Moving Forward with Health Care Reform

presented by | Adam Jensen
Professional Credentials

Adam P. Jensen, Vice President with Cottingham & Butler, has worked in the insurance and employee benefits industry since 1986. He specializes in providing regulatory compliance and plan design services for health and welfare plans. He also advises executive clients on non-qualified deferred compensation issues. Prior to joining Cottingham & Butler, Adam was the Senior Compliance Officer for Virchow Krause Employee Benefits, LLC. He was previously a manager in the human capital practice of a Big Four accounting firm and has also served as an in-house ERISA attorney for a well-known national financial and retirement plan services firm. He leads Cottingham & Butler’s Compliance and Human Resource Consulting practice group.

Specific Experience
• Advises Fortune 500 clients on HIPAA and ERISA compliance issues for health and welfare plans
• Advises Fortune 500 clients on plan design and IRS/DOL compliance issues for benefit plans
• Provides cost containment expertise for businesses and major health plans throughout the Midwest

Industry Involvement
• Milwaukee Chapter of the International Society Certified Employee Benefits Specialists
• 2008, 2009 Madison Chapter President
• 2007 Madison Chapter Vice-President
• International Foundation of Employee Benefit Plans
• Greater Madison Chapter of Society for Human Resource Management (SHRM)

Education
University of Minnesota - Minneapolis
-Bachelor of Arts in History

William Mitchell College of Law
-Juris Doctorate
Life Office Management Association
-Fellow, Life Management Institute (FMLI) designation

International Society of Certified Employee Benefits Specialists/ Wharton School of Business
-Certified Employee Benefits Specialist (CEBS) designation
-Group Benefits Associate (GBA) designation
-Certificate in Global Benefits Management
Agenda

- Notice Requirements
- Plan Design Changes
- What is Delayed?
- What does this Mean?
- What’s Still in Effect?
- Play or Pay
- Safe Harbor Plan Strategies
- Look Back Safe Harbor Options and Examples
- Self-Funding Opportunities
- Using Integrated Wellness to Control Plan Costs
- Putting it all Together- Client Case Study
- Next Steps
Notice Requirements

Summary of Benefits and Coverage

• SBCs should have been provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012

• Persons who are newly eligible for coverage and special enrollees must receive an SBC by the first day of the 2013 plan year
  - Part of the new hire packet

• Employers should contact their insurance carrier or TPA and verify that this item will be handled for them

• An imperfect SBC is better than no SBC
  • Proper disclosure of info is more important than number of pages
Notice Requirements

Disclosure of Grandfather Status

• To maintain grandfather status, self-funded plans and insurers must include a disclosure of grandfather status when sending out materials describing the benefits provided under the plan
  - Included in DOL Audits

Notice of Patient Protections and Selection of Providers

• Plans must notify participants of their right to choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician
• Notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage

Notices available at: http://www.dol.gov/ebsa/healthreform/
Notice Requirements

Availability of Exchange Notice

• The Affordable Care Act (ACA) requires that employers provide all employees with a written notice about the Exchanges which are also known as Health Insurance Marketplaces.

• The notice must be provided to each new employee at the time of hiring from October 1, 2013 onward.
Notice Requirements

Who Must Receive a Notice?

• Employers must provide the Exchange notice to each employee, regardless of plan enrollment status or of part-time or full-time status
  - Includes union employees

• Employers are not required to provide a separate notice to dependents or other individuals who are or may become eligible for coverage under the plan but who are not employees

• Employers may also consider sending the notice to those enrolled in COBRA and any retirees that may be covered on the plan

• Include in the new hire/benefits packet
Notice Requirements

What are the content requirements of the Notice?

