An Affordable Care Act Update:
Navigating the Changes and Challenges

October 24, 2014

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Today’s Presenter

James ("Jim") S. Gandolfo, Senior Vice President, Treasury Management, Senior Consulting Manager

Jim Gandolfo has been the Healthcare lead for PNC’s Treasury Consulting Group (TCG). TCG provides a variety of support to both industry and PNC’s Treasury Management professionals related to comprehensive solutions for commercial payments, receivables and information management.

Currently, Jim is responsible for HSA development and distribution. Previously, he was with PNC Global Investment Servicing, where he was responsible for their Health Savings Account administration solution (HSA). His experience also includes a long tenure with Wilmington Brokerage Services Company, a registered broker-dealer, where he was president and chief executive officer.

A graduate of Radford University in Radford, Virginia, Gandolfo holds a bachelor of science degree in political science and history. His FINRA licenses include Series 6, 7, 24 and 63. He is chairman of the American Bankers Association’s HSA Council and a member of the board of directors of the HSA Coalition. Jim has been recognized by an industry forum, for his work with public policy. He is based in Wilmington, Delaware.
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Note: The views expressed in the foregoing presentation are those of James S. Gandolfo and not of PNC and are not intended as legal, tax or financial advice or recommendations.
Industry Update and Trends
U.S. Leads in Health Expenditures per Capita

The U.S. spends more, per capita, on health than all other OECD countries; it is ranked first in health expenditures at $8,508 which is more than double the OECD average of $3,467.

Source: Organization for Economic Co-operation and Development (OECD); http://www.oecd.org/statistics/
Breakdown of US Health Care Expenditures

National Health Expenditures as a Percentage of Gross Domestic Product and Breakdown of National Health Expenditures, 2012

Public Funding* Continues to Grow as a Source

National Health Expenditures by Source of Payment ($Billions)

* State and Federal payments via Medicare and Medicaid
The Affordable Care Act
Goals of Reform

1) Universal Coverage
2) Target Major Issues
   - Access
   - Costs
   - Quality

1) Focus on Three Key Areas
   - Insurance Reform
   - Payment Reform
   - Delivery Reform
Impact of Health Reform
(Sample of 500 Hospitals)

2010+ Market Basket & Productivity Cuts, Geographic Variation, Wage Index


-0.5%  -1.5%  -2.8%

2013+ Readmission Penalties

2013+ Value Based Purchasing, P4P

2014+ Medicare DSH Cuts

2015+ Hospital Acquired Conditions

18% Reduction in Inpatient Medicare Payments by 2019

Status of State Medicaid Expansion Decision

The Healthcare Financing Accounts

Focus: Health Savings Accounts
Health Care Policy Premiums Costs Continue to Rise

Exhibit 1.13
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2013

* Estimate is statistically different from estimate for the previous year shown (p<.05).

How Did We Get Here?

Mid 1970’s – Cafeteria Plans allow employees to choose benefits that meet their needs.

1980’s /'90s – Expansion: FSAs, HRAs, MSAs

2004 – Congress enacts legislation creating HSAs

2008 – Massachusetts state-wide health reform includes an HSA option - Indiana “Patient Power” program

2010 PPACA – Patient Protection and Affordable Care Act

2012 HSA "Plans" Embraced as “One Type” of Bronze Plan
HSA Deposits & Covered Lives

Total HSA Deposits & Covered Lives

- HSA Deposits (Billions)
- HSA Covered Lives (Millions)

Source: AHIP, Center for Policy and Research, (Jan 2013); http://www.ahip.org/hsa2013/; http://www.jama.ama.assn.org
Growth of HSA-Qualified High-Deductible Health Plan Enrollment, (Millions), March 2004 to January 2014

Sources: AHIP Center for Policy and Research, 2005 - 2014 HSA/HDHP Census Reports
Notes: For this census, companies reported enrollment in the large- and small-group markets according to their internal reporting standards, or by state-specific requirements for each state. The “Other Group” category contains enrollment for companies that could not break down their group membership into large- and small-group categories within the deadline for reporting. The “Uncategorized” category was necessary to accommodate companies that were able to provide information on the total number of people covered by HSA/HDHP policies, but were not able to provide a breakdown by market category within the deadline for reporting.
Growth in Deductibles

*Average deductibles for visits are increasing*

In-network and out-of-network deductibles

Statistics and Trends

- The number of enrollees with HSA/HDHPs rose to nearly 17.4 million in January 2014, up from 15.5 million in January 2013

- On average, HSA/HDHP enrollment increased 16 percent from 2013 to 2014 for plans that participated in the census both years

