - HSA, HRA and Health FSA contributions by the employer

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Not a Tax Yet – But a Reporting Requirement (continued)

Form W-2 Reporting for Value of Health Coverage (Issued after 1/1/13)

- Reporting of "aggregate cost" of benefits – Employer and Employee.
- There are several ways an employer can calculate the cost of the plan. A common method would be the COBRA applicable premium method, the reportable cost for the period equals the COBRA applicable premium for that coverage for that period (without the 2% fee).
- The employer must account for changes that are made to the employee coverage during the year.
- The aggregate cost of employer-sponsored coverage will be reported in Box 12, using Code DD.

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How Do I Know What Portions of ACA Apply to Me?

Step 1 – Determine how many full-time equivalent employees you have.

Step 2 – Employers, with more than 50 FTEs, will be subject to the Employer Shared Responsibility (Employer Mandate). Employers need to determine if they want to "Pay or Play". If they "play" they must ensure that the coverage:

1. Is **affordable**
2. Meets a Minimum Actuarial Value
3. Offered to at least 95% of full-time (30 or more hours per week) employees and their children.

Or will be subject to penalties.

Step 3 – Employers, with 50 FTE's or less are not subject to the Employer Mandate.

Definition of a Large Employer

- Applicable Large Employer Definition
  - IRC Section 4980H(c)(2) provides that an applicable large employer is an employer that employed an average of at least 50 full-time employees on business days during the preceding calendar year.
  - For purposes of determining whether an employer is an applicable large employer, full-time equivalent employees (FTEs) are taken into account.
- Controlled group rules under IRC § 414(b),(c), (m) or (o)
  - Controlled group combined for determining if large employer, but applicable penalty (if any) is allocated back to each employer group

Definition of a Large Employer (continued)

How to Calculate the Number of FTE's In Order To Determine Large Employer Status

1. Calculate the number of full-time employees.
   - A "full-time" employee is an individual working 30+ hours per week
     - Determine if you have at least 50 full-time employees (includes full-time equivalent employees) during the preceding calendar year.
     - IRS: 130 hours of service in a calendar month = 30 hours of service per week
     - Includes common law employees, FTE part-time, and FTE seasonal
   - Test determined on a monthly basis
   - "Hours of service" include:
     - Each hour for which an employee is paid or entitled to payment

Definition of a Large Employer (continued)

How to Calculate the Number of FTE's In Order To Determine Large Employer Status (Continued)

2. Calculate the number of FTE's (part-time employees), including seasonal employees for each calendar month in proceeding calendar year.
   - Calculate aggregate number of hours of service (no more than 120 hours) for all non-full-time employees for a month
   - Divide total hours of service by 120
   - Add each month's numbers to arrive at a calendar year total
   - Divide calendar year total by 12.
3. Add the number of full-time employees and FTE's (part-time employees) calculated in (1) and (2) above for each of the 12 months in the proceeding calendar year.
4. Add up the 12 monthly totals and divide the sum by 12; round down to the nearest whole number.

Definition of a Large Employer (continued)

How to Calculate the Number of FTE's In Order To Determine Large Employer Status (Continued)

5. If the number of employees is less than 50 the business is not a large employer for the current calendar year.
6. If the number of employees is 50 or more, the business is a large employer, unless the seasonal exception applies.
7. Seasonal retail worker exceptions (since delay this is now pending):
   a) If business exceeded 50 full-time for 120 days (4 calendar months) or fewer during calendar year, and
   b) The Employees in excess of 50 who were employed during the same period were seasonal employees, then
   c) The employer is not a larger employer.

Definition of a Large Employer (continued)

Sample Calculation

- **Number of Employees**
  - Full-time employees (2013) : 35
  - Part-time employees (June – December) : 40
    15 work 100 hours per month during this time period
    25 work 125 hours per month during this time period
- **Aggregate Hours:**
  - 15 employees x 100 = 1,500
  - 25 employees x 120 = 3,000 (max # of hrs. considered is 120)
  - Total hours = 4,500
  - Divide total hours by 120 = 37.50 (FTE for each month)
  - Add Full Time Employees
  - **37.50 FTE + 35 FT = 72.50**

Definition of a Large Employer (continued)

Sample Monthly Calculation

Month	Total Counted Employees (Full-Time + FTE)
January	35
February	35
March	35
April	35
May	35
June	72.5
July	72.5
August	72.5
September	72.5
October	72.5
November	72.5
December	72.5
Total for Year	**645**

Divide the yearly total by 12 = 53.75 FTEs
This group is subject to the Employer Mandate