1. Informing the employee of the existence of the Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance.

2. If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the employee purchases a qualified health plan through the Marketplace; and

3. If the employee purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.
Notice Requirements

Model Notice

• DOL has created a model notice
• 3 pages, Part A and Part B
• According to the regulations, employers only need to provide the content on Page 1
• Pages 2 and 3 contain information that might help employees complete an exchange subsidy application
  - The model notice states that only page 3 is optional, but that does not match what is in the published regulations!
Notice Requirements

Methods of Providing Notice

• The notice is required to be provided automatically, free of charge

• Distribution methods:
  - First Class Mail
  - Electronically
  - Memo/payroll stuffer

• Merely placing a disclosure on a company website available to employees or on a physical bulletin board will not by itself satisfy this disclosure requirement
Notice Requirements

Who Gets the Notice?

• Notice must be provided to:
  - Current employees
  - New Hires
  - COBRA continuees
Plan Design Changes

A number of plan changes which were required to be in place by the first day of the 2014 plan year:

• Removal of pre-existing conditions exclusions for everyone
• Removal of Restricted Annual Limits (totally phased out)
• Removal of dollar limits for non-essential benefits
  - Can still limit number of days or treatments
• Waiting period of not more than 90 days
  - If using “first of the month following”, consider setting waiting period to 60 days
• Plan Out of Pocket limits not greater than HSA limits (non-grandfathered plans)
  - $6,350 Individual, $12,700 Family
  - Out of Pocket must include any expenditure, such as deductibles, co-payments, co-insurance and similar charges. All costs must track to OOP. Can have separate limits in 2014 if PBM is separate entity.
• Maximum deductible limits recently eliminated!
Plan Design Changes

Essential Health Benefits DO NOT need to be provided by:

- Self-funded plans
- Grandfathered plans
- Large employer plans (currently over 50 employees)

The only employers who are required to offer Essential Health Benefits are Non-Grandfathered fully-insured plans of employers with fewer than 50 employees
Plan Design Changes

Wellness Regulation changes for 2014 Plan Year

• General wellness incentive increases to 30%
  - Cannot count towards meeting Affordability in 2015

• New tobacco incentive of 20%
  - Can count towards meeting Affordability in 2015

• Changes to Reasonable Alternative Standard Rules
  - Nearly everyone will have access to an RAS
  - Don’t have to develop it until it is requested
  - Employee physicians will be able to suggest RAS
  - Tiered incentives will become difficult if not impossible to administer

• Mandatory HRAs allowable for 2014, but will go away with Play or Pay in 2015/2016
  - The increased incentives should make up for loss of mandatory HRAs
What is Delayed?

Section 6055 Information Reporting
Section 6056 Information Reporting
Section 4980H Employer Shared Responsibility Provisions
What is Delayed?

Section 6055 Information Reporting

• Section 6055 applies to insurers, self-insuring employers, and other providers of minimum essential coverage
  • name, address and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy
  • dates during which such individual was covered under minimum essential coverage during the calendar year
  • whether or not the coverage is a qualified health plan offered through an Exchange
  • amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act of any cost-sharing reduction under section 1402 of such Act or of any premium tax credit under section 36B with respect to such coverage
What is Delayed?

Section 6056 Information Reporting

- Section 6056 applies to “applicable large employers” subject to the Share Responsibility rules
  - name, date, and employer identification number of the employer
  - a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan
  - length of waiting period and months during the year coverage was available
  - monthly premium for the lowest cost option in each of the enrollment categories under the plan
  - employer share of the total allowed costs of benefits provided under the plan
  - number of full-time employees for each month during the calendar year
  - name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans
What’s Delayed?

Section 4980H Employer Shared Responsibility Provisions

1. Requirement to **offer coverage** to all FT employees and their dependents or face $2,000 per employee fine

2. Requirement to **offer minimum essential coverage** (60% Actuarial Value/Minimum Value) or face $3,000 fine per employee obtaining a subsidy

3. Requirement to **offer affordable coverage** or face $3,000 fine per employee obtaining a subsidy
   - Employee contribution for single coverage does not exceed 9.5% of household income
What’s Delayed?

Play or Pay Pushed Back

• 50-99 full time employees delayed until 1/1/2016
  - Allowed to exclude first 30 employees from fines if not offering coverage

• 100+ full time employees delayed until 1/1/2015
  - For 2015 allowed to exclude 80 full time employees from fines if not offering coverage; goes down to 30 employees in 2016
What does this mean?