- Most enrollment gains in the HSA/HDHP market in 2014 were in the large group market. The share of HSA/HDHP lives enrolled in large group plans jumped from 59 percent in January 2012 to 68 percent in January 2013, to 74 percent in January 2014

- Fifty-two (52) percent of all HSA/HDHP enrollees in the individual market (including dependents covered under family plans) were age 40 or over; 48 percent were under age 40

- Preferred provider organizations (PPOs) were the most popular HSA/HDHP product types, representing more than 75 percent of all enrollment in HSA/HDHPs

* Source: America’s Health Insurance Plans, Center for Policy and Research 2013 CDHC Survey
## State by State Adoption

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<th>State</th>
<th>HSA/HDHP Enrollment</th>
<th>Percentage of Commercial Enrollment</th>
</tr>
</thead>
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<tr>
<td>United States</td>
<td>17,368,764</td>
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<td>Alabama</td>
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<td>Arizona</td>
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<td>Arkansas</td>
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<td>California</td>
<td>597,535</td>
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<td>Colorado</td>
<td>271,030</td>
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<td>Connecticut</td>
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<td>Delaware</td>
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<td>Hawaii</td>
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<td>Idaho</td>
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<td>Illinois</td>
<td>1,054,916</td>
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<td>Indiana</td>
<td>396,934</td>
<td>10.9%</td>
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<td>Iowa</td>
<td>146,059</td>
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<td>Kansas</td>
<td>64,808</td>
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<td>Kentucky</td>
<td>139,599</td>
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<td>Louisiana</td>
<td>172,476</td>
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<td>Maine</td>
<td>93,215</td>
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<td>Maryland</td>
<td>356,890</td>
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<td>Massachusetts</td>
<td>199,700</td>
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<td>Michigan</td>
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<td>Minnesota</td>
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<tr>
<td>Mississippi</td>
<td>30,297</td>
<td>2.1%</td>
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<table>
<thead>
<tr>
<th>State</th>
<th>HSA/HDHP Enrollment</th>
<th>Percentage of Commercial Enrollment</th>
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</thead>
<tbody>
<tr>
<td>Missouri</td>
<td>183,447</td>
<td>5.2%</td>
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<tr>
<td>Montana</td>
<td>24,066</td>
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<td>Nebraska</td>
<td>133,704</td>
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<td>Nevada</td>
<td>62,694</td>
<td>4.3%</td>
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<td>New Hampshire</td>
<td>73,974</td>
<td>8.7%</td>
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<tr>
<td>New Jersey</td>
<td>228,186</td>
<td>4.2%</td>
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<tr>
<td>New Mexico</td>
<td>43,882</td>
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<td>New York</td>
<td>587,835</td>
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<td>North Carolina</td>
<td>367,025</td>
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<td>North Dakota</td>
<td>39,720</td>
<td>8.4%</td>
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<td>Ohio</td>
<td>802,511</td>
<td>12.1%</td>
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<tr>
<td>Oklahoma</td>
<td>89,285</td>
<td>4.7%</td>
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<tr>
<td>Oregon</td>
<td>163,743</td>
<td>7.6%</td>
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<td>Pennsylvania</td>
<td>691,750</td>
<td>8.9%</td>
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<tr>
<td>Rhode Island</td>
<td>39,468</td>
<td>6.6%</td>
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<tr>
<td>South Carolina</td>
<td>93,752</td>
<td>3.5%</td>
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<tr>
<td>South Dakota</td>
<td>28,328</td>
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<td>Tennessee</td>
<td>342,422</td>
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<tr>
<td>Texas</td>
<td>1,042,642</td>
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<tr>
<td>Utah</td>
<td>105,351</td>
<td>5.6%</td>
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<td>Vermont</td>
<td>26,187</td>
<td>7.5%</td>
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<td>Virginia</td>
<td>221,740</td>
<td>4.4%</td>
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<td>Washington</td>
<td>546,179</td>
<td>13.8%</td>
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<td>West Virginia</td>
<td>86,777</td>
<td>8.9%</td>
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<td>Wisconsin</td>
<td>115,735</td>
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<tr>
<td>Wyoming</td>
<td>13,936</td>
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</tr>
<tr>
<td>Uncategorized</td>
<td>74,917</td>
<td>N/A</td>
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</table>
Why High Deductible Health Plans?

