

Benefitfocus Healthcare Reform Roadmap

As the industry-leader in healthcare and benefits software, our goal at Benefitfocus is to provide technology that makes life easier for our clients. To achieve that purpose, we're focused on the BENEFITFOCUS® Platform's readiness for relevant provisions of the Patient Protection and Affordable Care Act (PPACA) – otherwise known as healthcare reform. Carriers, employers, brokers and consumers using our Web-based platform have the tools they need to remain compliant, understand requirements and take advantage of new options as they shop, enroll, manage and exchange benefit information.

The Benefitfocus Platform is built on a comprehensive eligibility rules engine that handles complex plan designs, business rules and reporting. Our technology is scalable and can meet many current and future PPACA requirements. We're also making new investments to ensure that you and your customers not only abide by the law but also understand and benefit from subsidy programs and other PPACA offerings. Our timeline below breaks down key features of the PPACA, and specifically outlines how the Benefitfocus Platform meets and exceeds business needs relevant to each provision. Healthcare reform is complex. We're here to help.

2010

Pre-Existing Conditions: Eliminates denial of coverage for dependents under the age of 19 based on a pre-existing condition. In 2014, no member shall be denied coverage due to a pre-existing condition.

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- Eliminates pre-existing condition clauses for dependents
- Includes life events and reinstatement options for previously canceled dependents
- Allows carriers and employers to waive pre-existing exclusions for specific employees
- Notifies clients of outdated plan materials with pre-existing conditions for dependents under 19
- Enforces health statement and underwriting rules for subscribers and non-child dependents under age 19, with option to NOT include children or students under age 19 during enforcement

Dependent Coverage: Extends dependent coverage to children up to age 26 for all individual and group policies.

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- Increases plan age eligibility to age 26 for children and students
- Provides reinstatement options for previously canceled dependents
- Includes flexible coverage levels and relationship types
- Requires employees and consumers to acknowledge that they can only be covered in particular situations – for example, if they do not have coverage elsewhere
- Notifies clients of outdated plan materials with plan age out rules
- Identifies clients with invalid dependent age-out rules and updates coverage for dependents up to the age of 26

2011

Tax Advantage Savings Accounts: Increases the penalty for non-qualified withdrawals from Health Savings Accounts (HSAs) to 20 percent and excludes non-prescription, over-the-counter drugs from tax-free reimbursement. Reduces tax-free individual contribution to Flexible Savings Accounts (FSAs) to \$2,500 beginning January 1, 2013.

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- Helps employers and consumers understand these changes through integrated video, e-mail notifications and plan documents loaded into the Platform's plan shopping and workflow
- Configures the Platform to cap FSA contributions based on new federal levels

Standardized Benefit Summaries: Department of Health and Human Services (HHS) announces standards for carrier-provided summaries of plan benefits, including minimum essential benefits coverage. Failure to provide enrollees with this information will result in a \$1,000 fine for each failure.

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- Configures plan summary display to align with the standards defined by HHS
- Updates inbound data integration standard and all existing carrier versions to include name value pairs for plan attributes required by the HHS standard plan summary display

Electronic Eligibility Determination: HHS defines standard rules for determination of electronic eligibility for health plans and claim status transactions.

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- Manages complex business rule logic through an eligibility rules engine that helps determine enrollment eligibility of members. Standard rules can be defined to determine electronic eligibility for carriers and claim status transactions

Medical Loss Ratio: Requires annual carrier reporting on premium dollars spent on medical care and healthcare quality activities, providing member rebates if premium spending is less than 85 percent in large groups, 80 percent for small group and individual policies.

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- Provides efficient benefit management tools and data exchange services at a low transactional cost to quickly reduce carrier operating expenses
- Integrates detailed membership reports to help determine total benefit costs

Grandfathered Plans: Grandfathered plans must comply with information transparency requirements, allowing consumers to compare plan benefits, cost sharing requirements, and renewability and continuation of coverage provisions.

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- Provides plan and benefit summary information, and updates displays to align with HHS standards if needed

2014 and beyond

Small Business Tax Credits: From 2010 – 2013, The PPACA provides a tax credit up to 35 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the total premium cost or 50 percent of a benchmark premium. After 2014, the government will provide a tax credit to eligible small businesses that purchase coverage through their state's exchange.

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- Builds an Employer Contribution Report calculating employer contribution percentage for each employee and for the company as a whole. The report also allows employers to manage their contributions and understand if they are eligible for the tax subsidies

Reinsurance Program: Creates a temporary reinsurance program for employers providing coverage to retirees age 55 to 64 and ineligible for Medicare. The government will reimburse employers or insurers for 80 percent of retiree claims between \$15,000 and \$90,000.

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- Provides a report that identifies employees who meet the reimbursement program requirements for retiree status and age, allowing carriers and employers to determine employees eligible for subsidized coverage

Employer Mandate: Employers must create an essential health benefits package that provides a comprehensive set of services, covers at least 60 percent of the actuarial value of the covered benefits, limits annual cost-sharing to \$5,950 for individuals and \$11,900 for families and is not more extensive than the typical employer plan.

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- Supports complex business rules and a variety of plans based on benefit design needs and incorporates new essential benefit packages designed by employers

State Health Insurance Exchanges: Requires states to establish Health Insurance Exchanges through which individuals and small businesses can purchase affordable insurance.

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- Provides an exchange-ready platform to states for Web-based plan shopping, consumer education, eligibility and enrollment management, bill presentment and payment and data exchange

Treasury Report: Requires employers to report a variety of data to the U.S. Treasury Department, including the number of full-time employees, length of waiting period and the employer's share of the total allowed cost of benefits.

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- Offers a Treasury Report that allows employers to report summary and employee-specific information for PPACA-required data. The report will be in the Treasury Department's required format and can be saved or printed for submission

Employer Penalty: If large employers (over 50 employees) offer coverage but an employee receives a tax credit or cost-sharing subsidy through the State Health Insurance Exchange, then the employer pays the lesser of a. a penalty of \$3,000 for each full-time employee receiving a subsidy or b. \$2,000 per full-time worker after subtracting the first 30 full-time workers.

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- Identifies and captures specific reasons as to why employees are declining coverage

Wait Periods: Limits any waiting period for coverage to 90 days.

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- Configures wait periods to comply with new restriction and proactively reach out to impacted clients to ensure their rules are adjusted accordingly

Individual Mandate: Individuals are required to purchase qualified health insurance or pay a fine of \$95 for each family member or 1 percent of taxable income, whichever is greater.

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- Integrates plan shopping tools that help individuals find appropriate plans, estimate out-of-pocket costs and provide persona-based product recommendations

Small Group Health Plan Deductible Limit: Caps deductibles for plans offered by small employers at \$2,000 for individuals and \$4,000 for families, unless offsetting contributions are offered for deductibles above these amounts.

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- Updates existing deductible configurations to generate a warning message whenever a user attempts to set a deductible value above the defined limits