Definition of a Large Employer (continued)

- Determining Full-Time Status for New Employees (New Hires)
  - If, based on the facts and circumstances, a new employee is reasonably expected to work full-time (i.e., more than 30 hours a week), then the employer must offer coverage within 3 months of employment.
  - For variable hour employees who are not reasonably expected to work full-time, the proposed regulations allow employers to use an initial measurement period of between 3 and 12 months to determine whether the employee is full-time.
  - If an employer determines that the variable hour employee worked full-time during his or her initial measurement period, then the employer must provide coverage to the employee for a subsequent stability period. This stability period must be equal to the stability period used for variable ongoing employees.
  - Employers can use an optional administrative period to enroll the new employees who are determined to work full-time so long as the initial measurement period and administrative period combined do not exceed 13 months and a fraction of a month.

Definition of a Large Employer (continued)

- Determining Full-Time Status for Variable Hour Ongoing Employees
  - Employers may use a look-back measurement period between 3 and 12 months to determine full-time status, followed by a stability period which must be at least 6 months or the length of the measurement period, whichever is greater.
  - Employers can use an administrative period of up to 90 days, but it may not reduce or lengthen the measurement or stability periods.
  - Employers may use different measurement and stability periods for the following categories of employees:
    - Collectively bargained vs. non-collectively bargained employees
    - Salaried vs. hourly employees
    - Employees in different states

Employer Mandate Penalties ("The Delay") – Effective January 1, 2015

Large employers must offer a plan that meets Minimum Value and Affordable

- Minimum value
  - Requires that the plan's share of the total allowed costs of benefits provided under the plan is at least 60%.
  - Minimum value regulations now provide design-based safe harbors.
- Affordable Coverage
  - In order for coverage to be affordable, an employee's contribution for self-only coverage cannot exceed 9.5% of the employee's household income.
  - Safe harbors
    - W-2, Box 1
    - Rate of pay (monthly salary or hourly rate multiplied by 130)
    - Federal Poverty Level ($11,490 for 2013)

Employer Mandate Penalties ("The Delay") – Effective January 1, 2015

No Coverage – "Pay"

- If an employer fails to provide its *full-time* employees (and their dependents) the *opportunity to enroll* in "minimum essential coverage," **and**
- One or more *full-time* employees enrolls for coverage in an exchange and qualifies for a premium tax credit or cost-sharing reduction, **then**
- Employer penalty = $2,000 for each of its *full-time* employees in the workforce
  - This penalty is non-deductible
  - Penalty does not offset the cost of employee coverage

Employer Mandate Penalties ("The Delay") – Effective January 1, 2015

Unaffordable Coverage / Minimum Actuarial Value Plan

- If an employer offers its *full-time* employees (and their dependents) the *opportunity to enroll* in minimum essential coverage, **and**
- One or more *full-time* employees enrolls for coverage in an exchange and qualifies for a premium tax credit or cost-sharing reduction because:
  - The employee's share of the premium exceeds 9.5% of income (or safe harbor rules), or
  - The actuarial value of the coverage was less than 60%, **then**
- Employer penalty = $3,000 for each of its full-time employees who receives a tax credit or cost-sharing reduction
  - If the employer has many employees in this category, the alternative penalty reverts to $2,000 per full-time employee.

Employer Mandate Penalties ("The Delay") – Effective January 1, 2015

Additional Details

- Penalties assessed on a monthly basis.
- No penalties assessed on first 30 full-time employees.
- No penalties apply to part-time employees.
- No penalties for waiting periods (if any).
- Total "affordability" penalty is capped. May not exceed penalty for "no coverage."

Employer Considerations: "Pay or Play"?

You Decide to "Pay", Challenges to Consider:

- Penalty Amount
- How much do you gross up to allow employees to purchase post-tax coverage
- Possible issues with retention and attraction of talent
- Unknown cost/trend of exchange premiums
- Lack of consistency across States
- Productivity impacts

Employer Considerations: "Pay or Play"? (continued)
Individual and Employer Mandates

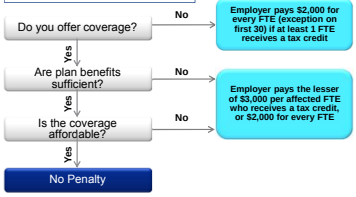
Individual Mandate

- Individuals must have qualifying minimum coverage or pay tax penalty (greater of: 1% of income or $95 in 2014, 2% or $325 in 2015, 2.5% or $695 as of 2016)
- Individuals with no employer coverage or with "insufficient" or "unaffordable" employer coverage are eligible for Exchange coverage and may receive a federal tax credit subsidy (sliding scale based on income)

