



The New Era of U.S. Health Care:

What the Affordable Health Care Act Means for You

Webinar Transcript

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The Patient Protection and Affordable Care Act (ACA) became law in 2010, but questions abound. What does it mean for companies and the greater health care community?

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Webinar At A Glance

Although the Patient Protection and Affordable Care Act (ACA) was passed in back in 2010, questions abound. What does it mean for companies and the greater health care community?

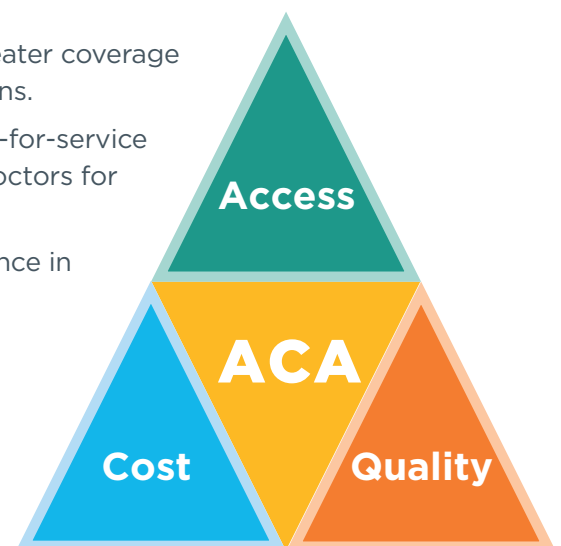
Castlight Health hosted a webinar, *The New Era of US Health Care: What the Affordable Care Act Means for You*, in April 2013 to help companies begin to understand this important legislation. Here are five highlights.

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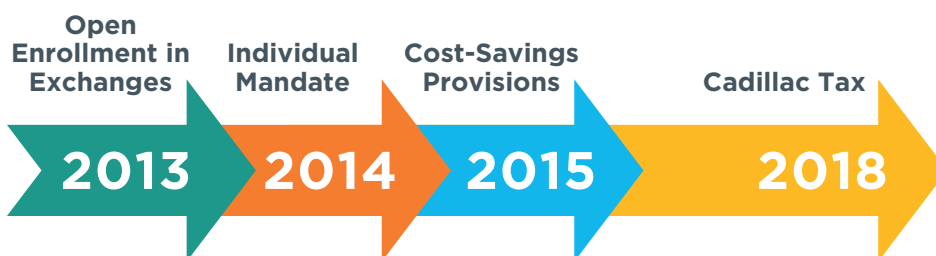
The ACA tackles three big health care problems: access, cost, and quality.

Core provisions of the ACA include:

- **Expanding access** through state exchanges, greater coverage from federal programs, and consumer protections.
- **Controlling costs** by changing the Medicare fee-for-service payment system to other systems that award doctors for improving quality and lowering costs
- **Improving quality** by penalizing poor performance in hospitals, creating incentives for wellness and prevention programs, and investigating new approaches for better, lower-cost care



Rollout of ACA Provisions

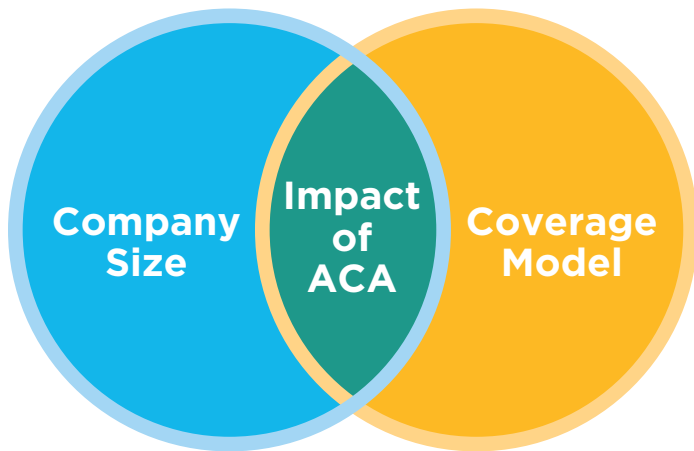


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ACA provisions roll out over the next decade.

Health care reform is a process. Some important dates include:

- **October 2013:** The open enrollment period begins for buying health insurance through exchanges.
- **January 2014:** The individual mandate takes effect.
- **2015:** Important cost provisions are enacted, including the hospital-acquired condition fee for complications and bundled payments.
- **2018:** The “Cadillac” tax plan takes effect.



3 The ACA has both direct and indirect effects on companies.

The impact of ACA's effects on companies depends on two things: size (defined by number of employees), and the type of insurance coverage (e.g., fully insured or self-insured models) it offers its employees.

4 A company's decision to offer health insurance to its employees is complex.

Companies need to decide if, how, and at what level they provide insurance to employees. Each coverage choice has cost implications. There may be penalties for not providing coverage, or for providing coverage that doesn't meet minimum value and affordability requirements. Companies need to consider the impact of the Cadillac tax, which takes effect in 2018, when deciding to offer a very rich benefit plan to employees.

5 Companies have many different coverage options under the ACA.

The marketplace is changing dramatically. Coverage options include private exchanges, Health Reimbursement Accounts (HRAs), traditional coverage (fully insured or self-insured), and small business Health Options Program (SHOP) exchanges.

Download
the webinar
replay here:
<http://ow.ly/kV8of>

Introduction



A recording of this presentation, along with a copy of the slides, will be sent to you following the webinar.

The New Era of US Health Care: What the Affordable Care Act Means for You April 4, 2013

Wendy:

Hello, everyone and welcome. My name is Wendy Rennin, and I'll be your host for today's Castlight Health webinar, The New Era of U.S. Health Care: What the Affordable Health Care Act Means for You. Just a few housekeeping items before we begin the presentation. All your phones will be muted during the session. If you have any questions or technical issues, please submit them via the question control box on your right side of your screen. We'll respond to technical questions throughout the webinar, and our speakers will answer content related questions following the presentation. Finally, you'll receive an email following the webinar containing the recording of the presentation along with a copy of the slide deck.

With that, let's get started. I'd like to introduce you to Castlight's chief marketing officer, Peter Isaacson. Peter will say a brief word about Castlight and then introduce our featured speakers, Bob Kocher and Gary Bacher. With that, Peter, please take it away.

Today's speakers

The New Era of US Health Care: What the Affordable Care Act Means for You



Peter Isaacson
Chief Marketing Officer, *Castlight Health*



Bob Kocher
Partner, *Venrock*



Gary Bacher
Principal, *Healthspieren, LLC*

Castlight Health Overview

Castlight Health

Our mission is to create health care consumers.



Let's look at
health care
differently.

Offering

Health care management suite that helps you reduce spending while improving quality of care

Difference

- Configured for your programs and personalized to each employee
- Best-in-class product that enables benefit designs for any size company
- Experts at driving real behavior change

Results

- Up to 80% engagement rates
- Has enabled employers to achieve up to 13% savings

Peter:

Thanks, Wendy, and thanks everyone for joining us for this webinar. We have a great turnout today. Before I get to the main event, I just wanted to give everyone a brief overview of Castlight. At Castlight, we're all about helping employers lower their spending while improving the quality of care. This is really a mission for us. I think everyone on this call has seen the data on price variation and markets for basic procedures and services, or you've seen the data on how little correlation exists between cost and quality in health care market, or more recently maybe you've read Steven Brill's article in Time magazine in which he reported on the high cost of health care in the United States. At Castlight, our mission is to really help solve this, to give companies and their employees the information they need to make better health care decisions.

Now as we've been out talking to various employers and customers, one of the consistent themes that we've heard is the Affordable Care Act. What is it? What does it mean, and what do I have to do as an employer? There's just a lot of confusion out there right now. To help employers and really the extended health care community that's on this call and this webinar right now understand this important legislation we have with us today two experts on the Affordable Care Act.

Our first speaker today is Bob Kocher. Bob is a partner is at Venrock and focuses on health care IT and services investments. Prior to Venrock, Bob served in the Obama administration where he helped shape health care reform legislation by focusing on costs, quality, and delivery system reform, and meaningful use policy around health care IT.

Our second speaker today is Gary Bacher. Gary is a principal at Healthsperien, a consulting firm he co-founded. He also serves as the director of the AHIP Foundation's Institute for Health Systems. He focuses on regulatory and public policy and transactional issues in the health care industry. He's also been deeply involved in health care reform. With that, let's begin the presentation. Bob, please take it away.

