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Health Care Reform – The Journey Continues

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September 17, 2012

This presentation is only a high level summary of the Patient Protection and Affordable Care Act (ACA). Information contained in this presentation is subject to change as regulations are issued and interpretation evolves. This presentation should not be considered to be legal guidance regarding ACA or its potential impact and should not be distributed.

Our vision for a sustainable, affordable Health Care system

The **Affordable Care Act (ACA)** is an important milestone in addressing the issue of the nation's uninsured. But more must be done to address the challenges of health care quality and affordability. As we continue to advocate for solutions to these issues, we are guided by Aetna's values and vision of a health care system that helps all Americans have access to affordable, quality health care.

Our vision is grounded in a belief that:

- Consumers will increasingly be in charge of their own health care
- Access to, and affordability of, high quality health care is a universal issue
- Accountable Care Organizations are the new platform for provider/plan collaboration
- Health Information Technology (HIT) will be a key enabler in helping people live healthier lives

Key 2012 Events – Supreme Court Ruling & the Elections

The Affordable Care Act (ACA) and the 6/28/12 Supreme Court Ruling

- The ***Supreme Court upheld the ACA as constitutional***, ultimately ruling on two areas: the ***individual mandate*** and ***state Medicaid expansion***
- The ***individual mandate was upheld as a valid exercise of Congress's constitutional taxing power***, rather than the use of its authority to regulate interstate commerce as argued by the Obama Administration
- The Court also ruled the ***ACA's requirement that states expand Medicaid eligibility to up to 133 percent of the Federal Poverty Level is constitutional***, provided that the states only lose new Medicaid expansion funds if they fail to comply with the expansion requirements, rather than all of their federal Medicaid funding
  - Since the Federal government will cover 100% of the cost until 2017, some states may proceed with the expansion. The federal expansion "match" phases down to 90% by 2020
  - Other states may opt-out of the expansion as Medicaid is a large and growing proportion of State budgets

2012 Elections and ACA Implementation

States will continue to determine pace of ACA implementation

Obama with divided Congress	Obama with Republican Congress	Romney with Republican Congress
Democratic Priorities		
• ACA validation • Implementation proceeds • Highlight "popular" provisions" • Single issue fixes possible, but hard	• Implementation proceeds • Maintain as much of ACA as possible • Potential compromises on cost, coverage, and timeline	• Prevent ACA repeal • Fight to maintain popular insurance reforms • Fight to maintain Exchange Subsidies and Medicaid expansion
Republican Priorities		
• Full ACA repeal effort • Highlight ACA cost and complexity • Potential compromise on cost, coverage, and timeline	• Initial ACA repeal effort • Push defunding and delay • Potential compromises on cost, coverage, and timeline	• Legislative and regulatory ACA repeal effort • Some popular provisions remain • Replacement unclear

Moving Forward Despite Uncertainty

The ACA addresses access without providing for quality and / or affordability

Deficit Reduction Efforts

2012 Elections

Opportunities to improve the ACA remain

ACA compliance remains a top priority

The "fiscal" cliff is real

Political change will shift ACA strategies

State-level support remains uneven

Employer sponsored coverage will continue to thrive

ACA – The Path to Implementation & Compliance

Health Care Reform Timeline

2010

- Benefit coverage changes
  - Preventive Care at 100% in network
  - Dependent children < age 26
  - No pre-ex < age 19
  - Prohibits rescissions except fraud
  - No lifetime / annual dollar limits on essential benefits
  - Patient protections
  - Appeals and External Review updates
- Temporary high-risk pool
- Uniform MLR definition (NAIC)
- HHS Plan Finder

2011

- Minimum MLR requirements
- Medicare Advantage plans begin to have payments frozen
- Medicare Advantage cost sharing limits effective for certain covered services
- Pharmaceutical fee
- Rate review implementation

2012

- Patient Centered Outcomes Research fee
- MLR reporting goes "live"
- Administrative Simplification begins to phase in
- Summary of Benefits and Coverage (SBC)
- Women's Preventive Services

2013

- Medical Device fee
- Exchange coverage notice
- FSA Cap
- Tax deduction for employers for Medicare Part D subsidy eliminated

