Employer Responsibility and Reporting Requirements
4980H In a Nutshell

Only applicable to “Applicable Large Employers”

*Generally effective January 2015 (but see transition relief)*

*Small Applicable Large Employers* are not subject to excise taxes until 2016 (but must still report for 2015)

- Small applicable large employer is controlled group of corporations that satisfy the following conditions:
  - 50-99 FTEs in 2014
  - Employer does not reduce size of workforce or reduce overall hours of service of employees for other than bona fide business reasons
  - Employer does not eliminate or materially reduce health coverage maintained on 2/9/14
    - Contribution for employee only coverage must be at least 95% of dollar amount on 2/9/14 or same or higher percentage
    - Changes in employee only coverage permitted so long as coverage retains minimum value status
    - No reduction in classes of employees/dependents who were eligible on 2/9/14
4980H In a Nutshell

Compliance with 4980H determined on controlled group member basis

Full-time employee
- Any common law employee who has the requisite *hours of service* to qualify as a full-time employee

2 methods for identifying employees who qualify as a full-time employee
- Look back measurement
- Monthly measurement

Excise tax rules:
- They are assessed against a controlled group member for each month generally for each month that an employee who qualifies as a full-time employee to whom qualifying coverage must be offered receives a subsidy in the Exchange
- Do you offer coverage each month through an eligible employer sponsored plan that is both affordable and provides minimum value to 100% of your employees who qualify as a full-time employee to whom coverage must be offered (and their dependent children)?
  - If yes, no excise taxes for that month
  - If no, determine which excise tax bucket you are in
4980H In a Nutshell

Sledgehammer Bucket

- You fail to offer coverage through an eligible employer sponsored plan to 95% of your employees who qualify as a full-time employee to whom coverage must be offered (and their dependent children) and ONE employee who qualified as a full-time employee to whom coverage must be offered receives a subsidy in the Exchange
  - 70% in 2015 ONLY
- 1/12 of 2080 ($173.33) x all employees of the controlled group member who qualified as a full-time employee to whom coverage must be offered reduced by the employer’s allocable share of 30
  - 80 in 2015
- The reason that employee receives subsidy is not relevant
4980H In a Nutshell

Tackhammer Bucket

- Employer satisfies substantially all test but does not offer affordable, minimum value coverage through an eligible employer sponsored plan to 100% of its employees who qualify as full-time employee to whom qualifying coverage must be offered (and their dependent children) and a full-time employee to whom coverage must be offered receives a subsidy in the exchange

- $260.50 \times \frac{1}{12} \times \text{total number of full-time employees who receive a subsidy in the Exchange that month}
4980H In a Nutshell

• “Offer” coverage
  – Effective opportunity to enroll or decline each year
• Affordability
  – safe harbors
    • W-2 wages (annual determination)
    • Rate of pay
    • FPL
  – Affordability in Exchange is based on household income
• 6056 Reporting
  – Provide coverage offer information for each month during the year with respect to each employee who qualifies as a full-time employee at least 1 month
4980H In a Nutshell – Fiscal Year Transition Relief

• Fiscal Year Transition Relief available for those that did not change their plan year after 12/27/2012
• Effective first day of plan year in 15 for all employees who satisfy the terms of eligibility that were in effect on 2/9/14 and not eligible for a calendar year plan
• Effective first day of plan year in 15 for everyone else if coverage/offer percentage satisfied
4980H In a Nutshell – Fiscal Year Transition Relief

• All employee test:
  • Employer offered coverage under the fiscal year plan to 33 1/3% of its employees during the enrollment period preceding 2/9/14 or
  • employer covered 25% of its employees at some date in 12 month period ending on 2/9/14
  • Not applicable to employees who would have been eligible for a calendar year plan maintained by the employer on 2/9/14

– All full-time employee test
  • Employer offered coverage under the fiscal year plan to 50% of its full-time employees during enrollment period preceding 2/9/14 or
  • Employer covered 33 1/3% of its full-time employees at some date in 12 month period ending on 2/9/14
Key Terms and Concepts

• Who is an Applicable Large Employer (ALE) subject to the penalty?
• Who are full-time employees?
• What is minimum essential coverage offered through an eligible employer sponsored plan?
• When is coverage affordable?
• When does coverage provide minimum value?
Compliance with 4980H—Generally

• **Compliance is determined on a controlled group member by controlled group member basis!!!!!!**
  – Analysis must be done at the subsidiary level—not at the corporate level.

• “Compliance” with 4980H is simply a matter of identifying the assessable payment an ALE owes (if any)
  – IT IS NOT A MANDATE TO OFFER COVERAGE
    • i.e. full-time employees have no cause of action under 4980H for coverage if not otherwise offered coverage
  – In some situations, paying the excise tax for a month may be optimal to providing coverage
Compliance with 4980H-Key Concepts

• Identifying full-time employees
  – Who is an employee that qualifies as a full-time employee during a month?
  – Who is a full-time employee that qualifies as a full-time employee during a month TO WHOM COVERAGE MUST BE OFFERED IN ORDER TO AVOID EXCISE TAXES

• What is an “offer” of coverage for purposes of 4980H?
• What is minimum essential coverage?
• What is affordable minimum essential coverage?
• When does minimum essential coverage provide minimum value?
Compliance with 4980H

Identifying full-time employees
Who is a full time employee?

- 4980H(c)(4): A full-time employee is, with respect to a month, an employee who is employed, on average, 30 or more hours of service per week during a month
- 2 key elements:
  - COMMON LAW EMPLOYEE of employer
  - with the requisite HOURS OF SERVICE
    - Monthly measurement
      - Each month except during a limited non-assessment period
    - Look back measurement period
      - New Employees
        » Non-Variable-Monthly
        » Variable/PT/Seasonal: Measurement period
        » Caution: Initial Measurement Period is a limited non-assessment period
      - Ongoing Employees
        » EVERYONE!!!!!!
Who is a full time employee?

• Employee who qualifies as a full-time employee

• Employee who qualifies as a full-time employee to whom coverage must be offered to avoid excise taxes
  – EMPLOYEE WHO QUALIFIES AS A FULL-TIME EMPLOYEE AND IS NOT IN A LIMITED NON-ASSESSMENT PERIOD
Who is a full time employee?

• 3 key questions:
  – Who is a “common law employee”?
  – What is an “hour of service”?
  – How do you apply the measurement methods to identify employees who qualify as a full-time employee for a month?
Who is a common law employee?

• 20 factor IRS test
• Essence of Test: *Do you have the right to control the manner in which the services are performed?*
• Trouble areas:
  – Individuals obtained from staffing agency
    • Rev. Rul. 70-630
  – Temporary employees (individuals that YOU hire for short periods of time but who do not qualify as seasonal)
  – Section 530 Employees
  – Statutory Employees
  – “Leased Employees” as defined in Code Section 414(n)
  – Individuals with H2A/2B Visas—Maybe
What is an Hour of Service?

- HOURS OF SERVICE are defined as
  - Each hour for which an employee is paid or is entitled to payment for performance of services AND
  - Each hour for which an employee is paid or is entitled to payment on account of a period for which no services are performed due to the following (i.e. Paid Leave):
    - Vacation
    - Holiday
    - Illness/disability
      - Issues with disability benefits paid for solely by the employee!!!
    - Layoff,
    - Jury duty
    - Military duty
    - Leave
  - Paid leave defined according to 29 C.F.R. 2530.200b-1(a)
    - Is there a limit on the hours of service allocable to a paid leave?
    - What about employees on a workers compensation leave?
What is an Hour of Service?

• Hourly Employees—based on records of *actual* hours of service

• Non-Hourly (SALARIED)—KEY POINT!!!!!!!
  – Actual hours
  – Days equivalency: A day credited with one hour of service is credited with 8 hours of service
  – Weeks equivalency: A week with one hour of service is credited with 40 hours of service
    • Cannot use the equivalency method if it operates to substantially understate the hours of service (e.g. nurse that works 3, 12 hour shifts per week)
    • May use different methods for different classifications of non-hourly
    • May change method each calendar year
What is an Hour of Service?

- Services performed outside the U.S. are not do not count as Hours of Service for purposes of 4980H
  - Do NOT treat hours of service performed outside the united states as 4980H hours of service if compensation for such services is considered income from a source “without the United States”
  - Generally, pay for services performed outside the U.S. is considered income from sources without the U.S.
  - Don’t confuse with income tax rules as U.S. Citizens are generally taxed on income within and without the U.S.
- U.S. is defined as the 50 states and D.C.
  - Territories and possessions are NOT considered the U.S. for this purpose
- See Measurement Period rules applicable to domestic employees who transfer to foreign subsidiary and vice versa
What is an Hour of Service?

- Hours of service performed for one ALE member treated as performed by any other ALE member for whom the employee provides services during the year
  - If hours of service with two or more members during a month, treated as employee of member with most hours of service
  - If same number for each member, then members may choose whose employee he/she is.
- Issues arise when different subsidiaries use different measurement periods.
What are Hours of Service?

• Employees whose hours of service each month will be difficult to calculate are subject to special rule:
  – commission employees,
  – adjunct faculty,
  – transportation employees, and
  – similar positions
• Any reasonable method may be used (until further guidance is issued)
  – A method is NOT reasonable if it takes into account only a portion of the employee’s hours of service such that it re-characterizes as non-full-time an employee in a position that traditionally averages 30 hours of service or more per week
• Safe harbors for
  – Adjunct faculty
  – Employees subject to layover
  – On call
What is an Hour of Service?
Safe Harbors for Difficult Employees

• Adjunct Professors
  – IRS method: 2.25+ rule
    • Multiply each hour teaching by 2.25
      – This accounts for not only time in class but an additional 1.25 hours preparing for class
    • Add any additional hours performing duties outside the classroom that faculty member is required to perform
      – Required office hours
      – Staff meetings
  – Not only method that might be considered reasonable
  – Is IRS rule a safe harbor?
  – May be relied on at least through 2015
What is an Hour of Service?
Safe Harbors for Difficult Employees

• Employees subject to a layover (e.g. airline employees)
  – Must credit layover hours IF:
    • Employee receives compensation for the layover hour beyond the compensation received w/o regard to layover OR
    • Layover hour is counted towards required hours of service for the employee to earn his/her regular compensation
  – Otherwise, if neither of the above apply, it would be deemed reasonable for an employer to credit 8 hours of service for each day in an overnight stay unless that substantially understates actual hours of service

• Not limited to airline employees
  – Over the road drivers
  – Others?
What is an Hour of Service?
Safe Harbors for Difficult Employees

• On Call Employees
  – Must count hours of service for:
    • Time required to stay on premises
    • Hours during which activities while on call are subject to substantial restrictions
      – The “Kill Your Weekend” rule
What is an Hour of Service?