What Happens Next? The Implications of Health Reform on Employers



Bob:

Thank you, Peter, and thank you everyone for joining us today. It's a real pleasure to talk you about health care and how it's changing. I think health care has changed more actually in the last three years than it probably has in the last 30, and that's making, I think, health care better and is happening faster than people may expect.

I'd offer you three points of I think hope and excitement, and then jump in a bit more as to what the ACA does and how it's going to work. The first one is that costs are slowing down in America. The last three years have been the slowest rate of cost growth that we've had in the last 15, and that's exciting because it means that people have lower premium increases, less cost sharing, and we're seeing signs of competition actually happening in health care.

The second thing that's really exciting is that there's 1.3 million less uninsured people. We've had the biggest increase in employer-sponsored coverage since 1999, and that's promising because more people have access to great care.

The third is that the care is getting better. Readmissions have been reduced. In fact, we've seen a reduction in readmissions by almost 2% in just the last year on the heels of CMS beginning to have the penalties to hospitals on readmissions, and that's a great sign because that's fewer people having to go back unexpectedly for care that was unnecessarily imperfect.

The fourth one is a lot more interest in primary care and a lot more interest in non-fee for service payment models. The revolution in health care is really all around primary care and how do we help patients avoid high-cost, high-complexity care through better primary and secondary treatments.

The ACA Is Being Implemented



Now let's take a look at the next slide. The passage of health care reform has been tremendous uncertainty around what's going to happen the and when will it happen. Is it really going to be law? I happily say, from my perspective, yes, it's going to be law. It's going to be enacted and we should now think through how to work in an ACA world and anticipate the changes that will over the next several years. With the reelection of President Obama you can be confident that

The individual mandate is constitutional and is going to take effect beginning in 2014.

this law will implemented on the schedule that the law laid out, that we won't have repeal or replace or new alternatives passing in the near term. With the Supreme Court decision we've learned that the mandate's constitutional and going to take effect beginning in 2014. While states have latitude over Medicaid expansion, I'd expect that most states will extend Medicaid as well over the next several years.



What Is the ACA?

Let's go to the next slide. I would start by saying while the passage of the law took longer than many expected and was more cantankerous and certainly much less well understood by the public than I might've expected, I want to talk through now what are the core elements of health care reform and how does it all fit together?

Let's go to the next slide.

The ACA Is Designed to Tackle Access, Cost, and Quality



The basic premise of the Affordable Care Act is that the best way to tackle health care in American is to tackle the three big problems that we face together. The first one's access. How do you make sure the people have access to primary care, hospital care, a chronic disease care, preventative care? Do you get access? How do we afford it? Then, how do we make sure that people are getting great care, care that actually delivers better outcomes, more consistency and a better experience?

The premise of this law is to take advantage of the fact that we spend more than any country does per capita, twice as much, as any other country and take some of that spending of which between 20% and 30% most people say is unnecessary or wasteful and direct that into actually those savings into providing affordable access to care for those without insurance. Then, how do we make sure that the care that people get is spectacular? Across America, what we have today is some of the very best hospitals in the world. Unfortunately, we also have more variation than almost any country has in the world, and so how do we reduce that variation in health care to make sure that evidence-based care is happening more reliably and make sure the economics makes sense too, that hospitals and doctors can invest in system of care that remind you, that anticipate complications before they happen and avert them and make sure that the hand-off that happen all so often work even better. The idea here is that we will reduce the rate of health care cost growth to the tune of 50 billion dollars every year, direct that into access, raise the new revenue to support access, create more dynamic markets so that more people shopping and buying, and then create economic incentives for the providers—the hospitals, the doctors, the insurance companies, and the suppliers

to create products that work better and work better together so the system is more coordinated, and that that together will reduce the rate of health care cost growth and improve productivity for our country.

Let's go to the next slide and talk to some of the specifics.

Core Provisions of the ACA

Core provisions

- Access**
 - Extends coverage through state exchanges
 - Expands coverage from federal programs
 - Protects consumers
- Cost**
 - Reduces Medicare Advantage payments to create parity with FFS
 - Reduces growth of hospital payments to reflect productivity
 - Incentivizes bundled payments, ACOs, and shared saving models of reimbursement
 - Streamlines administrative processes
- Quality care**
 - Penalizes poor performance in hospitals
 - Incentivizes wellness and prevention
 - Funds Center for Innovation to investigate new approaches for better lower cost care

On access, which is the thing that most people have spent the most time thinking about, that perhaps less important in the longer term than the cost and quality provisions. In access, beginning next January there'll be a mandate for all Americans to buy insurance. If you're an individual, you'll be able to buy insurance on exchanges which are websites, which will remind of e-commerce websites, where you can select from bronze, silver, and gold plans. Based upon your income, you will get a subsidy to help make sure the premium's affordable, and also based upon your income get a cost-sharing subsidy to defray some of the out-of-pocket costs if you have an income below 250% of poverty. Either state run programs, and each state will have some variation and latitude about they exactly set them up and which plans are offered. Broadly speaking, they will have bronze, silver, and gold plans. The bronze plan equating to an actuarial value of 0.6 or covering 50% of one's costs, silver 70%, and gold a 90% level.

On the cost side, the most important things to highlight is the fact that the Medicare fee-for-service payment system is changing from fee-for-service to a variety of other systems that will award doctors for better quality and lowering costs. These include bundled payment programs, which begin in 2015, accountable care organizations, patients that are in medical homes, and then the Medicare shared savings program that many have heard about.

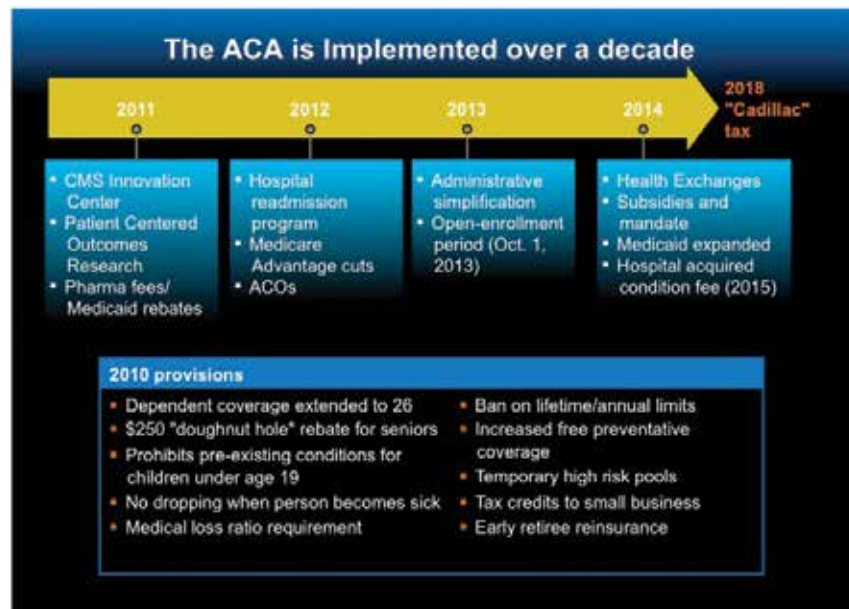
On the quality side, supervisions that I've highlighted are the readmissions reduc-

... small changes in where employer-sponsored people go will have really big effects on how suppliers compete in the market. You should realize that the market power that you have is disproportionate to your size.

tion incentive that hospitals will no longer get extra money when patients are readmitted, rather it'll be a penalty when the patient's readmitted within 30 days, and also Medicare will stop paying for hospital complications like infections and surgical mistakes.

Let's go to the next slide.

The ACA Is Implemented Over a Decade



This program is rolling out over a decade. It's important to think about health care reform as a process. Many of the insurance market regulations were enacted in 2010—things like extending coverage to 26-year-olds, free preventative care, out-of-pocket maximums being taken away. Medicare began a very ambitious and exciting innovation center, which is basically an \$11 billion venture capital fund where Medicare can test any new treatments and approaches. If they save money and are quality promoting, they can actually implement them across the entire program without going back to Congress, which speeds the rate of innovation in Medicare. I think the main thing is being followed on by the private sector.