Employer Mandate - "Pay or Play"

- If no employer plan is offered and 1 or more FTEs receive Exchange coverage tax credit subsidy, employer pays penalty of $2,000/FTE (FTE= avg. 30 hours/week)
- If employer coverage is "insufficient" or "unaffordable" and 1 or more FTEs receive Exchange coverage tax credit subsidy, employer pays penalty of $3,000/FTE receiving subsidy (up to $2,000 each for all FTEs)

"Pay or Play" Decision Tree:



- ✓ ***"Insufficient" Benefits*** – plan's actuarial value is <60% (benefits pay less than 60% of cost of services)
- ✓ ***"Unaffordable" Benefits*** – household income <400% federal poverty level ($45K sgl, $92K fam) and single-tier contribution is >9.5% of employee's W-2 income
- ✓ ***Full-Time Employee (FTE)*** – employee working avg. 30+ hrs/wk

Employer Considerations: "Pay or Play"? (continued)
Employer Mandates: It's a Business Decision

You first should decide how important offering competitive healthcare benefits is to your business – and if important, then decide how to effectively manage annual employer costs.

Determine health benefits not key to retention/recruitment → "Pay" → $2,000 penalty on all FTE's → Pay adjustment to keep employees whole

OR

Determine health benefits matter → "Play" → Engage employees to manage health → Aggressively manage plan on a long term basis

"The Delay"

What Does the Delay Mean?

WHAT'S DELAYED?	WHAT ISN'T DELAYED?
• Employer mandate to offer coverage to employees who work on average 30 or more hours per week. • Minimum value requirement for plan offering. • Affordable contribution requirement. • Employer reporting to IRS on full-time employees and health coverage status.	• Enrollment in employer-sponsored plans could still increase with individual mandate requirement effective January 1, 2014. • Public exchanges and expanded Medicaid (in some states) still slated for January 1, 2014 effective date. • Summaries of Benefits and Coverage and exchange notices to employees, including data on whether employer plan provides minimum value. • Employers may still want to respond to coverage verification requests for employees attempting to enroll in public exchange coverage. Employees eligible for minimum value, affordable coverage will still be ineligible for exchange subsidies. • ACA fees (PCORI, Temporary Reinsurance and Health Insurer Fees) will still apply. • Plan design requirements for all plans, including maximum 90-day waiting period, no limits on pre-existing conditions or essential health benefits, expansion of wellness incentives, dependent coverage to age 26. • Auto enrollment for health plans and nondiscrimination rules for fully insured, non-grandfathered plans are still to come. • Waiver for limited medical plans still expected to expire at the end of the 2013 plan year.

What's Delayed?

- Employer mandate to offer coverage to employees who work on average 30 or more hours per week
- Minimum value requirement
- Affordable contribution requirement
- IRS reporting requirement on full-time employees and health coverage status

What Isn't Delayed?

- Public exchanges and expanded Medicaid (in some states) still slated for January 1, 2014 effective date
- Summaries of benefits and coverage and exchange notices to employees
  - 10/1/2013 Exchange Notice Requirements
  - Update Model COBRA Notices
- Responding to coverage verification requests for employees enrolling in public exchange coverage

What Isn't Delayed (cont.)?

- ACA fees (PCORI, Temporary Reinsurance, Health Insurer fees)
- Plan design requirements:
  - Maximum 90-day waiting period
  - No limits on pre-existing conditions or essential health benefits
  - Expansion of wellness incentives
  - Dependent coverage up to age 26
- Auto enrollment for health plans and nondiscrimination rules for fully insured
- Waiver for limited medical plans

What's Uncertain?

- Transitional relief for large employer status
  - For 2013, employers could choose any 6 month period to assess applicable large employer status for 2014
- Transitional relief for fiscal year plans
  - Special rules for fiscal year plans pegged assessment at December 27, 2012 and enrollment data for end of 2012
- Transitional relief for Variable Hour Employees
  - For 2014, employers could use a 12 month stability period but use data only from July on (for the look-back period)

Individual and SHOP Marketplace 2014 and Beyond

Health Insurance Marketplace (formerly Exchanges)

