the inside track

Better benefits at work.

A health care reform roadmap
Key steps and strategies for 2013 and beyond

- Deciding whether to "pay or play"
- Adapting existing plans to meet reform requirements
- Reporting to the IRS — and other deadlines for 2013–2018

HEALTH CARE REFORM: Top of mind for employers

75%

of respondents to a Deloitte Consulting LLP study said that managing health care costs, especially in the context of health care reform, was one of their most worrisome challenges[1]

85%

of human resources and benefit managers surveyed said they expect health care costs to rise in the next five years as a result of the law[2]

68%

said they plan to reevaluate their benefits strategy to offset reform's impacts[3]

An objective approach

Unum remains committed to providing practical and impartial information about health care reform and how it may impact employers, workers, insurance brokers and the entire benefits industry.

Health care reform heats up

Since 2010, with the passage of the Patient Protection and Affordable Care Act (PPACA), employers have been gearing up for provisions that will significantly change how and when they must provide health insurance for their employees. In 2013, major provisions will take effect, and by 2014, employers must be prepared to fully participate in the most dramatic change to health insurance delivery since Medicare was enacted in 1965.

PPACA is a sweeping and complex piece of legislation that has required years of regulatory refinement. As new rules and guidance have been adopted, many employers are uncertain about their new responsibilities for providing insurance to their employees, recording information — and reporting it to the government.

As part of Unum's commitment to help our customers develop benefits strategies that grow their businesses and protect their employees, we are providing this guide — which describes the employer responsibilities that are coming in the next few years. These include duties related to some of reform's centerpiece provisions: the individual and employer mandates, and the launch of the Health Insurance Exchanges (which the Department of Health and Human Services — HHS — is now calling "Competitive Health Care Marketplaces").

The health care reform law: A recap

Signed into law on March 23, 2010, the health care reform law significantly changes the way health insurance is sold, purchased and delivered in America. At its core, this broad and complex legislation:

- Requires individuals to have health insurance or pay a penalty
- Requires businesses with 50 or more full-time-equivalent employees to provide affordable insurance to their full-time employees or pay a penalty
- Provides subsidies to make insurance affordable for people with lower incomes
- Changes the way insurance is sold, to make it easier to get and keep
- Changes insurance market practices to provide greater consumer protection

From its inception, the law has been controversial and weathered several court challenges. In June 2012, the Supreme Court largely upheld the legislation, affirming the constitutionality of the individual mandate, but reducing the scope of the law's requirement that states expand Medicaid eligibility. **With President Obama's reelection, PPACA implementation will move forward,** and the federal agencies involved are expected to issue a great deal of guidance in 2013 and beyond. Some of this guidance may spur new legal challenges, but in the near term, these are unlikely to derail the journey toward health care reform implementation.

It's possible that several PPACA provisions could change. In the three years since its passage, numerous parts of the law have been delayed, modified or repealed, as the broad goals of this immense reform ran into the realities of the marketplace. The need to make the legislation workable may result in future changes. **If and when these changes happen, Unum will update employers and brokers with information to help them keep abreast of employer responsibilities.**

Escalating employer obligations

Employers are already dealing with a number of changes set in motion by health care reform. **The next couple of years, however, will see implementation of the provisions likely to have the greatest impact on the insurance marketplace — and on employers.** In 2013 and 2014, employers will have many things to decide, report and implement. Plus, they will need to keep up with changes in regulations and guidance that may affect their decisions and responsibilities. Please see the pullout summary at the end of this guide for an overview of the issues on employers' plates for the upcoming years, including some 2012 responsibilities that are continuing implementation into 2013.

Brokers will play a key role in advising employers. Employers will need help understanding exchanges, guidelines, fees, changing regulations, various state approaches and — especially — the "employer mandate." Brokers will need to stay up to date about all aspects of reform as the law takes hold. In addition, brokers should be prepared to help employers think through their benefits strategies more broadly — and provide the tools and advice they will need to reassess their total benefits packages.

In the remainder of this guide, we provide details about each of these key decisions and responsibilities. However, **please remember that this booklet is not a substitute for legal guidance**. Consult with your legal advisor to ensure you are fully complying with the requirements of the PPACA legislation, and contact your Unum representative to discuss your benefits strategy.

YEAR: 2012

Begin distributing Summary of Benefits and Coverage

The **Summary of Benefits and Coverage** (SBC) is intended to help employees more easily understand and compare the terms and provisions of different insurance plans. **Beginning with the first open enrollment after September 23, 2012**, employers are now responsible for distributing SBCs for group plans, although they **will not incur any penalties for the first year** if they are working toward compliance.

The requirements for SBCs are very detailed. In general, though, **SBCs must:**

- Explain in simple language the employee's health plan and offer examples of how it works
- Follow a government-approved template, with four double-sided pages and a 12-point font
- Include a customer service phone number and Internet address
- Include copies of plan documents

Employers must distribute SBCs:

- When employees are applying for coverage
- Every year when coverage is renewed
- At least 60 days before significant changes in coverage take effect (see page 7)
- Any time an employee requests it, within seven days of the request
- In printed form or electronically (complying with the Department of Labor's e-delivery rules). People who are not worksite employees, such as spouses of employees or former employees, must actively "opt in" to receive their SBCs electronically.

Grandfathered plans

Health insurance plans that existed on or before March 23, 2010, are eligible for grandfathered status and do not have to meet all the requirements of the PPACA. However, if an insurer or employer makes significant changes to a plan's benefits or the amount members must pay (premiums, co-pays or deductibles) then the plan loses that grandfathered status and must comply with all requirements of PPACA.

SBC requirements apply to all self-funded and insured medical plans subject to PPACA, including grandfathered plans.

They are not required for HIPAA-excepted benefits — such as dental, vision, disability, life, accident, critical illness or hospital indemnity plans. SBC regulations also require that employers give their workers a glossary of commonly used health care coverage terms — such as deductible and co-pays — upon request, within seven days. For individual plans, the insurer is responsible for delivering the SBC; for self-funded plans, the plan administrator is responsible. Employees have the right to see the SBC for an insurance carrier's product before signing any application.

Excepted benefits and HIPAA

HIPAA refers to the Health Insurance Portability and Accountability Act, which, among other provisions, provides federal protections for personal health information. The Department of Labor defines excepted benefits as those provided under a separate policy, certificate or contract of insurance, such as voluntary health benefits that are offered as a supplement to group health coverage.

The 60-day advance notice rule

The government's final PPACA regulations clarify that plans and issuers must distribute a 60-day advance notice when:

- A material modification affects the SBC's content;
- The change is not already included in the most recently provided SBC; and
- The modification is a mid-plan-year change (that is, occurs in between renewal/re-enrollment periods).

A material modification is any change that — by itself, or in connection with other changes taking place at the same time — the average plan participant would consider an important change in coverage. A material modification can make a plan more generous (for example, by lowering deductibles or adding coverage) or less so (for example, by increasing co-pays or adding new referral requirements).

Employers may provide either a separate notice of a change, or an updated SBC reflecting the change. They do not need to provide 60 days notice when new regulatory changes affect the SBC, unless the regulations specify that a mid-year modification notice is necessary. They do have to provide a copy of the SBC, indicating any changes from the last plan year, each year at renewal time.

Employers should note that the **60-day advance notice rule is significantly different than the notification timeframes required under the Employee Retirement Income Security Act (ERISA).** ERISA requires notification of any plan changes within 210 days after the end of the plan year or 60 days after a material reduction in services or benefits. Complying with PPACA notification requirements will satisfy ERISA requirements in this area.[4]

Impact on employers

Employers must ensure that their employees with health care coverage receive SBCs at the required times. Penalties for noncompliance can range from $100 to $1,000 per employee, with the highest fine incurred for "willful" noncompliance. As long as an employer is making progress toward compliance, no penalties will accrue during the first year.

Impact on employees/individuals

The purpose of the SBC is to help consumers understand their health coverage — and easily compare plans — by providing simple language and consistent formats. They show clear examples of how the plan works, what its limits are, and how costs are shared between the employer and employee.

Report health coverage value on employee W-2s (as distributed in 2013)

Employers who issue at least 250 W-2s are now required to report the **total value of group health coverage** provided to an employee on the **employee's W-2** form. This requirement was optional for 2011 (and will remain optional for businesses that issue fewer than 250 W-2s annually) but generally began with the 2012 W-2 forms that were distributed in early 2013.

"Value" includes the premium costs paid by the employer and the employee. While including this information will help employees better understand what their health coverage is worth, it **does not mean that employees will have to begin paying taxes on that value**. The W-2 data will also help the federal government better understand the aggregate value of the health coverage and related benefits being provided by the nation's employers.

Impact on employers

Employers will report benefit costs on W-2s in Box 12 under Code DD. They will most likely need to explain to employees that they are not being taxed on their benefits value.

Impact on employees/individuals

The information reported on their W-2s should help individuals more fully understand the role their insurance coverage plays in their compensation structure. Individuals are not required to do anything with this information, and the benefits reported on their W-2s will not increase their taxable income.

