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Agenda

- Upcoming requirements
- Recent developments
- Regulatory landscape

Upcoming Requirements for Group Health Plans

2012	2013	2014	2018
<ul style="list-style-type: none"> • Comparative Effectiveness Research Fee • W-2 reporting of health value • Summary of Benefits and Coverage • Women’s Preventive Health Coverage 	<ul style="list-style-type: none"> • Health care FSA drops to \$2,500 • Employer notifications regarding Exchanges and subsidies • Medicare tax • RDS tax 	<ul style="list-style-type: none"> • Play or Pay • No annual limits on “essential health benefits” • Auto-enrollment in health plans* • Allowable wellness incentives increased to 30% • Employer reporting requirements • Health insurance fees/taxes 	<ul style="list-style-type: none"> • Cadillac Tax
<p>Potential loss of grandfathered plan status, if applicable.</p>			

*Effective date pending regulations

Summary of Benefits and Coverage (SBC)

- Plan sponsors and carriers must create SBCs for each benefit package effective March 23, 2012 (unless extended).
- What is it?
 - A “short” explanation of coverage and cost-sharing provided in a uniform format (standalone, 4 double-spaced pages, 12 point font)
- The template developed by NAIC has four sections appearing on six pages:
 - Important questions, “Why it matters” and a disclaimer (page 1)
 - List of common medical events and services (pages 2 – 4)
 - Shows cost-sharing for network and non-network providers
 - Shows limitations and exceptions
 - Shows excluded services and covered services
 - Describes continuation rights & grievance/appeal rights
 - Coverage examples (pages 5 – 6)
 - Shows how a plan might cover medical care for having a baby, treating breast cancer and managing diabetes
 - Includes Q&As about coverage examples
- Ironically, the instructions are 15 pages long.

Summary of Benefits and Coverage

- Who provides SBCs?
 - For a self-insured group health plan, the plan administrator
 - For a fully-insured group health plan, *both* the plan administrator and the health insurance issuer
 - Issuers & administrators must send SBCs to participants & beneficiaries
 - Issuers must send SBCs to plan sponsors
- When do they have to be provided?
 - With initial enrollment and annual enrollment materials
 - Within 7 days of a special enrollment or other request
 - 60 days before a mid-year material change
- How can they be distributed?
 - Paper
 - Electronic delivery
- Who receives SBCs?
 - Participants & beneficiaries of group health plans (all ELIGIBLE employees)
 - Plan sponsors of fully-insured group health plans

Insurance Company 1: PPO Plan 1

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011

Coverage for: Individual + Spouse | Plan Type: PPO



This is not a policy. You can get the policy at www.insurancecompany.com/PLAN1500 or by calling 1-800-XXX-XXXX.

A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why this Matters:
What is the premium ?	\$481 monthly	The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible ?	\$2,500 person / \$7,500 family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes; \$300 for pharmacy expenses	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. \$2,500 person / \$7,500 family	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Co-payments, premium, balance-billed charges, prescription drugs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the insurer pays?	No.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.insurancecompany.com for a list of participating doctors and hospitals.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term in-network , preferred , or participating for providers in their network.
Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

OMB Control Numbers 1545-XXXX,
1210-XXXX, and 0938-XXXX
(expires XX/XX/XXXX)

Insurance Company 1: PPO Plan 1

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Policy Period: 1/1/2011 – 12/31/2011

Coverage for: Individual + Spouse | Plan Type: PPO



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your co-insurance payment of 20% would be \$200. If you haven't met any of the deductible and it's at least \$1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 co-pay/visit	40% co-insurance	————none————
	Specialist visit	\$50 co-pay/visit	40% co-insurance	————none————
	Other practitioner office visit	20% co-insurance for chiropractor and acupuncture	40% co-insurance for chiropractor and acupuncture	————none————
	Preventive care/screening/immunization	\$0	40% co-insurance	
If you have a test	Diagnostic test (x-ray, blood work)	0% co-insurance	40% co-insurance	————none————
	Imaging (CT/PET scans, MRIs)	0% co-insurance	40% co-insurance	————none————
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions .	Generic drugs	\$10 co-pay (retail); \$10 co-pay (mail order)	40% co-insurance	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% co-insurance (retail and mail order)	40% co-insurance	————none————
	Non-preferred brand drugs	40% co-insurance (retail and mail order)	60% co-insurance	————none————
	Specialty drugs (e.g., chemotherapy)	0% co-insurance		————none————

