AFFORDABLE CARE ACT (ACA)
WHAT YOU NEED TO KNOW
WHAT TO EXPECT IN 2014
Today’s Speakers

• **ROY S. LYONS** Managing Director, Marsh US Consumer
  – Roy serves as the client manager for the New York City Bar Association member insurance programs as well as a number of other major professional associations including the State Bar of California and the California Medical Association. He has been active in developing Marsh’s strategy on the impact of healthcare reform on associations and their members.

• **DANIEL J. CORR** Principal, Mercer
  – Dan Corr serves as a senior consultant and relationship manager for medium sized employers on a wide range of health care and group benefits issues.
  – Prior to joining Mercer he worked at a regional brokerage firm and worked as a benefits administrator with a large hospital center in New York City.
  – Dan holds graduate degrees from Cornell University’s School of Industrial and Labor Relations and Fordham University’s Graduate School of Education. He has also earned the Certified Employee Benefits Specialist and Compensation Management Specialist designations.

• **GREGORY TROTTA** Senior Account Consultant, UnitedHealthcare/Oxford
  – Gregory Trotta is a Senior Account Consultant with UnitedHealthcare. Gregory manages relationships with key national brokerages and general agents. He consults on various aspects of the healthcare industry including: underwriting & participation requirements; corporate, administrative & clinical policies and healthcare reform.
  – Gregory has earned his juris doctorate degree from Villanova University School of Law.
## Agenda

### Discussion Topics for today

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ACA Overview</td>
</tr>
<tr>
<td>2</td>
<td>Individual Mandate, Essential Health Benefits Package and Grandfathered Plans</td>
</tr>
<tr>
<td>3</td>
<td>Exchanges – Individual and Small Business (SHOP)</td>
</tr>
<tr>
<td>4</td>
<td>Large Employers - Employer Shared Responsibility, Private Exchanges</td>
</tr>
<tr>
<td>5</td>
<td>Questions</td>
</tr>
<tr>
<td>6</td>
<td>Resources</td>
</tr>
</tbody>
</table>
ACA OVERVIEW
2014 – the Road Ahead Highlights
**Affordable Care Act**

**Background**

- ACA signed into law March 23, 2010
  - Patient Protection and Affordable Care Act (PPACA)
  - Most transformational change in health insurance since Medicare
  - Survived:
    - a Supreme Court challenge
    - Presidential election
    - Repeated (40+) congressional attempts to repeal or remove funding and more challenges on the way
  - Changes began taking place September 23, 2010

**October 1, 2013**

- Opening of state and federally run health Exchanges ?
- Employer Notice Requirement
- Threatened Federal government shut down
- Focus on changes being implemented January 1, 2014 and forward
Affordable Care Act
Overview

Major Changes in 2014

- **Individual mandate** — Individuals must have and maintain health insurance that provides minimum essential coverage

- What are the **Individual penalties**?
  - In 2014: greater of $95/individual (3 per family) or 1% of family income
  - In 2015: greater of $325/individual (3 per family) or 2% of family income
  - In 2016: greater of $695/individual (3 per family) or 2.5% of family income

- **Insurers** are unable to deny coverage due to pre-existing conditions
  - In NY, now cannot impose pre-existing conditions

- **Exchanges** — Creation of individual and small group (SHOP) exchanges run by the states, federal government or both
  - New York State of Health
  - SHOP - 2-50 employees (expands to 100 employees in 2016)
Affordable Care Act
Overview

 Mouth Changes in 2014

- **Tax credits and benefit subsidies** available only through Exchange plans
- **Essential benefits** for individual and small group plans (non-grandfathered)
- **Out-of-pocket** expense limits for co-pays, co-insurance, deductibles, etc. for in-network services.
  - $6,350/individual; $12,700/family
  - Transition relief for separate prescription drug plans
- **Metal Tiered Benefit Levels (+ or – 2%)**
  - Platinum – 90%
  - Gold – 80%
  - Silver - 70%
  - Bronze – 60%
- **Elimination** of small group risk adjustment factors (.90 to 1.10) (Not NY)
Affordable Care Act - Overview

**Major Changes in 2014**

- **Limits** on small group plan **deductibles**
  - $2,000/individual; $4,000/family
  - **Relief:** Insurers can exceed annual deductible limits if plans “cannot reasonably reach” the actuarial value the law sets for a given level of coverage without doing so

- **Premium** may vary only by:
  - Geography
  - Family composition
  - Age (3:1 ratio) (not a factor in NY)
  - Tobacco use (not a factor in NY)

- **Waiting period** for new full-time employees must not exceed 90-days

- Imposition of **new taxes and fees**

- **Catastrophic Plan** for individuals under age 30, financial hardship
  - Does not qualify for tax credit /subsidy
Recent Legislation

**H.R. 2775, INTRODUCED BY REP. DIANE BLACK, R-Tenn**
Prohibits distribution of premium tax credits and cost reduction subsidies before HHS has a program in place to verify household income and other coverage qualifications and that the program is operational.

**H.R. 2577, INTRODUCED BY REP. LUKE MESSER, R-IND**
Requirement to either offer coverage or pay a penalty would only apply to employers with at least 100 FTE employees.