1. Employers do not have to offer coverage to all FT employees until 2015/2016
2. Coverage does not have to meet the Minimum Essential Value of 60% until 2015/2016
3. Coverage does not have to meet the Affordability Safe Harbor until 2015/2016
4. Individuals can still get exchange premium assistance in 2014
5. All other ACA provisions are still in effect
What is still in effect?

Comparative Effectiveness Research Fee (PCORI)

Amount of fee:

• $1 per covered life in 2012 and increased to $2 in 2013. In 2014 through 2018, the fee will grow based on increases in the projected per capita amount of National Health Expenditures.

Fee Due Date:

• July 31, 2014. This fee must be reported and paid through IRS Form 720.
What is still in effect?

Calculation of Fee:

1. **Actual Count Method** – add the number of lives covered each day of the plan year and divide by number of days in the plan year.

2. **Snapshot Method** – add total lives covered on a date in each quarter of the plan year, or an equal number of dates for each quarter, and divide the total by the number of dates used.

3. **Snapshot Factor Method** – Same as Snapshot method, but tally single coverages and set aside. Multiply all non-single coverages by 2.35 and add to total of single coverages. Nearly always results in lower count.

4. **Form 5500 Method** – use the number of participants reported on the Form 5500 for that plan year.
What is still in effect?

PCORI Fee

Self-funded Plans
- TPAs are not allowed to calculate or remit on behalf of plan sponsor
- Anti-double counting rule for self-funded plans with HRAs

Fully-insured Plans
- Insurance carrier will calculate and pay, but will pass on the cost

Plans sponsors should build this expense into their benefit plan budgets

This fee is not tax deductible and may not be paid out of plan assets
What is still in effect?

Transitional Exchange Reinsurance Fee

Purpose of Fee:

• To help stabilize premiums in the individual market during the first three years of Exchange operation (2014 through 2016).

Amount of Fee:

• Will be based on a national contribution rate, which HHS will announce annually. For 2014, HHS proposes a national contribution rate of $5.25 per month ($63 per year).

Fee Due Date:

• Submit an annual enrollment count to HHS no later than Nov. 15th. Within 15 days of submission (or by Dec. 15th), HHS notifies plan sponsor of required reinsurance amount due. Payment must be remitted to HHS within 30 days of the date of HHS’ notification.

Fee Calculation:

• Average number of lives can be calculated based on the Actual Count, Snapshot, Snapshot Factor or Form 5500 Methods.
What is still in effect?

Fee Calculation Example:
- 790 Actual Lives (Employees, Spouses, Dependents)
  - 102 Employee Only
  - 87 Employee +1 contracts
  - 127 Family contracts

Snapshot Actual Method
- **790 Members** x $63/Member = $49,770

Snapshot Factor Method
- Separate single contracts
  - 102 Employee Only
- Add non-single contracts and multiply by 2.35
  - 87 + 127 = 214; 214 x 2.35 = 503
- Add singles and non-singles
  - 102 + 503 = 605 Members
- **605 x $63/Member = $38,115, SAVINGS OF $11,655**
What is still in effect?

Transitional Exchange Reinsurance Fee

Self-funded Plans

• TPAs may calculate or remit on behalf of plan sponsor

Fully-insured Plans

• Insurance carrier will calculate and pay, but will pass on the cost

Plans sponsors should build this expense into their benefit plan budgets

This fee is deductible and DOL has also confirmed that they will be a valid plan expense under ERISA and may be paid from plan assets
What is still in effect?

Health Insurance Industry Fee- 2014

Purpose of Fee:
• The health insurer annual fee applies to "covered entities" engaged in the business of providing health insurance in the U.S. A covered entity is liable for the annual fee if its aggregate net premiums for covered health insurance policies exceed $25 million in the calendar year immediately preceding the year in which the fee is assessed.

• **Self-funded** employers are exempt.

Amount of Fee:
• $7 - $9 per member per month or 2.5% - 3% of premium
What is still in effect?