Exclusions!

- Even though common law and “paid” the following will not be treated as having “hours of service” for purposes of 4980H:
  - Bona fide volunteer
  - Certain clergy
  - Student in a federal/state work study program
How do you identify employees who qualify as “full-time employees” in a month?

• 2 methods:
  – Monthly measurement period approach
  – Look back measurement period approach
• Each ALE member may use a different approach
• Each ALE member may apply a different method to each distinguishable class of employees
  – Special rules apply when employee switch between positions that use different methods
• Key Concept: If an employee qualifies as a full-time employee for a month, qualifying coverage must be offered for that month or the ALE member could be subject to an excise tax for that month unless . . .
  – The employee is a limited non-assessment period
How do you identify employees who qualify as “full-time employees” in a month?

• What are the distinguishable classes of employees?
  – Hourly
  – Salaried
  – Union (generally)
  – Employees subject to different collective bargaining agreements
  – Employees working in different locations

• Variable and non-variable are NOT distinguishable classes of employees!!!!!!!
Monthly Measurement Period Approach

- If employee has requisite Hours of Service in month, employee qualifies as a full-time employee.
- If employee qualifies as a full-time employee for that month but is in limited non-assessment period, then does not qualify as a full-time employee to whom coverage must be offered to avoid excise taxes.
- Limited non-assessment period applies only once to a continuous employee
  - I.e. employee who has not experienced a break in service
Monthly Measurement Period Approach

• What are the requisite hours of service?
  – Average of 30 hours of service per week during the month
  – 130 hours of service in the month
  – Weekly rule:
    • Months with 4 weeks--120 Hours of Service
    • Months with 5 weeks--150 hours of service
  – Do you round up?
Monthly Measurement Period Approach

• What is a limited non-assessment period under monthly measurement period approach?
  – First month of partial employment
  – First 3 full calendar months beginning with first full month that that employee first becomes eligible ("3 month limited non-assessment period) provided that:
    • Employee is “otherwise eligible” during those 3 months but for a waiting period AND
    • Coverage is offered by the first day of 4th full calendar month following that first full month that the employee was first full-time
      – If coverage through eligible employer sponsored plan is offered but it does not provide minimum value, then employee is disregarded for purposes of substantially test BUT could trigger Tackhammer Tax
      – If coverage also provides minimum value, then employer is treated as offering affordable, minimum value coverage during the 3 month limited non-assessment period
    • Only applicable 1 time for a continuous employee (i.e. employee who has not experienced a break in service)
Monthly Measurement Period Approach Example

- Bob is employed by ABC on June 5, 2015.
- Bob is does not have the requisite hours until August 2015.
- Bob does not have the requisite hours of service again until January 2017.
- Bob does not have a break in service.
- ABC will not be subject to an excise tax for June.
- ABC will not be subject to an excise tax with respect to Bob for August provided that:
  - Bob is otherwise eligible for the Plan but for a waiting period during August, September, and October AND
  - Bob is offered coverage providing minimum value that will be effective November 1, 2015
    - Presumably he would only have to be offered coverage for November 2015
- ABC will not be subject to an excise tax with respect to Bob for January 2016 if Bob is offered minimum value coverage for January 2016
  - The 3 month limited non-assessment period rule applies only once to a continuous employee. Since Bob has not had a break in service, he is a continuous employee.
Look Back Measurement Period

• Two different parts to the look back measurement period method:
  – New employees
    • Variable/part-time/Seasonal
    • Non-variable
  – Ongoing employees—ALL employees employed during the applicable measurement period
    • NO DISTINCTIONS between variable, non-variable!!!!!!!
    • Impact of this felt during a stability period in the following situations:
      – Full-time employee rehired as part-time employee
      – Full-time employee takes unpaid, personal leave of absence
      – Full-time employee changes from a full-time position to a part-time position
Look Back Measurement Period Approach

• 3 components to each part:
  – Measurement Period
    • New Employees-Initial Measurement Period
    • Ongoing-Standard Measurement Period
  – Administrative Period
  – Stability Period
Look Back Measurement Period Approach

• New Employee:
  – employee who has not been employed as a common law employee for one standard measurement period (the measurement period for ongoing employees)
  – Employee who is rehired after 13 weeks or more with no hours of service

• Types of New Employees (2 buckets)
  – Non-Variable Bucket
  – Other Bucket
    • New Variable
    • Seasonal Employees
    • Part-time
Look Back Measurement Period Approach
New Employees

• What is a non-variable employee?
  – Facts and circumstances test
  – On the start date, you can make a determination that they are reasonably expected to have the requisite hours each month while employed by you.
    • Expected length of service generally NOT relevant
      – Exception for seasonal employee
      – Subject to monthly measurement period approach until they become ongoing employee

• Who is a variable employee?
  – Facts and circumstances
  – On start date, you cannot make a determination that they will be reasonably expected to have the requisite hours of service because their hours will fluctuate or are uncertain
Look Back Measurement Period Approach
New Employees

• Who is a seasonal employee?
  – Employee hired into a position the typical duration of which is 6 months or less and
  – The start date is the same time each year
  – GET TO TREAT AS VARIABLE EVEN THOUGH MIGHT OTHERWISE BE NON-VARIABLE!!!!!
    • Contrast with “Temporary”—position does not necessary start same time each year

• Who is a part-time employee?
  – On the start date, you can make a determination that they are not expected to have the requisite hours of service
  – Why does it matter?
Look Back Measurement Period Approach New Employees

- Initial Measurement Period ("IMP")
  - 3-12 month period
  - Begins on any date between start date (date first credited with an hour of service) and first day of the first calendar month following employee’s start date
    - If start of IMP delayed to first day of month following employment delay counted towards the administrative period

- Recommendation: 11 or 12 month initial measurement period
Look Back Measurement Period Approach
New Employees

• Initial Measurement Period may now utilize pay periods to determine hours of service using 2 options:

  – **Option 1**: exclude the entire payroll period that includes the beginning of the year and include the entire payroll period that includes the end of the measurement period, or

  – **Option 2**: Include the entire payroll period that includes the beginning of the year and exclude the entire payroll period that includes the end of the measurement period
Look Back Measurement Period Approach
New Employees

• Change in Position to Non-variable during IMP:
  • Applies to changes in positions that if originally hired into the new position, the employee would have reasonably been expected to be employed on average 30 hours of service or more per week
  • 3 month limited non-assessment period rule applies following the month in which the status change occurs, with one twist
    – If stability period would begin earlier, and the employee averaged requisite hours over measurement period, then must be offered qualifying coverage by first day of stability period
Look Back Measurement Period Approach

New Employees

• Administrative period
  – No more than 90 CALENDAR days
  – Any period preceding the start date of the IMP is counted towards 90 days
  – IMP and Administrative period cannot extend beyond end of the month beginning on or after the anniversary of the employee’s start date
Look Back Measurement Period Approach
New Employees

- Stability Period following IMP
  - Employees who average requisite hours of service over IMP qualify as full-time employee during each month of the stability period that they are employed; employees who don’t average requisite hours of service qualify as other than a full-time employee during each month of the stability period
    - Hours of service during each month of the stability period NOT relevant
  - Employees who average requisite hours of service over the IMP
    - No shorter in duration than the IMP (but at least 6 months)
    - **IMP is a limited non-assessment period:**
      - If offered minimum value coverage by start of stability period, no excise tax with respect to the employee for months actually full-time during IMP
      - If only offered MEC that does not provide minimum value, then disregarded for purposes of substantially all test only BUT could trigger a Tackhammer Tax
      - **Reporting on 6056 for employees who qualify as full-time in one or more months during IMP**
      - Employees determined **NOT to be full-time** during IMP
        - Stability period not more than 1 month longer than the IMP
Look Back Measurement Period Approach

New Employees

- Special rules for Stability Period following IMP:
  - Stability period following the IMP will overlap with the standard measurement period and stability period following standard measurement period will control if determined to be full-time
  - Special rule if gap between end of stability period following IMP and start of stability period following standard measurement period
    - E.g. employees hired in October or November after stability period beginning in October has begun
    - Treat “as is” until start of next stability period
  - Change in employment status during stability period for continuing employee will GENERALLY NOT affect status during stability period
    - If changes to a position that would not have been expected to have the requisite hours of service, then may apply the monthly measurement period beginning with the fourth full calendar month following the change in positions IF:
      - Employee had continuously been offered minimum value coverage since 1st day of fourth full month of employment and
      - The employee does not average the requisite hours of service during each of the three full calendar months following the month in which the position change occurs
Look Back Measurement Period Approach

Ongoing Employees

• Standard Measurement Period (SMP)
  – 3-12 months
  – Payroll period rule applies
  – **ALL ONGOING EMPLOYEES ARE IN SMP**
    • Biggest impact on full-time employees who experience the following during a stability period:
      – Unpaid leave of absence
      – Terminate/rehire to part-time position (unless the period between is 13 weeks or longer)
    • Unlike IMP, SMP is NOT a limited non-assessment period
  • Administrative Period-no more than 90 calendar days
Look Back Measurement Period Approach
Ongoing Employees

• Stability Period following SMP
  – If employee averages requisite hours of service over SMP
    • Stability must be at least 6 months but no shorter in duration than the SMP
  – If employee determined NOT to be full-time
    • Stability period same duration as SMP
  – Recommend 12 months SMP
  – Transition Rule for 2015:
    – May use a standard measurement period of 6 months or more and a stability period of 12 months for both full-time and non-full-time
Look Back Measurement Period Approach
Ongoing Employees

• Special rules for Stability Period following SMP:
  
  – Change in employment status during stability period for continuing employee will NOT affect status during stability period
  
  • If changes to a position that would not have been expected to have the requisite hours of service, then may apply the monthly measurement period beginning with the fourth full calendar month following the change in positions IF:
    
    – Employee had continuously been offered minimum value coverage since 1st day of fourth full month of employment and
    
    – The employee does not average the requisite hours of service during each of the three full calendar months following the month in which the position change occurs
Breaks in Service

If an employee has a period with no hours of service (other than a special unpaid leave) that is at least 13 full weeks (week=7 consecutive calendar days), he has a break in service. If he/she resumes service after the break in service, he/she is treated as a “new employee”

- Rule of Parity: A period of at least 4 weeks that is longer than the prior period of employment
  - See special unpaid leave rule

If the employee has a period with no hours of service that is less than 13 weeks and then resumes service, he/she is treated as a “continuous employee”

Impact of Break in Service Rules:

- Look Back Measurement Period:
  - If continuous, employee resumes measurement period
  - If resumes during a stability period and was full-time, then must be offered coverage by first day of month following start date IF employee was previously offered and accepted coverage. If coverage was offered and declined, no need to offer again during that stability period.