**H.R. 2575, INTRODUCED BY REP. TODD YOUNG, R-IND.**
Would change the definition of FTE to those working an average of 40 hours per week

**S.1330 INTRODUCED BY SEN. MARK BEGICH, D-ALASKA**
Employers would have until 2016 to offer coverage to full time employees or face the employer penalty

**Representatives Tom Reed (R-NY) and Mike Thompson (D-CA)**
Repeal the $2,000 deductible limit on small-group health insurance plans under PPACA.
INDIVIDUAL MANDATE
ESSENTIAL HEALTH BENEFITS
GRANDFATHERED PLANS
Affordable Care Act
Individual Mandate

Individuals must have and maintain health insurance that provides minimum essential coverage through

- the individual insurance market
- an employer plan that is affordable and meets minimum value
- a state or federal health insurance exchange
- a government program (e.g. Medicaid, CHIP)
- grandfathered plans

Exceptions:

- Religion
- Income below tax filing thresholds
- Incarcerated
- Undocumented
- Native American
- Gap in coverage of less than 3 months
Affordable Care Act
Essential Health Benefits

All non-grandfathered plans offered in the individual and small group markets (both inside and outside exchanges) must provide:

**Essential Health Benefits** (without annual or lifetime limits):

- Ambulatory Services
- Emergency Services
- Hospitalization
- Maternity and Newborn Care
- Mental Health/Substance Abuse Treatments
- Prescription Drugs
- Rehabilitative Services
- Laboratory Services
- Preventive/Wellness Services

- Including additional preventive care services for women

- **Pediatric Services** – Dental and Vision
Affordable Care Act
Essential Health Benefits Package

- Limit out-of-pocket expenses for co-pays, co-insurance, deductibles, etc. for in network services
  - $6,350/individual; $12,700/family
- have an actuarial value that corresponds to one of the following metal tiers
  - Platinum - 90% of the benefits paid by the plan, 10% by the insured
  - Gold - 80% of the benefits paid by the plan, 20% by the insured
  - Silver - 70% of the benefits paid by the plan, 30% by the insured
  - Bronze - 60% of the benefits paid by the plan, 40% by the insured
Grandfathered Plans

- Plans in place prior to March 23, 2010 are not required to provide minimum benefit standards (metal levels)

- Plans lose grandfathered status if
  - Eliminate benefits to diagnose or treat a particular condition
  - Increase in a percentage cost sharing requirement (increase co-insurance)
  - Increase in deductible or OOP max that exceeds 15% plus inflation
  - Increase in co-pay by more than $5 plus inflation
  - Decrease in employer contribution by more than 5%
  - Imposition of annual limits on the dollar value of all benefits below specified amounts
  - Or if a carrier changes all its plan designs on January 1, 2014
Grandfathered Plans

Exempt from majority of reforms except:

- Prohibition on lifetime and annual limits for essential benefits
- Coverage for dependents children under 26
- Coverage for pre-existing conditions
- 90-day limit on waiting periods
- Prohibition on rescissions
- Medical loss ratio reporting and premium rebates
- Uniform explanation of coverage documents
EXCHANGES
INDIVIDUAL AND SMALL BUSINESS (SHOP)
NEW YORK STATE OF HEALTH
Qualified Health Plans

Benchmark Plan
New York Exchange selected:
- Oxford EPO small group plan
- Added missing essential benefits
- Became the basis to establish actuarial value

Goal: Cover many of the 2.7M uninsured under 65 (16%)

Premiums lower on average by 53% than historical rates

More insurers to choose from

Limited networks to achieve savings

8 regional rating areas
## Standard Plan designs

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Platinum</th>
<th>Gold</th>
<th>Silver</th>
<th>Bronze</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$0</td>
<td>$600</td>
<td>$2,000</td>
<td>$3,000</td>
<td>$6,350</td>
</tr>
<tr>
<td><strong>Max. OOP</strong></td>
<td>$2,000</td>
<td>$4,000</td>
<td>$5,500</td>
<td>$6,350</td>
<td>$6,350</td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hosp, SNF, Hospice</td>
<td>$500 per adm.</td>
<td>$1,000 per adm.</td>
<td>$1,500 per adm.</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Outpatient Facility -surgery</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Surgeon</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>PCP</td>
<td>$15</td>
<td>$25</td>
<td>$30</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Specialist</td>
<td>$35</td>
<td>$40</td>
<td>$50</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$10/$30/$60</td>
<td>$10/$35/$70</td>
<td>$10/$35/$70</td>
<td>$10/$35/$70</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Mail order (90 day supply)</td>
<td>2.5 times</td>
<td>2.5 times</td>
<td>2.5 times</td>
<td>2.5 times</td>
<td>na</td>
</tr>
<tr>
<td>Rehab &amp; Hab Therapy</td>
<td>$25</td>
<td>$30</td>
<td>$30</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>ER</td>
<td>$100</td>
<td>$150</td>
<td>$150</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$100</td>
<td>$150</td>
<td>$150</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$55</td>
<td>$60</td>
<td>$70</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>DME /Med Supplies</td>
<td>10% co-ins</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Eyewear, Hearing Aids</td>
<td>10% co-ins</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Pre-adm testing</td>
<td>0% copay</td>
<td>0% copay</td>
<td>0% copay</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Diag, x-ray, Imaging, lab</td>
<td>$35</td>
<td>$40</td>
<td>$50</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Chemo, radiation,</td>
<td>$15</td>
<td>$25</td>
<td>$30</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$15</td>
<td>$25</td>
<td>$30</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
</tbody>
</table>
**New York State of Health - Manhattan - Insurer List**

**Individual Exchange**

- Affinity Health Plan, Inc.
- Empire Blue Cross Blue Shield
- Fidelis Care
- Freelancers Co-Op (Health Republic Insurance)
- Health Insurance Plan of Greater New York (EmblemHealth)

- Healthfirst New York
- MetroPlus Health Plan
- Oscar Insurance Corporation
- United Healthcare of New York, Inc. (United, Oxford)
New York State of Health Open Enrollment

- Open Enrollment begins October 1, 2013
- January 1, 2014 first coverage effective date
  - Open Enrollment ends March 31, 2014
- Special Enrollment Periods
  - Individual changes
    - Loss of Minimum Essential Coverage qualifying employer coverage
    - Life event: birth, marriage, etc.
- Next Open Enrollment will be October – December 2014
- Employer groups may enroll throughout the year
Individual Exchanges
Financial Assistance

- **Premium tax credits**
  - Sliding scale of tax credits paid directly to insurers
  - Based on the second lowest cost silver plan offered
  - Household income between 133% and 400% of the federal poverty level (FPL)
    - (max: $45,960 for individuals and up to $94,200 for a family of 4)
  - Those with incomes below 250% FPL will also have cost sharing subsidies
    (apply only to the silver level plan design)
  - May apply for some or all of the credit at time of application