Employers must report premium costs for:	Employers do not need to report costs of:
• Medical plans • Medicare supplemental policies • Prescription drug plans • Dental or vision plans that are **"integrated"** into a group health plan — that is, part of the same insurance policy, contract or certificate of insurance. Dental or vision coverage in a self-funded medical plan is included unless employees make a separate election and/or contribution for the dental or vision coverage. • Hospital indemnity, critical illness, cancer or other specified-disease insurance **only if** the employer makes at least **some contribution** to the cost of coverage, or the employee purchases the policy on a **pre-tax basis** under a Section 125 cafeteria plan. • Employee assistance programs that qualify as group health plans which are **subject to COBRA*** (paid with employer dollars, unless no COBRA premium is charged for this coverage when it is elected by qualified beneficiaries. This rule also applies to wellness program and on-site clinic costs. This "no COBRA premium" exception could be subject to change in future guidance from the Internal Revenue Service, or IRS). • The aggregate cost of COBRA continuation coverage (or similar federal continuation coverage) for any of this reportable coverage	• Coverage for certain "HIPAA excepted benefits," such as accident insurance and disability insurance** • Hospital indemnity, critical illness, cancer or other fixed-indemnity or specified-disease insurance that is paid 100% with employee after-tax dollars • Long term care coverage • Liability insurance • Life insurance • Archer Medical Savings Account (MSA) contributions • Health reimbursement arrangements • Health savings account contributions • Flexible spending accounts (FSAs), as long as contributions occur only through employee salary-reduction elections — one exception: employer flex-credit contributions are reportable • Workers' compensation • Automobile medical-payment insurance

* COBRA stands for Consolidated Omnibus Budget Reconciliation Act of 1985. Part of this act requires that employees who are between jobs be able to keep their health coverage.

** HIPAA refers to the Health Insurance Portability and Accountability Act.

Manage distribution of Medical Loss Ratio (MLR) rebates

PPACA's Medical Loss Ratio provision is designed to ensure that a set percentage of every premium dollar collected by health insurers is used to **pay for medical care for covered individuals or for health care quality improvement**. For large employers' health plans, that percentage is 85%. For small employers' and individual plans, it is 80%. **(Self-insured plans are not subject to this provision.)** The law allows health insurers to use the remaining 15% or 20% for administrative expenses, commissions, etc., and to claim the percentage as profit. Insurers who did not spend the required percentage on claims and quality improvement in a plan year are required to **refund the difference** to policyholders.

Each insurer's MLR is calculated **annually**, based on the ratio of the insurer's claims and quality improvement expenses to total premium dollars earned (minus federal and state taxes and licensing and regulatory fees). In the individual market, HHS can adjust a state's MLR standard if it might destabilize that state's individual market.

The **rebate to policyholders** may be issued as a premium credit, a lump-sum check or a lump-sum reimbursement to the enrollee's account. In the case of employer plans, **any MLR rebate is paid to the employer**, not the individual employees. It is the employer's responsibility to determine whether all or part of the rebate should be refunded to employees or otherwise used to their benefit.

When an MLR rebate is issued, the insurer must provide written notices to group policyholders — and their subscribers. This notice must include:

- The purpose of the PPACA MLR requirement
- The MLR standard that applies to the plan
- The insurer's MLR for the year and its "adjusted aggregate" premium revenue[5]
- The rebate that is being provided
- An explanation that the rebate is being provided to the policyholder (if applicable). It must also state that policyholders of ERISA plans may have legal obligations for handling the rebate; for other plans, the notice must explain how the rebate is being used to benefit subscribers.

Impact on employers

Employers offering group health insurance plans will need to be aware of their duties as policyholders when it comes to handling any rebates that may need to be distributed to employees. ERISA plan sponsors will need to understand their responsibilities under Title I of ERISA. Because of the complexities of these requirements, employers will want to make sure they consult with their benefits attorney/legal counsel to discuss their obligations and options.

Impact on employees/individuals

Theoretically, the MLR provision should help ensure that employees receive good value for their health insurance premium dollars. Employees who receive rebates from group health insurers are not liable for tax on this income.

YEAR: 2013

Adapt to new limitations on Flexible Spending Accounts

Effective January 1, 2013, the pre-tax contributions an employee can make to an FSA under an employer cafeteria plan will be limited to $2,500 and indexed for inflation. This provision will **limit the tax savings on medical spending that FSAs provide**, to help offset the costs of the reform program. It is also based on the assumption that health care reform will lessen the need to save for medical expenses.[6]

- **Impact on employers**

  Employers must amend their plans to recognize the $2,500 limit and notify employees of the change.

- **Impact on employees/individuals**

  This new limitation will have a significant impact on employees who have high health care expenditures and typically set aside more than $2,500 in their FSAs. Because they will not be able to use pre-tax dollars to pay for expenses past the $2,500 limit, medical spending will become more costly for these employees.

Deduct additional Medicare taxes for high-income employees

To help pay for reform, **Medicare taxes will increase for high-income taxpayers** in 2013. Employers are responsible for deducting a new **0.9% Medicare surtax** from the paychecks of employees whose wages exceed $200,000. The new surcharge is in addition to the 2.9% tax currently split between employers and employees, and applies only to the income above the $200,000 threshold.

Employees will need to know, however, that this **may not be the extent of their additional Medicare tax liability**. If married couples filing jointly earn more than $250,000 in wages, they are subject to the 0.9% surcharge, even if neither spouse's wages reach the $200,000 threshold that will trigger the employer deduction.[7]

Also, 2013 brings an additional 3.8% Medicare tax on the amount by which modified adjusted gross income (MAGI) or investment income exceeds $200,000 for individuals or $250,000 for married couples filing jointly, whichever is less.

Impact on employers

Employers should be aware of their responsibility to deduct the Medicare tax for highly paid employees and should make these employees aware of the new tax.

Impact on employees/individuals

Applicable high-income earners will have a higher tax obligation. Employees whose family income is high enough to subject them to the tax should consider adjusting their tax withholding to avoid underpaying their taxes.

Notify employees about Health Insurance Exchanges and premium credits

PPACA requires employers to **tell their employees in writing** about the new Health Insurance Exchanges and how these relate to their workplace benefits (see page 23 for more information about the exchanges). This requirement applies to all employers subject to the Fair Labor Standards Act (FLSA). The original guidance required that all existing employees be notified by March 1, 2013, and that new employees receive the notice when they are hired. However, given the progress of exchange implementation, the Department of Labor has delayed this notification date. A specific new date has not yet been provided, but guidance from the IRS/HHS says the notification date may be in the late summer or early autumn of 2013.

Health Insurance Exchange notification

- Tell employees that the exchanges exist and list the services they provide, including appeal rights and ways to contact the exchange for help.
- Notify employees that they might be eligible for a tax credit and cost-sharing reduction if
  - the employer's plan does not meet certain coverage and affordability requirements; and
  - the employee purchases a Qualified Health Plan through a public exchange (see page 23 for details on Qualified Health Plans).
- Caution employees that if they choose to purchase their coverage through an exchange, they may not receive any employer contribution toward their premium, nor any related tax advantage.

Additional guidance is expected, but as of this guide's printing several questions about the requirement remain:

- The current assumption is that the notice should be distributed to all employees, not just those who are eligible for health insurance — but this has not been confirmed.
- The current assumption is that the notice may be distributed electronically, in accordance with Department of Labor (DOL) guidelines — but the accepted methods of distributing the notice are not yet known.
- It's not yet known whether multi-state employers will be required to tailor notices for each state.
- As of this writing, the government has not specified penalties for failing to comply with this requirement.

» Impact on employers

Employers who are subject to the FLSA must quickly familiarize themselves with these notice requirements in order to comply by the effective date of the announcement. The notices may require state-specific contact information.

» Impact on employees/individuals

The notices will help employees make better-educated health insurance decisions, by providing them with important information about state insurance exchanges and available subsidies.

Understand how the medical device manufacturer levy could affect you

Beginning in 2013, manufacturers will be assessed **a 2.3% tax on the sale of taxable medical devices,** as defined by section 201(h) of the Federal Food, Drug and Cosmetics Act. Some examples of relevant devices are pacemakers, X-ray machines and other medical test equipment. The law exempts most items generally purchased at retail by individuals, including eyeglasses, contact lenses and hearing aids, as well as consumable medical supplies such as tongue depressors, exam gloves and personal hygiene necessities.

Impact on employers

If manufacturers who are liable for this tax decide to build the cost into their pricing models, medical costs and health insurance premiums could rise, affecting employers' benefits costs.

Impact on employees/individuals

Employers could decide to pass along all or a portion of any increased premiums to employees.

Understand the Patient-Centered Outcomes Research Institute (PCORI) fee

The Patient-Centered Outcomes Research Institute fee (formerly known as the Comparative Effectiveness Fee), will be used to establish an **independent non-profit corporation dedicated to studying patient outcomes.** The reasoning is that with better data about outcomes, doctors, patients, purchasers and policymakers can make evidence-based decisions about the best ways to diagnose, prevent and treat health conditions — and patients can become more engaged in their own health care.[8]

The PCORI fee will be charged to the providers of fully insured medical plans and to the "plan sponsor" of self-insured plans, according to this schedule:

Plans ending during 2013 will pay $1 per covered individual per year.
Plans ending 2014 – September 2019 will pay $2 per covered individual per year.

This provision will expire after policy years ending September 30, 2019, but Congress will have the option to renew it.

Impact on employers

This fee will have the greatest direct impact on self-funded employers or plan sponsors. For all employers, this fee will likely increase insurance premium costs.

Impact on individuals

Employees could see increased premiums if employers choose to pass along all or some of their increased costs.

YEAR: 2014

Prepare for effects of Transitional Reinsurance Program fee

Sponsors of **self-insured group health plans** will be required to make contributions to the Transitional Reinsurance Program. The purpose of this program is to stabilize individual-market premiums during the years 2014–2016, by supporting payments to individual-market issuers that cover high-cost individuals. Regulations proposed by HHS specify that plans may use a third-party administrator or administrative-services-only contractor to transfer the contributions.[9]

For 2014, according to HHS estimates, **the Transitional Reinsurance Program fee will total $5.25 per covered individual per month, or about $63 annually**. Contributors must submit enrollment information to HHS by November 15, 2014. Within a month, HHS will notify them of any contributions due; these must be paid within 30 days of notification.[10]

- **Impact on employers**

  Employers with self-insured group health plans will face increased costs with this fee.