- Monthly Measurement Period
  - If continuous, then no available limited non-assessment period upon resumption of services if already used
Special Leaves of Absence/Employment Break

- Applicable only if you use look back measurement period
- Special unpaid leaves of absence include leaves subject to FMLA, USERRA and jury duty leaves
- Employment Break for educational organizations (limit to 501 hours of service)
  - ANY PERIOD WITH NO HOURS OF SERVICE OTHER THAN A SPECIAL UNPAID LEAVE
- When calculating average hours worked for a measurement period that includes a special leave of absence/employment break, employers have 2 options:
  - Option 1: disregard the weeks of unpaid special leave and average the remaining weeks, or
  - Option 2: credit employees with hours of service for special unpaid leave at the rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not special unpaid leave
    - Employment break credit/disregard limited to 501 hours of service
Compliance with 4980H

Assessment of Penalties
Excise Tax Buckets – No Tax Bucket

No excise taxes for any month that:

- An ALE Member offers to 100% of its employees who qualify as a full-time employee to whom qualifying coverage must be offered coverage that is affordable and provides minimum value
  - Must also offer to dependent children
- No full-time employees received a Premium Subsidy in the exchange for that month
  - Coverage under health plan was not affordable but they were enrolled anyway
  - Did not qualify based on household income
  - Did not enroll in the Exchange
Excise Tax Buckets – Sledgehammer Tax

• If ALE Member failed to offer coverage through an eligible employer sponsored plan to all but 5% (or if greater, 5) of its employees who qualify as a full-time employee to whom coverage must be offered AND

• 1 employee who qualifies as a full-time employee to whom coverage must be offered receives a premium subsidy in the exchange
  – Reason that employee received subsidy isn’t relevant!!!!!!!
  – 2015-70%
Excise Tax Buckets – Tackhammer Tax

• You are in Tackhammer Bucket for a month if you do not fit in either of the other two buckets AND 1 employee who qualifies as a full-time employee to whom QUALIFYING coverage must be offered receives a subsidy
• The reason they receive the subsidy isn’t relevant!!!!
Assessment of Penalties: Offer

• Offer
  – Must extend to children (natural and adopted/placed for adoption) under age 26 BUT NOT SPOUSES
  – Effective opportunity to enroll (or decline to enroll) no less than 1 time per plan year
    • 125 election rules not impacted
    • Special enrollment rules not impacted
  – Partial Calendar Month Rule: Generally must offer coverage for whole month
    • Special rule for mid-month terminations
  – COBRA premium payment rules apply
    • Grace period
    • Insignificant shortfall Rule
Minimum Value

- Minimum value (MV) is satisfied if:
  - The plan must pay 60% of the “allowed costs”
  - What are “allowed costs”?
    - Based on EHB
- 3 ways to determine if plan provides minimum value—
  - Minimum value calculator
  - Array of design-based safe harbors provided by the IRS, or
  - Appropriate certification by an actuary that the plan provides minimum value
- HRA (if limited to expenses covered by plan) and HSA contributions may be taken into account in determining MV
Affordability

• Based on self-only premium for lowest cost option that provides minimum value

• Safe harbor for determining affordability
  – W-2
  – Rate of pay
  – FPL
Affordability

• W-2 wages
  – Based on annual wages for current year compared to sum of premiums for employee only coverage
  – Wages does NOT include pre-tax salary reductions
  – Adjustments required for partial year offer of coverage
  – Premium must remain a constant amount or percentage of W-2
  – This safe harbor poses problems where employee changes from full-time to part-time during the year or has an unpaid leave of absence
  – Premiums must remain same amount or same percentage of compensation during plan year
Affordability

• Rate of Pay Safe Harbor (hourly and monthly rate determined *generally* prior to start of coverage period)
  - Hourly rate of pay X 130 (for hourly employees)
  - Monthly rate of pay (for salaried employees)
  - This appears to be based on GROSS pay
  - Can still use if hourly rate changes during coverage period
    • Use lower of rate of pay at start of coverage period or rate of pay for that month
    • **CANNOT USE IF SALARY CHANGES**

• Federal Poverty Safe Harbor
  - Federal poverty limit for single individual (based on most recent published report at start of plan year or anytime in last 6 months)
    • SIMPLEST TO USE
Government Reporting – 6055/6056
6055

• Why?

  – To give IRS and Taxpayers information necessary to administer the individual mandate!!!!!!
• Who?
  – “Coverage Provider”
    • If plan is fully insured, carrier is responsible for reporting
    • If plan is self-insured, “plan sponsor” reports
      – Each member of a controlled group whose employees participate in a health plan constitute a separate and independent plan sponsor
        » Special reporting rule if not an ALE
      – Each employer participating in a MEWA constitute a separate and independent plan sponsor
        » What if MEWA is maintained by “bona fide association”? 
      – If plan is multi-employer plan, joint board of trustees, association, or committee who maintains the plan
      – If a plan is a union plan (but not a multi-employer plan), the employee organization is the plan sponsor
• **Who?**

  – Third Party may file on behalf of coverage provider **BUT** coverage provider remains liable

  • What steps must third party take to file on behalf of a coverage provider?

  – Special rule for governmental entities that allows governmental entity to designate another, related governmental entity as the party responsible for filing (to the extent the designated entity agrees in writing)
6055

What?

- Identify all individuals covered under a plan providing minimum essential coverage at least one day of any month DURING THE CALENDAR YEAR
  - Includes employees, retirees, dependents, independent contractors, qualified beneficiaries, “alternate recipients” covered pursuant to a QMCSO, non-employee board members

- 6724 Solicitation of Dependent’s SSN
  - The “3 requests” requirement
    » When the relationship begins
    » By December 31 of the year in which the relationship begins
    » By December 31 of the next year
  - Use DOB if unable to receive the dependent’s SSN
6055

• What?
  – Plan year not relevant; all reporting is done on a calendar year basis
  – No description of coverage needed
    • Only reporting for those covered under a plan that qualifies as MEC generally
  – What is MEC?
    • Any group health plan that provides other than excepted benefits
      – Affordability not relevant
      – Minimum value not relevant
• How?
  – Generally, coverage providers will use 1094/1095-B series to report MEC enrollments to IRS and “responsible individuals”
  – HOWEVER, if plan is *self funded* and sponsored/maintained by *applicable large employer member*, then . . . . . .
    • **MUST** use 1094/1095-C series to report any individual who was an employee in any month of the calendar year, and his/her dependents, who were covered under the self-insured MEC plan at least one day of any month in the calendar year
    • May *but not required to* use C-Series to report individuals covered under self-insured MEC plan who were not employees *at any time during the year*
      – If C-series not used for non-employee covered individuals, then use B-Series.
6055

• How?
  – Send to last known address of “responsible individual”
    • Employee
    • Former employee
    • Parent
      – Alternate recipient covered pursuant to QMCSO
    • Other individual who enrolls themself and others
      – Qualified beneficiary ex-spouse?
    – First class mail
    – Electronic if advance consent provided by responsible individual
When?

- In the year following the calendar year being reported

- To IRS:
  - March 31 if filing electronically
  - February 28 if filing paper forms

- To primary responsible individual: January 31
6056

• Why?
  – So IRS can administer employer shared responsibility requirements

  – So IRS and taxpayers can administer the premium tax credit/subsidy under Code Section 36B

• Although any employee can qualify for credit/subsidy, no reporting for credit/subsidy related reporting required for other than full-time employees
6056

• Who?
  – Each applicable large employer member

• Each member of the controlled group of corporations ("ALE member") that constitute an applicable large employer is independently responsible for reporting

• Third Party may file on behalf of ALE member BUT ALE member remains liable
  » Special rule for governmental entities (same rule as applicable under 6055)
6056

• What?
  • Identify all employees who were full-time employees (as defined by 4980H) at least one *full month* during the year

  • Identify the coverage that was offered, if any, during months that the employee was a full-time employee was made during the months that the employee was full-time employee

  • If coverage was not offered for an entire month, identify whether any exceptions to excise tax apply
    – E.g. employee not employed during that month
    – E.g. employee part time during the month
    – E.g. employee in limited non-assessment period

  • If coverage offered during a month, indicate whether coverage was affordable or not in such month
6056

• What?

  – It doesn’t matter for 6056 purposes whether coverage is fully-insured or self-insured, or even whether coverage is offered at all.

  – If an employer is an ALE member, and the employer has at least one employee who qualified as a 4980H full-time employee, 6056 REPORTING IS REQUIRED!!!!!!!
6056

- How?
  - Use 1094/1095-C series to report to IRS and full-time employees.
  - Send to last known address of full-time employee
    - First class mail
    - Electronic if advance consent provided by responsible individual
  - Relief for full-time employee reporting for:
    - Full-time employees who received a “Qualifying Offer” for all 12 months
      - Relief not applicable with respect to such full-time employees who actually enrolled in a self-insured plan
    - Employers subject to Qualifying Offer Method Transition Relief (only for 2015)
  - Relief for reporting to IRS and full-time employees under 98% offer method
When?