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-insurance	40% co-insurance	_____none_____
	Physician/surgeon fees	0% co-insurance	40% co-insurance	_____none_____
If you need immediate medical attention	Emergency room services	0% co-insurance	40% co-insurance	_____none_____
	Emergency medical transportation	0% co-insurance	40% co-insurance	_____none_____
	Urgent care	0% co-insurance	40% co-insurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-insurance	40% co-insurance	_____none_____
	Physician/surgeon fee	0% co-insurance	40% co-insurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% co-insurance	40% co-insurance	After 8 visits, not covered.
	Mental/Behavioral health inpatient services	0% co-insurance	40% co-insurance	_____none_____
	Substance use disorder outpatient services	0% co-insurance	40% co-insurance	_____none_____
	Substance use disorder inpatient services	0% co-insurance	40% co-insurance	_____none_____
If you become pregnant	Prenatal and postnatal care	Not Covered	Not Covered	_____none_____
	Delivery and all inpatient services	Not Covered	Not Covered	_____none_____
If you have a recovery or other special health need	Home health care	0% co-insurance	40% co-insurance	_____none_____
	Rehabilitation services	0% co-insurance	40% co-insurance	_____none_____
	Habilitation services	0% co-insurance	40% co-insurance	_____none_____
	Skilled nursing care	0% co-insurance	40% co-insurance	_____none_____
	Durable medical equipment	0% co-insurance	40% co-insurance	_____none_____
	Hospital service	0% co-insurance	40% co-insurance	_____none_____
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	_____none_____
	Glasses	Not Covered	Not Covered	_____none_____
	Dental check-up	Not Covered	Not Covered	_____none_____

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Routine hearing tests
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

Your Grievance and Appeals Rights:

- A **grievance** is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit www.XXXXXXXXXXXXXX.com.
- An **appeal** is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit www.XXXXXXXXXXXXXX.gov.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

About these Coverage Examples:

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much insurance protection you might get from different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- Amount owed to providers: \$10,000
- Plan pays \$0
- You pay \$10,000 (maternity is not covered, so you pay 100%)

Sample care costs:

First office visit	\$100
Radiology	\$300
Laboratory tests	\$200
Routine obstetric care	\$2,000
Hospital charges (mother)	\$4,100
Hospital charges (baby)	\$1,900
Anesthesia	\$1,000
Circumcision	\$200
Vaccines, other preventive	\$200
Total	\$10,000

You pay:

Deductibles	\$0
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$10,000
Total	\$10,000

Treating breast cancer

(lumpectomy, chemotherapy, radiation)

- Amount owed to providers: \$98,000
- Plan pays \$94,800
- You pay \$3,200

Sample care costs:

Office visits & procedures	\$4,000
Radiology	\$4,000
Laboratory tests	\$2,400
Hospital charges	\$3,300
Inpatient medical care	\$200
Outpatient surgery	\$3,400
Chemotherapy	\$64,000
Radiation therapy	\$13,000
Prostheses (wig)	\$500
Pharmacy	\$2,000
Mental health	\$1,200
Total	\$98,000

You pay:

Deductibles	\$2,500
Co-pays	\$200
Co-insurance	\$0
Limits or exclusions	\$500
Total	\$3,200

Managing diabetes

(routine maintenance of existing condition)

- Amount owed to providers: \$7,800
- Plan pays \$6,800
- You pay \$1,000

Sample care costs:

Office visits & procedures	\$960
Laboratory tests	\$300
Medical equipment & supplies	\$40
Pharmacy	\$6,500
Total	\$7,800

You pay:

Deductibles	\$300
Co-pays	\$260
Co-insurance	\$400
Limits or exclusions	\$40
Total	\$1,000

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy period.
- There are no other medical expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✖ **No.** Treatments shown are just examples. The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✖ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Glossary of Health Insurance and Medical Terms

- This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate. You can get a copy of the policy at [www.insurancecompany.com] or you may call [1-800-xxx-xxxx.]
- **Bold** text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

A request for your health insurer or **plan** to review a decision or a **grievance** again.

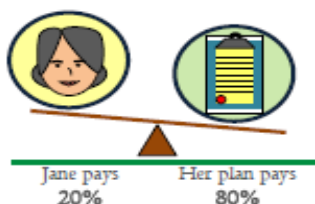
Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service.

You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



(See page 4 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

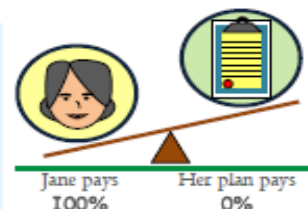
OMB Control Numbers 1545-XXXX,
1210-XXXX, and 0938-XXXX
(expires XX/XX/XXXX)

Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met



(See page 4 for a detailed example.)

your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services received in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

SBC Resources

- Completed template
<http://www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf>
- Instructions (group plans)
<http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf>
- Why it matters “Yes” answers
<http://www.dol.gov/ebsa/pdf/SBCYesAnswers.pdf>
- Why it matters “No” answers
<http://www.dol.gov/ebsa/pdf/SBCNoAnswers.pdf>
- Uniform glossary
<http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf>
- *A Word version of the template can be found at:*
<http://www.dol.gov/ebsa/healthreform/index.html>

Chip's Thoughts...