In 2012, the readmission reduction program began and Accountable Care Organizations began. You've probably been following the news around Medicare Advantage. The rates at which Medicare Advantage plans increase are going to be cut over the next decade, and there's been a lot of debate over exactly what rate and how to make the assumptions. Some of the cuts began last year and there are more planned for 2013 and 2014. Beginning in October, October 1, 2013, is when the open enrollment period will happen for individuals who want to buy coverage on the exchange. There's also a host of things around administrative simplification right at the billing and collecting and data collection and quality measurement reporting, which are also happening this year and next. Then, 2015, is when the hospital acquired condition fee for complications is enacted as well as bundled payments. 2018 is the year at which the Cadillac tax will take hold and Gary's going to talk a bit about that in his remarks. You can see this is going to be a process of evolution which occurs over the next decade which these are the ones that you should probably keep your eye on now as an employer.

Next slide please.

What We Know For Sure



What we know for sure...

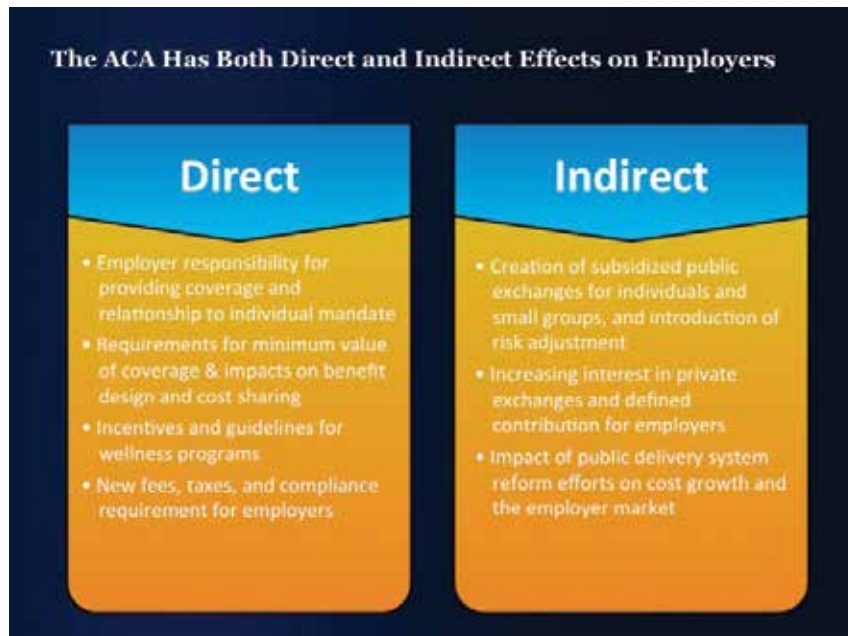
- 1 Labor productivity will improve
- 2 Demand for hospitals will fall
- 3 Small changes in commercial patients matter
- 4 Risk will shift to patients and providers

When you put this altogether, there's a handful of things that we know for sure. The combination of pressure on the ability to raise prices and raise reimbursement rates is going to lead towards major focus from the part of providers to improve labor productivity. The new payment systems that reward doctors for spending less money, and for reducing readmissions and for averting complications will reduce the demand for hospitals, even when you account for the fact that we're aging of the population.

The next thing to highlight is that because commercial patients today account for virtually all of the profits, small changes in where employer-sponsored people go will have really big effects on how suppliers compete in the market. You should realize that the market power that you have is disproportionate to your size.

Then, shift economic risk is going to shift from payers to patients and providers who will have alignment around coming up a cost effective approaches to care and being more judicious and value conscious on how they consume their health care.

The ACA Has Both Direct and Indirect Effects on Employers



When you put this all together, next slide please, employers can think about this as a series of direct and indirect consequences. The direct ones are things that you will actually have to do and be responsible to in the law. The indirect ones are perhaps even more interesting and important which are things happening in the health care ecosystem and marketplace that will create opportunities for you as employers and also create challenges perhaps.

With that, I want to go to the next slide.



Thank you for your time and attention and hand it over to my good friend and colleague, Gary Bacher, who's going take us through some of the important direct and indirect consequences. Thank you very much, and Gary I look forward your remarks.

When is your company subject to employer responsibility requirements and/or penalties? What are the coverage options, and do these relate to health care reform?

Implications of Health Care Reform



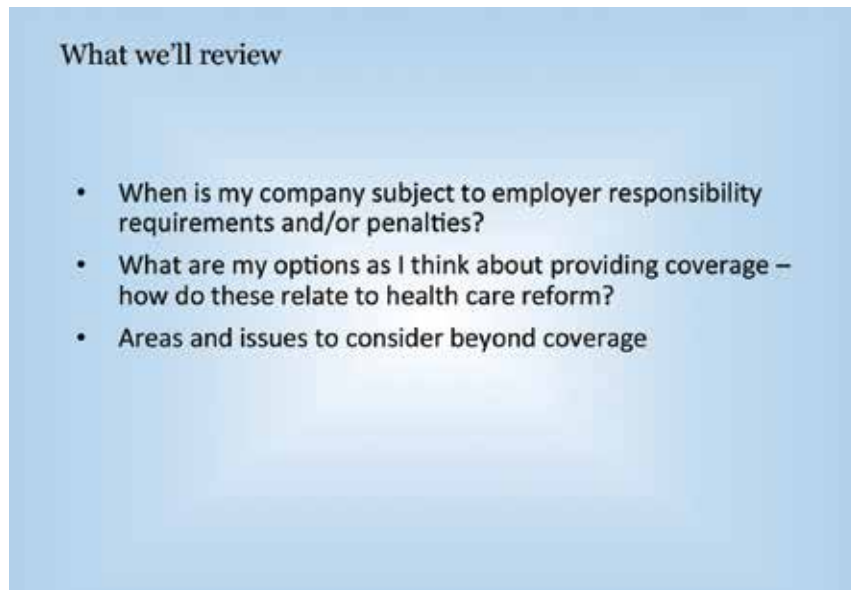
Gary:

Great, thank you so much, Bob. Really a great pleasure to be here with you. I'm going to now pick up where Bob left off, particularly with respect to his focus between as Bob put it the direct and indirect consequences. As you'll see, there's quite a bit of detail that we have in some of these slides. My philosophy in trying to talk about this, though, is really to focus a little bit more on the key concept. I think you can get the key concept across that it becomes easier to follow some of the rules without, in a sense, getting stuck in the minutiae without really having a compass.

What I'm first going to try to do as we go through this is try to provide a little bit of background about why these particular provisions exist, creating the context, and I think that will make it a little bit easier to understand where the real roles and regulations come from.

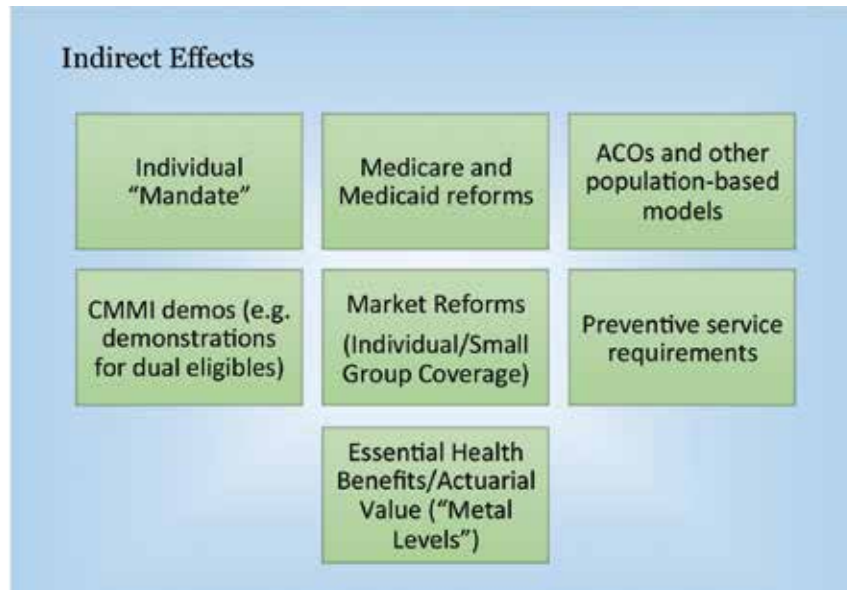
Then, at the end of the presentation, you'll see we've given you a list of reference points if you want more detail of places you can look to learn more. But I want try to provide a little bit of a guide with respect to how to think about these key issues.

Next slide, please.