Employers use HDHPs and HSAs to:

Entice individuals to behave as rational consumers with regards to health care expenditures

Carrot and Stick approaches to change consumer behavior
- Higher deductibles or co pays
- Tax free medical spending accounts (FSA, HRA, Archer MSA, HSA)
- Incentive programs

Alternative to merely shifting costs to employees

Often used in conjunction with wellness and disease management programs

Quality and cost of care resources improve effectiveness of consumer driven health plans
How Are High Deductible Health Plans Defined by Statute?

Minimum annual deductible for combined medical and prescriptions in 2014
- $1,250 for individuals
- $2,500 for families

Maximum annual out-of-pocket maximum in 2014 (includes deductible, co pays, coinsurance and prescriptions)
- $6,350 for individuals
- $12,700 for families

Individual deductibles and OOP maximums are non-embedded
- Family or employee + dependent coverage, no individual deductible

No co pays available until deductible has been satisfied (including prescriptions)

Preventive care covered without cost sharing

Non or low charging physicians paid through capitated payments would not disqualify plan

* Source: Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Types of so called “CDHC Accounts”

- Flexible Spending Accounts (FSA)
  - Fixed amount set aside by the employee pre-tax
  - Use it or lose it- must spend by end of plan year, or rollover $500

- Health Reimbursement Accounts (HRA)
  - Employer-funded
  - Unused funds remain with employer

- Health Savings Accounts (HSA)
  - Funded by employee, employer, or combination
  - Funds always belong to the account holder

Note: HSAs can only be used alongside FSAs or HRAs if the latter are limited purpose plans for dental or vision only

* Source: Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Health Savings Account (HSA)

- **HSA Overview**

  - **Qualified HDHP**

    |                  | Plan deductible must be at least | Out of pocket max can be no more than | HSA Annual Contributions can be no more than |
    |------------------|----------------------------------|---------------------------------------|---------------------------------------------|
    | Single           | $1,250 | $1,250 | $6,250 | $6,350 | $3,250 | $3,300 |
    | Family           | $2,500 | $2,500 | $12,500 | $12,700 | $6,450 | $6,550 |
    | Allowable catch-up contribution for age 55+ | $1,000 | $1,000 |

- **HSA Benefits to Individuals**
  - The funds in the HSA are owned and controlled by the individual and may be rolled over from year-to-year
  - HSAs provide a Triple Tax Benefit to the individual:
    - Money goes in tax-free
      - Contributions to HSA come out of an individual’s pay pre-tax, thereby reducing taxable income
      - NOTE: An individual can also contribute to an HSA on an after-tax basis
    - Money grows tax-free
      - HSAs earn tax-free interest
      - Once an account balance reaches $1,000, an individual has the option to select and manage investments through a brokerage account
    - Money comes out tax-free for qualified medical expenses
      - NOTE: For ineligible or non-health related expenses, if the individual is 65 or older, the withdrawal will be taxed as ordinary income, and if the individual is under age 65, the withdrawal will be taxed as ordinary income and is subject to an additional 20% penalty

HSA Taxation

Employees do not pay income tax on HSA contributions

Employers and employees do not pay FICA or FUTA on HSA contributions

HSA expenditures on Qualified Medical Expenses are not taxed

Account balances “roll over” in full each year
  • No maximum account balance, just maximum annual contribution
  • Do not have to be enrolled in HDHP to use HSA, just to contribute to one

IRS allows non-taxed HSA investing
  • e.g. interest bank accounts, annuities, certificates of deposits, stocks, mutual funds, bonds

Use of HSA funds for non medical expenses results considered taxable income + 20% penalty tax
  • Penalty tax waived after age 65
  • Still considered taxable income

Health Savings Account (HSA)

- Tax Benefits of HSAs Compared to Traditional Retirement Accounts

### Annual Contributions
- **Not Taxed**
- **Taxed as Ordinary Income**
- **Not Taxed**

### Types of Accounts
- **401(k) / Traditional IRA**
- **Roth IRA**
- **HSA**

### Distributions
- **May be subject to 10% tax penalty before 59.5 yrs old**
- **Not Taxed**
  - Beneficiary must attain the age of 59 1/2 (and trust must be in existence for five years to qualify for distribution). Early withdrawals and nonqualified distributions are taxable. Early withdrawals and non-qualified distributions are both subject to 10% penalty.
- **Not Taxed**
  - If used for approved medical expenses
- **Taxed as Ordinary Income**
  - If used for non-medical expenses.
  - Subject to penalty if under 65

Health Savings Account (HSA)

- **Retirement Investment Product**
  - Based on the benefits offered, an individual employee may consider using pre-tax income to take advantage of the following:
    - Employer match by contributing to a 401(k) up to the percentage offered by the company
    - Tax-free savings and tax-free withdrawals for qualified medical expenses by contributing to a HSA up to the annual limit
      - Unspent HSA funds roll over every year and can be invested, earning tax-free interest
      - Similar to a 401(k), a HSA is taxable on withdrawal for non-qualified medical expenses, but is not penalized after age 65
    - Tax-free savings by additionally contributing to a 401(k) above the employer match level

What To Expect
Deductibles vary widely by metal level in the public marketplace.