2014

- Guaranteed issue
- Individual coverage mandate
- Individual subsidy
- State individual and small group Exchanges operational
- Rating rule changes
- Insurer taxes
- Employer "Pay or Play" Mandate
- Essential health benefits
- Medicaid expansion

2015-2019

- 90-Day maximum waiting period
- Auto-Enrollment of Newly Hired, Newly Eligible Full-Time Employees
- Annual reporting of employee coverage
- Definition of full-time employees
- Wellness incentives
- Medicare Advantage MLR Requirements
- Increased penalties on individual mandate
- Increased insurer taxes
- States must allow groups with <100 employees into Exchanges (2016)
- "Cadillac tax" (2018)

Source: Patient Protection and Affordable Care Act

Health Care Reform Timeline

ACA compliance priorities for 2012+

Targeted Areas of Focus in 2012	Targeted Areas of Focus in Anticipation of 2014	Targeted Areas of Focus in Anticipation of 2014+
MLR • 6/1/12 reporting for 2011 experience year • Payment of rebates by 8/1/12 **Employer Reporting Requirements** • Summary of Benefits & Coverage (SBC) • W-2 reporting **Taxes & Fees** • Patient Centered Outcome Research Institute Fee **Women's Preventive Health Services** **Administrative Simplification Operating Rules** **Readiness for 2014+ Marketplace**	**Continued Readiness for 2014+ Marketplace** • Exchanges • Other 2014 Insurance Reforms – Guarantee Issue and Rating Changes – Individual Mandate – Tax Credits and Subsidies – Employer Mandate **Product & Plan Impacts** **Additional Employer Reporting Requirements** **Taxes & Fees** • Annual health insurer fee • Reinsurance Fee **Medicare MLR**	**Adaptation to 2014+ Marketplace** **Taxes & Fees** • Increased health insurer taxes • "Cadillac tax" (2018) **Additional Insurance Reforms** • States must allow groups with <100 employees into Exchanges (2016) • Increased penalties on individual mandate

ACA – Areas of Expected Employer Impact

ACA – Areas of Expected Employer Impact

- Benefits Strategy
- Products & Plans
- Administrative
- Taxes, Fees & Penalties

ACA – Areas of Expected Employer Impact

Benefits Strategy

Beginning in 2014, a number of prominent ACA provisions take effect, including the launch of state and federal exchanges, which may impact employer benefit strategies and purchasing decisions.

Individual Exchange

Exchange Eligibility:

- US citizen or legal alien
- Not incarcerated
- Resident of the state in which Exchange is based

Small Business Health Options Program

Exchange Eligibility:

- Full-time employees of small businesses from 1 to 100 employees
- State option to limit to businesses of 50 or less until 2016
- States will decide on the degree of choice offered to employees through the small business Exchange and how employers can provide contributions toward employee coverage
- Beginning in 2017, states will have the option to open the Exchanges to large employers

Private Exchange

Description:

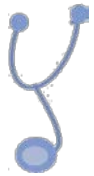
- Free market for plans to target employers that are potentially interested in defined contribution for their employees
- Potentially more plan flexibility as plans may not need to meet QHP standards
- No access to tax credits and subsidies

ACA – Areas of Expected Employer Impact
Benefits Strategy

Healthcare reform will bring unprecedented change and opportunity to the health care industry.

Significant Growth Opportunity

The Individual market is expected to increase by 24M lives by 2016



Focus on Affordability

Health plans will offer low-cost and simple-to-understand products that attract a balanced risk pool

Retail Healthcare and Consumerism

Coverage expansion, transparency, and defined contribution will result in an unprecedented number of consumers shopping online and seeking products that meet their individual needs

ACA – Areas of Expected Employer Impact
Products & Plans: Full-Time Employee Definition

Effective in 2014, employers must offer all "full-time" employees "affordable" coverage not below a defined "minimum value."