– In the year following the calendar year being reported

– To IRS:
  • March 31 if filing electronically
  • February 28 if filing paper forms

– To full-time employee: January 31
Key Clarifications in Instructions

• Clarity on 6055 reporting by ALE members for individuals who are not employees at any time during calendar year but are enrolled in self-insured plan
  – May use C-series form to report non-employee covered individuals
  – Must use B-series if no SSSN
• Reporting relief for full-time employees who receive a qualifying offer for all 12 months not available if actually enrolled in a self insured plan.
• Offer to spouse conditioned on reasonable objective restrictions still considered an offer even if spouse doesn’t meet condition
  – E.g. spouse is eligible to enroll only if not eligible for other employer coverage is “reasonable” objective restriction
Sections 6055 & 6056 Vendors

- The marketplace offers a variety of different packages from full service reporting to basic software
- The product best suited for one company may not be useful for another
- The size of a company is the biggest driver of both 1) the simplicity of the reporting & 2) the cost
## Market Pricing Survey

<table>
<thead>
<tr>
<th></th>
<th>National Payroll Vendor</th>
<th>Consulting Company</th>
<th>Consulting Company</th>
<th>Software Company</th>
<th>Software Company</th>
<th>Software Company</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-Service</td>
<td>Full-Service</td>
<td>Full-Service</td>
<td>Software with Training and Support</td>
<td>Software with Support Hotline</td>
<td>Software Only; No E-File Option</td>
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<tr>
<td><strong>Company 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>$650</td>
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<tr>
<td>75 Full-Time Employees</td>
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<td>$3,400</td>
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<td>Plus additional E-Filing Cost</td>
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<tr>
<td><strong>Company 2</strong></td>
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<tr>
<td>243 Full-Time &amp; 528 Part-Time Employees</td>
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<td>$5,416</td>
<td>$10,409</td>
<td>$2,250</td>
<td>$3,087</td>
<td>Plus additional E-Filing Cost</td>
</tr>
</tbody>
</table>
What Allied Can Do

- Allied will create a web-based report to assist with completing specific portions of Forms 1095-B & 1095-C
- The report will include enrollment data on employees & dependents covered under the medical plan(s)
- The report can be used in conjunction with payroll data to successfully complete Forms 1095-B & 1095-C
Cadillac Tax
Background

• The Affordable Care Act added new Internal Revenue Code Section 4980I
  – New nondeductible 40% excise tax starting in 2018
  – Tax on the value of applicable employer-sponsored coverage in excess of statutory thresholds
    • Initial Statutory thresholds:
      – $10,200 for self-only
      – $27,500 for family
Background

• Purpose of Tax
  – Prevent over-consumption
  – Stop tax “leakage” from employee exclusion for employer provided health care
  – Revenue raiser to pay for ACA (such as individual premium subsidies)
Applicable Employer Sponsored Coverage

- Applies to “applicable employer sponsored coverage”:
  - All “group health plan” (as defined by Code Section 5000) coverage that is excluded from income or would be excluded if it were provided by the employer, except:
    - Fully insured Dental
    - Fully insured Vision,
    - Long-term care insurance, and
    - after-tax funded hospital indemnity and/or specified disease coverage)
Applicable Employer Sponsored Coverage

• Types of coverage included by virtue of statute:
  – Major medical coverage for actives AND retirees
  – Health FSAs
  – HRAs
  – HSA contributions (both employer and employee pre-tax)
  – Onsite medical clinics
  – Wellness programs
  – EAP
  – Self insured dental/vision
  – Pre-tax indemnity/specified disease coverage
  – Supplemental coverage (“gap” coverage)
Applicable Employer Sponsored Coverage

• Notice 2015-16 requested comments on:
  – Self insured dental/vision
  – EAP
  – HSA contributions
  – Onsite medical clinics
Value of Coverage

• Value determined in accordance with rules similar to the rules that apply to COBRA premiums
  – Focus is on “similarly situated”

• Special rules for:
  – Health FSA (includes employer flex credits)
  – Retiree Coverage (can treat pre and post 65 folks as similarly situated)
Value of Coverage

• Notice 2015-16 requested comments on potential approaches for determining value:
  – Aggregation by benefit package option
  – Mandatory disaggregation between self-only and other than self only
  – Permissive aggregation for other than self-only
    • Treat everyone with other than self only as similarly situated
    • Treat all with same number of family members as similarly situated
  – Permissible disaggregation based on other “traditional distinctions”
• Notice 2015-16 also requested comments on determining value of HRAs
Thresholds

• Threshold adjustments
  – The higher family threshold applies to both single and family coverage offered under a multiemployer plan
  – An employer may make an adjustment if employer's age and gender demographics are not representative of national average
  – No adjustments for high-cost areas (e.g., Northeast, metro areas, etc.)
Thresholds

- Threshold adjustments
  - The annual limit for retirees between ages 55 and 64, individuals engaged in certain high-risk professions (e.g., law enforcement professionals, EMTs, longshoremen, construction workers, and miners), and those employed to install electrical or telecommunication lines is increased to $11,850 for individual coverage and $30,950 for family coverage
Thresholds

• Future adjustments
  – Threshold amounts are to be adjusted automatically if health costs increase by more than anticipated before 2018
    – Health Cost Adjustment Percentage (HCAP) Formula based on percentage increase in FEHBP standard option minus 55% from 2010-2018
    – The thresholds are increased by CPI-U + 1 in 2019, and by CPI-U thereafter
Who Pays Tax?

• Determined by the employer and assessed against "coverage providers"
  – "Coverage providers" are defined to include:
    • In the case of fully insured plans, the health insurer
    • In the case of HSA contributions, the employer making the contributions
    • In the case of a self-insured plan or flexible spending account (FSA), the person that administers the plan (e.g., the TPA)
  – In many cases, employer-sponsored coverage will include both fully insured and self-insured contributions (it may also include HSA contributions)
    • The coverage provider's applicable share of the tax will bear the same ratio to the total excess benefit as the cost of the coverage provider's coverage to the total value of employer-sponsored coverage
Who Pays Tax?

• Because provision is an excise tax, all employers may be subject to tax:
  – Private, for-profit employers regardless of size
  – Non-profit and tax-exempt entities
  – Governmental entities
The Impact

Excerpt from CBO Budget Outlook 2015-2025

- CBO and JCT expect that premiums for health insurance will tend to increase more rapidly than the threshold for determining liability for the high-premium excise tax, so the tax will affect an increasing share of coverage offered through employers and thus generate rising revenues. In response, many employers are expected to avoid the tax by holding premiums below the threshold, but the resulting shift in compensation from nontaxable insurance benefits to taxable wages and salaries would subject an increasing share of employees’ compensation to taxes. Those trends in exchange subsidies and in revenues related to the high premium excise tax will continue beyond 2025
The Impact

Projections:
  – Employers with more than 500 employees impacted (assuming no plan changes)
    • 2018 – 29%
    • 2019 – 32%
    • 2020 – 40%
    • 2021 – 48%
    • 2022 – 54%

2013 Mercer study assuming 6% medical trend and 2% CPI
Employer Responses

- Wellness
- Increase employee OOP
- Implement CDHP (HSA)
- Eliminate high cost options
- Unbundle Dental and Vision
- Reductions in spousal coverage
- Convert/Eliminate ancillary benefits
Employer Responses

• Wellness
• Increase employee OOP
• Implement CDHP (HSA)
• Eliminate high cost options
• Unbundle Dental and Vision
• Reductions in spousal coverage
• Convert/Eliminate ancillary benefits
Nondiscrimination Rules
Wellness Rules
Disease Management vs. Employee Wellness Programs

- **Wellness Programs**: Designed to improve general health of overall employee population *before* employees get sick.
  - *Example*: Weight Watchers

- **Disease Management Programs**: Designed to improve health of particular employees *after* they have developed chronic health conditions (e.g., asthma, diabetes, heart condition, hypertension, renal disease).
  - *Example*: Health coach to advise about options
Health Risk Assessments

• **Health Risk Assessment**: Series of medical and health-related questions aimed at obtaining "baseline" information about employees' overall health to identify persons with chronic conditions or who are at risk for developing a condition.

• **Additional terms**
  – Disability based inquiry
  – Participation based program
  – Health contingent based program
    • Activity based program
    • Outcome based program
Compliance Issues

- Practical and legal compliance issues may arise with Disease Management and Wellness Programs under . . .
  - HIPAA And ACA Nondiscrimination Requirements
  - Americans With Disabilities Act (ADA)
  - Genetic Information Nondiscrimination Act (GINA)
  - Age Discrimination in Employment Act (ADEA)
  - HIPAA Administrative Simplification (Privacy and Security)
  - COBRA
  - ERISA
  - Income Tax
  - Plan Design/Integration Issues (e.g., HRAs and HSAs)
  - State law
Carrots and Sticks

• Two Competing Approaches:
  – Carrot:
    • Health club memberships
    • Reduced health care premiums
    • Smoking cessation programs
    • Weight loss programs
    • Free health examinations
    • Healthy eating programs
    • Stress reduction programs
  
  – Stick:
    • Refusal to hire
    • Disqualification from health care plan
    • Termination
HIPAA / ACA Implications for Wellness Programs

• Generally cannot vary benefit based on health status... but variation allowed for
  – Discrimination in favor of those with health conditions
  – Certain "bona fide" wellness programs
• Non-discrimination Rule does not apply to programs Participation Based Programs:
• Health Standard based programs can survive if they comply with special rules
HIPAA / ACA Implications for Wellness Programs

- *Participation based*—(i) **none** of the conditions for obtaining a reward is based on satisfying a standard related to a health factor or (ii) there is **no reward** associated with the program
  - Incentives to participate in testing (regardless of outcome)
  - Waiver of co-payment/deductible if participate in pre-natal program
  - Reimbursement of health club membership
  - Compensation to fill out health risk assessment
HIPAA / ACA Implications for Wellness Programs

• Health Standard: Any program that provides a "reward" based on the ability to meet a health standard must satisfy these rules:
  – Limit reward to specified percentage
    • 30 % of total cost of employee only coverage
    • 30% of total cost of family coverage if family allowed/required to participate
  – Be reasonably designed to promote health or prevent disease
    • Significant employer flexibility
  – Annual qualification requirement/reward must be available for entire year
  – Must be available to all similarly situated participants
    • Alternatives must be made available in certain situations, depending on the type of program
  – Notice of individual accommodations must be provided
HIPAA / ACA Implications for Wellness Programs

• Key Rules/Principles
  – *Health Standard based*—a program that conditions reward on achieving health standard
  – 2 types of health standard based programs:
    – Activity Based
      » E.g., those identified with risk factors must walk, exercise, diet, etc.
      » Must provide alternative to those who have medical condition that makes it unreasonable to accomplish
    – Health Outcome Based—reward conditioned on achieving certain health related goals or you must jump through additional hoops to get reward if you don’t satisfy certain goals
      » E.g., can you achieve BMI or cholesterol goal
      » EVERYONE is entitled to an alternative
      » Must accommodate physician’s recommendations with respect to alternative provided
Age Discrimination in Employment Ace (ADEA)

- ADEA prohibits employers from discriminating against individuals on the basis of age with regard to employment and the privileges of employment (e.g., benefits)
  - Generally can't reduce or terminate benefits due to age
    - May reduce benefits based on equal cost/equal benefit rule
  - ADEA impacts both
    - The ability to stop DM/Wellness program incentives /surcharges upon reaching a particular age and
    - Varying incentives/surcharge due to age
    - Imposing additional requirements for incentive based on age
Are disease management, wellness programs subject to HIPAA Privacy/Security?