First off, a little bit of a road map before we get into it with respect to what we'll review. One of the things that obviously of direct interest for employers is when is my company subject to employer responsibility requirements and/or penalties known under the regulations of obtainment? We'll talk a little bit about that. What are my options as I think about providing coverage? As an employer, what choices might I have, what are those "big picture" options that are available with respect to the provision of coverage and how do those choices relate to health care reform. Then, finally, we want to come back to thinking about some areas and issues to consider beyond coverage to the point that Bob was making with respect to the indirect effects which I think are very important to consider. Next slide, please.

Indirect Effects



To level set a little bit before we get into some of the direct effects, I think it's helpful to talk about some of these indirect effects. Bob already laid the foundation. I'm going to come back to emphasize a few points that I think will also make the discussion about the direct effects go a little bit more smoothly.

When you first look at this set of tiles, if you will, one thing you'll notice is that we have a real mix of things that are occurring with respect to the delivery system side of the house in terms of payment and delivery system reform. Those reforms are absolutely essential. We have those tied together with changes that are occurring with respect to new methods of providing coverage and new marketplaces, specifically, for instance, the exchange that Bob mentioned, and as I'll talk about, we have really different kinds of exchanges. We have the public exchanges known as the ACA exchanges that the Affordable Care Act has created, but we also have a very big movement towards private exchanges, which many of you have heard something about. We want to make a little bit of a distinction between those and talk about them.

One thing I think that's becoming increasingly apparent from a policy perspective is that people, particularly large employers, are thinking about how, as a colleague once put it, "the peanut butter and the jelly go together." It's really how reform in progress in the health care system, how to do best marry together what's happening in terms of the develop of new coverage models in marketplaces with what's happening with respect to payment and delivery system reform. I think that will be one of the things to watch, is people figuring out a way to better join these two sets of reforms that sometimes occur on different tracks.

The ACA provisions that apply to you as an employer depend on the size your company (defined by number of employees), and the type of insurance coverage (e.g., fully insured or self-insured models) you offer.

The other level-setting comment I wanted to make, and you'll see this throughout the presentation, is that which provisions of the Affordable Care Act directly apply to you as an employer really depends in some respect with respect to whether you're a considered providing or a small employer or whether you're in the large group market or whether you're self-insured. Just as a general rule under the Affordable Care Act, the definition of "large group" will now be technically 100 or more employees. Until 2016 for virtually every state in the country, it's really up to 50 employees. Just to level-set, when we talk about "small and large," right now when we talk about "small" we mean quite small, so 50 or fewer employees. When we talk about "large" we then mean above 50 employees. Beginning in 2016, that's the Federal rule meaning the law of the land will be 100 or more employees will define the large group market.

The other concept that I'm sure you're familiar with is the concept of self-insuring. The concept of self-insuring is the distinct from the concept of fully-insured coverage. In the case of fully insured coverage, and employer is purchasing coverage from a licensed insurer and that insurer is basically taking the risks for providing the coverage.

In the self-funded context, what's happening is that the employer, typically a large employer who has a significant or sufficient list pool to be able to have a good estimation of expected costs, that large employer is carrying the risk itself and it's typically hiring what's known as a TPA, a third-party administrator, which may or may not be a company that also provides insurance to help manage those benefits. As we'll see, many of the rules under the Affordable Care Act don't directly apply with respect to self-insured arrangements, but there are a number of provisions that do. One of the tricky things again in the ACA is thinking about what kind of coverage am I providing? Where do I fit in the marketplace in terms of understanding what rules apply to me?

Real quickly, and then we're going right into the meat of it, as Bob mentioned, some of the direct/indirect effects, from an employer standpoint, to really think about are, one, the individual mandate. That's the requirement that all individuals carry coverage or pay a penalty. Why is that important from an employer standpoint?

One of the reasons why that's important is that as you think about your employee, they need to satisfy mandate or they're subject to the penalty. That, if you will, raises the ante on employers with respect to thinking about how their employees are going to be getting coverage.

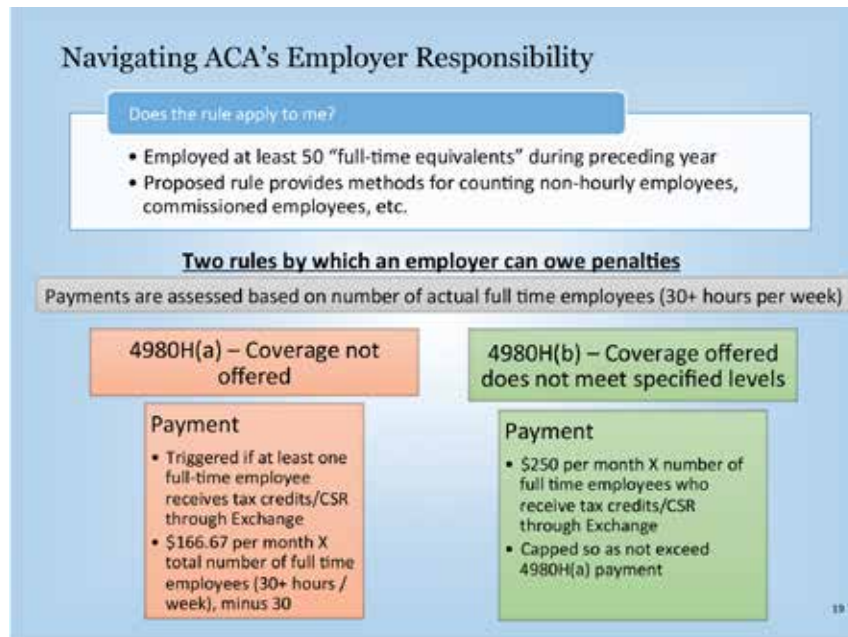
Two, the market reforms which we've identified, for instance, with respect to individual and small group coverage, this is a real sea change in terms of what's happening in most parts of the country with respect to the provision of fully-insured coverage. The rules that I'm referring to here really apply primarily with respect to individual and small group coverage. You might say, "Why is it really important to me?" The marketplace is changing so dramatically what may happen in the future is that the way employers now think about the consequences for their employees, of providing coverage or not, may change. In particular, in most places around the country today, individual coverage is provided on an underwritten basis. What that means is that the coverage doesn't necessarily have to be provided. Someone has to go through the underwriting process in order to get the coverage and the premiums would vary based on somebody's health status. That's most places in the country.

From an employer's perspective, if you're concerned about your employees being able to get coverage, in most places around the country today there's a concern that if we don't provide the coverage our employees won't be able to get coverage in individual markets. That will fundamentally change beginning in 2014, and that may indeed over time change the way that employers look at the provision of coverage.

The next one that I mentioned to you with some emphasis is the essential health benefits and actuarial value. Bob mentioned these, these are the "metal levels. You've probably heard of it as the bronze, the silver, the gold, the platinum plan. Basically, what's happening is that we have a big change with respect to the actual coverage itself. The essential health benefits is generally referred to as the types of services that are being provided, the so-called EHB provision, specifies 10 categories of services that have to be provided. The actuarial value is really a provision that talks about the generosity of that coverage. It's really saying what percentage of covered claims have to be paid out in benefits for a standard population. While the EHB and actuarial value provisions don't apply to the large group markets directly, they only apply to the self-insured market, it's such a big change. You can there's some bootstrap ways that they do apply, so that's a big change that people may indeed begin talking about these things in those terms. Even if you're a large employer, these concepts are likely to begin spilling over.

Let's go to the next slide.

Navigating the ACA's Employer Responsibility



With that, I know want to get into some of the direct effects. The first one what we're going to talk about is the Affordable Care Act's employer responsibility provisions. To understand what's going on here, again, I'm going to avoid dwelling on some of the detail that's on the slide for you and we've provided the resources. To understand what's happening here, the first thing is to realize is that there's a presumption under the ACA that says that people who are offered employer-sponsored coverage will take that coverage. If you're offered employer-sponsored coverage as an employee, then that's where you'll get your coverage. There's this expectation that that's what will happen and that's how they'll fulfill the mandate. There's also as a result of that, a firewall that's created with respect to employees and their accessing exchanges, in particular, they're accessing the premium subsidies and cost-sharing subsidies that are available on those exchanges. Let me just mention that a little bit more.

There's this concept to the firewall that says that, in most cases, if an employer, for instance, offers coverage while their employee could go through an exchange (and here I mean ACA exchanges) instead of paying coverage, there's nothing that prevents them from doing that. They won't qualify for the premium assistance or the subsidies unless some different conditions apply. The corollary to this is that the employers if they're either not providing coverage or they don't provide coverage that meets specified levels, they'll be responsible for making the payment to defray the cost of those premium subsidies from cost-sharing reductions.