- **Eligibility**
  - Not eligible for affordable and minimum value coverage through an employer
  - Are U.S. citizens or legal residents

- **Subsidy Estimator**

  NYStateOfHealth.NY.gov/PremiumEstimator
Premium Tax Credit Calculation Example

- Premium required to pay cannot exceed these amounts

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Premium as a % of income</th>
</tr>
</thead>
<tbody>
<tr>
<td>130% - 150% FPL</td>
<td>3% - 4%</td>
</tr>
<tr>
<td>150% - 200% FPL</td>
<td>4% - 6.3%</td>
</tr>
<tr>
<td>200% - 250% FPL</td>
<td>6.3% - 8.05%</td>
</tr>
<tr>
<td>250% - 300% FPL</td>
<td>8.05% - 9.5%</td>
</tr>
<tr>
<td>300% - 400% FPL</td>
<td>9.50%</td>
</tr>
</tbody>
</table>

For example:
- Married couple with 2 children earning $47,100 annually (200% FPL)
- Annual premium for second lowest cost silver plan is $10,000 annually
- Tax credit equals $10,000 minus $2,968 (6.3% of $47,100)

$7,032 premium tax credit $2,968 premium payment
Sample Subsidies: Individual Exchange, Manhattan, Silver Level

<table>
<thead>
<tr>
<th>Category</th>
<th>Example 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of adults</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Children ages 19-25</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Children under 19</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Family Type</td>
<td>Single</td>
<td></td>
</tr>
<tr>
<td>Annual taxable income</td>
<td>$40,000</td>
<td></td>
</tr>
<tr>
<td>Percent of FPL</td>
<td>348%</td>
<td></td>
</tr>
<tr>
<td>Estimated Subsidy</td>
<td>$48.61</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subsidized Premium</th>
<th>For Adult 1</th>
<th>For Children under 19</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity</td>
<td>$393.20</td>
<td>$-</td>
<td>$393.20</td>
</tr>
<tr>
<td>Emblem</td>
<td>$336.70</td>
<td>$-</td>
<td>$336.70</td>
</tr>
<tr>
<td>Empire</td>
<td>$390.24</td>
<td>$-</td>
<td>$390.24</td>
</tr>
<tr>
<td>Fidelis</td>
<td>$341.54</td>
<td>$-</td>
<td>$341.54</td>
</tr>
<tr>
<td>Health Republic</td>
<td>$338.81</td>
<td>$-</td>
<td>$338.81</td>
</tr>
<tr>
<td>Health First</td>
<td>$391.39</td>
<td>$-</td>
<td>$391.39</td>
</tr>
<tr>
<td>Metro Plus</td>
<td>$310.65</td>
<td>$-</td>
<td>$310.65</td>
</tr>
<tr>
<td>Oscar</td>
<td>$370.80</td>
<td>$-</td>
<td>$370.80</td>
</tr>
<tr>
<td>United</td>
<td>$593.82</td>
<td>$-</td>
<td>$593.82</td>
</tr>
</tbody>
</table>
Sample Subsidies: Individual Exchange, Manhattan, Silver Level

<table>
<thead>
<tr>
<th>Category</th>
<th>Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of adults</td>
<td>2</td>
</tr>
<tr>
<td>Children ages 19-25</td>
<td>0</td>
</tr>
<tr>
<td>Children under 19</td>
<td>0</td>
</tr>
<tr>
<td>Family Type</td>
<td>Ind w Spouse</td>
</tr>
<tr>
<td>Annual taxable income</td>
<td>$ 40,000</td>
</tr>
<tr>
<td>Percent of FPL</td>
<td>257%</td>
</tr>
<tr>
<td>Estimated Subsidy</td>
<td>$ 454.59</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subsidized Premium</th>
<th>For Adults</th>
<th>For Children under 19</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity</td>
<td>$ 429.03</td>
<td>$ -</td>
<td>$ 429.03</td>
</tr>
<tr>
<td>Emblem</td>
<td>$ 316.03</td>
<td>$ -</td>
<td>$ 316.03</td>
</tr>
<tr>
<td>Empire</td>
<td>$ 423.11</td>
<td>$ -</td>
<td>$ 423.11</td>
</tr>
<tr>
<td>Fidelis</td>
<td>$ 325.71</td>
<td>$ -</td>
<td>$ 325.71</td>
</tr>
<tr>
<td>Health Republic</td>
<td>$ 320.25</td>
<td>$ -</td>
<td>$ 320.25</td>
</tr>
<tr>
<td>Health First</td>
<td>$ 425.41</td>
<td>$ -</td>
<td>$ 425.41</td>
</tr>
<tr>
<td>Metro Plus</td>
<td>$ 263.93</td>
<td>$ -</td>
<td>$ 263.93</td>
</tr>
<tr>
<td>Oscar</td>
<td>$ 384.23</td>
<td>$ -</td>
<td>$ 384.23</td>
</tr>
<tr>
<td>United</td>
<td>$ 830.27</td>
<td>$ -</td>
<td>$ 830.27</td>
</tr>
</tbody>
</table>
## Sample Subsidies: Individual Exchange, Manhattan, Silver Level