Chart 8: Average Medical Deductible By Metal Level

What Type of Plans Are Consumers Choosing?

Chart 9: Marketplace Plan Selection By Metal Level, October 1, 2013 – March 31, 2014*

- Silver: 65%
- Bronze: 20%
- Gold: 9%
- Platinum: 5%
- Catastrophic**: 2%


*Based on the total number of plan selections for which the applicable data are available (excluding unknown). Percentages do not add to 100% due to rounding.

**Catastrophic plans do not cover benefits other than three primary care visits per year and preventive services until the deductible is met. Premiums are generally lower than other ACA health plans, but deductibles, copayments and coinsurance are generally higher. Eligible enrollees must be under 30 years old or receive a “hardship exemption.”
### Overall Employee Satisfaction

#### Figure 5. Satisfaction with health care plan, 2007 – 2013

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<tbody>
<tr>
<td><strong>All</strong></td>
<td>69%</td>
<td>64%</td>
<td>64%</td>
<td>59%</td>
<td>−10</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger than 40</td>
<td>67%</td>
<td>69%</td>
<td>65%</td>
<td>64%</td>
<td>−3</td>
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<tr>
<td>40 – 49</td>
<td>70%</td>
<td>64%</td>
<td>63%</td>
<td>57%</td>
<td>−13</td>
</tr>
<tr>
<td>50+</td>
<td>71%</td>
<td>61%</td>
<td>63%</td>
<td>56%</td>
<td>−15</td>
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<tr>
<td><strong>Health status</strong></td>
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<tr>
<td>Very good</td>
<td>71%</td>
<td>70%</td>
<td>72%</td>
<td>64%</td>
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<tr>
<td>Good</td>
<td>67%</td>
<td>60%</td>
<td>58%</td>
<td>57%</td>
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<td>Fair or worse</td>
<td>67%</td>
<td>56%</td>
<td>61%</td>
<td>44%</td>
<td>−23</td>
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<td><strong>High-deductible health plan</strong></td>
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</tr>
<tr>
<td>Not HDHP eligible</td>
<td>72%</td>
<td>65%</td>
<td>66%</td>
<td>61%</td>
<td>−11</td>
</tr>
<tr>
<td>HDHP eligible, not enrolled</td>
<td>66%</td>
<td>65%</td>
<td>60%</td>
<td>60%</td>
<td>−6</td>
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<tr>
<td>HDHP eligible, enrolled</td>
<td>55%</td>
<td>58%</td>
<td>64%</td>
<td>48%</td>
<td>−7</td>
</tr>
</tbody>
</table>

Note: Based on full-time employees enrolled in their employer's health care plan. Percentages indicate responses of “agree” or “strongly agree.”

Results: Employer Benefit Research Institute

Study finds evidence that adults in a CDHP and those in an HDHP were more likely than those in a traditional plan to exhibit a number of cost-conscious behaviors.

• Checked whether the plan would cover care
• Asked for a generic drug instead of a brand name; talked to their doctors about prescription options and costs
• Talked to their doctors about other treatment options and costs; asked a doctor to recommend less costly prescriptions
• Developed a budget to manage health care expenses
• Checked the price of a service before getting care
• Used an online cost-tracking tool provided by the health plan

How Are Health Plans Adapting?

- Physician-specific quality data: 57%
- Provider cost information (e.g. negotiated rates, drug prices, procedures): 66%
- Hospital-specific quality data: 70%
- Personal Health Record: 75%
- Member access to health savings account information (e.g. view balances): 84%
- General physician-specific information (e.g. hospital affiliation, medical education): 88%
- Health education information: 91%

Sources: AHIP Center for Policy and Research, 2014 HSA/HDHP Census
Economic Reasons Employers May Choose HSA Plans

- Greater employee engagement in health care decisions and spending
- Ability to influence or control premium cost by plan design
- Effective January 1, 2018, a “Cadillac” Plan Tax Excise tax of 40% will be applied to employer-sponsored coverage that has a benefit value in excise of $10,200 for single coverage and $27,500 for family coverage.
- More efficient use of dollars: Provide qualified medical coverage rather than paying penalties under Employee Responsibility clause in ACA (69% of employers stated they will definitely continue to provide employer-sponsored health care in 2014)