Automatic Enrollment Rules
Will apply to large employers that offer health benefits
  • Applies to GF and non-GF plans
  • Large employer = more than 200 employees

Will need to automatically enroll new employees and re-enroll current participants

Adequate notice and opt-out option will be required

DOL:
  • Regulations were not ready to take effect in 2014
  • Employers not required to comply until regulations issued and applicable
  • Expect to see this in 2015 or 2016
Am I Subject to Play or Pay?
Did you average more than 50 full time employees for the year?
• If “yes”, you will be subject to Play or Pay in the following year
• If “no”, then you will not be subject to Play or Pay in the following year

Threshold formula to determine whether employer has over 50 employees factors in PT employees to determine FTEs
• Add all part time employees’ hours together and divide by 120, add this to the number of full time employees for the month
Calculate month by month for entire year and divide by 12
• Round down if not a whole number
Control Groups Must be Considered

• Controlled group member employees must be included for Play or Pay threshold test

Types of Control Groups

• Parent/Subsidiary
  - 80% common ownership

• Brother/Sister
  - 80% common ownership
  - 50% common ownership of voting rights

• Combined Group of Corporations
  - each corporation is a member of either a parent-subsidiary controlled group or a brother-sister controlled group; and
  - at least one of the corporations is the common parent of the parent-subsidiary controlled group and also is a member of a brother-sister controlled group
Employer Penalty Amounts

Employers that do not offer coverage to all full-time employees:

• $2,000 per full-time employee.

• Excludes first 30 employees (80 Employees for 2015).

Employers that offer coverage:

• $3,000 for each employee that receives subsidized coverage through an exchange.

• Capped at $2,000 per full-time employee (excluding first 30 employees or 80 employees in 2015).

Penalty amounts are NOT tax deductible to employers

Control group members are each responsible for their own penalties
Safe Harbor Plans

Avoiding Play or Pay

• Offer group medical coverage to at least 95% of full time employees and their dependents
• Meet 60% minimum actuarial value safe harbor
• Meet 9.5% employee contribution affordability safe harbor
Safe Harbor Plans

Offering Coverage to Full time Employees

• 2015 Transitional safe harbor relief temporarily lowers the 95% coverage requirement to 70% for one year only
  • Another reason NOT to comply too early!
Safe Harbor Plans

Offering Coverage to Full time Employees

• Not “full time” if under 30 hrs/wk
• Consider limiting some classes of employees to 29 hours/wk
• Would require more total employees to make up short fall of hours
• Increased burden to staff and retain work force
• Increased cost for workers’ compensation, other employee-related expenses
• Need to determine which classes of employee can be less than full time
• Review classifications of employees- who is full time and who is part time?
Safe Harbor Plans

Offering Coverage to Full time Employees

• Spousal Carve Out/Surcharge
  • Require spouses with access to their own employer-sponsored coverage to take other coverage or pay higher contributions
  • Carve outs are typically not permitted by state insurance depts. and are not available to fully insured plans
  • Surcharges are available to fully insured plans

Verify Eligibility

• Employers should verify whether dependents are eligible for employer-sponsored coverage, either separately or as part of an overall plan eligibility audit
Safe Harbor Plans

Minimum Economic Value Requirement

- A plan fails to provide minimum value if “the plan’s share of the total allowed costs of benefits provided under the plan is less than 60% of such costs”
- Approximately 98% of individuals currently covered by employer-sponsored plans are enrolled in plans that have an actuarial value of at least 60%
Safe Harbor Plans

Minimum Economic Value Requirement

• Employers need to determine Actuarial Value (AV) for the plan(s)
• AV calculators are available
• Depending on current plan costs and company wage structure employers can either adjust their existing plan(s) or create a separate “safe harbor” plan offering
• Coverage must be offered, but no one actually has to take it
  • Depending on corporate philosophy, employers may wish to make the safe harbor plan unattractive
Safe Harbor Plans

Affordability Requirement

• Employee contribution must be less than 9.5% of household income
  • Applies to cost of single coverage on lowest cost plan
• How are employers supposed to measure this?