<table>
<thead>
<tr>
<th>Category</th>
<th>Example 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of adults</td>
<td>2</td>
</tr>
<tr>
<td>Children ages 19-25</td>
<td>1</td>
</tr>
<tr>
<td>Children under 19</td>
<td>1</td>
</tr>
<tr>
<td>Family Type</td>
<td>Ind W Family</td>
</tr>
<tr>
<td>Annual taxable income</td>
<td>$ 50,000</td>
</tr>
<tr>
<td>Percent of FPL</td>
<td>322%</td>
</tr>
<tr>
<td>Estimated Subsidy</td>
<td>$ 645.21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subsidized Premium</th>
<th>For Adults</th>
<th>For Children under 19</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity</td>
<td>$ 613.94</td>
<td>$ 45.00</td>
<td>$ 658.94</td>
</tr>
<tr>
<td>Emblem</td>
<td>$ 452.92</td>
<td>$ 45.00</td>
<td>$ 497.92</td>
</tr>
<tr>
<td>Empire</td>
<td>$ 605.51</td>
<td>$ 45.00</td>
<td>$ 650.51</td>
</tr>
<tr>
<td>Fidelis</td>
<td>$ 466.71</td>
<td>$ 45.00</td>
<td>$ 511.71</td>
</tr>
<tr>
<td>Health Republic</td>
<td>$ 458.93</td>
<td>$ 45.00</td>
<td>$ 503.93</td>
</tr>
<tr>
<td>Health First</td>
<td>$ 608.79</td>
<td>$ 45.00</td>
<td>$ 653.79</td>
</tr>
<tr>
<td>Metro Plus</td>
<td>$ 378.68</td>
<td>$ 45.00</td>
<td>$ 423.68</td>
</tr>
<tr>
<td>Oscar</td>
<td>$ 550.10</td>
<td>$ 45.00</td>
<td>$ 595.10</td>
</tr>
<tr>
<td>United</td>
<td>$ 1,185.71</td>
<td>$ 45.00</td>
<td>$ 1,230.71</td>
</tr>
</tbody>
</table>
Sample Subsidies: Individual Exchange, Manhattan, Silver Level

<table>
<thead>
<tr>
<th>Category</th>
<th>Example 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of adults</td>
<td>2</td>
</tr>
<tr>
<td>Children ages 19-25</td>
<td>1</td>
</tr>
<tr>
<td>Children under 19</td>
<td>1</td>
</tr>
<tr>
<td>Family Type</td>
<td>Ind w Fam</td>
</tr>
<tr>
<td>Annual taxable income</td>
<td>$ 95,000</td>
</tr>
<tr>
<td>Percent of FPL</td>
<td>Exceeds 400%</td>
</tr>
<tr>
<td>Estimated Subsidy</td>
<td>$ -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subsidized Premium</th>
<th>For Adults</th>
<th>For Children under 19</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity</td>
<td>$ 1,259.16</td>
<td>Full Cost</td>
<td>$ 1,259.16</td>
</tr>
<tr>
<td>Emblem</td>
<td>$ 1,098.13</td>
<td>Full Cost</td>
<td>$ 1,098.13</td>
</tr>
<tr>
<td>Empire</td>
<td>$ 1,250.72</td>
<td>Full Cost</td>
<td>$ 1,250.72</td>
</tr>
<tr>
<td>Fidelis</td>
<td>$ 1,111.93</td>
<td>Full Cost</td>
<td>$ 1,111.93</td>
</tr>
<tr>
<td>Health Republic</td>
<td>$ 1,104.15</td>
<td>Full Cost</td>
<td>$ 1,104.15</td>
</tr>
<tr>
<td>Health First</td>
<td>$ 1,254.00</td>
<td>Full Cost</td>
<td>$ 1,254.00</td>
</tr>
<tr>
<td>Metro Plus</td>
<td>$ 1,023.89</td>
<td>Full Cost</td>
<td>$ 1,023.89</td>
</tr>
<tr>
<td>Oscar</td>
<td>$ 1,195.32</td>
<td>Full Cost</td>
<td>$ 1,195.32</td>
</tr>
<tr>
<td>United</td>
<td>$ 1,830.93</td>
<td>Full Cost</td>
<td>$ 1,830.93</td>
</tr>
</tbody>
</table>
Individual Exchanges
Enrollment Assistance

Navigators
- Compensated by a grant
- Cannot provide guidance or advice on which plan to choose
- Training

In Person assister; Certified application counselors
- Paid a one time fee per enrollment or funded through grants
- Cannot provide guidance or advice on which plan to choose
- Training

Agents and Brokers
- Compensated by commission paid by insurer
- Licensed by the state DFS
- Certified to sell
- Broker compensation on the exchange and off the exchange is the same
Affordable Care Act
Small Business Health Options Program (SHOP) Exchange

- Qualified Health Plans
- Qualified Dental Plans
- Multiple insurer choice for employees at a metal level (consolidated billing)
- One standard plan per metal tier – all insurers
- Non-standard plans – insurers may offer by metal tier and by county level.

Differ from standard plans by:
- Additional cost share options
- Networks
- Alternative benefits i.e: acupuncture, wellness programs
- Product types (EPO, PPO, HMO)

All plan designs offered on the exchange must be offered off the exchange at same cost and with same network
Affordable Care Act
Small Business Health Options Program (SHOP) Exchange

Small business tax credits available to employers:
- Providing at least 50% of the cost of health care coverage
- Employ less than 25 full-time employees (excludes business owners and family members)
- Paying annual wages averaging less than $50,000 per FT employee

Maximum credit for tax years 2014 and beyond
- For employers with ten or less full-time employees and averages annual wages below $25,000
  - For Profit — 50% of ER contribution
  - Tax-Exempt — 35% of ER contribution

- Plan pays 90%
  - Enrollee pays 10%

- Plan pays 80%
  - Enrollee pays 20%

- Plan pays 70%
  - Enrollee pays 30%

- Plan pays 60%
  - Enrollee pays 40%
## Standard Plan designs (Same as individual)