- **Impact on employees**

  Employees could pay increased premiums if employers decide to pass on part or all of this increased cost.

Prepare for effects of health insurance sector fee

Beginning January 1, 2014, PPACA imposes a new tax on health insurers to help pay for the law's reforms. **The tax will bring in $8 billion the first year, with increases each year that follows**. Each insurer's fee will be based on its share of the total nationwide fully insured premium. According to the Joint Committee on Taxation, these fees may total $70 billion to $100 billion over the next 10 years.[11] Insurers will most likely pass this fee onto their customers, including employers and individuals.

Impact on employers

Employers should anticipate increased costs for their health insurance plans due to this fee. Employers with fully-insured plans will pay through increased premiums. Employers with self-insured plans are liable for the payment but can arrange for their third-party administrator (TPA) or administrative services only (ASO) provider to make the contributions.

Impact on employees/individuals

Individuals could also feel the impact of this fee if it is passed on to them through higher insurance costs.

Ensure plans offer "essential health benefits" with no annual coverage limits

Beginning in 2014, all individual and small-group health plans must cover certain essential health benefits (EHBs). (Grandfathered plans are exempt.) This provision applies to plans both inside and outside of the Health Insurance Exchanges.

EHBs are a package of core services that must include the following categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Preventive and wellness care
- Pediatric services
- Chronic disease management
- Maternity and newborn care
- Mental health and substance use disorder services
- Rehabilitative and habilitative services
- Prescription drugs
- Laboratory services
- Vision and dental care

Benchmark plans

To determine the minimum coverage required in each of these categories, **states must select an EHB benchmark plan**. Insurers offering individual and small-group plans will need to provide EHBs that are "substantially equal" to those found in the benchmark plan.

HHS guidance for selecting a benchmark plan basically allows states to choose from an existing small-group, federal-employee or HMO plan. Any state that failed to select a benchmark by December 26, 2012, will use the HHS default selection, which under current proposals will be the largest small-group product in the state.

In addition, insurers may not place annual or lifetime limits on essential health benefits in any plans that provide EHB coverage. The prohibition on annual limits applies only to the EHB services.

Impact on employers

Employers will need to make sure that their benefit plans meet the minimum standards for offering EHBs, and amend them if they do not. They should also be aware that the EHB requirement may raise premiums. The prohibition against annual or lifetime limits is a change from most insurers' past practices and may contribute to higher premiums.

Impact on employees/individuals

The EHB requirement will assure employees that their health benefit package provides comprehensive coverage, and the annual/lifetime dollar limit prohibition will provide extra financial protection.

Ensure plans do not exclude people with pre-existing health conditions

On January 1, 2014, one of PPACA's centerpiece features takes effect: the provision prohibiting all health plans, including self-funded and grandfathered plans, from refusing to cover adults with pre-existing conditions. The same rule for children under 19 took effect in 2010. This means that insurers must sell coverage to anyone who wants it. The requirement applies only to health insurance, not to most other employee benefits.

Impact on employers

Employers need to make sure the plans offered to their employees do not exclude anyone based on pre-existing health conditions. This will likely contribute to higher premiums.

Impact on employees/individuals

Employees and individuals will now have access to health insurance coverage even if they have medical conditions that prevented them from getting insurance in the past. For many families and individuals, this provision will dramatically increase their ability to obtain health insurance.

Make sure plans comply with limits on deductibles and out-of-pocket expenses

Since 2010, PPACA has been limiting the out-of-pocket expenses that people in individual and small-group plans must pay. **For 2014, the 2013 limits on out-of-pocket expenses for high-deductible health plans (HDHPs) will remain in effect: $6,250 for individuals and $12,500 for families**. Beginning in 2015, these limits will be subject to an annual inflation adjustment.

In 2014, deductibles for **small business** will also be limited — **to $2,000 for individuals and $4,000 for families**. The maximum deductible allowed will also be adjusted for inflation, and will increase annually based on the cost of living.

Impact on employers

Employers will need to ensure their health insurance plans meet the new law's requirements. If an employer's plan must lower its cost-sharing limits to comply with PPACA, it may be faced with higher costs. Please note, however, that for many employers, a $2,000 deductible will result in a plan that covers more of an employee's health care costs than the minimum required (60% of costs, also known as "actuarial level"). As a result these limits are currently under review.

Impacts on employees/individuals

This provision is intended to keep medical expenses from wiping out a family's finances if family members require costly or extensive treatment within a plan year.

Comply with rule extending dependent child coverage to age 26

One of the most popular provisions of health care reform has been the requirement that health insurers cover the children of their plan members until those children turn 26. In 2014, the current requirement expands to require that this coverage be available **even if the adult child is working and has access to coverage** at work. It applies to all health insurance plans, including self-insured, fully insured large-group, and grandfathered plans, as well as individual and small-group plans. While the employer is required to provide these children with access to insurance, **it does not have to subsidize their coverage**.

- **Impact on employers**

  Employers should make sure their plans comply with the expanded provision. The new law may increase costs in plans that cover dependents. If so, employers will need to decide whether or not to share these higher costs with employees. Although required to make these benefits available to children up to age 26, employers have no obligation to subsidize benefits for those children.

- **Impact on employees/individuals**

  People with children who were not able to obtain health insurance through their own employers have already been benefiting from this feature of PPACA. In 2014, the expanded provision allows parents to keep children on their employer policies regardless of access to coverage, until they turn 26.

Ensure waiting periods for coverage don't exceed 90 days

Many employers' health plans require new employees to work a certain period of time before their coverage becomes effective. **For plan years beginning on or after January 1, 2014, PPACA prohibits group health plans from imposing a waiting period of more than 90 days**. The waiting period starts the first day the employee or dependent meets the plan's eligibility requirements (often, the day the employee starts work). The law applies only to full-time employees and prohibits plans from designing their eligibility conditions to avoid complying with the 90-day limitation.

Impact on employers

Employers who currently require a waiting period longer than 90 days will need to amend their plans, which may increase costs. In workplaces with high levels of employee turnover, this requirement may increase administrative burden.

Impact on employees

A newly hired full-time employee can generally expect to be enrolled in the company health plan within 90 days of his or her start date.

Institute automatic enrollment for group health plans

At some point in 2014, HHS will likely issue guidance requiring large employers to begin automatically enrolling eligible new employees in group health plans unless they actively "opt out." The guidance to date indicates that auto enrollment will be required only for employers with 200 or more workers.

Automatic enrollment, which is widely used for employee retirement savings plans, increases participation rates, because it requires no action on the employee's part. The requirement is intended to maximize participation in health insurance plans. It will increase costs for employers, as they will ultimately share health premium costs with a larger number of employees.

The original law did not specify a start date for this requirement. However, announcements from DOL, HHS and the IRS indicate that final regulations will be released in 2014, at which time the start date and other provisions will be finalized.

Impact on employers

Once this provision is implemented, employers with 200 or more full-time employees will need to incorporate auto-enrollment and opt-out functions into their enrollment processes. Increased enrollment may increase employers' costs.

Impact on employees/individuals

New employees will be enrolled in their employers' health plans automatically, whether they have taken the time to understand the coverage or not. If they do not wish to participate in the company plan, employees will have to actively refuse the coverage.

Understand the individual mandate

Effective January 1, 2014, **most U.S. citizens and legal residents must buy and maintain health insurance that provides "minimum essential coverage."** (See page 17's discussion of essential health benefits.) If they do not do so, they must pay an annual penalty, which will increase over time.

- In 2014, the penalty for each **individual** without coverage will be **$95 or 1% of income, whichever is greater**.
- In 2015, the penalty will rise to the greater of **$325 or 2% of income**.
- In 2016 and thereafter, it will be the greater of **$695 or 2.5% of income**. By 2016, the maximum penalty a family can pay is **$2,085 or 2.5%** of household income, whichever is greater.

Also beginning in 2014, low-income individuals may become eligible for a refundable tax credit that will help them purchase coverage through the public Health Insurance Exchanges.

Impact on employers

Enrollment in employer-sponsored medical coverage may rise or fall for individual employers, as employees decide what they want to do. Some employees may decide that paying the penalty is less expensive than purchasing coverage — and may drop or decline to enroll in employer plans. Some who have declined employer coverage in the past may decide to sign up to comply with the mandate. Either way, employers should be prepared to answer employee questions about the mandate.

Impact on employees/individuals

Individuals will need to choose whether to enroll in a health insurance plan or pay the penalty associated with not having coverage. When making this decision, they should factor in the help available from the government in paying for insurance, and the type and quality of health care they can expect if they do not have coverage.

These individuals are exempt from the mandate:

- Individuals with a religious-conscience exemption (applies only to certain faiths)
- Incarcerated individuals
- Undocumented aliens
- Individuals who cannot afford coverage (i.e., whose required contribution exceeds 8% of household income)
- Individuals with a coverage gap of less than three months
- Individuals in a hardship situation (as defined by the Secretary of HHS)
- Individuals with income below the tax-filing threshold
- Members of Native American tribes

Understand the Health Insurance Exchanges

The Health Insurance Exchanges are mandated to take effect in 2014. Enrollment will begin in October 2013.