Again, there's quite a bit of detail on these slides. What I would suggest to you is the big question here, first question, is does the rule apply to me? That depends on your size. As we were talking before, if you're a small employer, these provisions won't apply to you. If you're a large employer they will. Small and large being defined by whether you have 50 full-time equivalents, and that's a concept, this idea of an FTE as opposed to a full-time employee that addresses those full-time and part-time employees. Different as we say in the slide with respect to how the payments themselves are assessed. Again, basic ideas that you could be subject to penalties for two reasons: either you're not providing coverage at all or you're providing coverage that doesn't meet specified levels.

Next slide, please.

Minimum Value, Affordability, Relationship to "EHB/AV"

Minimum Value, Affordability, Relationship to "EHB/AV"

To avoid penalties, coverage must meet minimum value and affordability requirements.

Minimum Value	Affordability
<ul style="list-style-type: none">• A measure of whether the plan's cost-sharing is sufficiently generous• On average, the plan must pay at least 60% of an enrollee's total allowed costs• Large employers not technically subject to EHB/AV	<ul style="list-style-type: none">• Required contribution can't exceed 9.5% of employee's household income• If IRS "safe harbors" are complied with, employer can assume coverage meets the requirements

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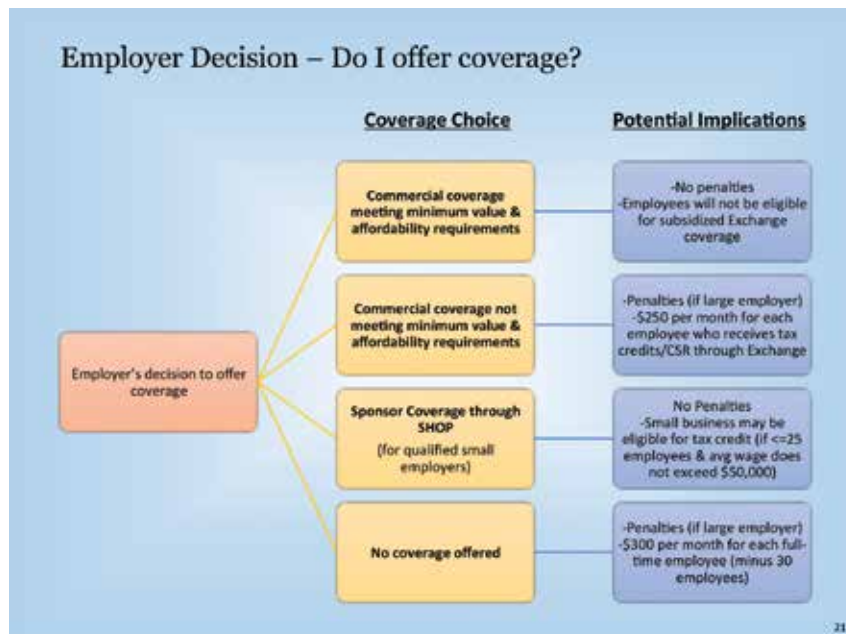
Just to pick up on this point, and not to dwell on tremendous detail, one of the situations where you might as an employer offer coverage, but the coverage wouldn't be sufficient for an employee to have to take up the coverage from you, but the employee, for instance, would be able to go to the exchange and access the subsidies, which quite frankly sometimes would clearly be in the employee's best interest. There're two rules that apply in terms of determining whether the coverage is adequate from the employer standpoint. Again, if the coverage is not adequate, if it doesn't meet these requirements, what happens is that if one of your employees goes off and accesses the exchanges and gets the premium subsidy or a cost-sharing reduction you'll be responsible for making those employer responsibility payments.

The first test here is with respect to minimum value. Very similar to actuarial value that I was mentioning before, the issue here is whether on average the group health plan is providing at least or paying at least 60% of the value of an enrollee's total allowed costs. This is a little different from actuarial value. There's going to be a calculator that's made available to employers and their actuaries to help them figure this out. One of the questions here is 60% of what? It's a little bit of an open-ended question because there's a bit of flexibility with respect to what's the baseline for the 60%.

The other test that gets applied is affordability. The basic idea is that the required contribution can't exceed (meaning the required contributions of the employee) can't exceed 9-1/2% of the employee's household income. A couple of things on this. One, the test is only with respect to employee or self-only coverage. The 9.5 percent of the coverage for that employee, not the coverage with respect to their dependents. That's raise a lot of concerns from a policy perspective about what this does with respect to people's access, but the rule remains that it's 9.5 percent of the employee's household income with respect to self-only or single coverage. There are some safe harbors. There are complications around, gee, how will the employer actually know what the household income is. Basically, the employer can look, for instance, at the W2 wages, so people have recognized some of the concerns and have tried to respond.

Next slide, please.

Employer Decision to Offer Coverage



This slide, we're now looking at, we're summarizing and saying, "What are my big choices now as they relate to providing coverage and what are the implications?" Now we've covered much of these points, but just to summarize, what we see here is that in the first block with respect to providing commercial coverage and meets these minimum value and affordability requirements that I was just talking about, if you do that you're providing full coverage, if you will. There's really no opportunity for payments or penalties, and your employees are going to be taking their coverage from you. They wouldn't be able to access the subsidized coverage through an exchange. It could be case that you're offering coverage that doesn't meet these requirements. Then, as we mentioned before, these potential payments would be required.

If you're a small employer, you would be able to sponsor coverage through what's known as a "SHOP exchange." That's a small business health options program. That's the small business side of the ACA exchanges. For now, again, the definition in terms of can you access the exchange, in most cases is going to be are you 50 or fewer employees. In the future, beginning, for instance, in 2017, it's possible depending on the state that large groups will be able to sponsor coverage on the exchange. In 2016, as I mentioned, the definition will change so it will be groups of up to 100. Then, the last possibility is that you wouldn't offer coverage at all and you would be potentially responsible for these payments or penalties that I mentioned before.

Next slide.

Potential Coverage Options for Employers



The concept of a private exchange is that you as the employer are still sponsoring coverage, but you're trying to provide potentially more choice for your employees.

Where this leads us then, so what the options then that I have as an employer and, in some ways, how do these relate to what happens under the Affordable Care Act. I mentioned before that we're going to come back to this concept of providing coverage through a private exchange. I'll come back to that in a second. Another potential way that an employer can provide coverage is through an HRA or a health reimbursement account. We're going to talk about this for a second because one of the concepts here was that now that we've had those changes in the individual markets that I was referring to before, which means that as a result of the Affordable Care Act, everybody will be able to get coverage and the coverage and premiums won't vary based on their health status. If that's the case, then, as an employer, how about if I gave everybody a fixed amount of money and they can go buy their own individual coverage. Why isn't that a good idea, and would that be okay in satisfying the mandate? Can I actually do that?

There's a little bit of ambiguity on this, but that strategy appears like it could run into some problems from a regulatory standpoint. It deals with a complex set of rules around the fact that an HRA is itself a group health plan and whether it's fully insured or self-insured coverage, group health plans are subject to limitations where there can't be an annual limit on the coverage and there can't be a lifetime limit. That strategy has the potential to run into some regulatory hurdles. You could offer traditional coverage that's either fully-insured or self-insured, and we talked about that before. You could offer the coverage through a SHOP as I mentioned, that again is small business part of an ACA exchange, or what we're hearing more and more of a possibility, particularly for large employers, they may go direct to a provider group. This would be almost the marrying together of some of the reforms that are happening on the coverage side with what's happening with respect to accountable care organizations, something that Bob mentioned in his part of the presentation.

Just going back up to this concept of a private exchange for a second, and then we're going to come back to some aspects of it. For large employers, the concept of a private exchange has gotten very popular. The concept of a private exchange is that you as the employer are still sponsoring coverage, but what you're trying to do is you're trying to provide potentially more choice for your employees, so there's a company or a sponsor that's traded these private exchanges. By private, I mean they're nongovernmental. There are several different insurers that are offering their plans on the exchange and you allow your employees to choose which plan they want and you, for instance, would then make a defined contribution to the cost of that coverage, either a fixed dollar amount or a fixed percentage amount with respect to that coverage. There's been a lot of discussion about that, and obviously

it aligns with the idea of having putting consumers in the driver's seat with respect to their coverage giving them more choices and allowing them to decide is, "Is it worth it for me to pay more for coverage, or would I, for instance, like to go to this other plan and pay less because the amount that I'm getting from my employer will be the same, but the dollar cost to me and the premium is lower over here so I'll have savings?"