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Platinum</th>
<th>Gold</th>
<th>Silver</th>
<th>Bronze</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
<td>$600</td>
<td>$2,000</td>
<td>$3,000</td>
<td>$6,350</td>
</tr>
<tr>
<td>Max. OOP</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$5,500</td>
<td>$6,350</td>
<td>$6,350</td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hosp, SNF, Hospice</td>
<td>$500 per adm.</td>
<td>$1,000 per adm.</td>
<td>$1,500 per adm.</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Outpatient Facility -surgery</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Surgeon</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>PCP</td>
<td>$15</td>
<td>$25</td>
<td>$30</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Specialist</td>
<td>$35</td>
<td>$40</td>
<td>$50</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$10/$30/$60</td>
<td>$10/$35/$70</td>
<td>$10/$35/$70</td>
<td>$10/$35/$70</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Mail order (90 day supply)</td>
<td>2.5 times</td>
<td>2.5 times</td>
<td>2.5 times</td>
<td>2.5 times</td>
<td>na</td>
</tr>
<tr>
<td>Rehab &amp; Hab Therapy</td>
<td>$25</td>
<td>$30</td>
<td>$30</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>ER</td>
<td>$100</td>
<td>$150</td>
<td>$150</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$100</td>
<td>$150</td>
<td>$150</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$55</td>
<td>$60</td>
<td>$70</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>DME /Med Supplies</td>
<td>10% co-ins</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Eyewear, Hearing Aids</td>
<td>10% co-ins</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Pre-adm testing</td>
<td>0% copay</td>
<td>0% copay</td>
<td>0% copay</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Diag, x-ray, Imaging, lab</td>
<td>$35</td>
<td>$40</td>
<td>$50</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Chemo, radiation,</td>
<td>$15</td>
<td>$25</td>
<td>$30</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$15</td>
<td>$25</td>
<td>$30</td>
<td>50% co-ins</td>
<td>0% co-ins</td>
</tr>
</tbody>
</table>
New York State of Health – Manhattan - Insurer List

SHOP Exchange

MetroPlus Health Plan
Bronze, Silver, Gold, Platinum
1 HMO plan at each level

Health Republic
Bronze (2), Silver (3), Gold (2), Platinum (2)
EPO Plans

Oxford
Bronze (1 EPO plan)
Silver (2: EPO,PPO plans)
Gold (1 EPO plan)
Platinum (2: EPO,PPO)
### Sample Premiums: SHOP Exchange, Manhattan, Standard, Silver Level

<table>
<thead>
<tr>
<th>Category</th>
<th>Monthly Premiums</th>
<th>Employee Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>Health Republic EPO</td>
<td>$408.44</td>
</tr>
<tr>
<td></td>
<td>Metro Plus HMO</td>
<td>$387.23</td>
</tr>
<tr>
<td></td>
<td>Oxford EPO</td>
<td>$554.71</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Monthly Premiums</th>
<th>Employee + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee + Family</td>
<td>Health Republic EPO</td>
<td>$1,164.05</td>
</tr>
<tr>
<td></td>
<td>Metro Plus HMO</td>
<td>$1,103.61</td>
</tr>
<tr>
<td></td>
<td>Oxford EPO</td>
<td>$1,580.92</td>
</tr>
</tbody>
</table>
SHOP Exchange

**Employer may select**
- One plan for employees
- Multiple plans by carrier
- Multiple plans by coverage level (e.g. all silver)
- Multiple plans with all coverage levels

**Billing**
- Consolidated billing by Exchange
- Defined contribution levels
- No Minimum Participation Standards
- No minimum contribution levels

**Off Exchange Products**
- Large number of insurers off the exchange
- Greater selection of product of plan designs and pricing
- On exchange products, plan designs and costs must be offered off the exchange on the same basis
Sole Proprietors

Sole proprietors were considered a group eligible for guaranteed issue coverage as a group of 2 or more
- With a spouse as an employee
- With two owners

Under ACA, sole proprietors are not considered to be small employers
- Unless they enroll at least one non-spouse employee (non-owner)
- That receives a W2 and is listed on quarterly employer wage report (NYS 45).

Existing small employer groups without one non-spouse employee will be offered individual coverage upon renewal.
EMPLOYER NOTICE: New Health Insurance Marketplace Coverage Options and Your Health Coverage

DOL Exchange Notice

- All employers subject to the FLSA with at least one employee and annual gross sales in excess of $500,000

- No later than October 1, 2013 for current employees
  - At time of hire or within 14 days of date of hire for future new employees

One notice for Employers who don’t provide coverage

One notice for Employers who provide coverage

Provide to

- Full time or part time employees
- Union employees
- Employees in waiting period
EMPLOYER SHARED RESPONSIBILITY
Groups of 50+ full time equivalent employees
## Health Care Reform Issues for Employer-Sponsored Plans

**Patient Protection and Affordable Care Act, as amended**

### Beginning in 2013

| $2,500 health FSA contribution cap | • Employee contributions to health FSAs capped at $2,500 per plan year  
• Applies to plan years beginning on or after Jan. 1, 2013  
• $2500 must be prorated for short plan years  
• Amounts carried over into a grace period do not count against $2,500 for next plan year  
• Plans must be amended by Dec. 31, 2014  
• Adjusted annually for increases in the cost of living for plan years beginning on or after Jan. 1, 2014 |
| New taxes for high-income households | • 0.9% increase in Medicare payroll tax on wages exceeding $200,000/ individual; $250,000/couples |
| Tax on medical devices | • A 2.3% tax applies to medical devices |
Health Care Reform Issues for Employer-Sponsored Plans
Patient Protection and Affordable Care Act, as amended

Beginning in 2013

Fee on group health plans to fund Patient-Centered Outcomes Research Institute (PCORI)

- Insurers and sponsors of self-insured plans (often the employer) will have until the July 31st of the calendar year immediately following the last day of the plan year to file IRS Form 720 and pay fee (first due July 31, 2013 for plan/policy year ending on/after Oct. 1, 2012, and before Oct. 1, 2013 – including calendar-year plans)
  - The first year’s fee is calculated as the average number of covered lives under a policy or plan multiplied by $1. The multiplier increases to $2 for the next plan year, then may rise with health care inflation through plan years ending before Oct. 1, 2019, when the fees are slated to end.
  - IRS has issued final rules on which plans must pay PCORI fees and methods for counting covered lives
  - Plan sponsors of self-insured plans generally can use any reasonable method to determine the average number of covered lives in the first plan year, and will choose from available approaches in later years
- Used to fund federal research on comparative effectiveness research
- Sunsets in 2019
### Health Care Reform Issues for Employer-Sponsored Plans