One-stop shopping for individual and small-group plans

The Health Insurance Exchanges will create an online marketplace through which individuals and small businesses can purchase coverage online, over the phone and potentially in person. **Each exchange will act as a clearinghouse for insurance plans that are offered in a specific geographic area**. The exchange model is designed to:

- Introduce managed retail competition into the marketplace, to encourage better pricing and quality coverage
- Make coverage more affordable, through rate oversight and subsidies
- Make it easy for individuals and small businesses to "comparison shop" for coverage
- Offer choices in standardized benefit plans and levels of coverage
- Clearly communicate plan descriptions and rates

Each state can decide whether to implement its own exchange, to run an exchange in partnership with the federal government, or to use a fully federally run exchange. Two exchanges will be constructed:

- One for **individuals**, where they can purchase coverage, enroll in Medicaid and the **Children's Health Insurance Program (CHIP)**, and gain access to other federal subsidies for coverage.
- One for **businesses with fewer than 100 employees**, although most states will likely limit initial employer size to 50 until 2016. These exchanges are called **SHOPs** (Small Business Health Options Programs). Through SHOP, smaller employers can eventually offer employees a variety of **Qualified Health Plans**, and employees can choose the plans that fit their needs and their budget. Early in 2013 the federal government decided to limit the number of plans offered on the government-run exchanges to one, and to delay the requirement for a choice of plans on both the federal and state-run exchanges until 2015. States running their own exchange will have the option to offer a variety of plans in 2014. Once they begin offering multiple plans, the **SHOP exchanges can help smaller businesses by simplifying**

Children's Health Insurance Program (CHIP):

CHIP is designed to provide health coverage to uninsured children in families with incomes that are modest, but too high to qualify for Medicaid.

A Qualified Health Plan must:

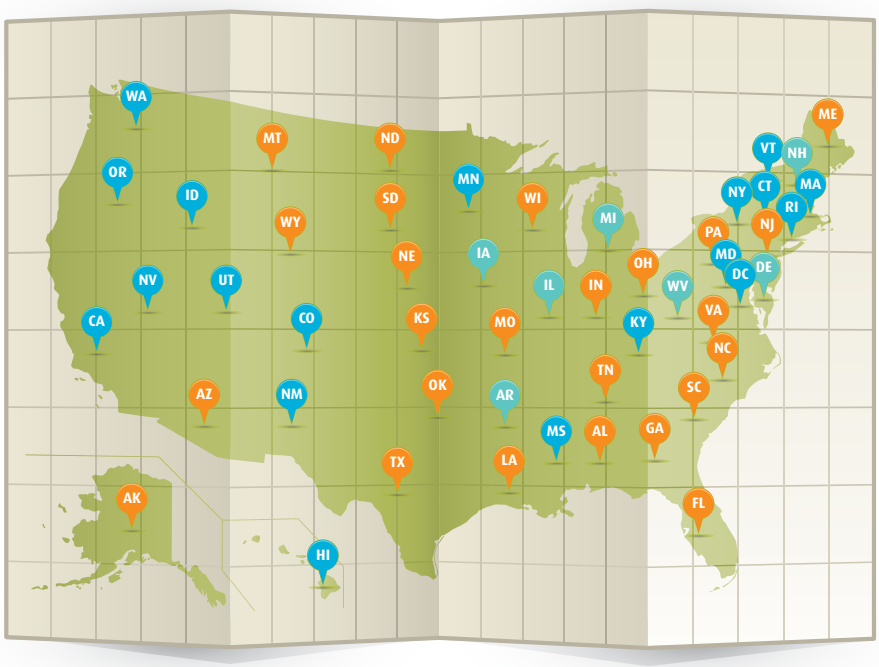
- Meet certain criteria for certification issued or recognized by each exchange through which the plan is offered
- Provide the "essential health benefits" package
- Be offered by an approved health insurer

choices, preserving employer control and lowering costs by spreading insurers' administrative costs across more employers. Businesses may also be eligible for small business tax credits when they offer health coverage through a SHOP exchange. Eventually these exchanges could be open to businesses of any size.

Only 16 states and the District of Columbia have moved forward with implementing state-based exchanges. Funding for states to build their own exchanges is essentially unlimited, and to date, the federal government has provided $1.8 billion to help states develop and build the IT and business systems that exchanges will require. Going forward, the exchanges must be self-funded.

Thirty-three states have notified the federal government that they will not set up their own exchanges, including highly populated Texas and Florida, which together account for nearly 20% of the uninsured in the U.S. As a result, the federal government will be responsible for building and operating exchanges for the majority of states. Seven of the states that are not setting up their own exchanges had signaled that they wish to participate in federal/state partnership exchanges, which allow states to tailor exchanges to local needs and market conditions. Under the partnership arrangement, the federal government will build and implement the exchanges, and the states will be responsible for plan management and/or customer service.

State plans for Health Insurance Exchanges (as of April 2013)[12]



Helping people afford insurance

Three types of assistance will be available to help lower-income people pay for insurance.

- **Medicaid expansion:** States may choose whether to expand Medicaid eligibility to people with incomes of up to 138% of the federal poverty limit (FPL). The federal government will pay for 100% of this expansion from 2014 to 2016, when it will begin paying for at least 90%. As of January 15, 2013, 10 states have chosen to forgo this federal funding. In these states, people who are not eligible for Medicaid but have incomes below 100% of FPL will not have access to government help in paying for insurance. Six other states have not yet decided, but are leaning toward not participating.
- **Tax credits:** People with incomes between 100% and 400% of FPL (approximately $92,000 for a family of four) are eligible for tax credits to help pay insurance premiums for coverage purchased through an exchange.
- **Reduced cost sharing:** People with incomes up to 250% of FPL will have access to coverage with lower deductibles and co-payments.

Exchange organization

Consumers (in 2014) and small businesses (later on) will be able to compare plans online by their cost and features. The plans are categorized in four tier levels based on the percentage of total health care costs they cover, from Bronze to Platinum, and provide increasingly richer levels of coverage. Subsidies for coverage will be based on the Silver plan, the second lowest plan available. These plans will likely be HDHPs that will cover about 70% of total health care costs, with the covered individual paying the rest through deductibles, co-pay and co-insurance. The cost sharing is compliant with HSA requirements.

Once the SHOP exchanges are expanded to include multiple plans, employers that are small businesses will be able to select the tier(s) on which their employees shop for coverage, and potentially the plans within the tier(s). Tier selection will determine how much the employer will need to contribute for the coverage to be deemed "affordable" — an important metric that will factor into employers' decisions whether to provide coverage or pay a penalty to the government. (See the "pay or play" section on page 32.)

For larger employers, **private exchanges** may become more popular, as an efficient, flexible way to provide a wide range of benefit choices for employees. Private exchanges may also be useful in helping employers move toward a "defined contribution" — rather than a "defined benefits" — model of funding, to help control costs in an era of rapidly rising premiums. While the private exchange idea is just beginning to take hold, it represents an interesting new development in the marketplace for employee benefits.

Impact on employers

Employers will need to understand how the exchanges work, especially small employers who can offer insurance through the exchanges to their employees. Employers with more than 50 employees will need to understand which plans they can offer their employees and how much of the premium costs they'll need to pay to avoid paying penalties. All employers will also need to communicate much of this complex information to their employees. The exchanges may ultimately influence the way employers of any size approach employee health benefits, and whether they continue to provide health coverage for active workers and retirees.

Impact on employees/individuals

The exchanges are intended to make it easier for employees to access and compare health insurance policy information, and to obtain subsidies for insurance costs, if they are eligible.

For more information on the Health Insurance Exchanges, check out our dedicated health care reform website at **unum.com/healthcarereform**.

Decide whether to "pay or play"

The key employer responsibility under health care reform is to provide employees with health insurance or pay a penalty — dubbed "pay or play." Employers need to understand this requirement in order to decide the best course of action. Because this decision is so critical, a separate section of this report is devoted to the issue. See the "pay or play" section on page 32.

By 2014, to comply with "pay or play," businesses with **50 or more full-time-equivalent employees** must offer health insurance to their employees and their dependent children. To avoid penalties, employers must ensure that the coverage they provide is both **adequate** (meets defined coverage guidelines) and **affordable**.

Impact on employers

Employers will need to understand the technical components of the employer responsibility provision to determine whether they qualify as a "large employer" and whether their existing medical plans and benefit eligibility practices are in compliance with the law. As medical coverage becomes more widely available and employee financial responsibilities continue to grow, employers will also need to think about their broader benefits strategy in an evolving marketplace.

Impact on employees/individuals

With the employer mandate, some employees may receive access to health insurance that they previously lacked, either in the workplace or through the exchanges.

Report employer-provided health insurance to IRS and employees, in context of "pay or play"

For the 2014 tax year, large employers (those with 50 or more full-time equivalent employees) are required to file an information report with the IRS describing the health care coverage they provided on or after January 1, 2014. These reports will be filed in 2015. The IRS will use this information to determine whether an employer is liable for any penalties under PPACA. (See the "pay or play" discussion on page 32.)

The reporting requirements have not been finalized, but preliminary guidance suggests that employers will need to report:

- Whether the employer offered its full-time employees (and their child dependents) the opportunity to enroll in an employer-sponsored plan (spouses are not considered dependents for purposes of PPACA)
- Whether the plan includes minimum essential coverage
- The plan's waiting period
- In what months the coverage was available
- The monthly premium for the lowest-cost option in each enrollment category
- The employer's share of the total allowable costs of benefits provided under the plan
- The number of full-time employees for each month of the year
- Each employee's name, address and taxpayer identification number
- The months during which each full-time employee (or any dependents) was covered under the employer's plan

In addition, by January 31, 2015, employers will have to supply a written statement to each full-time employee whose name appears in the report to the IRS, presenting information about the coverage provided to that employee and any dependents. This information will be used to administer the individual mandate.

Impact on employers

Employers will likely need to develop new data-tracking and reporting processes and systems to satisfy these reporting requirements.