Only if:

- The DM/Wellness is part of a "Health Plan" or
- The DM/Wellness vendor is a "Health Care Provider"

Most argue that DM/Wellness is part of a "health plan"

- Facilitates information sharing with health care providers without authorization and marketing concerns
- Enables VEBA/Trust funding
COBRA

- Most "group health plans" are required to provide COBRA continuation coverage to qualified beneficiaries if coverage is lost as a result of certain qualifying events
  - "Group health plan" means a plan that provides "medical care" and is maintained by the employer
  - Will DM/Wellness programs provided by the employer be subject to COBRA?
    - If they provide "medical care"
    - General health not medical care
COBRA

• COBRA considerations:
  – Is Medical care offered?
  – What type of incentive is offered?
    • Impact of cash incentives/premium reductions?
    • Impact of HRA/HSA incentives?
  – Part of overall health program or stand alone arrangement?
    • Participation limited to plan participants or all employees?
  – What benefit must be provided?
  – What is cost of program?
Tax Issues

• Tax issues arise when
  – Employer pays for coverage that does not constitute "medical care"
    • General health and wellness programs
      – Weight reduction programs not limited to obesity
      – Membership in a gym
    • If not for medical care, the value of such programs must generally be included in gross income and subject to withholding?
Tax Issues

• Non-health incentives raise tax issues
  – Cash payments
    • Taxable and subject to withholding
  – Gift certificates
    • Likely taxable and subject to withholding
  – If paid through VEBA, could be a disqualified benefit
    • De minimis exception
Tax Issues

• Health related incentives
  – E.g., contribution to HRA or HSA or Health FSA
  – Generally non-taxable if health plan related
    • No tax exclusion for self-employed individuals
    • Health FSA
    • Possible change of election issues
  – Potentials for health benefit restricted debit card
  – HSA
    • Must be structured to be made "through the cafeteria plan"
ACA Tax Issues

• Wellness programs and 4980H
  – Treat tobacco use incentives as if complied with for MV and affordability
    • EEO is considering whether unaffordable = involuntary
  – Ignore non-tobacco incentives
• Cadillac tax Implications
  – Impact of Cadillac tax is to “squeeze” out anything other than base “metal” coverage (and maybe even that)
    • Where does that leave Account based plan incentives
    • Should incentives really be treated as “benefit” or cost of coverage?
State Law

- Statutory Restrictions:
  - **Smokers' Rights**: 20 states, including Arizona, Connecticut, District of Columbia, Indiana, Kentucky, Louisiana, Maine, Missouri, Mississippi, New Hampshire, New Jersey, New Mexico, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Virginia, West Virginia, Wyoming

  - **Example**: "An employer may not ... require as a condition of employment, an employee or prospective employee to refrain from using; or ... discriminate against an employee with respect to the employee's compensation and benefits or terms and conditions of employment based on the employee's use of tobacco products outside the course of the employee's or prospective employee's employment."
    Ind. Stat. 22-5-4-1
State Law

- Statutory Restrictions:
  - **Lawful Conduct / Lawful Products**: 11 states, including California, Colorado, Illinois, Minnesota, Montana, Nevada, New York, North Carolina, North Dakota, Tennessee, and Wisconsin.

  - **NY Example**: "It shall be unlawful for any employer or employment agency to refuse to hire, employ or license, or to discharge from employment or otherwise discriminate against an individual in compensation, promotion or terms, conditions or privileges of employment because of: ... an individual's legal use of consumable products prior to the beginning or after the conclusion of the employee's work hours, and off the employer's premises and without the use of the employer's equipment or other property."
Americans With Disabilities Act (ADA)

- Americans With Disabilities Act
  - **Coverage:** 15 or more employees
  - **Substantive Provisions:**
    - Non-discrimination / Accommodation
    - Restrictions on Medical Examinations
    - Confidentiality of Medical Information
Americans With Disabilities Act (ADA)

• **Non-Discrimination/Accommodation**
  – Provisions only apply to "disabled" individuals
    • **Definition:** Physical or mental impairment that substantially limits one or more major life activities.
  – Most behaviors targeted by wellness programs do not rise to the level of a "disability" under the ADA
    • Smoking – No
    • Weight – Maybe
    • Alcohol Consumption – Yes
  – Beware: "Regarded As" Disabled Claims
Americans With Disabilities Act (ADA)

• Rules for Medical Examinations and Inquiries:
  o **Applicants:**
    ➢ **Pre-Offer:** No examinations or inquiries allowed
    ➢ **Post-Offer:** Examinations permitted, but must apply to all employees
  o **Employees:** Must be "job-related and consistent with business necessity"
    ➢ Applies to all employees (whether disabled or not).
    ➢ "Job-related" = Ability to perform essential job functions
Americans With Disabilities Act (ADA)

• Voluntary Wellness Program Exception:
  – Statute: "A covered entity may conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site."
  – Regulation: Prior to this spring, EEOC had not promulgated any regulation about meaning of "voluntary"—or how incentives fit in
  – Prior Enforcement Guidance: "Voluntary" means no penalty can be imposed for not participating; anything other than "de minimis" incentive is prohibited.
Case Law Prior to New Regulations

• *EEOC v. Honeywell*: EEOC contends the financial "penalties" for those who do not complete biometric tests include: (1) a $500 surcharge for the employee; (2) a $1,000 tobacco surcharge for the employee; (3) a $1,000 tobacco surcharge if the employee's spouse refused to complete the tests; and (4) non-receipt of a Health Savings Account (HSA) contribution up to $1,500

• *EEOC v. Orion Energy Systems, Inc.*, (E.D. Wis., 8/20/14) – loss of employer subsidy plus $50 "surcharge" if no biometrics (incl blood work)

• *EEOC v. Flambeau, Inc.*, (W.D. Wis., 9/30/14) – loss of coverage if no biometrics (incl blood work)

• *Seff v. Broward County*, 691 F. 3d 1221 (11th Cir. 2012)
  – ADA's bona-fide group health plan safe harbor provision allowed wellness incentives (no review of "voluntariness" issue).
Proposed EEO Regulations

• Programs with disability-related inquiries/medical exams must be “voluntary:”
  – No exclusion from health plan (or ANY plan options) or limiting coverage based on refusal to answer disability based inquiry
  – No requiring participation
  – No retaliation for not participating
Proposed EEO Regulations

• If wellness program makes disability related inquiries/requires medical exam and is part of group health plan, then “voluntary” element also includes:
  – 30% Limit on all incentive based wellness programs that are part of group health plan and make disability related inquiries/require medical exam
    • Based on total cost of self only (no rule for family members)
    • Applies to HIPAA’s participation based program
    • Does not apply to tobacco cessation if tobacco use determined through certification
  – If part of a group health plan, must provide specific notice of programs terms
Proposed EEO Regulations

- Other rules applicable to all wellness programs:
  - Accommodation applies to ALL wellness programs (absent undue hardship)
    - Regs contemplate waivers if under treatment plan
  - Heightened confidentiality requirements
    - Can only receive aggregate, unidentified info unless identifiable info is necessary for plan administrative purposes
    - Basically the same as HIPAA requirements (if part of group health plan)
  - Must be “reasonably designed to promote health and prevent disease”
    - Can’t be overly burdensome, a subterfuge for violating the ADA or highly suspect in method chosen
Marketplace, Exchanges
The Retail Revolution

Four Years Post-Reform, New Paradigm Finally Becoming Clear

Major Themes Reshaping Provider Strategy

1. Medicare Reforms and the Transition to Risk

2. Coverage Expansion and the Rise of Individual Insurance

Source: Health Care Advisory Board Interviews and analysis
Slow Shift to Risk

Providers Still Have a Foot in Two Boats
ACA Making a Dent in Uninsurance

Percentage of U.S. Adults Without Health Insurance

2013 Q3
18.0%
(highest on record)
Insurance exchanges launch
2014 Q3
13.4%
(lowest on record)
Medicaid expansion begins
Employer-sponsored coverage grows

Medicaid Expansion Contentious – and Consequential

28 States + DC Have Opted for Expansion

State Participation in Medicaid Expansion
As of February 2015

Financial Impact

“For-profit health systems… report far better financial returns through the first half of the year than expected, owed in large part to expanded Medicaid”

PricewaterhouseCoopers

9.6M

6.7%
Average Medicaid enrollment increase across non-expansion states

2.4%
Advisory Board estimate of impact of Medicaid expansion on typical hospital’s 10-year operating margin projection

1) Children’s Health Insurance Program.
2) Estimate does not include CT or ME.

Second Open Enrollment Offers Fewer Surprises

Demographics Remain Stable, but Many Re-Enrollees Switched Plans

![Chart showing enrollment data]

1) Includes all enrollees in states using the Healthcare.gov enrollment platform.

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Premium Adjustments Abound

Average Proposed Increase Modest, but High Variability Plan-to-Plan

**Modest Premium Increases on Average**
As of November 25, 2014
3.7% Average premium change across all states, metal tiers

**Significant Variation at Plan Level**

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<thead>
<tr>
<th>State</th>
<th>Average Change</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>-2.5%</td>
<td>-20.6</td>
<td>10.6</td>
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<tr>
<td>Colorado</td>
<td>2.0%</td>
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<tr>
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<tr>
<td>New York</td>
<td>0.7%</td>
<td>-15.3</td>
<td>13.0</td>
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</tbody>
</table>

**A Closer Look:**
Dynamics in New York

- **Correction:** Plans with high market share tended to propose higher rates for 2015
- **Competition:** Plans with low market share tended to propose lower rates for 2015
- **Convergence:** Gap between most expensive, least expensive silver plans narrowing by 10%

# Exchange Analysis 2014-2015

## 2014 LAND OF LINCOLN

<table>
<thead>
<tr>
<th>GENDER</th>
<th>EXAMPLE 1</th>
<th>EXAMPLE 2</th>
<th>EXAMPLE 3</th>
<th>EXAMPLE 4</th>
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<td># of Dependents</td>
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<td>28</td>
<td>35</td>
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<tr>
<td>Use of Tobacco</td>
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<td></td>
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<td>$4,250</td>
<td>$4,250</td>
</tr>
<tr>
<td></td>
<td>OOP Max</td>
<td>$6,250</td>
<td>$6,250</td>
<td>$6,250</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>70%</td>
<td>70%</td>
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</tr>
<tr>
<td></td>
<td>Copayment</td>
<td>$25</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td></td>
<td>Monthly Premium</td>
<td>$85.32</td>
<td>$266.86</td>
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</tr>
<tr>
<td>Gold Level Plan</td>
<td>Deductible</td>
<td>$750</td>
<td>$750</td>
<td>$750</td>
</tr>
<tr>
<td></td>
<td>OOP Max</td>
<td>$3,000</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>75%</td>
<td>75%</td>
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<tr>
<td></td>
<td>Copayment</td>
<td>$35</td>
<td>$35</td>
<td>$35</td>
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<tr>
<td></td>
<td>Monthly Premium</td>
<td>$104.91</td>
<td>$287.96</td>
<td>$340.53</td>
</tr>
</tbody>
</table>