- “One-size fits all” is a poor communication strategy
- Our employees aren't in 3rd grade
- Plan sponsors need flexibility and accuracy
- Is paper really the best alternative?
 - Electronic comparison tools are powerful and efficient
 - Look at comparison tools used by the Massachusetts Connector, by Medicare, by the Office of Personnel Management
- Let's take more time and get this right

Women's Preventive Services

- Non-grandfathered group health plans are required to cover specific preventive care services at no cost sharing.
 - Can include prescription drugs.
- The list of *women's* preventive services was released in August.
- Group health plans must comply with these additional requirements effective the first plan year beginning on/after August 1, 2012.
 - January 1, 2013 for calendar-year plans.

What's Covered?

- Non –grandfathered plans are required to cover the following for free:
 - well-woman visits
 - screening for gestational diabetes
 - human papillomavirus (HPV) DNA testing for women 30 years and older
 - sexually-transmitted infection counseling
 - human immunodeficiency virus (HIV) screening and counseling
 - FDA-approved contraception methods and contraceptive counseling
 - breastfeeding support, supplies, and counseling, and
 - domestic violence screening and counseling
- These benefits are mandated, except for certain religious exemptions.
- We project an additional 1% load for these coverage enhancements.

Building Blocks for 2014

- Multiple agencies are working on health reform “building blocks” for 2014. The construction zones include:
 - Employer penalties
 - Individual mandate
 - Premium subsidies (aka premium tax credits)
 - Exchanges

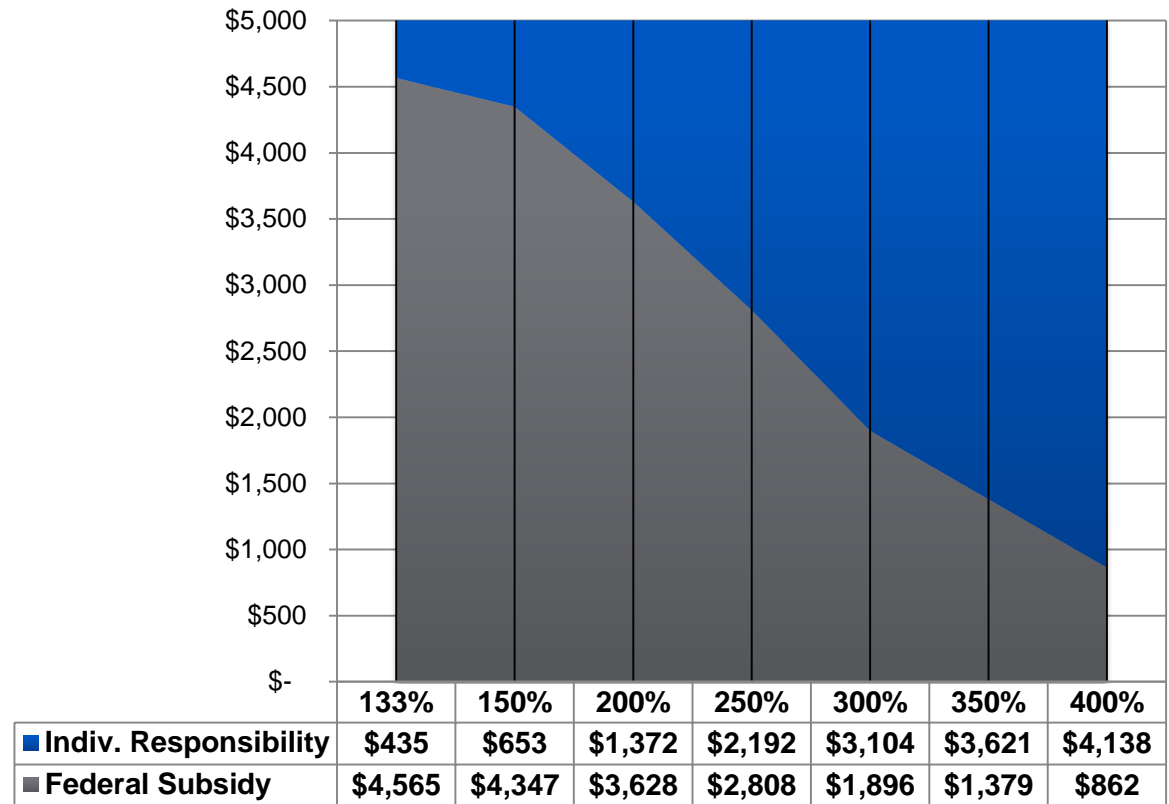
Premium Subsidies

- Eligibility – Buy on Exchange & income < 400% FPL
 - Not eligible for governmental plan, and
 - Not eligible for employer plan, unless inadequate or unaffordable
 - Inadequate = actuarial value < 60%
 - Unaffordable = contribution for self-only > 9.5% of household income
 - Note - individuals who enroll in employer plans are NOT eligible
- Subsidy amount – Paid as advance tax credit = excess of benchmark premium over % of household income
 - Benchmark is 2nd lowest cost silver plan
 - % of household income increases as FPL level increases
- Year-end reconciliation required

Premium Subsidies – How Much?