Impact on employees

Employees will need to understand what information about their insurance coverage employers will be providing to the IRS. They will also need to understand their own role in providing information that shows they have satisfied the individual mandate requirement, as well as information required to obtain premium subsidies on the public exchanges, if needed.

YEAR: **2015**

Consider new plan options through the SHOP exchanges

This year the SHOP exchanges should begin offering a variety of plans from multiple carriers. Employers should reexamine the SHOP exchanges in their states and consider their offerings.

YEAR: **2016**

Understand SHOP expansion

When the health care reform law was written, it required that SHOP exchanges be available in 2014 to businesses with fewer than 100 employees — but it also gave states the option of limiting initial eligibility to employers with fewer than 50 employees.

Starting in 2016, all SHOP exchanges must be open to employers with fewer than 100 employees.

» Impact on employers

Since SHOP exchanges may make it more affordable to offer health coverage, employers may find them a worthy investment in attracting and retaining top talent.

» Impact on employees

Small-business employees who previously lacked workplace health coverage may now have access through their employer if the employer chooses to offer benefits through the SHOP exchanges.

YEAR: **2017**

Check on SHOP for larger employers

Beginning in 2017, states have the option to expand SHOP coverage to larger employers.

» Impact on employers

Many more employers may be eligible to offer coverage through SHOP.

YEAR: 2018

Calculate any "Cadillac" tax liability

"Cadillac tax" is the informal name bestowed on the excise tax PPACA imposes on **certain health insurance plans**. Its purpose is to help offset the costs of health care reform and encourage employers to provide cost-effective plans. Beginning in 2018, health insurers (or self-insured employers) must pay a **40% tax on the excess value** of any insurance plan whose premium exceeds standards set by HHS.

This tax will apply if the annual aggregate value of a medical insurance plan is higher than:

$10,200 for single coverage
$27,500 for family coverage

Certain groups, such as qualified retirees and employers in high-risk professions, will have higher limits. The limits also may be increased by characteristics such as age and gender, and will be adjusted annually based on the Urban CPI (Consumer Price Index), not the rate of medical-cost inflation.

The 40% tax applies only to the **excess** value of the plan. For example, if a plan's value is $12,000 per year for single coverage, the insurer would pay 40% of $1,800 (the difference between $10,200 and $12,000) as the health insurance excise tax, or $720 per covered employee.

Under the law, the "aggregate value" of a plan includes:	It does not include non-medical ancillary benefit plans, including:
• Medical insurance premiums (employer- and employee-paid)	• Dental and vision coverage offered through "stand-alone" plans
• Flexible Spending Accounts (FSA), Health Savings Accounts (HSA) and Health Reimbursement Arrangements (HRA) if part of the health plan (employer and employee contributions)	• Voluntary benefits when premium is paid with post-tax dollars
• On-site medical clinics (not "wellness centers")	• Any accident plan (paid with pre- or post-tax dollars)
• Voluntary benefits when premiums are paid with pre-tax dollars (except accident plans)	• Life and disability coverage • Long term care coverage

Employers are responsible for calculating whether they are subject to the Cadillac tax. **They must calculate their liability for each employee and report this calculation to the IRS and to each insurance carrier in the plan**. (The information employers must report to the IRS for this requirement is the same information they are required to report on employee W-2 forms beginning in 2012. The government has not yet said whether it will use the W-2 reporting as the means to gather this information or whether it will implement a new method for assessing the tax.)

Impact on employers

Employers will need to determine how their benefits package aligns with the "Cadillac" plan tax and may choose to lessen the aggregate value. Many analysts, including those in the Congressional Budget Office, estimate that businesses may respond by changing their benefits to have lower premiums and higher deductibles and co-payments, and by terminating employer contributions to HSAs and FSAs. Economists say employers may pass the savings to workers in the form of higher wages.[13] Employers who plan to decrease plan values should make incremental modifications so employees don't suffer from rapid, drastic changes.

2012 Towers Watson survey shows:[14]

- 83% of employers are planning to take steps to control their costs to avoid the Cadillac tax.
- 58% of employers expect they will trigger the Cadillac tax in 2018 if they do not make changes to their current benefit strategy.

Impact on employees/individuals

Individuals may see changes to their health benefits if insurers attempt to lower the aggregate value of benefits to avoid the excise tax.

"Pay or play" — An employer's biggest decision

The most critical decision employers face under heath care reform is this: Will the employer offer health care coverage to employees, or pay a penalty instead? This decision must be made in time for employees to begin receiving coverage in 2014.

Many factors go into this decision. Not all employers are required to "pay or play" (as the requirement has been dubbed) and not all employees are required to have coverage. To determine whether they need to pay a penalty — and how much that penalty will be — employers need to determine:

- Whether they are **large enough** for the law to apply to them
- Whether the coverage they offer (or plan to offer) provides essential health benefits and is **affordable**

What is your employer size?

Companies must have 50 or more **full-time equivalent** employees — and 31 or more **actual full-time employees** — to be subject to the pay or play penalty.

What's the difference? Actual full-time employees are individual people who work at least 30 hours per week or 130 hours per month. But a company may have more full-time equivalent (FTE) employees, based on the number of hours part-time and seasonal workers, work in a month. (See the FTE calculation on page 33.)

A company with 30 or fewer actual full-time employees, regardless of the number of FTEs, is exempt from paying any penalty.

What if the number of FTEs changes during the year? If a company had 50 or more FTEs during the prior year, the employer must provide health insurance for all full-time employees in the current year, even if the number of FTEs drops below 50 during the current year. For example:

In November 2013, Employer A needs to determine whether it is a large employer, and thus obligated to offer benefits in 2014. Because the calculation is being made in November, the employer doesn't have access to full-year data for 2013. To decide 2014 status, the IRS permits employers to measure any consecutive six-month period in 2013. Here's how the FTE calculation for 2013 is made:

1

Find the number of actual full-time employees — those who worked an average of 130* hours or more per month during the six-month period.

Employer A has 32 full-time employees.

2

Next, add the hours worked per month by part-time employees. Divide those total hours by 120.* The resulting number is the additional number of full-time equivalents (FTEs) among the part-time employees.

Employer A also has a total of 28 part-time employees. Twenty of those employees work 24 hours per week and the other eight work 12 hours per week. This works out to 19 full-time-equivalent employees, like this:

20 employees x (24 hours x 4 weeks per month) = 1,920 hours per month
1,920 hours ÷ 120 hours per month = 16 FTEs

8 employees x (12 hours x 4 weeks per month) = 384 hours per month
384 hours ÷ 120 hours per month = 3 FTEs

16 + 3 = 19 FTEs in part-time workers

3

Add up the full-time and part-time FTE employees. ***32 + 19 = 51 FTEs***

Because this employer has more than 50 FTEs, it must provide health insurance to its 32 full-time employees or pay a penalty. This requirement is in effect for all of 2014, even if the number of FTEs falls below 50 during the year. In late 2014, the employer will repeat the calculation to determine its obligation for 2015.

** The IRS uses 130 hours per month to determine full-time employees, but 120 hours to determine FTEs among part-timers.*

It is important to note that part-time employees are included in the calculation for determining whether an employer is large enough to be subject to the employer insurance mandate, but only actual full-time employees are counted when it comes time to assess any penalties. Also, only actual full-time employees are required to have coverage.

Determining who's a full-time employee and eligible for insurance

Beyond determining whether an employer is large enough to be liable for penalties, employers must also determine exactly who is a full-time employee, and is thus eligible for employer-provided health insurance. Until further notice, and at least through 2014, employers can use a voluntary "safe harbor" method to determine whether an employee with variable hours is full time or part time.

Under current IRS guidance, a new employee is a **"variable" employee** if, based on the facts and circumstances at the employee's start date, it is unclear whether the employee is reasonably expected to work an average of at least 30 hours per week. For purposes of determining eligibility for insurance, variable and seasonal employees start out in a **"measurement period,"** during which the hours they actually work are recorded. Then there's an **"administrative period."** In this period, the employer analyzes the employee's hours, determines if the employee worked full or part time during the measurement period, and enrolls the employee in the health care plan (if he or she is eligible).

Finally, there is a **"stability period,"** during which the employee is considered and treated as full time or part time, as determined during the measurement period, even if his or her hours change during the stability period. Hours worked during the stability period are also averaged into the next measurement period which runs concurrently with the stability period.

Example:

Arlina has been working variable hours at Company C. Her employer has implemented a 12-month standard measurement period, which begins October 15. It's followed by an administrative period ending December 31. A 12-month stability period then begins on January 1.

Every year after October 14 — the end of the measurement period — Company C averages Arlina's weekly hours for the past 12 months. In October 2013, Company C determines that Arlina has worked an average of 30 hours per week during the prior measurement period (October 1, 2012 to September 30, 2013) and is therefore considered a full-time employee.

YEAR 1

The safe harbor method for ongoing variable-hour employees

Term	Length	Definition	Notes
Standard measurement period	3-12 months (chosen by employer)	Time period during which an ongoing employee's hours are averaged to determine full- or part-time status	Ongoing employees are those who have been employed for at least one measurement period
Administrative period	Up to 90 days	Interval after the measurement period during which the employer can analyze an employee's hours and, if full time, enroll eligible employee in the benefits plan	Optional, although employees must not be subjected to a waiting period longer than 90 days
Stability period	At least six months, and no shorter than the measurement period	Period during which the employer provides benefits to eligible employees as determined during the measurement period even if that employee's hours drop below the "full-time" level of 30 hours/week	Employee's hours may change during this period, but the "full- or part-time" determination doesn't change until the period ends

As long as the above requirements are met, measurement or stability periods can have different start dates, end dates or lengths for collectively bargained and non-collectively bargained employees, salaried and hourly employees, employees of different entities and employees located in different states.