## 2015 LAND OF LINCOLN

<table>
<thead>
<tr>
<th>GENDER</th>
<th>EXAMPLE 1</th>
<th>EXAMPLE 2</th>
<th>EXAMPLE 3</th>
<th>EXAMPLE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td>Discount $25.00</td>
<td>Discount $81.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage</td>
<td>Female</td>
<td>Female</td>
<td>Male</td>
<td>Male</td>
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<tr>
<td># of Dependents</td>
<td>21</td>
<td>28</td>
<td>35</td>
<td>25</td>
</tr>
<tr>
<td>Use of Tobacco</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Total Household Income</td>
<td>$20,000</td>
<td>$50,000</td>
<td>$70,000</td>
<td>$40,000</td>
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<tr>
<td>Bronze Level Plan</td>
<td>Deductible</td>
<td>$5,500</td>
<td>$5,500</td>
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</tr>
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<td></td>
<td>OOP Max</td>
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<td>$6,500</td>
<td>$6,500</td>
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<tr>
<td></td>
<td>Coinsurance</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
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<tr>
<td></td>
<td>Copayment</td>
<td>$35</td>
<td>$35</td>
<td>$35</td>
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<tr>
<td></td>
<td>Monthly Premium</td>
<td>$85.72</td>
<td>$182.74</td>
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<td>Silver Level Plan</td>
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<td></td>
<td>OOP Max</td>
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<tr>
<td></td>
<td>Coinsurance</td>
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<td>30%</td>
<td>30%</td>
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<tr>
<td></td>
<td>Copayment</td>
<td>$25</td>
<td>$25</td>
<td>$25</td>
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<tr>
<td></td>
<td>Monthly Premium</td>
<td>$102.29</td>
<td>$210.08</td>
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<td>Gold Level Plan</td>
<td>Deductible</td>
<td>$750</td>
<td>$750</td>
<td>$750</td>
</tr>
<tr>
<td></td>
<td>OOP Max</td>
<td>$3,500</td>
<td>$3,500</td>
<td>$3,500</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Copayment</td>
<td>$35</td>
<td>$35</td>
<td>$35</td>
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<tr>
<td></td>
<td>Monthly Premium</td>
<td>$126.96</td>
<td>$250.75</td>
<td>$290.52</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>2014 BCBS IL</th>
<th>2015 BCBS IL</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>EXAMPLE 1</td>
<td>EXAMPLE 2</td>
</tr>
<tr>
<td><strong>GENDER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AGE</strong></td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td><strong>21</strong></td>
<td>22</td>
<td>26</td>
</tr>
<tr>
<td><strong>COVERAGE</strong></td>
<td>Single</td>
<td>Single</td>
</tr>
<tr>
<td><strong># OF DEPENDENTS</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL HOUSEHOLD INCOME</strong></td>
<td>$20,000</td>
<td>$50,000</td>
</tr>
<tr>
<td><strong>USE OF TOBACCO</strong></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>BRONZE PLAN: Blue Choice Bronze PPO 006</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DEDUCTIBLE</strong></td>
<td>$6,000</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>OOP MAX</strong></td>
<td>$6,000</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>CONTRIBUTION</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>COPAYMENT</strong></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>MONTHLY PREMIUM</strong></td>
<td>$383.36</td>
<td>$125.49</td>
</tr>
<tr>
<td><strong>SILVER PLAN: Blue Precision Silver HMO 002</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DEDUCTIBLE</strong></td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>OOP MAX</strong></td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>CONTRIBUTION</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>COPAYMENT</strong></td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td><strong>MONTHLY PREMIUM</strong></td>
<td><strong>$85.13</strong></td>
<td><strong>$180.04</strong></td>
</tr>
<tr>
<td><strong>GOLD PLAN: Blue PPO Gold 001</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DEDUCTIBLE</strong></td>
<td>$3,250</td>
<td>$3,250</td>
</tr>
<tr>
<td><strong>OOP MAX</strong></td>
<td>$3,250</td>
<td>$3,250</td>
</tr>
<tr>
<td><strong>CONTRIBUTION</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>COPAYMENT</strong></td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td><strong>MONTHLY PREMIUM</strong></td>
<td><strong>$196.58</strong></td>
<td><strong>$304.45</strong></td>
</tr>
<tr>
<td><strong>PLATINUM PLAN: Blue Precision Platinum HMO 004</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DEDUCTIBLE</strong></td>
<td><strong>$0</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td><strong>OOP MAX</strong></td>
<td><strong>$1,500</strong></td>
<td><strong>$1,500</strong></td>
</tr>
<tr>
<td><strong>CONTRIBUTION</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>COPAYMENT</strong></td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td><strong>MONTHLY PREMIUM</strong></td>
<td><strong>$167.81</strong></td>
<td><strong>$276.95</strong></td>
</tr>
</tbody>
</table>

*Note: Use of copays for most services*
Individuals Gravitating Toward Leaner Plans

Premium Sensitivity Manifest at Two Levels

**Level 1: Choice of Metal Tier**
- Silver: 65%
- Gold: 9%
- Platinum: 5%
- Catastrophic: 2%
- Bronze: 20%

**Level 2: Plan Choice Within Metal Tier**
- **All Metal Levels**
  - Any Other Plan: 36%
  - Lowest-Cost Plan: 43%
- **Second-Lowest-Cost Plan**
  - Any Other Plan: 21%

1) Data from federally-facilitated exchanges only.

Source: HHS, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period," May 1, 2014; Health Care Advisory Board interviews and analysis.
High Deductibles Dominating Exchange Markets

Aggressive Cost Sharing Potentially Troublesome of Provider Strategy

<table>
<thead>
<tr>
<th>Individual Deductibles Offered On Public Exchanges</th>
<th>Median</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$2,500</td>
<td>$6,250</td>
</tr>
</tbody>
</table>

Individual Deductibles Chosen on eHealth Individual Marketplace

- <$1,000: 16%
- $1,000-$2,999: 39%
- $3,000-$5,999: 30%
- $6,000+: 16%

Challenges for Providers

- High out-of-pocket costs discourage appropriate utilization
- Large patient obligations lead to more bad debt, charity care
- Price-sensitive patients more likely to seek lower-cost options

Premium Sensitivity Supporting Narrow Networks

Payers Betting Individual Consumers Value Affordability Over Broad Choice

Average Percent of PPO Network Specialists Included in Exchange Plan Networks

Anthem BlueCross BlueShield, 2014

Breath of Hospital Networks in Exchange Plans

20 Urban Markets, December 2013

1) "Pathway X" bronze plans compared to leading PPO plan offering across nine states.
2) Comparing products by the same carrier of the same tier, across 7 carriers.

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Tradeoff Between Premium, Choice Often Stark

Will Ultra-Low-Premium Options Be Sustainable for Payers? Providers?

1) Pseudonym.

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Proper Risk Pricing Still Essential

Is It Worth Winning Share With Unsustainable Premiums?

Low Premiums Moving the Market...

2013:
- PreferredOne offers lowest Silver plan premium in country;
- wins massive market share on Minnesota exchange (MNsure)

...but Perhaps Not the Right One

2014:
- PreferredOne exits exchange
- Will still offer individual coverage through other successful channels with different risk profile

2% Market share in 2012
58% Market share in 2014

“Continuing to provide this coverage through MNsure is not sustainable.”

Marcus Merz
CEO, PreferredOne

Source: Crostby J, “Top Selling Insurer on MNsure Won’t Be Back This Year,” Minneapolis Star Tribune, September 16, 2014; Health Care Advisory Board interviews and analysis.

1) Pre-exchange individual market

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Increased Insurer Participation Driving Competition

Robust Marketplaces Beginning to Develop

“We had a very modest footprint in 2014. We do have a bias to increase that participation in 2015. [...] The size of the overall market is positive.” Gail Boudreaux, EVP UnitedHealth Group

Issuers Offering Qualified Health Plans

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally-Facilitated Marketplace (36 states)</td>
<td>191</td>
<td>248</td>
</tr>
<tr>
<td>State-Based Marketplace (8 states reporting)</td>
<td>61</td>
<td>67</td>
</tr>
</tbody>
</table>

Competition At Work

4% Estimated reduction in second-lowest-cost silver premium of one new issuer entering market

Patient Cost-Sharing Continues to Accelerate

Particularly Severe for Out-of-Network Care

Low Premiums Shaping More than Network Selection

Care Choices, Network Assembly Dynamics Driven by Premium Pressure

Consequences of Premium Sensitivity

"Our price is now given by the market. Our business is changing from cost-based pricing to price-based costing."

Health Care Executive
Pharmacy Strategies
Agenda

• Background
• Specialty Growth and Pipeline
• Compounding Growth and Pipeline
• CVS Health Solutions
Specialty Drugs Continue to Drive Pharmacy Trend

<table>
<thead>
<tr>
<th>TRADITIONAL AND SPECIALTY TREND</th>
<th>TREND DRIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Specialty Drug Trend</td>
<td>• Utilization</td>
</tr>
<tr>
<td>Specialty Drug Trend</td>
<td>• Price increases</td>
</tr>
<tr>
<td>∆ 18.3%</td>
<td>• Hepatitis C therapies</td>
</tr>
<tr>
<td>∆ 15.6%</td>
<td>• Compounded pharmaceuticals</td>
</tr>
<tr>
<td>-3.8%</td>
<td></td>
</tr>
<tr>
<td>0.8%</td>
<td></td>
</tr>
<tr>
<td>6.8%</td>
<td></td>
</tr>
<tr>
<td>32.4%</td>
<td></td>
</tr>
</tbody>
</table>

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Increasing Utilization of Specialty Drugs

Three Key Drivers 2011-2014

- New Drugs: 88
- New Indications: 110
- Aging Population: 6x PMPM costs for older patients

= Increasing Utilization

Utilization Trend

Rxs per million members per month

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6,622</td>
<td>6,973</td>
<td>7,457</td>
<td>8,099</td>
</tr>
</tbody>
</table>

Source: CVS/caremark Enterprise Analytics, data 2011 through 2014. PMPM (Per Member Per Month).