FPL Percent	Subsidy Cap As % of Income
133%	3.00%
150%	4.00%
200%	6.30%
250%	8.05%
300%	9.50%
400%	9.50%
>400%	No Cap
Cap % grades between points	

Subsidies by FPL Percentage
 Single / FPL = \$10,890 / Premium = \$5,000



Exchanges – Eligibility Determinations

- Aug 2011 regulations describe Exchange eligibility determination rules for Medicaid/CHIP/premium tax credits
- Exchanges must verify:
 - Citizenship (via SSA)
 - Household income (via IRS)
 - Eligibility for employer coverage (?), enrollment status (by attestation) and adequacy and affordability of employer coverage (?)
- Employer responsibilities vis-à-vis Exchanges not clear
 - Possibly respond to an “Exchange-provided” template
 - Possibly provide information to a centralized database


Information Reports – Large Employers

- IRC § 6056 – applies only to large employers (50+ FTEs)
 - Name, date, and EIN of employer
 - Certification whether employer offers FTEs (and dependents) opportunity to enroll in minimum essential coverage
 - Length of plan waiting period
 - Months during which plan coverage is available
 - Monthly premium for lowest-cost option in each coverage tier
 - Employer's share of plan's cost of covered benefits
 - Number of FTEs for each month of calendar year
 - Name, address and SSN of each FTE and months (if any) during which the employee (and dependents) were covered by plan
 - Other information required by the IRS

Coming Attractions

- Essential health benefits
- Reporting requirements (theoretically, Jan 1, 2014)
 - Information reports for large employers
 - Information reports for employers and carriers

The Big Picture - In the Courts

- *Thomas More Law Center v. Obama* 
 - 6th Circuit says law is constitutional (Jun 29, 2011)
 - Affirms district court, 2-1
- *Florida vs. HHS* 
 - 11th Circuit says law is unconstitutional (Aug 12, 2011)
 - Affirms district court, 2-1
 - Both sides have appealed to the Supreme Court
- *Virginia vs. Sebelius & Liberty University v. Geithner* 
 - 4th Circuit dismisses both cases (Sep 8, 2011)
 - Virginia doesn't have standing to sue, and Liberty U. can't sue because of the anti-injunction act

The Big Picture - Over at HHS

- The public relations campaign is unrelenting
 - ACA themes appear in 15 news releases in September (32 total)
 - 135 “hits” for the phrase “thanks to the Affordable Care Act”
- More health reform money is being made available
 - \$200M to develop effective premium rate review programs
 - \$500M to implement State Exchanges
- And requests for exceptions continue
 - 1,472 plans have received one-year annual limit waivers
 - 16 states have applied for MLR waivers (5 “yes”, 2 “no”)
 - Taft-Hartley plans want to be treated as qualified health plans

The Big Picture – What? There's a Deficit?

- CBO “Monthly Budget Review” (Oct 7, 2011)
 - In Sep 2011 – we spent \$64B more than we collected
 - For FY 2011 – we spent \$1.3T more than we collected
- It's a bird, it's a plane, it's **THE SUPERCOMMITTEE!!!**
 - Budget Control Act tasks Super-C with trimming deficit by \$1.5T
 - If \$1.2T in cuts aren't passed by Jan 15, 2012, then automatic cuts are triggered to get to \$1.2T (18% reduction to debt service, then equal \$ cuts to defense and nondefense discretionary spending)
 - Will they modify the tax exclusion for employer health coverage?
 - Will they repeal the CLASS program?
 - How much is \$1T? (<http://www.pagetutor.com/trillion/index.html>)

Final Thoughts

- Health reform is not dead yet, not by a long shot.
- The majority of requirements are administratively tedious but will not have a significant impact on the majority of large employers - although it will likely have a negative impact on medical trend.
- The biggest *strategic* considerations are Play or Pay (2014) and the Cadillac Tax (2018).
 - What factors might cause you to exit employer-sponsored coverage? Does this change if state exchanges prove effective?
 - The Cadillac tax is currently law. Would you exceed cost thresholds absent changes to reduce medical trend? Even if there is no excise tax, can you sustain the projected costs?