The company arranges for her health care coverage to begin on January 1. From January 1, 2014, through December 31 (the 12-month stability period), Arlina receives health coverage, even though her hours reduce and she is no longer averaging 30 hours per week.

In October 2014, when the new administration period starts, Arlina will be determined to be a part-time employee. Her coverage will continue until December 31, 2014 — the end of the stability period.

YEAR 2

Minimum standards: Is the coverage "rich" enough? And is it affordable?

Even if a company does offer health care coverage, it may still be liable for a penalty if the coverage does not meet minimum standards set by the government. These standards dictate that:

- Non-grandfathered plans in the individual and small-group markets must include coverage for each category of **essential health benefits (EHB)**, as defined by the individual states. (Self-funded and large-group market plans are exempt.) The plan cannot impose annual or lifetime dollar limits on the EHBs. See page 17 for a more complete discussion of EHBs.
- The plan must cover **at least 60%**, on average, of an employee's health care costs in a given year. For example, if an employee incurs $1,000 in health care expenses, the plan must cover at least $600, with the employee responsible for the balance through a combination of deductibles, co-pays and co-insurance. (This is also referred to as a 60% actuarial value.)

In addition, employers must ensure that the health care they provide to their employees is affordable. To be considered affordable, an employee's **premium costs may not exceed 9.5% of his or her household income**. Under a current "safe harbor" provision, the household income qualification has been met if the employee's contribution for individual coverage does not exceed 9.5% of the employee's W-2 wages alone. (This safe harbor provision is the subject of a great deal of discussion and may be revised.)

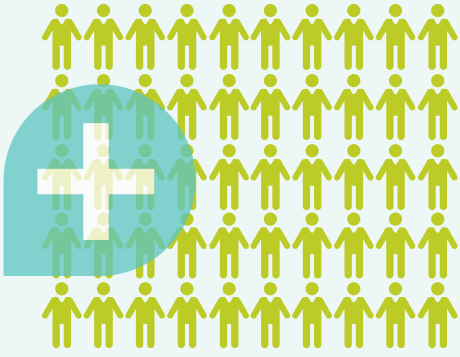
Whether an employer offers coverage or not, or meets quality and affordability standards or not, **penalties kick in only if one or more employees receives premium assistance on the state's Health Insurance Exchange**. Through the exchanges, premium assistance, in the form of tax credits or subsidies, is available for people who make between 100% and 400% of the Federal Poverty Level (FPL). For 2013, 400% of the FPL equals an income of $45,960 for an individual and $94,200 for a family of four. (Amounts differ in Alaska and Hawaii. See specific state charts on this government website: http://aspe.hhs.gov/poverty/13poverty.cfm).

This chart shows how to determine whether an employer is eligible for a "pay or play" penalty:

Does the employer have at least 50 FTEs?

NO:
Penalties do not apply to small employers

YES:
Does employer offer coverage?



NO:
Did at least one employee receive tax credit or cost subsidy?

YES:
Does insurance pay at least 60% of covered health expenses?

YES:
Does coverage cost more than 9.5% of household income for any employee?

YES:
Employer must pay $2,000 annual penalty for each full-time employee, less the first 30

NO:

YES:

Did any employees receive tax credit or cost subsidy on exchange?

NO:
Employer not subject to any penalty

YES:
The lesser of:

- $3,000 for each employee receiving premium assistance
- $2,000 for each full-time employee in the company, not counting the first 30 employees

FTE = Full time equivalent

What is the penalty?

As the chart on the previous page shows — whether an employer offers coverage or not — no penalty kicks in unless one or more employees receive a tax credit or cost subsidy on the Health Insurance Exchange. Once that happens, the penalties are calculated like this:

Employer		Annual Penalty
Large employer who doesn't offer health coverage	AND at least one employee is receiving premium assistance through a Health Insurance Exchange	$2,000 per full-time employee *(not full-time equivalent)*, not counting the first 30 employees. A full-time employee is one who works 30 or more hours/week.
Large employer who offers health coverage, but does not meet quality or affordability standards		The lesser of: • $3,000 for each employee receiving premium assistance • $2,000 for each full-time employee in the company, not counting the first 30 full-time employees

You'll need to reevaluate your "pay or play" decision every year, as regulations take effect and the marketplace evolves.

The penalties are designed to offset some of the costs of the government subsidies for employees who do not receive adequate benefits at work.

As of this printing, HHS was taking comments on new proposed pay or play guidance. Under this change employers offering adequate and affordable coverage to at least 95% of their full-time employees would not be subject to the employer mandate penalty.

Let's look at some examples. In example 1, an employer is large enough to be subject to the penalty and does not offer coverage.

Example 1

An employer has 60 workers, **does not** offer coverage and has one employee who receives premium assistance from the government

To determine the financial penalty:

- Deduct the first 30 employees
- Multiply remaining 30 employees by $2,000 per person

Employer pays $60,000

	60	total employees
–	30	first employees
	30	remaining employees
x	$2,000	fee for each
	$60,000	penalty

In example 2, the employer does provide coverage, but it is unaffordable, and several employees have received premium assistance on the exchange.

Example 2

An employer has 60 workers, **does** offer coverage and has 15 employees who receive premium assistance from the government

To determine the financial penalty:

- Deduct the first 30 employees
- Multiply remaining 30 employees by $2,000 each
- Employer assessed penalty of $60,000

or

- 15 employees receiving premium assistance x $3,000
- Employer assessed penalty of $45,000

Employer pays $45,000

	60	total employees
–	30	first employees
	30	remaining employees
x	$2,000	fee for each
	$60,000	penalty

	15	employees with assistance
x	$3,000	fee for each
	$45,000	penalty

Employer pays the lesser amount

Think beyond direct costs when making your decision

When deciding whether to "pay or play," employers have more to think about than the trade-off in direct coverage or penalty costs. There are other things at stake, including employees' **morale, loyalty, productivity and health**. Employers must recognize that benefits are important in **attracting and retaining workers** with skills critical to the company's success. And employers choosing to "drop" coverage must recognize that they are, in effect, reducing employee compensation — and employees will almost certainly look to somehow be "made whole."

Most employers will likely offer coverage, according to the majority of studies conducted since the health care reform law was passed. A much-quoted 2011 study by McKinsey & Company said that 30% of employers might drop employee health coverage after health care reform took effect. But a 2012 study by Deloitte found that 81% of companies (representing 84% of the workforce) said they did not anticipate abandoning coverage. Only 9% (representing 3% of the workforce) said they were likely to drop coverage within the next three years, and 10% were not sure what they would do.[15]

It's important to note that employer-sponsored health plans of the future could be different — in both content and delivery — from those offered today, as they are influenced by market changes that occur through the exchanges and other elements of health care reform. Today, employers need to balance a benefits plan that is appealing to talented workers with the cost controls that are essential to business success, taking into consideration the penalties and tax advantages of each option.

Employers who choose not to offer health coverage still have responsibilities under the law. They will need to communicate to their employees about the Health Insurance Exchanges and the opportunities they offer for individual coverage.

When employers plan to continue coverage, it is because:

- Higher earners (>$60,000) may be worse off if an employer drops coverage and the employee purchases health care through the exchanges. According to a study by Lockton, 30% of employers planning to continue coverage said they do not believe the exchanges will be able to provide the same level of affordable coverage the company can offer.[16]
- Dropping coverage could have a negative impact on employees' health, making them less productive.
- Employers need to hire and keep the best employees. In a 2012 Aon Hewitt study, nearly all employers (94%) said they were committed to offering and financially supporting health benefit coverage for their workforce into the foreseeable future.[17]
- Choosing to "pay" rather than "play" may not lower costs.
  - Group health insurance receives favorable tax treatment. If employers have to increase wages (including FICA contributions, etc.) to make up for not providing benefits, the math may not work in their favor.
  - A 2012 Truven study modeled the financial impact of the "pay or play" decision and determined that employers are unlikely to see a significant cost benefit, now or later, if they choose to pay the penalty. To retain skilled workers, employers will need to provide competitive benefits and compensation, and "will not be able to unilaterally cut benefits and expect employees to absorb the projected inefficiency of exchange-based coverage."[18]

The changing face of employee benefits

Health care reform is part of a long and ongoing national conversation that has reshaped the U.S. health insurance market and the landscape of employee benefits. And it will continue to do so for years to come.

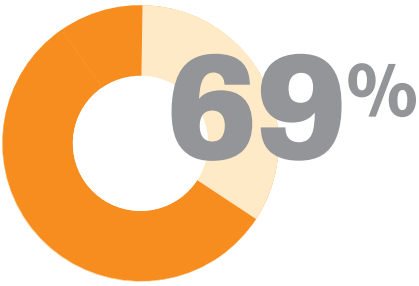
While the government is enacting bold measures to provide affordable coverage to all Americans, challenges remain. Health care costs are likely to continue to rise, partly because our population is aging, suffering from more chronic diseases, and surviving serious illnesses longer thanks to improved treatments and technologies. The health reform act attempts to limit costs borne by individuals — and has set up some mechanisms for attempting to lower health care costs overall — but these actions will not do much in the short term to blunt the cost impact on insurers and employers.

Cost sharing will continue to shift toward employees

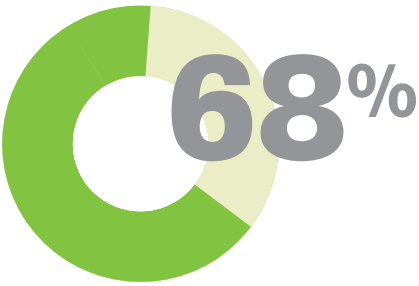
Employers have recently begun to feel the impact of health care reform, but their challenges are just beginning. **The laundry list of decisions and responsibilities described in this booklet will likely add up to a significant additional burden on employers**. In addition, they will likely see significant costs stemming from insuring more people and investing in systems and processes to meet their obligations under the health care reform law.