Next slide, please.

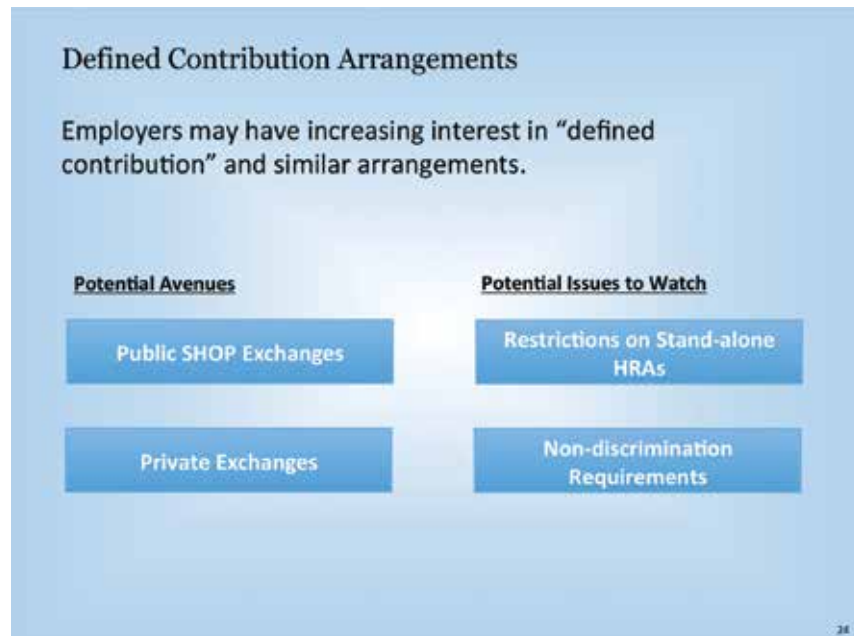
Embedded Issues to Consider



We're going to talk about that in just a moment here, a little bit. I just want to tee up, if you will, where we are on the agenda. We're going to go quickly through some of this stuff now that we've laid the groundwork. We want to touch a little bit on the wellness programs. I want to spend another couple of minutes on the defined contribution employee choice. We'll talk about fees, taxes, and compliance issues, and then we'll mention briefly risk adjustment.

Next slide.

Defined Contribution Arrangements



Just to finish off on the defined contribution arrangements, I mentioned before that there're two kinds of exchanges, and I mentioned before that particularly in the private exchange world there's a lot of interest in these defined contributions type arrangements for the reasons we were just talking about. This concept has also emerged in the context of the SHOP exchanges, so giving small employers and their employees that same kind of choice that we were just talking about with respect to the private exchanges and the same idea of providing a defined contribution. That is still one of the goals, I think, with respect to the SHOP exchanges. It looks like it's going to take a little bit longer to develop in that area. Very recently you all may have seen some articles in the papers about this. HHS (meaning the Federal Department of Health and Human Services) recently announced that they don't expect that they'll be allowing what's known as the Employee Choice Option in most of the public exchanges. It has to do with operational complexities. As you may know, most states around the country will be having a Federally run exchange known as Federally-Facilitated Exchange. That will probably put some delay in the idea of potentially for defined contribution arrangements or at least the employee choice fess. It still is the case that small employers could, for instance, pursue a define contribution strategy in the SHOP exchange, but we'll have to see how that develops.

Some other issues to watch, and so whether we're talking about the SHOP exchange or back to the private exchanges which are more geared towards large employers, I mentioned before these restrictions on standalone HRAs. A standalone HRA is in contrast to an HRA that's actually integrated with the health plan. Then, more and more of what you may begin to hear about are some questions about whether

defined contribution arrangements, do they raise nondiscrimination issues. There are really two categories of issues that typically arise. One has to do with hiring higher income employees versus lower income employees. There's also an issue potentially with respect to age. Without getting into too much detail here, there's a concern with respect to age discrimination that if you actually provide a true fixed dollar amount, does that raise a problem that, depending on how the premiums are being developed, older individuals would end up paying more than younger individuals. Again, I think we'll see some more developing on that topic, but it's something to watch.

Next slide, please.

Regulations Around Wellness Programs

Regulations around Wellness Programs

The ACA and Wellness Programs

- Federal law prohibits group health plans from discriminating against members of the group based on health status
- The ACA expands an existing exception for wellness programs in group coverage that meet certain requirements

Wellness program proposed rules:

- Reflect concerns that wellness programs could potentially discriminate against those with health conditions not within their control
- On the other hand, some concerned that the rules require too much customization and remove any real ability to have an incentive-based wellness program

Flow Diagram:

- Participatory programs → Health-contingent programs → Requirements for Health-contingent programs

Requirements for Health-contingent programs:

- Must have opportunity to qualify at least once a year
- Size of reward can't exceed 30% of cost of coverage
- Must provide "reasonable alternative" for certain individuals

Regulations around wellness programs. A couple of things to understand here without dwelling on too many details. The first thing is that the ACA is really building on existing law with respect to these wellness programs. Again, the wellness programs have gotten a tremendous amount of attention. People believe that there's potentially great promise in those programs whether it's because they have the opportunity to help hold down health care costs or they just lean to a higher performing workforce. People have gotten very interested in the wellness program. What the ACA does is it basically increases the threshold for rewards that you can have in a wellness program. It then codifies some existing regulations, but also imposes what some people might think are some more constraints with respect to those programs. To understand what's going on in this area it's important to think about a few things.

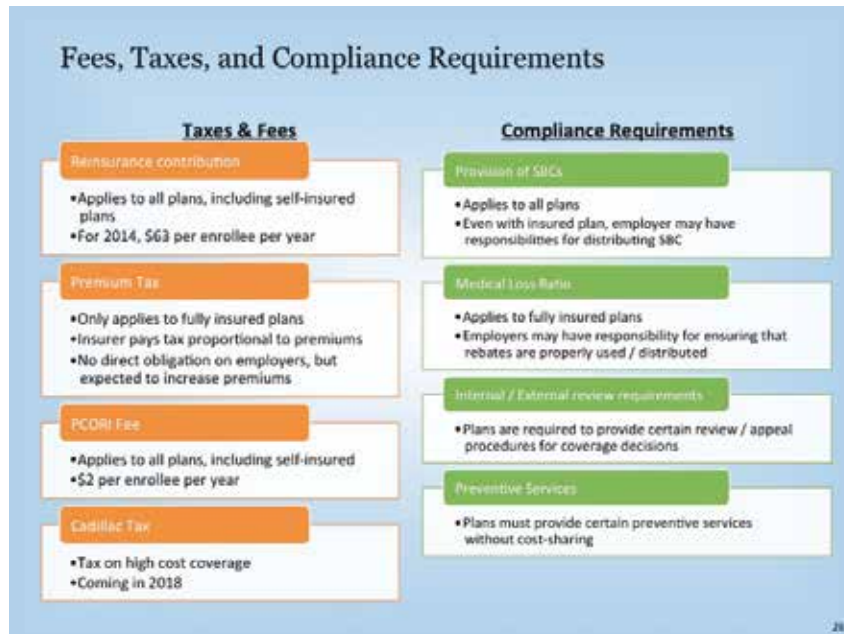
The first is that what we're talking about here is that Federal law as the backdrop prohibits members of a group health plan from being discriminated against based on their health status. When we're talking about large employers, a large employer its overall premiums—and I'll just focus on fully insured coverage for a moment—its overall premiums might reflect the experience of the group, but the members within that group are supposed to pay the same premium. Their premiums are not supposed to vary based on their particular health care conditions. Existing law in the ACA expands on this, provides an exception for what are sometimes referred to as bona fide wellness programs that meet certain requirements. The other concept to keep in mind here is that not all wellness programs are subject to these regulatory requirements.

There are two kinds of wellness programs. There are participatory programs and there are health contingent programs. The basic idea between the two is that a participatory program is either one that doesn't really have a reward associated with it or its one that doesn't tie getting the reward to the satisfaction of any kind of a program that would tie to a health condition. The health contingent programs are the ones that have gotten a little bit more focused. They involve a reward. Those rewards under the ACA can increase from 20% of the overall cost of a premium to 30%, technically up to 50% if you're talking about a tobacco-related program. These health contingent programs are more stringent with respect to what the employees have to do and they do relate to health factors. As we list here, there are a number of requirements that have to be met to have those kinds of programs.