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Increasing Specialty Drug Prices

AWP INCREASES

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>8.5%</td>
</tr>
<tr>
<td>2014</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

LAUNCH PRICES (ANNUAL PRICE IN THOUSANDS)

- **2014**: Harvoni®
- **2013**: Viekira Pak™
- **2012**: Sovaldi®
- **2011**: Tecfidera
- **2010**: Incivek®
- **2008**: Cimzia®
- **2007**: Tasigna®
- **2006**: Revlimid®
- **2004**: Tysabri®
- **2002**: Humira®
- **1998**: Enbrel®
- **1997**: Copaxone®

14% CAGR

Source: CVS/specialty Analytics. Annual drug costs based on average wholesale price (AWP) accessed summer 2013. This slide contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Health. Source: CVS/specialty 2010-2014 book of business.

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## Significant Pipeline Launches: By Product, Innovative & Generic, and Therapy Class

<table>
<thead>
<tr>
<th>PRODUCT LAUNCHES</th>
<th>INNOVATIVE AND GENERIC*</th>
<th>2015 AND 2016 THERAPY CLASSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Launch 1st Half of 2015</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cosentyx</td>
<td>- Ibrance (Breakthrough Breast Cancer)</td>
<td>- Hepatitis C</td>
</tr>
<tr>
<td>- Ibrance</td>
<td>- Orkambi (Breakthrough Cystic Fibrosis)</td>
<td>- Elbasvir/Grazoprevir</td>
</tr>
<tr>
<td>- Lumacaftor</td>
<td></td>
<td>- Daclatasvir</td>
</tr>
<tr>
<td><strong>Launch 2nd Half of 2015</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Praluent</td>
<td>- Praluent (New Class)</td>
<td>- Cystic Fibrosis</td>
</tr>
<tr>
<td>- Repatha</td>
<td>- Repatha (New Class)</td>
<td>- Orkambi</td>
</tr>
<tr>
<td>- Daclatasvir</td>
<td>- Glatopa - Glatiramer Acetate (Generic)</td>
<td>- Hyperlipidemia</td>
</tr>
<tr>
<td>- Upravi</td>
<td></td>
<td>- Praluent</td>
</tr>
<tr>
<td><strong>Launch 1st Half of 2016</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Elbasvir/Grazoprevir</td>
<td>- Erythropoietin (Biosimilar)</td>
<td>- Oncology</td>
</tr>
<tr>
<td></td>
<td>- Zarxio (Filgrastim - Biosimilar)</td>
<td>- Ibrance</td>
</tr>
<tr>
<td></td>
<td>- Imatinib mesylate - Gleevec (Generic)</td>
<td>- Auto Immune</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Cosentyx</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- IPF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ofev</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- PAH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Upravi</td>
</tr>
</tbody>
</table>

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Generics, Biosimilars and New Launches in Key Therapy Classes

- Hepatitis C
- Cystic Fibrosis
- Oncology
- Biosimilars
- High Cholesterol

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New Hepatitis C Therapies Create Competition

- **IMPROVED EFFICACY**: >95% CURE RATE
- **3M PEOPLE**: 50% UNDIAGNOSED
- **$115K PER PATIENT**: UP TO $15B ANNUALLY

**HARVONI COMPETITION EMERGING**

- **Q3/Q4 2015**: Daklinza (daclatasvir) 
  Bristol-Myers Squibb
- **Q1 2016**: Asunaprevir/daclatasvir/beclabuvir 
  Bristol-Myers Squibb
- **Q1/Q2 2016**: Elbasvir/grazoprevir 
  Merck

**Products in the pipeline are expected to gradually erode Harvoni’s market share.**

1. Mehdi Najafzadeh, PhD; Karin Andersson, MD; William H. Shrank, MD, MSHS; Alexis A. Krumme, MS; Olga S. Matlin, PhD; Troyen Brennan, MD, JD, MPH; Jerry Avorn, MD; and Niteesh K. Choudhry, MD, PhD. *Ann Intern Med.* 2015;162:407-419. doi:10.7326/M14-1152

This slide contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Health.

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**PCSK9 Inhibitors: Next-Generation Therapies for High Cholesterol**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Indication</th>
<th>Anticipated Launch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repatha (evolocumab)</td>
<td>Hyperlipidemia, heterozygous FH (HeFH) and homozygous FH (HoFH)</td>
<td>Q3 2015</td>
</tr>
<tr>
<td>Praluent (alirocumab)</td>
<td>Hyperlipidemia and heterozygous FH</td>
<td>Q3 2015</td>
</tr>
<tr>
<td>Bococizumab (Pfizer)</td>
<td>Hyperlipidemia and HeFH</td>
<td>Q4 2017</td>
</tr>
</tbody>
</table>

### Estimated Costs
- **$4.8K to $8.7K per patient per year**
- **Up to $70B potential annual spend; $4B in the first year**

### Potential Eligible Patients
- **Up to 7M potential eligible patients; 400,000 in the first year**
- **Up to 60% reduction in bad cholesterol (LDL-C) after 12 weeks with few side effects**

**PCSK9 inhibitors may sharply reduce the risk of heart attacks and strokes.**

---

1. CVS/caremark Internal Projections, March 2015.
3. Pipeline Services, March 2015. This slide contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Health.

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Biosimilars Update

**BPCI Act Established an Abbreviated Licensure Pathway**

<table>
<thead>
<tr>
<th>BIOSIMILAR PRODUCT</th>
<th>INTERCHANGEABLE BIOLOGIC PRODUCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Biologic product</td>
<td>• Biosimilar to the reference product</td>
</tr>
<tr>
<td>• Highly similar to the reference product</td>
<td>• Same clinical effect</td>
</tr>
<tr>
<td>• No clinically meaningful differences between the two in terms of safety, purity and potency</td>
<td>• Changing to the biosimilar is no more risky than repeated use of reference product</td>
</tr>
</tbody>
</table>

Biosimilars bring competition to the marketplace.

BPCI (Biologics Price Competition and Innovation Act).  

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The Utilization of Compound Drugs is a Growing Concern

More than 30 million prescriptions are compounded in the U.S. each year.\(^1\)

Gross costs per compounded claim increased nearly 1,700%.\(^2\)

They are not approved by the FDA; not required to undergo the same studies for clinical efficacy and safety.*

Average gross cost per 30-day script grew more than 10X over a three-year period.\(^3\)

Due to rising costs, safety concerns and aggressive campaigning by compounding pharmacies we are enhancing our drug management strategies.


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Core Solution Can Help Control Costs by Helping Ensure Appropriate Utilization

**PRIOR AUTHORIZATION (PA)**

Addresses cost; helps promote appropriate utilization through clinical review

- PA for all compound claims exceeding a $300 threshold
- **CVS/caremark™ will be absorbing the cost of PA for clients**

**EXCLUSIONS**

Addresses cost by excluding select ingredients or drugs from coverage

- Exclusion of costly bases and bulk compounding powders and compounding kits

---

*The dual approach of exclusions and PA will help address current and future compound drug issues.*

*For clients for whom we manage PA. Compound PAs only. Effective 7/1/15.*

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Additional Tools to Help Increase Visibility to Compound Use and Manage Costs

- Health care professionals manage appeals/medical exception process
- Client-specific reporting to identify compound management opportunities
- Dedicated audit team, concurrent review and proprietary audit tools
More Tools Available to Support a Comprehensive Specialty Trend Management Strategy

Illustrative Trend 20%
Integrated PA 6%

- Site of Care 3%
- Claims Editing & Repricing 2%
- Specialty Formulary 2%
- Generic Programs 1%
- Pricing Models 1%
- Exclusive Network 1%
- Remaining Trend 4%

Comprehensive CVS/specialty Tools

Source: CVS Caremark Specialty Client Solutions and Trend Management, 2013, internal analyses for estimated program savings.

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Summary

• Pipeline continues to grow, prices continue to rise

• New drugs potentially create higher level of competition

• Solutions exist that leverage increased competition to help control trend and spend

• You have to put the right programs in place to fully optimize available solutions
Pipeline Appendix
PD-1s Represent Promising Therapy Class

- Two front-runners for this class are Keytruda (pembrolizumab) and Opdivo (nivolumab)¹
- ~$12,500 per month²
- Trials are currently under way for a number of other cancers, including lung, liver, brain and solid tumors¹
  - FDA expanded approved use of Opdivo to treat lung cancer³

¹FDA (U.S. Food and Drug Administration).
Oncology - Ixazomib

- Oral agent being investigated for the treatment of myeloma
- This drug class includes the following injectables:
  - Velcade (bortezomib)
  - Kyprolis (carfilzomib)
- Anticipated launch Q2 2016

### ADDITIONAL PIPELINE HIGHLIGHTS

**Q3 2015**
Sonidegib
Basal Cell Cancer

**Q2 2016**
Binimetinib
Melanoma

**Q2 2016**
Duvelisib
Non-Hodgkin’s Lymphoma

1. Pipeline Services, March 2015

This slide contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Health.

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## Biosimilar Pipeline Highlights

<table>
<thead>
<tr>
<th>PRODUCT NAME/REFERENCE BRAND*</th>
<th>MANUFACTURER</th>
<th>ANTICIPATED FDA REVIEW DATE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remsima (infliximab)/Remicade</td>
<td>Celltrion</td>
<td>6/8/2015***</td>
</tr>
<tr>
<td>pegfilgrastim/Neulasta</td>
<td>Apotex</td>
<td>8/17/2015</td>
</tr>
<tr>
<td>Grastofil (filgrastim)/Neupogen</td>
<td>Apotex</td>
<td>10/13/2015</td>
</tr>
<tr>
<td>Retacrit (epoetin alfa)/Epogen/Procrit</td>
<td>Hospira</td>
<td>10/16/2015</td>
</tr>
</tbody>
</table>

*Biosimilars may or may not be approved for all of the same indications as the reference product. **Anticipated launch dates to be determined. ***Not likely to launch until after Remicade patent expires. All of the drugs on this slide are primarily covered under the medical benefit and the impact on the client’s pharmacy costs would likely be much smaller for these drugs.


This slide contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Health.