**Patient Protection and Affordable Care Act, as amended**

#### Beginning in 2014

<table>
<thead>
<tr>
<th><strong>Health plan standards – all plans</strong></th>
<th>Insured and self-insured plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective for plan years beginning on or after Jan. 1, 2014</td>
<td><strong>• Offer coverage to dependent children to age 26 regardless of access to other employer coverage</strong></td>
</tr>
<tr>
<td></td>
<td><strong>• No preexisting condition exclusions</strong></td>
</tr>
<tr>
<td></td>
<td><strong>• No waiting periods (i.e., eligibility conditions based solely on lapse of a time period) exceeding 90 days</strong></td>
</tr>
<tr>
<td></td>
<td>- Eligibility conditions not based solely on time period are permitted (e.g., being in an eligible job classification or achieving job-related licensure requirements), unless the conditions are designed to avoid compliance with the 90-day limitation. Waiting period longer than 90 days may be permitted for certain new hires (i.e., variable hour or seasonal employees) under agency guidance.</td>
</tr>
<tr>
<td></td>
<td><strong>• No annual dollar limits on essential benefits</strong></td>
</tr>
<tr>
<td></td>
<td>- HRAs with annual limits (and not otherwise exempt from health plan standards) to be integrated with other coverage that satisfies the ban on annual and lifetime limits on essential health benefits. --&quot;integrated&quot; means HRAs must be limited to employees who actually enroll in the employer group coverage.</td>
</tr>
</tbody>
</table>
### Health Care Reform Issues for Employer-Sponsored Plans

**Patient Protection and Affordable Care Act, as amended**

#### Beginning in 2014

| Medicaid Expansion | • Significant Federal funding offered to states to expand Medicaid by including a new group – low-income, childless adults – and by increasing Medicaid’s mandatory income eligibility level from 100% to 133% of the FPL
|                     | • Supreme Court decision lets states opt not to expand Medicaid and still receive federal funds for the rest of their Medicaid program; this could result in more state variation in Medicaid programs
|                     | • A state’s failure to expand Medicaid could have a significant impact on employer shared responsibility due to the corresponding increase in subsidized exchange coverage |

| Wellness incentive limit increased to 30% | • Annual limit on group health plan wellness incentives based on health status increased to 30% (up from 20%) of the total cost of coverage
| Plan years beginning on or after Jan. 1, 2014 | • Regulators given authority to raise the limit to 50%; regulators issued guidance permitting an incentive up to 50% for tobacco cessation programs only
|                                             | • Reasonable alternative standards must be provided for health contingent wellness programs. Conditions relating to the reasonable alternative standards vary for activity-only wellness programs vs. outcome-based wellness programs. |

| New Industry fees | • Health insurer fees begin |
Beginning in 2014

Temporary reinsurance fees

- Annual fee from 2014-2016 to fund a temporary reinsurance program to help stabilize the individual insurance marketplace, and to provide revenue to the federal government
  - Insurers and sponsors of self-insured plans are liable for fee (ASO may transfer the fee on behalf of self-insured health plan, at plan’s discretion)
  - $63 annually per enrollee for the initial year; amounts to decrease in subsequent years
- Proposed timeline for 2014 payment
  - By Nov. 15, 2014—contributing entity submits to HHS average number of covered lives
  - By Dec. 15, 2014 (or 15 days after submission of annual count, whichever is later)—HHS notifies contributing entity of amount due
  - 30 days after HHS notification—contributions due for the benefit year (i.e., generally first annual payment for the year 2014 will be due in late 2014/early 2015)
- HHS has proposed guidance on which plans must pay the temporary insurance fees and methods for counting covered lives
Health Care Reform Issues for Employer-Sponsored Plans
Patient Protection and Affordable Care Act, as amended

Effective Date Unclear

Auto-enrollment requirement for employers with more than 200 full-time employees

- Compliance is not required until regulations are issued and become applicable; DOL has indicated that guidance will not be ready to take effect by 2014
- Must automatically enroll new full-time employees in employer-sponsored plan
- Must automatically continue plan enrollment for current employees
- Required notice and opt-out opportunity

Effective date unclear
Employer Mandate – Delayed Until 2015
Shared Responsibility

- Large employers – those with at least 50 FTE equivalents in previous calendar year – may face penalties if at least one FTE receives tax-subsidized benefits through a public health exchange

- These employers must offer minimum essential coverage to “substantially all” FTEs or face a penalty of $2,000 multiplied by the number of FTEs (not counting first 30 FTEs)
  - Coverage offered to 95% of FT employees and dependent children considered offer to “substantially all”
  - FTE is any employee who works on average 30 or more hours per week
  - Must offer to FTEs and their dependent children under age 26 (but not required to offer to spouses or domestic partners)

- Employers offering minimum essential coverage may still face penalties if coverage does not have a value of at least 60% or is not “affordable” as defined in regulations.
  - Penalty is $3,000 for each employee receiving tax-subsidized benefits through a public health exchange (unless above penalty is smaller)
Employer Shared Responsibility
Affordable Contributions

What is the “affordability” test?

- An employee’s required contribution for self-only coverage cannot exceed 9.5% of the employee’s household income
- Safe harbors: contribution less than or equal to 9.5% of:
  - Employee’s W-2 wages (Box 1)
  - Hourly rate of pay x 130 hours for hourly employees or monthly salary for salaried employees
  - Federal poverty level (Projection for 2014 = $11,835)
- Employers must offer coverage to full-time employees and their dependent children under age 26, but not their spouses or domestic partners. There is a 2014 transition rule for plans that don’t now cover children but are working to add.