What the rules are reflecting is this tension between a concern on the one hand that the wellness programs could potentially discriminate against those that have health condition not within their control, and on the other hand the concern that says the rules are going too far, they're requiring too much customization, they're too stringent. What's going to happen is we're not going to be able to have really any effective incentive based wellness programs. These proposed rules that have been released, and so where this goes will likely be reflected in final rules that will come out later.

Next slide, please.

Fees, Taxes, and Compliance Requirements



Real quickly. Fees, taxes, and compliance requirements. One of the things to understand about the ACA is that there are a number of provisions that do impose new fees and taxes, and as you're very well aware, a number of additional compliance requirements. Many of these things do apply to both fully insured and self-insured coverage. Let me just highlight a few of them. The reinsurance contribution, the basic idea here is that reinsurance is going to be provided to help address the transition that's occurring in the individual market that I mentioned before. The basic idea is that those reinsurance contributions will be drawn from the entire health insurance market, both in the fully insured and the self-insured side. It's trying to also recognize this relationship I was indicating before about the fully insured market particularly for individual coverage and even the group market.

At the end of the day, for 2014 for instance, the reinsurance contribution is estimated by the Federal government to add \$63 per enrollee per year. There's a new premium tax. Technically it's a fee. This only applies to fully insured coverage. Some people estimate that it's probably between 2-3% per year in terms of the impact.

There's something known as the PCORI fee. PCORI stands for Patient Centered Outcomes Research Institute. This deals with comparative effectiveness with research helps people understand what kinds of treatments and therapies are more effective than another on a comparative basis. There's a fee to fund that research, and then something that we'll likely talk a little bit about in the Q&A, there's a Cadillac tax Plan that's coming in 2018 that may or may not apply. It really depends on whether the employer is offering "high-cost coverage." What

this was really about was a fancy way of trying to address a policy goal of trying to have more parity between the taxation of wages versus the taxation of benefits. I'm going to jump over to compliance requirements. Many of you are obviously familiar with those. If there are some questions about them we can handle that in the Q&A.

Next slide, please.

Risk Adjustment

Risk Adjustment

ACA's Risk Adjustment program - funds are transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees.

Risk adjustment and related activities such as "predictive modeling" are becoming increasingly widespread in all forms of population and value based payment models, across both the public and private sectors.

Trying to align payments with risk otherwise not reflected in premiums

Risk Adjustment Process - ACA

1. Enrollee risk scores
2. Plan Average Risk Scores
3. Payments / charges

Adjustments

- Geographic adjustment**
 - Account for differences in health care costs by geography
- Adjustment for benefit design**
 - Actuarial Value
- Allowable premium variations**
 - Account for ways in which the plan is allowed to vary premiums

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With respect to risk adjustments, the big point to make here is that the Affordable Care Act, with respect to the individual market and the small group market, creates what are known as the three R's. It involves risk adjustment, risk corridors, and reinsurance. I mentioned the reinsurance program before in the context of what it takes to fund that program. The basic idea is that there's such a big change occurring in these individual and small group markets that these what are known as "premium stabilization mechanisms" are needed for the first few years, although risk adjustment will be a permanent program. The bigger point here from an employer perspective, especially a large employer's perspective, is that really what we're seeing is that just about every value-based payment model across both the public and the private sectors are beginning to reflect risk adjustment. The basic idea of the risk adjustment is that payments should, at the end of the day, reflect underlying risks, underlying risks of the covered population. Very, very complex. I think what everybody generally agrees about risk adjustment is that it is necessarily imperfect, but it's better than not trying to risk adjust at all, and I'll be happy to talk a little bit more about the risk adjustment under the

ACA. It's important to realize that this is out there, both because it's very important under the ACA in terms of the individual and small group market, but also because this is becoming increasingly important across the health care system, in large group markets as well, both in the public and private sector side.

Next slide, please.

Key Takeaways

Key Takeaways

1. Health care reform and broader health system changes have both "direct" and "indirect" implications and effects for employers
2. The level of direct effects varies with which coverage market the employer participates in (i.e., small group, large group, self funded)
3. Many open questions about the impact of changes and how these impacts will reverberate across the health care system
4. Important to focus on what is happening both in the development of new coverage models and marketplaces and with payment & delivery system reform
5. Many believe that employers have great potential to drive the direction of change in health care

THANK YOU!!

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In summary, a number of takeaways here is both Bob and I have addressed the direct and indirect effects and implications. Very important. What market you're in—fully insured, self-insured, small group, large group—very important. Understanding how these impact across different markets, so how something might seem that's focused on the individual market but it also has some implications to the large group market. Focus on both what's happening on delivery systems side and the coverage side.

Finally, I think a point that Bob was making as well, there many who believe that employers really have great potential to drive the direction of change in health care. Thank you very much for the opportunity to talk to you today. I low forward to any questions. Thank you.

Other Information Resources

Employer Mandate

- Proposed rule on Employer Responsibility: <https://federalregister.gov/a/2012-31269>
- Employer responsibility flow chart (Kaiser Family Foundation): http://healthreform.kff.org/~media/Files/KHS/Flowcharts/employer_penalty_flowchart_1.pdf
- IRS FAQ on Employer Responsibility: <http://www.irs.gov/iaac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act>

Wellness Programs

- Proposed rule on wellness programs: <https://federalregister.gov/a/2012-28361>
- Healthcare.gov fact sheet on wellness programs: <http://www.healthcare.gov/news/factsheets/2012/11/wellness11202012a.html>

General

- Department of Labor's Health Care Reform Page: <http://www.dol.gov/ebsa/healthreform/>
- Center for Consumer Information and Insurance Oversight (CCIIO), HHS, resources pages:
 - Regulations: <http://ccio.cms.gov/resources/regulations/index.html>
 - Fact sheets: <http://ccio.cms.gov/resources/factsheets/index.html>
 - Other resources: <http://ccio.cms.gov/resources/other/index.html>

Questions?

Contact information:

Gary Bacher: gbacher@healthspieren.com

www.healthspieren.com

On the Cadillac tax, I think the place to start is to realize that there is a strong policy goal behind this provision.

Questions and Answers

Questions?



Peter Isaacson
Chief Marketing Officer, *Castlight Health*



Bob Kocher
Partner, *Venrock*



Gary Bacher
Principal, *Healthsperien, LLC*

Contact us at marketing@castlighthealth.com

Peter:

Thanks, Gary. That was really great, really informative, and also really thought provoking as witnessed by the number of questions that we've had come in over the chat and question box. There's no way we're going to get all of them. I'll do my best to consolidate some of the key ones that have been asked to us today, though. First question is going to go to Gary. Gary, can you talk a little bit more about the Cadillac tax that you mentioned today? What is it and what is it meant to do?

Gary:

Thanks very much. As I mentioned on the Cadillac tax, I think the place to start is to realize that there is a strong policy goal behind this provision. As all of you probably know, there's been historically—really since I think World War II—been a difference with respect to the taxation of benefits which are typically benefits and the taxation of wages. Typically, wages that are provided in the form of benefits are excluded from income tax, whereas, wages are taxed. What this provision was really trying to get at with the idea of let's try to, for instance, encourage some parity between how we think about the taxation of benefits versus the taxation of wages. The way this works in practice, just to give the details and then I'll say why we don't really expect there's going to be that many employers that will really be paying this tax, is that

beginning in 2018 the 40% excise tax will be imposed on the value of health insurance benefits that exceed certain thresholds. Those thresholds are really just estimates today are \$10,200 for individual coverage, \$27,500 for family coverage. The thresholds are adjusted for certain high-risk professions, they're adjusted for age and gender. The key is that because that such a large excise tax, 40%, what most people expect is going to happen is that employers, for instance, will be changing the structure of the benefits such that by 2018 and beyond they won't be paying this Cadillac tax, and also it's important to realize that especially in the early years there won't be very much that exceeds the threshold. The 40% excise tax is really just paid on the difference between the threshold, the cost level of the health plan itself and the threshold that's been established. Those are some details on the Cadillac tax.

Peter:

Great. Thanks, Gary. Next question is for Bob. Couple of questions came in about some news that came out this week, questions about whether fees increased for Medicare Advantage plan?