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Heart Failure: A Promising New Drug on the Horizon

• 5 million heart failure (HF) patients in the U.S.¹
• Sacubitril/valsartan is for the treatment of chronic HF in patients with reduced ejection fraction; ~50% of patients with HF²
• Reduced risk of death and hospitalization by 20% compared to standard treatment³
• Potential to replace ACE inhibitors and ARBs³
• ~$2,500 per patient per year³
• Anticipated launch Q3 2015

². AHA-Heart Disease and Stroke Statistics- 2014 Update http://circ.ahajournals.org/content/early/2013/12/18/01.cir.0000441139.02102.80, accessed March 26, 2015.
Compound Appendix
# Compound Drugs vs. Traditional Therapies: Cost and Safety Considerations

**HENRY, AGE 40, DIAGNOSED WITH FIBROMYALGIA**

<table>
<thead>
<tr>
<th>FDA APPROVED FOR PRESCRIBED USE</th>
<th>COMPOUND MEDICATION*</th>
<th>TRADITIONAL THERAPY*</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCUMENTED EVIDENCE OF EFFICACY</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>FOLLOWS STRINGENT QUALITY GUIDELINES TO HELP ENSURE SAFETY</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>COST</td>
<td>May vary by state</td>
<td>YES</td>
</tr>
</tbody>
</table>

|                       | Cost for Henry:       | Cost for Henry:       |
|                       | $63.09/month\(^1\)   | $25/month\(^1\)      |
|                       | Cost for plan:        | Gross cost for plan:  |
|                       | $10,594.17/month\(^1\)| $258/month\(^2\)    |

An effective compound drug strategy would help direct members to more cost-effective treatment with proven health outcomes.

FDA (U.S. Food and Drug Administration).*Derived from evidence-based clinical guidelines. Patient story is presented for illustrative purposes only. Any resemblance to an actual individual is coincidental. All data sharing complies with applicable privacy laws. 1. CVS/caremark, illustrative example of typical claim cost. 2. AWP for Cymbalta; other FDA-approved therapies are available, including a generic option. Projections based on CVS/caremark data. Individual results will vary based on plan design, formulary status, demographic characteristics and other factors. Client-specific modeling available upon request.

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Significant Savings: Comparing Average Cost per Claim for Clients with our Service vs. Those Without

Source: Enterprise Research and Analytic Development Book of Business analysis investigating impact of compound solutions on trend, April 2015.

Employers and health plans with strategy are clients that signed up for compounds strategy at different points in time from inception of the program. Projections based on CVS/caremark data. Individual results will vary based on plan design, formulary status, demographic characteristics and other factors. Client-specific modeling available upon request.

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Case Study: Compound Strategy

TOTAL GROSS COST FOR COMPOUND RXS

MONTHLY COMPOUND UTILIZATION


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CVS Health Solutions Appendix
We Have Broadest Set of Offerings to Address Trend

<table>
<thead>
<tr>
<th></th>
<th>PBM</th>
<th>SPECIALTY</th>
<th>SPECIALTY UNDER MEDICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>FORMULARY</td>
<td>Standard, Advanced, Value</td>
<td>Advanced Specialty</td>
<td></td>
</tr>
<tr>
<td>NETWORKS</td>
<td>30- and 90-Day Retail, Narrow and Preferred Networks, Mail, Maintenance Choice®</td>
<td>Preferred, Exclusive and Infusion Networks</td>
<td></td>
</tr>
<tr>
<td>UTILIZATION MANAGEMENT</td>
<td>PA, Retrospective Review</td>
<td>Clinical guideline management and PA tools</td>
<td></td>
</tr>
<tr>
<td>SITE OF CARE</td>
<td></td>
<td>Site of Care Transition Management with Coram CVS/specialty Infusion Services (&quot;Coram&quot;) Nurses</td>
<td></td>
</tr>
<tr>
<td>CLAIMS EDITING</td>
<td>PA, Retrospective Review</td>
<td>Pharmacy Benefit Claims Edits</td>
<td>Medical Benefits Claims Edits with Novologix® Technology</td>
</tr>
<tr>
<td>CARE COORDINATION</td>
<td>Pharmacy Advisor®</td>
<td>CareTeam including Pharmacist, Accordant® and Coram Nurses</td>
<td></td>
</tr>
</tbody>
</table>

Mail pricing at CVS retail for ERISA governed plans. The Maintenance Choice program is available to self-funded employer clients that are subject to ERISA. Non-ERISA plans such as insured health plans, plans for city, state or government employees, and church plans need CVS/caremark Legal's approval prior to offering the Maintenance Choice program. Prices may vary between mail service and CVS/pharmacy due to dispensing factors, such as applicable local or use taxes.

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HIPAA Privacy Refresher
Applicability of Privacy Rule

• “Covered Entity”
  • Health plans (insured and self-insured)
  • Health care clearing houses
  • Providers
General Privacy Rule

• A covered entity may not use or disclose protected health information (PHI) (individually identifiable information) except to:
  • The individual
  • For treatment, payment or health care operations, or
  • As otherwise permitted under the Privacy Rule
Minimum Necessary

- When disclosing PHI, must make “reasonable efforts” to limit disclosure to the “minimum necessary” to accomplish the request
- Information can also be “de-identified”
Accessing PHI

PHI should not be removed from a company’s premises, regardless of whether the PHI is contained on paper, portable drive, etc.

PHI should only be viewed or possessed:

1) On the company’s premises, or
2) Through remote access to the company’s computer system (if applicable).
Printed PHI

If you need to print a document which contains PHI, you must ensure that it is **destroyed** once you are done with it.

- **Destruction** – Paper, film, or other hard copy media must be shredded or destroyed such that the PHI cannot be read or reconstructed.
Whereas the HIPAA privacy rule applied to PHI in any form, the security rule is limited to *electronic* PHI the covered entity creates, receives, maintains or transmits.
HIPAA SECURITY RULE

How does the Security Rule apply to you?

You must password protect any electronic device that contains any EPHI, especially if you have remote access!

Do not store any EPHI on a remote device (i.e., computer, hand-held device, etc.) that can be accessed without a password!
HIPAA SECURITY RULE

Avoid downloading EPHI onto an external public device, such as a library computer or hotel business center.

Avoid leaving remote devices unattended or in public.
Disclosure to Business Associates

- Covered entity may disclose PHI to BA if written contract in place
- BA include:
  - Third party administrators
  - Preferred provider organizations
  - Utilization review companies
  - Case management companies
  - Medical review firms that review appeals
  - Pharmacy benefit managers
  - Any other vendor that uses individually identifiable health information
BREACH NOTIFICATION RULES

Federal law requires a covered entity to notify individuals in the event their *unsecured* PHI is breached or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach “without unreasonable delay” and in no case later than 60 days of discovery.
BREACH NOTIFICATION RULES

For a breach of unsecured PHI under the control of a business associate, the business associate upon discovery of the breach would be required to notify the covered entity under the same parameters as discussed above. The covered entity is then directly obligated to provide the individuals with notice of the breach.
What is a breach?

“What unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of such information”
BREACH ISSUES

An impermissible use or disclosure of PHI is presumed to be a breach unless the covered entity or business associate can demonstrate that there is a low probability that the PHI has been compromised.

The covered entity or business associate has the burden of proof.
BREACH ISSUES

Covered entities and business associates must assess the probability that the PHI has been compromised based on a risk assessment that considers at least the following factors:

1. The nature and extent of the PHI involved, including the types of identifiers and likelihood of re-identification,
2. The unauthorized person who used the PHI or to whom the disclosure was made,
3. Whether the PHI was actually acquired or viewed, and
4. The extent to which the risk to the PHI has been mitigated.
Method of notification – Notice must be provided by first class mail to the individual (or the next of kin or personal representative if the individual is deceased and the covered entity has access to the next of kin or personal representative’s address) at the last known address of the individual or the next of kin, respectively, or, if specified as a preference by the individual, by electronic mail.
Substitute Notice mandated if insufficient/out-of-date contact information exists to locate the individual. In the case in which there is insufficient or out-of-date contact information for fewer than 10 individuals, then such substitute notice may be provided by an alternative form of written notice, telephone, or other means.
BREACH NOTIFICATION RULES

In the case in which there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice shall:

(A) Be in the form of either a conspicuous posting for a period of 90 days on the home page of the Web site of the covered entity involved, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside; and

(B) Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual’s unsecured protected health information may be included in the breach.
BREACH NOTIFICATION RULES

Notice of the breach would have to be provided to “prominent media outlets” serving a state or jurisdiction if more than 500 individuals (from one covered entity) in that state or jurisdiction were impacted.

Regardless, if the breach impacted 500 or more individuals (regardless of location), the covered entity involved would have to inform HHS immediately (without unreasonable delay and in no case longer than 60 calendar days following the discovery of the breach).

If the breach involved less than 500 persons, the covered entity would have to maintain a log of such breaches and annually submit it to HHS no later than 60 days after the end of each calendar year in which the breach was discovered.
BREACH NOTIFICATION RULES

Content of notification – Notice of a breach must include, to the extent possible, the following:

1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

2) a description of the types of unsecured PHI that were involved in the breach (such as full name, Social Security number, date of birth, home address, diagnosis, account number, or disability code);
BREACH NOTIFICATION RULES

3) the steps individuals should take to protect themselves from potential harm resulting from the breach;

4) a brief description of what the covered entity is doing to investigate the breach, to mitigate losses, and to protect against any further breaches; and

5) contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, and email address, website, or postal address.
ENFORCEMENT PENALTIES

The Act significantly increases civil monetary penalties. Penalties, which were $100 per violation (and capped at $25,000 for multiple violations), have risen to:

- The covered entity did not know of the violation: $100-$50,000. Capped at $1.5 million per calendar year.

- The violation was due to reasonable cause and not willful neglect: $1,000-$50,000. Capped at $1.5 million per calendar year.

- The violation was due to willful neglect, but was corrected within 30 days of discovery: $10,000-50,000. Capped at $1.5 million per calendar year.

- The violation was due to willful neglect, but was not corrected within 30 days of discovery: Minimum $50,000. Capped at $1.5 million per calendar year.
Although individuals do not have a private right of action under HIPAA, state attorneys general are now authorized to file suit on behalf of their residents and obtain statutory damages (calculated by multiplying the number of violations by up to $100, but capped at $25,000 for all violations of an identical requirement).

Enforcement against individuals or employees through criminal penalties.
ENFORCEMENT (CONTINUED)

The Secretary of Health and Human Services will have the authority to bring criminal actions along with the Department of Justice.
Administrative Requirements for Group Health Plans

- Plan documents must be amended to include requirements for use and disclosure of PHI
- Notice must be provided to members regarding use and disclosure of PHI
- Designate privacy official and determine job duties
Administrative Requirements for Group Health Plans, continued

- Provide training to personnel with access to PHI
- Implement safeguards to protect privacy of PHI
- Process for individuals to make complaints
- Have and apply appropriate sanctions for failure to comply with policies and procedures
- Refrain from intimidating and retaliatory acts
- Retain documents for six years
Q&A

Closing Remarks