Public Marketplaces

- Are intended to help individuals and small businesses shop for, select and enroll in high quality, affordable private health plans that fit their needs at competitive prices.
- The Act requires Marketplaces in each State by January 1, 2014. In 2014 – 2016, only individuals and employers in the small group market are eligible to participate in a Marketplace.
- States seeking to operate a State-based Marketplace had to submit a blue print to HHS by December 14, 2012 (extended from November 16, 2012) to receive the required approval by January 1, 2013 for plan years beginning 2014.
- As of today:
  - 18 Approved State Based Marketplaces, including D.C.
  - 7 Partnership Models
  - 26 Federally-Facilitated Marketplaces

Health Insurance Marketplace (continued)

Public Marketplaces (continued)

- Federal/State-based health insurance marketplaces
  - Law requires the creation of an American Health Benefit Exchange (AHBE) (for individuals) and Small Business Health Options Program (SHOP) Exchange for small employers up to 100 lives
  - States can choose to expand their exchanges to serve employer groups of 100+ in 2017
- Offer choice of plans, carriers, networks (comparison shopping)
- Develop menu of choices based on quality, access, and premium costs
- Subsidies will be available for lower income individuals in the Government sponsored Individual Exchange Marketplace Only

Health Insurance Marketplace (continued)

Individual & Small Group plans must provide an Essential Health Benefits package, to include:

Essential Health Benefits	Out-of-Pocket Maximum	Small Group Deductible Ceiling	Metallic Coverage Levels
• 10 required coverage categories	• $6,350 Single • $12,700 Family • New accumulation rules	• $2,000 Single • $4,000 Family • Subject to change due to actuarial values	• Bronze – 60% • Silver – 70% • Gold – 80% • Platinum – 90%

- No Pre-Existing conditions for all ages.
- No lifetime or annual limits on Essential Health Benefits.
- Charges the same premium on or off the Exchange.

Essential Health Benefits

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder benefits, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Small Employer Health Insurance Tax Credit

- Fewer than 25 FTE employees (not counting owners or their family members)
- Employer must pay at least 50% of the premium for single coverage
- Average annual wages of employees less than $50,000
- Credits increase 35% to 50% in 2014
- 2014 – Must purchase insurance through the Shop Exchange

Group Rate Factors

- 2014 – all individual and fully insured policies under 50 lives must abide by strict modified community rating standard with premium variations only allowed for age in the adult premium market (3:1), tobacco use (1.5:1 – Not NJ), family composition and geographic area.
- Age factor categories:
  - Children ages 0 through 20
  - One year bands for adults ages 21 through 63 with every age having their own unique rate, and a single age band for adults age 64 and over.
- Rates are without regard to gender.
- Medicare status may not be used as a rating factor meaning there can no longer be Carve Out rates.
- Your census, rates and bills will look very different.

Strategies to Successfully "Play" in 2014 and Beyond – Large Employers

Employers that "Play" need to take Greater Control of Future Plan Costs

- Technology - Tracking all of your employees
- Pay or Play Analysis – Determine your Liability and Costs associated with "Playing" so that you can create a strategy
- Consumerism (CDHP)
- Alternative Funding of your Group Contract
  - Traditional
  - Benefits Captive
- Results-Based upon Population Health Management Strategies
- Marketplace / Exchange
  - Public
  - Private

Technology

- Tracking every employee, full-time or part-time, will be essential
- Talk with your payroll company to determine if they have a program that can help you track hours
- Consider purchasing a web-based Benefits Eligibility system to help count hours and administer/communicate your benefits program

"Pay or Play" Cost Analysis

- Take time now to set up the foundation for calculating your liabilities and costs associated with Health Care Reform
- Consider having a Health Care Reform "Pay or Play" analysis conducted prior to your 2014 renewal.
- What will you learn?
- Review current definition of eligibility and determine what increased costs may arise from a change of definition.
- Provide to you the lowest annual income of a Heath Care Reform eligible employee based upon your current census.
- Determine the actuarial value of the "lowest value plan" at 60%.
- Perform the Affordability Test (<9.5% Annual Income) to employee contributions.
- Calculate the number of eligibles with 2013 income below the affordable limit to project possible penalty.

Employer Considerations: "Pay or Play"? (continued)

How do you decide what to do? (continued)

- Illustrate your options and costs moving into 2014.
  - Maintain current benefits and eligibility.
  - Comply with PPACA Benefits, Eligibility and Affordability criteria.
  - Eliminate benefits without any contribution for employees to purchase benefits in the Exchanges.
  - Eliminate benefits, determine what contribution the employer will make to employees to buy coverage through the exchange.
- Excise Tax Review
- This powerful information will offer a solid plan and strategy.