Safe Harbor Available

• IRS has acknowledged the impossibility of an employer knowing what the household income is for each of their employees, so they have created three Safe Harbors
Safe Harbor Plans

Affordability Requirement

1. **Form W-2 safe harbor**: employee’s cost for self-only coverage under the plan does not exceed 9.5% the amount required to be reported in Box 1 of Form W-2.

2. **Rate of pay safe harbor**: employee’s cost for self-only coverage under the plan does not exceed 9.5% of employee’s applicable hourly rate of pay \( \times 130 \) hours (For salaried employees, monthly salary would be used instead of hourly salary multiplied by 130).

3. **Federal poverty line safe harbor**: employee’s cost for self-only coverage under the plan does not exceed 9.5% of the FPL for a single individual \( \frac{11,670 \times 0.095}{12} = $92.39/\text{month} \).
Safe Harbor Plans

Affordability Requirement

• A safe harbor plan meeting the 60% value requirement can have a lesser benefit than the plan you currently offer and would likely cost less, making it easier to meet the 9.5% affordability test for lower wage employees

• An employee contribution equal to 9.5% of income may be needed for some lowest paid classes of employees

• Affordability does not apply to coverage other than single
  - Safe harbor plan with single-only contribution for all classes of coverage

• Beware of offering only the base safe harbor plan to low paid employees- can trigger 105h issue for self-funded plans
Look Back Safe Harbor

To Count or Not to Count?

- Employers subject to Play or Pay will need to count fulltime employees on a monthly basis or use the Look Back/Measurement Period Safe Harbor
- Employers may choose a period of between 3 and 12 months to measure who is fulltime and who is not
  - Final rules state you may also use any 6 month period
Look Back Safe Harbor

- Employees who average 30 hours or more per week during the measurement period must be treated as fulltime during the following Stability Period as long as they are still employees.
- Stability Period must be at least 6 months long or as long as Look Back Period.
  - Look Back 3 months – 6 months, Stability Period = 6 months.
  - Look Back 7 months to 12 months, Stability Period = Look Back.
Look Back Safe Harbor

• Employers should use a Look Back that is right for their industry and employee population

• Many employers are using a 12 month Look Back to deal with “seasonal” employees who work more than 120 days per year
  • Example: Employee A works April through October (30 weeks, 1050 hours total) every year and averages 35 hours per week. These same hours averaged over 52 weeks drops the average to 20 hours per week.
Look Back Safe Harbor

• Employers are permitted to use an additional Administrative Period of up to 90 days between Look Back and Stability Period
  • Cannot alter length of Look Back or Stability Period
  • Cannot create a gap in coverage and **must overlap** with prior Stability Period
  • Hint: Stability Period should coordinate with plan year
Look Back Safe Harbor

Example

12 month Look Back is October 15, 2013 to October 14, 2014
Administrative Period is October 15 - December 31, 2014
Stability period is calendar year January 1, 2015 to December 31, 2015
Look Back Safe Harbor

Look Back Groups

• Existing Employees
  • Current employees should be measured as a group with the Look Back and Stability Period coordinating start/end of coverage with the plan year
  • Review employee classifications prior to 2015

• New Hires
  • Employees who are hired as fulltime, i.e. reasonably expected to work at least 30 hours per week, need to be added to the medical plan
  • Employees who are hired as part time or variable hour can be measured and averaged individually based on their date of hire before putting them on the medical plan
How do I Measure?

- Salaried fulltime are assumed to work at least 30 hours per week
- Hourly - draw information from your HRIS system or payroll provider
Look Back Safe Harbor

Teachers and employees of educational institutions

• Special rules for “employment breaks”
  - Period of at least 4 consecutive weeks without credited service hours
  - Carved out of Look Back
  - Paid breaks are included

• Must count reasonable prep time, not just teaching hours

Truck drivers and others not paid by the hour

• Need to track hours or develop a proxy variable
  • E-logs
  • Reasonable mileage conversion (until further guidance provided)
    • 80,000 miles per year/45 mph = 1778 hours, divided by 52 weeks equals 34 hours per week
Look Back Safe Harbor