<table>
<thead>
<tr>
<th>Employer safe harbor employee contributions for 2015 calendar year plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual W-2 wages (Box 1)</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>Individual coverage</td>
</tr>
</tbody>
</table>
What is the “minimum value” test?
- The plan must be designed to pay at least 60% of covered benefit
- Approach for determining minimum value
  - HHS minimum value calculator
  - Proposed safe harbor plans (not final)
  - Actuarial certification for non-standard plan designs

Proposed design-based safe harbors for minimum value
- $3,500 integrated medical and drug deductible, 80% plan cost-sharing, $6,000 maximum out-of-pocket limit
- $4,500 integrated medical and drug deductible, 70% plan cost-sharing, $6,400 maximum out-of-pocket limit*, $500 employer contribution to an HSA
- $3,500 medical deductible, $0 drug deductible, 60% plan medical expense cost-sharing, 75% plan drug cost-sharing, $6,400 maximum out-of-pocket limit*, and drug co-pays of $10/$20/$50 for the first, second and third prescription drug tiers, 75% coinsurance for specialty drugs
- Notes: Based on 2014 guidance; subject to change in 2015. Assumes coverage of all EHB categories; *Still have to comply with OPM max limit rules.
Health Care Reform Issues for Employer-Sponsored Plans
Patient Protection and Affordable Care Act, as amended

Beginning in 2015 (originally 2014)

Employer shared responsibility penalties (continued)

- Safe harbors generally work as follows
  - Employer may choose a lookback “measurement period” (of 3 to 12 months) to determine whether ongoing and newly hired variable hour or seasonal employees work more than 30 hours per week
  - “Stability period” follows during which this determination governs FTE status (and whether employees must be offered coverage)
  - Employers have the option of taking up to 90 days between a measurement and a stability period to facilitate enrollment (an “administrative period”)

- Employers who wish to use the shared responsibility safe harbors must consider
  - The complex specifics of the IRS rules governing the lookback periods
  - When to start tracking hours—first measurement period could begin in 2014, or in some instances late 2013

- IRS will send notice and demand for payment

Employer reporting requirements

- Employers required to report certain information on employer-provided health coverage
- No guidance yet, but will begin in 2016 for coverage beginning January 1, 2015
- Regulators are considering a one-page template to assist consumers; employers may voluntarily complete
### Beginning in 2018

<table>
<thead>
<tr>
<th>Excise tax on high cost coverage</th>
<th>40% excise tax on “high cost” coverage, including medical, health FSA contributions, onsite medical clinics, and employee pre-tax and employer contributions to HSAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective for all plans in 2018</td>
<td>- Does not include stand-alone insured dental and vision coverage or certain other coverage types</td>
</tr>
<tr>
<td></td>
<td>• Initial cap set at $10,200/single and $27,500 family</td>
</tr>
<tr>
<td></td>
<td>- Higher thresholds ($11,850/$30,950) for retirees and workers in high-risk professions</td>
</tr>
<tr>
<td></td>
<td>- Higher threshold ($27,500) for single multiemployer plan coverage</td>
</tr>
<tr>
<td></td>
<td>- Indexed to CPI (for 2019 only, CPI+1%)</td>
</tr>
<tr>
<td></td>
<td>• Aggregate cost determined using a methodology similar to that used for determining applicable COBRA premiums</td>
</tr>
<tr>
<td></td>
<td>• Employers must determine aggregate cost</td>
</tr>
<tr>
<td></td>
<td>- Insurers responsible for tax for insured coverage</td>
</tr>
<tr>
<td></td>
<td>- Benefit administrators responsible for tax for self-insured coverage</td>
</tr>
<tr>
<td></td>
<td>- Employers responsible for tax for HSA contributions</td>
</tr>
</tbody>
</table>
## Health Care Reform
### What To Prepare For In 2014…

### Design and Marketplace Changes
- New health insurance exchanges
- HIPAA Wellness Limit
- New healthcare plan design requirements….
  - No lifetime dollar limits
  - No annual dollar limits on essential health benefits (generally banning standalone HRAs)
  - No pre-existing condition limits
  - No waiting period over 90 days
  - Provider nondiscrimination
  - Coverage of clinical trails

### Enrollment Changes
- Dependents to age 26
  - 30-hour eligibility
  - Individual mandate
  - Medicaid Expansion
  - Auto enrollment*

### Fees
- Manufacturer’s fees
- Comparative effectiveness research
- Fees on Health Insurance Providers
- Transitional reinsurance fees

### DELAYED UNTIL 2015
### Employer Mandate and Shared Responsibility
- Minimum plan and contribution requirements
- Coverage must be offered to at least 95% of full-time employees and their children

### ALL WILL HAVE A DIRECT IMPACT ON THE IMMEDIATE AND FUTURE COSTS OF PROVIDING EMPLOYER SPONSORED HEALTH COVERAGE FOR EMPLOYEES

*Some time after 2014*
Emerging Strategy: Defined Contribution

- An approach that resets how the employer and employee share the cost of coverage
- A new way to connect employees to their health care – and a catalyst for employees to make better choices
- A budgeting tool that gives the employer more financial predictability
- A platform for delivering account-based health plans
- A strong parallel with retirement plan transition from DB to DC

Currently use or are considering a defined contribution approach

- Core | buy-up: 33%
- Flat-dollar subsidy | voucher: 11%
- Fixed employer increase: 8%

Source: Mercer’s National Survey of Employer-Sponsored Health Plans 2012
Re-set Benefit Value + Defined Contribution

- Employees can “buy up” to richer benefits (account-based plan or PPO)
- Targeted health management for all employees and dependents
- Consider adding new voluntary programs to enhance value and flexibility
### Public vs. Private Exchanges