Consumerism

- Employee education and engagement is critical
- Health Reimbursement Plans (HRA's) and Health Savings Accounts (HSA's)
- Employee and Employer Contribution Design to create a culture where your employees and families are smart consumers
- Understanding your population and their generational preferences

Alternative Funding of Your "Traditional" Group Insurance Contract

- Creation of a smart long term health plan strategy
- Potential cost savings and increased cash flow
- Flexibility in benefit decisions/plan design
- Exemption for state mandates
- Reduction in premium tax
- Elimination of a substantial ACA tax – Health Insurer Fee and Excise Tax
- Benefit from good claim experience
- If set up properly, limited risk to you
- Receipt of quality claims data to understand the specific plan utilization issues and health concerns of the group
- Partnership with the carrier to understand and improve the health of the employees and their dependents (biometric screenings).

A Benefits Captive

A *CAPTIVE* insurance company is:

- established to ***reinsure*** an insured risk – in this case, self-funded medical/Rx plan stop loss insurance – of the ***member employers***,
- who also ***invest in, own and direct*** the captive insurance company,
- with the expectation they'll ***share in*** the company's favorable financial results,
- by ***effectively managing*** the covered risk – in this case, their employee's health risk.

MMA has differentiated itself by establishing a proprietary group captive:

RightPath Insurance, LTD.

A Benefits Captive (continued)

RightPath Insurance, LTD captive can:

1. Reduce medical/Rx plan stop loss net annual cost up to 50% - 60%
2. Maximize ROI for effectively managing employee health risk
3. Avoid taking more risk to reduce annual stop loss premium
4. Provide preferred stop loss contract provisions
5. Enhance medical plan cost management through aggregate purchasing arrangements (Rx coalition, data analytics)
6. Offer a good investment managed by like-minded, high performing employers

A Benefits Captive (continued)

MMA also works with a Benefits Captive specializing in the Health Care Industry:

Innovative Health Plan

1. Create a proactive culture and align incentives for stakeholders
2. Customize enrollment and administration technology
3. Provide quality plans as a recruiting and retention tool
4. Decrease claim trend and limit volatility
5. Create the protection available to large groups by pooling the most volatile risks

Population Health Management Strategies

- Create a culture that promotes Health and Wellbeing:
  - Senior Leadership Buy-In
  - Branding
  - Wellness Committee
  - Challenges, Incentives, Education and Fun
- Empower and engage employees and their families to live a healthy lifestyle
- Partnerships that will reduce health care costs

Health Insurance Marketplace (formerly Exchanges)

Private Marketplace

- A new group insurance delivery option for employers of all sizes.
- A private benefits exchange is designed to help employers more effectively manage their benefit costs providing employees and their dependents with superior choice, flexibility and service.
- Instead of the usual “one size fits all” approach, personalized and right size each employee’s benefit portfolio.
- Technology based decision support tools so each employee and their family picks the right benefits for them.
- Embracing a total benefit Defined Contribution Design

Health Insurance Marketplace (formerly Exchanges)

Private Marketplace (continued)

- Each Private Marketplace is set up differently. Options include:
  - Fully Insured Medical Plans
  - Self Insured Medical Plans
  - Voluntary Products
- All benefits will be purchased under the marketplace
- A Private Marketplace can be available for clients 25 lives and above.
- Private Exchange / Marketplace availability:
  - Liazon "Bright Choices"
  - Mercer Marketplace
  - Horizon Blue Cross Blue Shield
  - OSCAR
  - HealthPass New York
  - Digital

In closing, where do you go from here?

- Use this time to prepare for the mandate
- Explore options to manage costs:
  - Contract funding, plan design, employee contributions and population health management
  - Explore private exchanges to manage costs/maximize value
  - Determine if a Partially Self Funded Plan or a Benefits Captive will help manage the plan costs and allow you to engage your employees and their families in the benefits program
- Evaluate benefits administration tools and resources
- Determine if you need to conduct a "Pay or Play" analysis.
- Educate employees
  - Institute a robust and ongoing employee communications campaign
  - Educate employees on insurance options
- Implement a Wellness/Health Management Program so that you can improve the health of your employees and their families. This will reduce your health insurance costs and improve productivity.
- Work with a knowledgeable broker/consultant in order to stay on top of updates and announcements.

QUESTIONS

PRESENTED BY

MARSH & McLENNAN AGENCY

Denise Angleman, CPIW
Regional Senior Vice President
Marsh & McLennan Agency LLC
66 Route 17 North
Paramus, NJ 07652
(201) 587-2778 direct
dangleman@mma-ne.com