Source: “2013 Employer-Sponsored Health Care: ACA’s Impact,” by the International Foundation of Employee Benefit Plans

- New research released July 2013 from the Employee Benefit Research Institute:
  - Introducing the full-replacement HSA plan reduced the plan’s total health care spending by 25 percent in the first year.
  - Spending on laboratory services and prescription drugs had the largest statistically significant declines (36 and 32 percent, respectively).
  - Reductions in pharmacy spending were large and mostly sustained over the four years after the HSA was adopted

Symphony or Cacophony?
Changing Health Care Policies and Health Care Financing
Industry Trends and The ACA
Effects on Healthcare Consumerism

- **Trends**
  - Employer cost of healthcare coverage for employees continues to grow. Medical services are projected to reach almost 20% of U.S. GDP by 2021.¹
  - One common strategy for employers to shift costs to the consumer is by offering high deductible health plans (HDHPs). In 2013, about 58% of employers offered a HDHP.²
  - Consumers are becoming more sensitive to price and quality, especially those with high deductible health plans.³
  - Patients are willing to pay if they are provided with information and options.⁴

- **Impacts and Challenges for Providers**
  - Increasing HDHPs = Increasing patient financial responsibility = Increasing AR and bad debt. Hospital uncompensated care rose to a record $45.9 billion in 2013.³
  - Out-of-pocket payments by insured patients are expected to grow by 68% from 2009 to 2015.⁴ While some providers are getting better at their point-of-service collection efforts, many still lack tools and processes to address the timely and effective collection of payments from patients.

- **The Solution**
  - Effective technologies and processes to help patients understand their out-of-pocket costs prior to service and provide options to pay in an easy and timely manner.
  - Patient payment estimation tools + best practice collection approach = POS Collections Bad Debt

3-http://www.aha.org/research/reports/tw/14/june-tw-consumerhc.pdf
Reform Impact on Insurance Coverage & Health Savings Accounts

Key Points: Insurance Coverage

Most Americans were required to carry health insurance January 1, 2014.

- **Health Insurance Exchanges (HIX)** were established with the intention of providing for the expansion of coverage, shift costs across the board and provide a range of choices.
  - State run (16 states and Washington, D.C.)
  - State-federal partnership marketplace (7 states)
  - Federally-facilitated marketplace

- **Private Insurance Exchanges** are developing in response creating online portals that are populated with a variety of health-plan options from either a single or multiple carrier.

- 4 plan types are offered, platinum (90% coverage), gold (80% coverage), silver (70% coverage), bronze (60% coverage). Bronze minimal level was designed to allow for the purchase of a qualified **Health Savings Account (HSA)**.

- Beginning in 2015 under the 2010 Affordable Care Act (ACA), employers employing 50 full-time employees or more will be subject to **Employer Shared Responsibility**.

- Effective January 1, 2018, a “Cadillac” Plan Tax Excise tax of 40% will be applied to employer-sponsored coverage that has a benefit value in excise of $10,200 for single coverage and $27,500 for family coverage.
CDHP Growth Predictions and Observations:

Growth in CDHPs could be accelerated by mandates and potential subsidies

• The government is requiring everyone to buy health insurance; trends are supporting large group in the least expensive product on the market

• Income-based subsidies are tied to the 2nd least-costly plan type (Silver plan) in the Exchange

• Individuals can only get the maximum subsidy if they choose this plan or a cheaper plan.

• Beginning in 2015 under the 2010 Affordable Care Act (ACA), employers employing 50 full-time employees or more will be subject to Employer Shared Responsibility.

• Cadillac Tax will continue to influence plan design

• Somewhat fluid situation ahead related to ACA
CDHP Growth Predictions:

The entire small group market may be replaced by Public Insurance Exchanges and essentially become a super-sized “individual choice” market combining those in the current market and the uninsured

✓ Update: recent issuance and clarification issued by Internal Revenue Service Notice 2013-54 (Disallow use of HRA to fund premium reimbursement)*

When employees (not the employer) are choosing their health insurance, most of them could gravitate to the cheapest plans

✓ HSA Plans will become more dominant

*Source: Internal Revenue Service Notice 2013-54
Contact Information

James Gandolfo, Senior Vice President
Senior Consulting Manager, PNC Treasury Consulting Group
(302) 429 - 2832 (office)
(302) 824 - 4616 (cell)
Email: james.gandolfo@pnc.com
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