Bob:

There is a lot of back and forth over the Medicare Advantage program. Just to set context, Medicare Advantage is the voluntary program for people eligible for Medicare where they can opt out of traditional fee-for-service Medicare and get Medicare via a private insurance company. The insurance companies are paid today about 114% of what it costs the same person risk adjusted to be treated in Medicare. That's been an area of target for overpayments and for cuts. In the Affordable Care Act, \$175 billion over 10 years in cuts are coming out of the growth rate of the Medicare Advantage program which will be enacted in a series of reductions in the growth rate. Medicare proposed for next year a large reduction in the rate of increase of Medicare Advantage to the tune of a 2.6 absolute cut in their payments. That was a surprise by many in the industry. After lots of to-ing and fro-ing and some revisions actually were changed from a cut to a net increase of 3.3% after Medicare recalculated the assumptions around what doctor payments happens. A policy caused sustainable growth rate. In aggregate, actually, Medicare Advantage plans are getting an increase, not a cut next year, which is larger than expected. Over the decade, though, you can expect that the rate of growth will be trimmed to yield some of the savings plan for the Affordable Care Act.

Peter:

Great. Thanks, Bob. Gary, is back to you around wellness program. There have been a couple of questions around these. I'll summarize them in one aggregate which is how large are the financial incentives that can be used for wellness programs now?

Gary:

With the change in the law, basically, the current threshold is that you can have a 20% reward. The maximum reward now under the ACA is going to increase to 30% of the total cost of coverage. That includes when you measure the total cost, both the employer and the employee contributions. As I mentioned, that amount can reach up to 50% for wellness programs that are designed to prevent or reduce tobacco use. When people talk about reward they can be both positive and negative, so it can be a true reward, it's something you get, or it can if you don't do X there's going to be a penalty. In both cases, it's considered, if you will, "reward."

Peter:

Great. Thanks, Gary. Another question for you, Gary. Large employers, they must meet the minimum value rule? Is that correct? The follow up on that is what do you meant that they are not technically subject to EHV and AV?

Gary:

Those are great questions. With respect to the first question, the context again for this is if you're an employer that's subject to the employer responsibility payment provision, there're two ways you can be, again, subject to those payments. One would be if you don't offer coverage at all, and the other way would be that you do offer coverage but either the coverage doesn't meet the minimum value to the question or that it's "not affordable." The minimum value concept goes back to this idea of, as the employer, am I paying at least 60% of the allowed costs. The idea is that if you're not paying 60% of the allowed costs what that means is that one of your employees could then, as I mentioned before, pierce the firewall. That means they can go off to the exchange and they could, if their income allowed it, then qualify for a premium subsidy or they could qualify for a cost-sharing reduction. Just for background, the premium subsidies are available for people up to 400% of Federal poverty. The cost-sharing reductions are effectively available for people up at 250% of Federal poverty. If you had someone that was just one person, for instance, if you had someone that accessed the subsidy you'd then be liable for the payment. That's how the concept of minimum value figures in.

I think the second part of the question was what did mean about technically a large employer wasn't subject to the EHV and AV provision. The way that the law works is that essential health benefits, the EHV, in actuarial value, those provisions apply with respect to individuals and small group coverage. There are some nuances, things that aren't technically part of what's known as the essential health benefits package that do apply to large employers and even self-funded employer. An example of that, for instance, would be the idea that the out-of-pocket maximum provision. Both HHS and the Department of Labor have clarified that those apply to everybody, so basically the backdrop for this is that one of the things that ACA does is it requires that all coverage have an out-of-pocket maximum. Very similar to what happened today if you offer a high deductible health plan plus an HSA. Out-of-pocket maximum meaning that, at some point,

once the consumer enrollee pays a certain amount they can't pay anymore. In general, the each being the AV don't apply to large employers whether they're fully-insured or self-insured. What that means is that those large employers don't have to ensure that they're providing benefits that exactly meet a benchmark plan, which is how the EHV provision is administered and they don't have to ensure that their coverage fits into one of those metal levels. The metal levels, again, tie to the actuarial value as we have talked about. The minimum value sort of mirrors the actuarial value concept in terms of how its calculated, but it's done for this very different purpose, as I mentioned which is really more about figuring out is it possible even if I'm offering coverage that I would have to make an employer responsibility payment. That's a lot, but it's a very good question but also complex. I hope that is responsive to it.

Peter:

That's great. Thank you, Gary. Here's question maybe more directed at Bob. It has to do with the \$63-per-employee coverage fee. A lot of people have heard about it. Is this true? When's it being implemented?

Bob:

This is the fee to cover the reinsurance program, which is a time limited three-year program to help make sure that, as the individual changes are set up, if the risk is not what's expected, there's enough money to defray that so that it's a viable market from a health plan perspective. It's a three-year fee, \$63 per worker, and then it ends. Yes, it's true, and it's the beginning of January.

Peter:

Thanks, Bob. I'm going to toss this out to both of you, not sure it's whether it's a question for Bob or for Gary. A couple of folks have asked about defined contributions and does a defined contribution strategy fulfill the affordability and minimum value requirements?

Bob:

Gary, do you want to start?

Gary:

Sure. I'll take a crack at that. The answer is probably it depends. Typically, the answer sometimes you get on these questions. The reason why it depends is that I think the question was asking what a define contribution strategy meet, for instance, the minimum value requirements that we were just talking about. If you go back to the discussion we were having, for instance, about a private exchange.

There have been several questions about private exchanges. Do the plans still have to meet the deductible and out-of-pocket maximums laid forth in the mandates for health plans?

If you have a private exchange that's basically the employer sponsoring coverage. I think the same two questions would apply, which is is the value of the coverage that's available on that private exchange, does it meet the minimum value, meaning is it going to provide for 60% of the covered claims being paid out? Then, with respect to the affordability tax, the way I would probably think about this is is the amount of the contribution, for instance, is being provided, is that going to ensure that the coverage is affordable? Again, affordable here meaning that the coverage would not exceed 9.5% of the employee's income for self-only coverage. Some of the questions have probably emerged would be well for which coverage. I think I've seen some information that suggests that you probably then look to the lowest cost options in terms of administering that test, but I'm not sure if that's necessarily how that would be rolled out. Bob, do you want to say anything behind me?

Bob:

I think you nailed it. I would say the answer is you can use defined contribution but you have to make sure the contribution's enough that workers can buy a minimum value plan at the level of cost sharing that's allowed. Generally, it should work.

Peter:

Great. Thanks, Gary. Gary, I'm going to put you on the spot again. There have been several questions about private exchanges. This one encapsulates most of the questions around it. Do the plans still have to meet the deductible and out-of-pocket maximums laid forth in the mandates for health plans?

Gary:

A couple things. A great question and implies a few different things. I think I heard in there the deductible requirements and the out-of-pocket max requirement. This goes back to something we were talking about before. First, to answer that fully, it depends on which market we're talking about. For example, if we were talking about a private exchange and talking about small group coverage, then we'd be thinking both about the deductible issue that was being raised and we'd be thinking about the out-of-pocket max issue. The reason for that is that in the provision that relates to essential health benefits there are also some nuance provisions regarding cost sharing. A lot of those provisions impose limits on the deductible for small group coverage. There are some exceptions, so if an actuary, for instance, reasonably determines that they can't meet the actual value amount and still comply with that limitation, then the limitations is effectively waived, but

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that's for small group coverage. If we're talking about large group coverage, which is really more what we generally think about in the context of private exchanges. There really shouldn't be a deductible requirement unless, again, we're talking about a high deductible health plan. In which case, the requirement that you have to meet from a deductible standpoint is really not about the ACA, but it's about preexisting requirements related to HDHP. The out-of-pocket maximum would be relevant. So the answer would be yes with respect to the out-of-pocket maximum. The plans that would be offered on that private exchange you would think would have to still have an out-of-pocket maximum. Again, if we're talking about large group coverage, the requirement, the limitation with respect to the deductible, wouldn't apply. If what we're really talking about is we want to have a high deductible health plan, then the deductible we're talking about here really isn't related back to the ACA but it's more related back to the requirements for high deductible health plans. I hope that helped.

Peter:

Gary, that's great. Actually, we are out of time. We are going to have wrap it up now. With that, I'm going to turn it back over to Wendy. Thank you, everyone.

Wendy:

Thank you everyone, for your participation today. As Peter said, we're out of time. As a reminder, they'll be a recording of the webinar sent via email along with a copy of the slide deck in the next coming days. Thank you again for joining us, and we look forward to seeing you on future Castlight Health webinars.



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