<table>
<thead>
<tr>
<th>PUBLIC (MANDATED)</th>
<th>PRIVATE (FLEXIBLE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose and Target Market</strong></td>
<td><strong>Ability to respond to market needs for active and retiree populations</strong></td>
</tr>
<tr>
<td><strong>Affordable Care Act</strong></td>
<td><strong>Expect various models to emerge</strong></td>
</tr>
<tr>
<td>Individual and small businesses (2014)</td>
<td><strong>Target market: Populations with a common unifier, likely an employment relationship, at least initially</strong></td>
</tr>
<tr>
<td>Large group (2017)</td>
<td></td>
</tr>
<tr>
<td>▪ Facilitates purchase of qualified health plan</td>
<td></td>
</tr>
<tr>
<td>▪ Establishes Small Business Health Options Program (SHOP) in competitive marketplace</td>
<td></td>
</tr>
<tr>
<td>▪ Goal: Insure all Americans</td>
<td></td>
</tr>
<tr>
<td><strong>Exchange Models</strong></td>
<td>**Consulting</td>
</tr>
<tr>
<td>▪ State-based</td>
<td><strong>Insurance companies</strong></td>
</tr>
<tr>
<td>▪ State partnership (with federal government)</td>
<td><strong>Technology companies</strong></td>
</tr>
<tr>
<td>▪ Federally facilitated (state opts out)</td>
<td></td>
</tr>
<tr>
<td><strong>Required</strong></td>
<td><strong>Decisions to make</strong></td>
</tr>
<tr>
<td>▪ Fully Insured</td>
<td>▪ Single vs. multi-carrier</td>
</tr>
<tr>
<td>▪ Multi-carrier</td>
<td>▪ Fully insured or self-funded</td>
</tr>
<tr>
<td>▪ Medical</td>
<td>▪ Medical-only or full-benefits exchange</td>
</tr>
<tr>
<td>▪ Rx and stand-alone dental</td>
<td>▪ Products</td>
</tr>
<tr>
<td>▪ Individual and group plans</td>
<td>▪ Actives and/or retirees</td>
</tr>
<tr>
<td>▪ Navigator role</td>
<td>▪ Distribution channel</td>
</tr>
<tr>
<td></td>
<td>▪ DC and/or DB options</td>
</tr>
</tbody>
</table>
# A Look at our Active Exchange

## Mercer Marketplace℠

<table>
<thead>
<tr>
<th>EXCHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vendors &amp; Carriers</strong></td>
</tr>
<tr>
<td>Medical</td>
</tr>
<tr>
<td>Insured, self-funded + collectives like MHA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits Admin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility &amp; enrollment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consumer Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer contribution</td>
</tr>
</tbody>
</table>

Full product suite with choice of plans

- **Health**
- **Life, accident & disability**
- **Voluntary**
Mercer Marketplace is a private benefits exchange designed to help employers and employees control and lower their benefit costs through collective buying and other levers.

Employees are offered an enhanced array of pre-screened benefit options and education tools. Mercer Marketplace helps employees customize their benefits to better fit their needs, rather than having to choose the “one size fits all” plan of today.

Optimizing the cost of employees’ benefits and enabling them to customize their benefit programs will increase the value of their total compensation package.

Mercer Marketplace will enable employers to streamline the administration of their benefits plans, facilitate vendor/carrier decisions and simplify compliance.

A more flexible set of benefit offerings is packaged into an easy-to-use platform that will improve employee satisfaction, buying efficiency, staff productivity and competitiveness…all at a fair and more controllable cost to employers.
Mercer Marketplace
What is available at the “Market”

Key Benefit Options

1. Benefit Options
   - Stocked with more than **20 types** of benefits
   - Five medical plan designs available, including account based plans
   - Multiple design options available for most other benefits

2. Core Benefits
   - Traditional “Core” Benefits such as medical, dental, vision, life and disability
   - Medical and dental available both fully-insured and self-funded
   - Mercer collectives available for self-funded clients, including pharmacy, stop loss and MHA

3. Voluntary Benefits
   - Voluntary benefits including critical illness, hospital indemnity and accident

4. Additional options
   - Several Value Service Provider (VSP) Carriers to be included in version 1.0
   - Customized Employer Portfolios
     - Size
     - Location
   - Support for employees to enable them to build a personal risk management portfolio
Preparing for 2014 – Lots to consider and do!

Employee communications
• Required communication about public exchanges (model notice issued 5/8/13)
• Desired communication informing employees about making their selections
• Potential for confusion with direct to consumer advertising for the public exchanges

Data requirements
• Tracking all workers for “look-back” period; rolling enrollment throughout the year
• Erroneous receipt of federal tax subsidies for Exchange coverage
• Coverage reporting and disclosure; guidance still needed

Navigating the 2014 requirements and the public exchanges will be complicated for both employers and employees

Issues for multi-state employers
• Public exchange options and Medicaid expansion will vary by State

System requirements
• Technology and tools to track employee hours and eventually report to federal/state exchanges
• Cost associated with upgrades and implementation
5 QUESTIONS ????
Resources

- Marsh
  - 888-882-2269
  - www.NYCBarhealth.com
  - www.marshhealthoptions.com

- New York State of Health
  - www.NYStateofHealth.com

- Federal Government
  - www.healthcare.gov

- Kaiser Family Foundation
  - www.kff.org
This document and any recommendations, analysis, or advice provided by Marsh (collectively, the “Marsh Analysis”) are intended solely for the entity identified as the recipient herein (“you”). This document contains proprietary, confidential information of Marsh and may not be shared with any third party, including other insurance producers, without Marsh’s prior written consent. Any statements concerning actuarial, tax, accounting, or legal matters are based solely on our experience as insurance brokers and risk consultants and are not to be relied upon as actuarial, accounting, tax, or legal advice, for which you should consult your own professional advisors. Any modeling, analytics, or projections are subject to inherent uncertainty, and the Marsh Analysis could be materially affected if any underlying assumptions, conditions, information, or factors are inaccurate or incomplete or should change. The information contained herein is based on sources we believe reliable, but we make no representation or warranty as to its accuracy. Except as may be set forth in an agreement between you and Marsh, Marsh shall have no obligation to update the Marsh Analysis and shall have no liability to you or any other party with regard to the Marsh Analysis or to any services provided by a third party to you or Marsh. Marsh makes no representation or warranty concerning the application of policy wordings or the financial condition or solvency of insurers or reinsurers. Marsh makes no assurances regarding the availability, cost, or terms of insurance coverage.

Marsh is one of the Marsh & McLennan Companies, together with Guy Carpenter, Mercer, and Oliver Wyman.

Copyright 2013 Marsh Inc. All rights reserved.