As employers feel the pressure of rising costs and enrollments in their health plans, they are likely to further increase the already rapid growth of Consumer Directed Health Plans (CHDPs), which require employees to pay an increased portion of their health care costs. **The introduction of the Health Insurance Exchanges may hasten this growth**. The typical corporate plan pays about 80% of an employee's annual costs.[19] The government will permit plans with an actuarial value of 60% or more to be offered on the exchanges. If employers begin moving their plans toward such levels, cost-sharing will shift even more significantly toward employees.

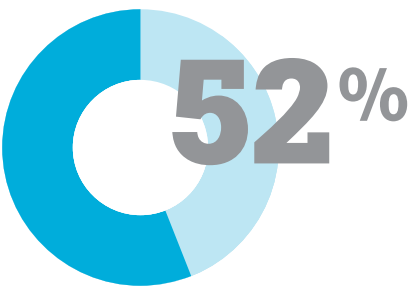
A 2012 study by Deloitte[20] found that:



of employers anticipate increasing employee cost sharing (deductibles and co-payments) in the next 3–5 years.



of employers anticipate increasing employee premium contributions in the next 3–5 years.



of employers anticipate introducing high-deductible/consumer-driven health plans in the next 3–5 years.

The total benefits package will matter more

As employees shoulder an unprecedented share of health-coverage risk — and as medical insurance becomes available outside of work — other workplace benefits will become more important. **Whether they decide to pay or to play, employers will have the opportunity — and responsibility — to address the financial risks their employees face in this new environment,** from substantial events (e.g., death, long-term disability, critical illness) to significant events (e.g., short-term disability) to common events (e.g., dental expenses).

First, employers must be aware that employees will view any reductions in the value of their health care plans — either through loss of medical coverage or increase in cost sharing — as a **reduction in compensation**. Benefits are a key part of the value of an employer's total compensation package. To ensure that the total package remains competitive with market rates for talent, employers will need to pay more attention to their company's **total benefits package** and ways to preserve or increase its value.

Accordingly, **disability and voluntary plans are expected to play an increasing role in providing financial protection for employees**. Many of today's workers — touched by hard economic times — are living paycheck to paycheck, and a single disability can leave them vulnerable to financial problems. Disability benefits can be critical in helping employees pay for rent, food, utilities and transportation until they can go back to work — and in dealing with the financial stress that can hinder their recovery or on-the-job focus.

Voluntary benefits can also help offset the impact of new financial responsibilities. These plans can fill the gaps created by high deductibles, co-pays and co-insurance by paying benefits in case of serious illness, accidental injury or death. Plans are offered in ways that let employees choose the **combination of coverage that best fits their needs and budget**. Employers have flexibility in deciding how to fund these plans — whether by paying the premiums for employees, asking employees to pay or sharing the cost. Paid-time-off policies will also become increasingly important within the total benefits package as health insurance costs rise and benefits decrease.

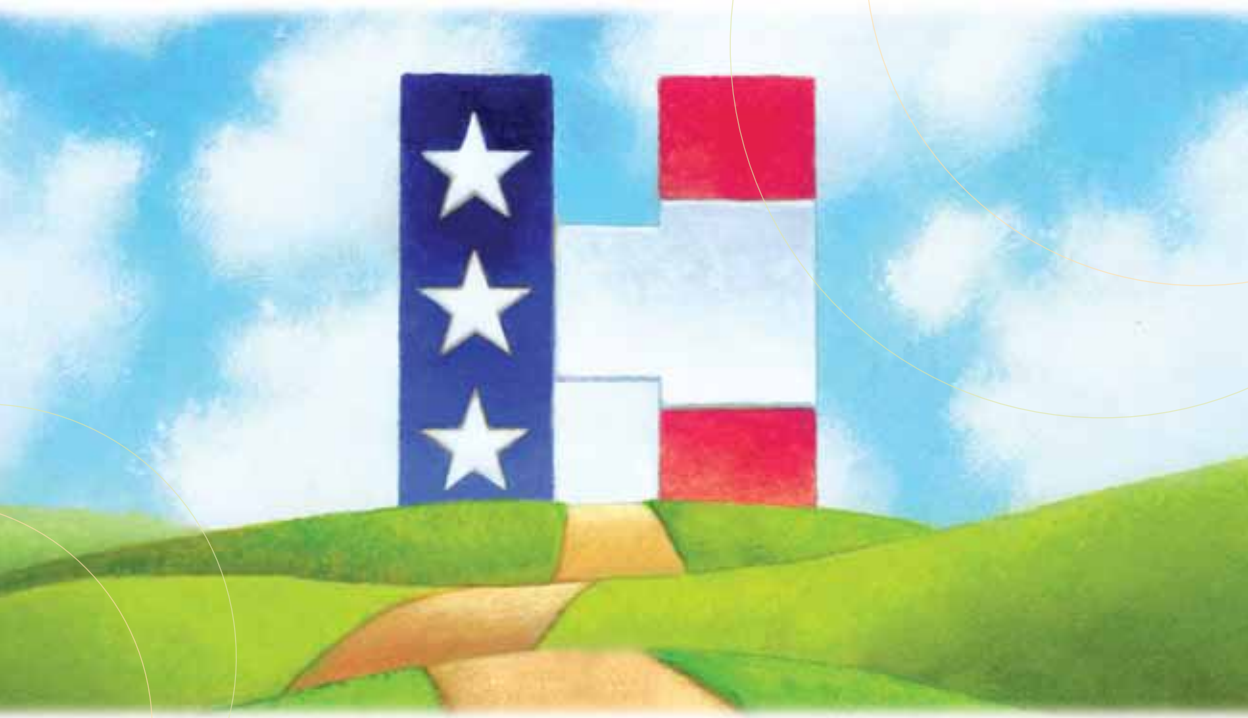
The best combination of traditional and voluntary benefits to offset employees' financial risk will depend on the employer's industry and specific workforce demographics.

Benefits education will be key

Most of all, employers must clearly and effectively communicate benefits options — and their value — to employees. **The many changes on the health care horizon will require better-educated benefits consumers**. If employees do not understand the benefits they are offered, they may have difficulty choosing those that are most relevant to their age and stage of life. But when employees understand their benefits, the payoff can be powerful. In fact, research shows that employees who are educated about their benefits are more satisfied with their jobs and feel their employers care about their well-being.[21]

The result: A happier, healthier, more loyal and more productive workforce.

The coming years are fraught with uncertainty — for providers, consumers and insurers of health care alike. The more employers understand how health care changes will impact their businesses in the future, the better prepared they can be to compete and thrive in the new health care landscape. **For this reason, Unum is dedicated to keeping its customers informed about every important development as health care reform takes hold**.



Benefits decision guide

Use these questions to help you decide on a benefits strategy — one that will work for your business and your employees.

1. Are you a large or small employer?

- Do you have more than 50 FTEs (see page 33 for calculation)? If yes, you are a large employer, and PPACA requires you to provide health insurance to your full-time employees or potentially pay a penalty.
- Do you have fewer than 50 FTEs? If so, you are a small employer. You are not required to provide insurance, but you can do so, and you may have additional options through the Small Business Health Options Program (referred to as "SHOP" exchanges). If you provide insurance through SHOP, you could be eligible for tax credits.

(Learn more about "SHOP" exchanges on page 23.)

2. Which of your employees are considered full time?

- Under PPACA, employees who work 30 hours per week are considered full time (refer to page 32 for details). If you have employees with variable schedules, or seasonal or hourly workers, please see page 34 for information on determining full-time status.

3. Is the coverage you offer affordable?

- Do any of your full-time employees spend more than 9.5% of their W-2 earnings for the lowest-cost, employee-only coverage plan available to them?
- If so, those employees may be eligible for tax credits to purchase coverage through the Health Care Exchanges. If even one employee accesses such subsidized coverage, your business may be subject to a penalty (see pages 38-39 for applicable penalties).

4. Does the plan you offer meet the "actuarial value" standard?

- The plan must cover at least 60%, on average, of the plan population's health care costs in a given year. For example, if an employee incurs $1,000 in health care expenses, the plan must cover at least $600, with the employee responsible for the balance through a combination of deductibles, co-pays and co-insurance.
- The plan must also provide all "essential health benefits" if the employer is fully insured.

Helpful tool: To determine your plan's actuarial value, access the HHS calculator at www.cciio.cms.gov. First, locate "Resources" at bottom left. Select "Regulations and Guidance." Scroll down to "Plan Management" and select the "Actuarial Value Calculator."

5. Should you pay or play?

- If you're a large employer and you don't offer health insurance to your employees, and at least one employee receives premium assistance through the Health Insurance Exchanges, you will be liable for a penalty of $2,000 per full-time employee, not counting the first 30 employees (see page 38 for a proposed change to this rule that would provide employers relief against having to cover 100% of employees). Whether paying the penalty is less costly than providing health insurance will depend on the employer.
- But this decision is more complex than just "doing the math." You must account for all the direct and indirect implications of dropping insurance, including the potential effects on employee morale, loyalty and productivity. (More details about the pay or play decision are found on page 40.)