Temporary employees

• Unless employed by outside temp agency, they are your employees

• Cannot be part time for you and part time for the temp agency to keep an employee under 30 hours per week
Self-funding Opportunities

Self-funding is expected to increase under the ACA because it provides employers with more flexibility than fully-insured plans.
Self-funding Opportunities

Self-funding options available for smaller employers

• New products available enable employers with fewer than 100 employees to self-insure
  • Aggregate-only coverage
  • Funding options to avoid peaks and valleys that resemble fully-insured premiums
  • No laser options
Self-funding Opportunities

Avoiding ACA Mandates

• Self-funded plans do not have to:
  • Offer Essential Health Benefits (EHBs)
  • Follow State-mandated external review rules
  • Avoids the Health Insurance Industry Tax
Self-funding Opportunities

Avoiding the Premium Explosion

• Self-funded plans can set their own funding rates
• ACA underwriting limitations will cause fully-insured plan premiums to rise dramatically
  • Age-rated groups are limited to 3:1 differential
  • Young healthy groups will get increases while older, sicker groups may see some decreases
Control costs by promoting good health

• Employers need to use the tools still available to them to manage plan costs, especially if plan populations rise
  • No change in employee behavior means no change in medical trend – cost increases
  • Employers can’t afford the cost of doing nothing – 2018 Cadillac Tax
• Healthy employees, spouses, and dependents use fewer health care resources
• Properly structured health risk assessments enable employers to inject accountability for the benefits being provided
Integrated Wellness

Control costs by promoting good health

- Provide tools for employees to better manage their health
- General wellness incentive increased to 30% in 2014
- Additional 20% incentive available for tobacco prevention
- Employers need to apply choice architecture and behavior-driven contribution strategies to develop lower-risk medical plan participants to maintain affordable benefit plans
  - Employees who won’t manage health will shift off plan or to the insurance exchange – no penalty to the employer if they have met the required safe harbors
- Persons not participating in a wellness program could be limited to the safe harbor plan
Case Study

C&B Client Case Study

• 2,000 U.S. based Employees
• 23 U.S. Locations
• Union and non-union workforce
• Predominantly male workforce
  with average employee age of 45+
Case Study

Plan Cost/Premiums Per Covered Employee

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What If Trend Had Been 8% Per Year?

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<td>2012-13</td>
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Plan Cost Savings Actual vs. Trended (millions):

$1.0, $3.5, $3.8, $5.7, $8.4

$22.4 Million of Plan Cost Savings Over 5 Years
# The 5-Part Intervention Model

<table>
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<th>STAGE</th>
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<th>% of costs</th>
<th>% of costs</th>
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<td>Chronic/ Catastrophic</td>
</tr>
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1. Healthcheck360 Biometric Screening & HRA
2. Review of Findings Call
3. Physical Activity Program
4. Health Coaching
5. Condition Management
Current Plan Choice & Premium Levels - Choice Architecture

LEVEL 1 - PARTICIPATE IN HC360 & ROF CALLS

Participate in HC360 Screening

LEVEL 2 - OVERALL HEALTH MANAGEMENT/IMPROVEMENT

Score 71+ or Improve 5 Points

Score <70 and Don’t Improve 5 Points

LEVEL 3 - CARE COMPLIANCE

Have a Chronic Conditions

ALL PLANS LOWEST PREMIUMS

ALL PLANS MIDDLE PREMIUMS

PLAN 4 (SIN BIN) HIGHEST PREMIUMS

ALL EMPLOYEES
Next Steps

• Review and update employee classifications
• Identify who you have to count for Look Back
• Determine how you will treat new employees
  • Use a 12-month individual Look Back?
• Pick a Look Back Period that gives you the best result for current employees
  • Most employers are using a 12-month Look Back
• Determine how much time you need for your Administrative Period
• Make sure your TPA/Carrier and HRIS system all can get you the reporting you will need
• Be prepared, but remain flexible- it could all change
For more information contact your Cottingham & Butler representative