6. Is your total compensation package aligned with your company's goals?

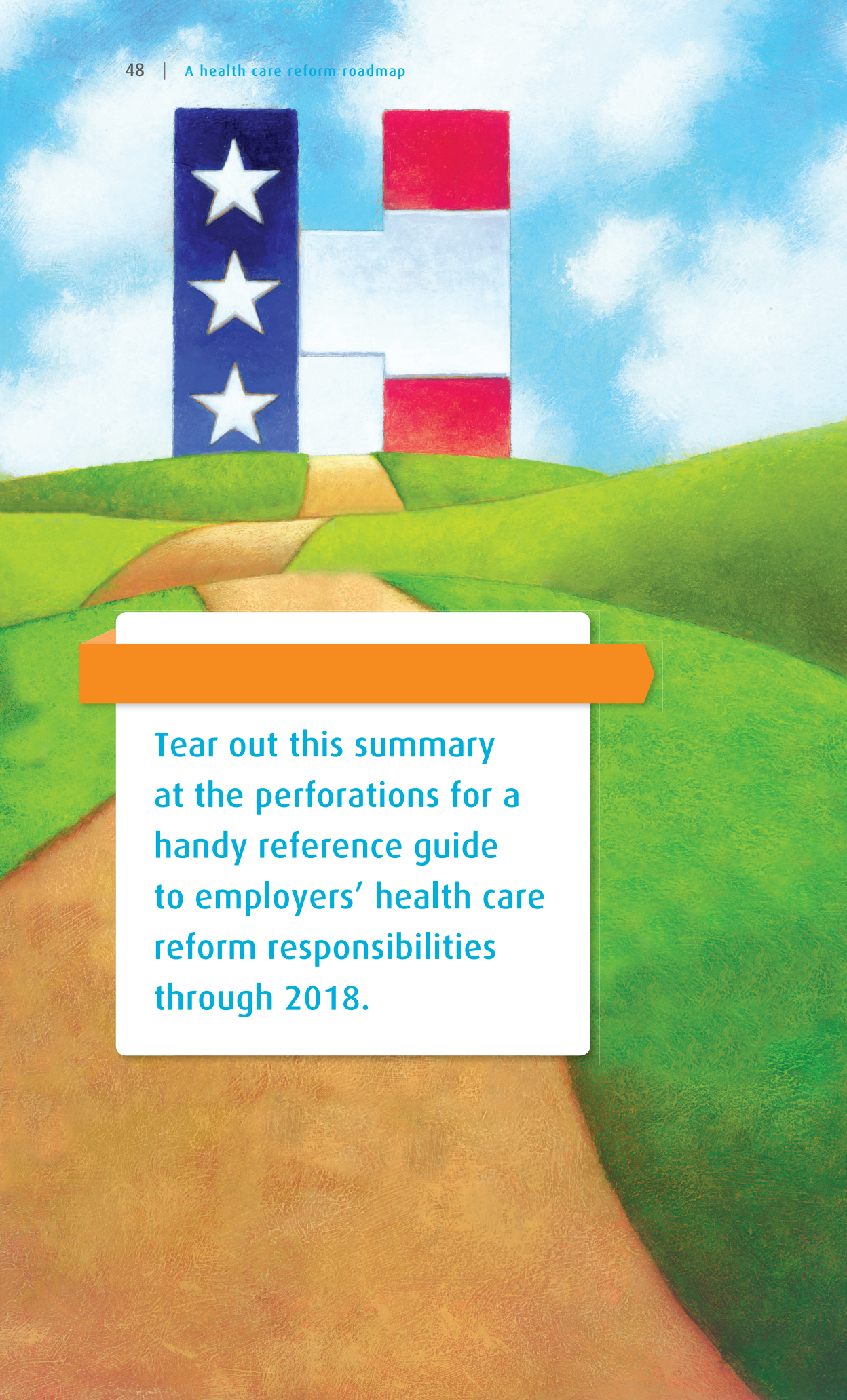
- To attract and retain the talent that will allow your company to reach its goals, your compensation package must be competitive. The total value of your compensation package includes the benefits you offer. As you reduce benefits and/or increase cost-sharing, you reduce compensation.
- Offering additional non-medical benefits can help rebalance your compensation package to get and keep valuable employees. For example, disability insurance can create value for employees by shielding them from much of the financial risk of disability. Voluntary benefits can provide additional protection from rising and increasingly shared health care costs, such as deductibles, co-pays and co-insurance. Both can be offered using various funding plans that help protect your bottom line.

7. Do your employees understand and value the benefits you offer?

- Whether you pay or play, you still need to communicate with employees about the options available to them. If increased financial responsibility is shifted to employees, you must ensure they understand the new risks they face, as well as the other benefits you offer to protect against those risks.
- Employees who understand the value of their benefits are more likely to be satisfied at work — and more likely to be happy, productive and loyal.

MORE

To learn more about health care reform, or if you have questions about how we can help you plan for this new era in employee benefits, call your broker or local Unum representative.



Tear out this summary at the perforations for a handy reference guide to employers' health care reform responsibilities through 2018.

the inside track

A health care reform roadmap

Key steps and strategies for 2013 and beyond

unum
Better benefits at work.

2012

Distribute Summary of Benefits and Coverage
- Starts first open enrollment after 9/23/12
- Provide 60-day advance notice on any material modification

Manage distribution of Medical Loss Ratio (MLR) rebates

Report health-coverage value on 2012 employee W-2s (for distribution in 2013)

2013

Limit Flexible Spending Account deductions to $2,500
- Applies if you generated more than 250 W2s.
- Ensure employees know they aren't taxed on reported value.

Deduct additional Medicare taxes for high-income employees
- You may need to adjust withholding for some employees. Employees may not reach the individual income threshold ($200,000), but might reach the one for married couples ($250,000). Advise employees to determine family liability.

Notify employees about Health Insurance Exchanges, options and impacts
- Clearly communicate:
  - All employee medical coverage options, including Health Insurance Exchanges
  - The impact of opting out of employer coverage and going to the exchanges
- Before notifying employees, finalize your own benefits planning so employees can make the best decisions.

Understand new fees: medical device manufacturer levy and Patient-Centered Outcomes Research Institute (PCORI) fee
- New fees will likely translate to increased premiums — how much of these increases will you pass on to employees?

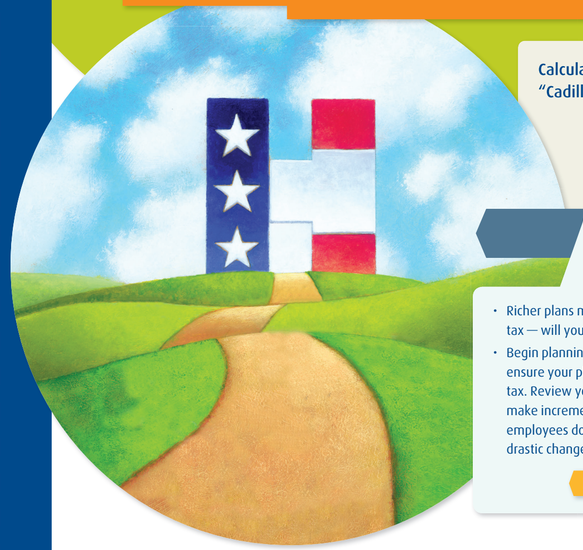
2014

Decide whether to pay or play
- By the beginning of this year, large employers must provide health insurance or be liable for a potential penalty. What will you do?
  - Are you a "large" employer?
  - What are the penalties?
  - What other factors should you consider?
- You'll need to reevaluate your "pay or play" decision every year, as regulations take effect and the marketplace evolves .

Begin planning in 2013

Determine whether or not you'll offer health coverage through the Small Business Health Options Program (SHOP) exchange (if applicable — small businesses only)
- New fees will likely translate to increased premiums — how much of these increases will you pass on to employees?

Prepare for health insurance sector fee and Transitional Reinsurance Program fee



2018

Calculate any "Cadillac tax" liability
- Richer plans may be subject to Cadillac tax — will your plan be one of them?
- Begin planning well in advance to ensure your plan is not subject to this tax. Review your benefits plan — and make incremental modifications so employees don't suffer from rapid, drastic changes.

Begin planning in 2013

Consult with your benefits attorney/legal counsel to discuss your obligations and options.
Consult with your broker to determine communication strategy.

2017

Check on SHOP for larger employers (100+ lives)
- More employers may gain access to SHOP exchanges.
- Some states may ban non-exchange sales.

2016

Understand SHOP expansion
- Some employers with 50–100 employees who didn't have SHOP access will have it now.

2015

Consider new plan options through the SHOP exchanges
- SHOP exchanges will broaden offerings in 2015 to small businesses only

Report employer-provided health insurance to IRS
- Further rules will be announced — but you will need to determine how you will report this information.

2014 continued

Revisit your benefits strategy in light of the individual mandate and the Health Insurance Exchanges
- The individual mandate will likely increase the number of people you cover.
- Talk with your broker about changes in the marketplace and how they will affect you.
- Make sure your benefits strategy is aligned with your goals for attracting and keeping valuable employees.

Institute auto-enrollment for group health plans (effective date to be determined)
- Keep watch for guidance on auto-enrollment.
- Make sure your benefits administrator builds in an auto-enrollment feature.

Make sure your health plan meets new requirements:
- Cover essential health benefits
- Comply with cost-sharing limits
- Comply with waiting-period restrictions
- Do not exclude people based on pre-existing conditions
- Cover dependents to age 26
- Fines may apply if your plan is not compliant – work with your broker to make sure it is.
- If you transfer more cost-sharing to your employees, how will you protect them from increased risk?
- Devise an appropriate communication strategy — for example, do you want to encourage workers to sign up their adult children?

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BACK OF POSTER

PERF

A valuable resource at your fingertips

To learn more about the reformation of the health insurance industry, visit our health care reform website at **unum.com/healthcarereform. There you can access:**

- A library of reports, podcasts and other resources
- Analysis of key mandates
- Important updates and what they mean
- Help creating benefits strategies for the post reform era
- An option to sign up for email alerts when news develops

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