Provision Overview

- ACA defines full-time employee as those who work an average of at least 30 hours per week, ***effective 1/1/14***
  *Note: definition relates to FTEs in employer's affordable coverage requirement
- New guidance was issued on 8/31/12, and will provide greater flexibility for employers to reasonably determine whether a current or new variable hour or seasonal employee qualifies for full-time benefits for purposes of the employer mandate rules under the ACA
- Employers may now apply a so-called "look-back" period of up to 12 months to determine whether or not a variable hour or seasonal employee is "full-time" (i.e., averages 30 or more hours per week) under the ACA
- Importantly, this guidance also describes how the ACA provision limiting group health plan waiting periods to no more than 90 days coordinates with the employer mandate, look-back period guidance
- The new guidance regulations largely adopts an approach actively advocated by Aetna and its employer community allies, notably the Employers for Flexibility in Health Care

ACA – Areas of Expected Employer Impact

Products & Plans: Women's Preventive Health Services

The Department of Health and Human Services issued guidance on 8/1/11, regarding women's preventive health services that must be covered by nongrandfathered plans without cost-sharing based upon the recommendations of the Health Resources and Services Administration (HRSA); these provisions took effect starting 8/1/12.

- **Well-woman visits**
- **Human papillomavirus testing**
- **Counseling for sexually transmitted infections**
- **Counseling and screening for human immune-deficiency virus**
- **Screening and counseling for interpersonal and domestic violence**
- **Screening for gestational diabetes**
- **Breastfeeding support, supplies, and counseling**
- **Contraceptive methods and counseling***

* *Qualifying religious employers and organizations may choose not to offer contraceptive coverage beginning with new or renewing plans effective on or after 8/1/12.*

ACA – Areas of Expected Employer Impact
Products & Plans: Other Impacts

90 Day Maximum Waiting Period for Private Insurance

- Waiting periods for coverage of greater than 90 days will be eliminated for new individual and employer-sponsored insurance plans ***effective 2014***
- Existing plans will need to amend waiting periods to not exceed this new requirement

Flexible Spending Account Cap

- Provision limits the amount of contributions to a flexible spending account (FSA) for medical expenses to $2,500 per year beginning 2013
- The FSA cap will be increased annually by the cost of living adjustment following implementation ***effective 1/1/13***

Wellness Incentives

- Employers will be permitted to offer employees rewards of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards (potentially increasing to 50% of the cost of coverage) ***in 2014***
- 10 state pilot programs will apply similar rewards in the individual market in July 2014

Auto-Enrollment

- Employers with more than 200 full-time employees and who offer health coverage will be required to automatically enroll new, full-time employees in a coverage option and continue existing elections for current full-time employees from year to year
- This ACA provision was originally slated to be ***effective in 2014***

ACA – Areas of Expected Employer Impact
Administrative: Employer Reporting Requirements

Overview: Key ACA-Mandated Employer Reporting Requirements

- Employers will be required to **disclose the value of the benefits they provide** for each employee's health insurance coverage on the employee's **annual W-2 form** (for W-2s issued in January 2013)
- **Summary of Benefits and Coverage (SBC)** will be provided to all participants of health plans by the employer or insurer. SBC will provide participants with information regarding cost sharing, continuation of coverage, limitations on coverage, and details on where participants can obtain more information about their health plans
- Other reporting requirements will also be promulgated through regulation, e.g., **quality of care reporting**

- Employers must **notify employees** about:
  - The availability of state health insurance Exchanges
  - How to access information regarding premium subsidies that might be available for Exchange-based coverage

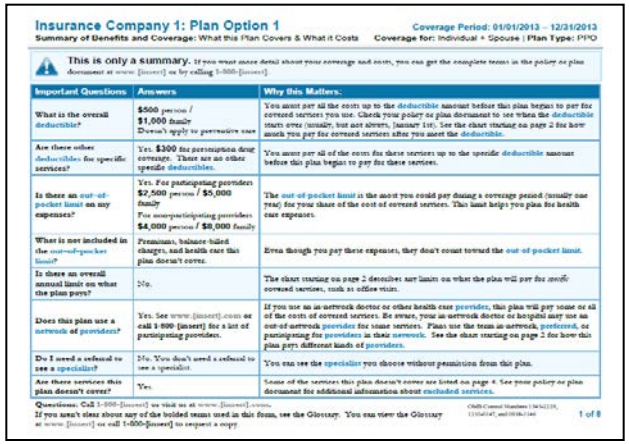
- Employers must **notify employees** about:
  - Whether the employer's plan meets minimum coverage requirements defined by ACA provisions
- In addition, **employers must report the following information to the Secretary of HHS:**
  - The length of any applicable waiting period
  - Certification that all full- time employees were offered health care coverage
  - The time period during which coverage was available
  - The premium charged to the employee for the plan
  - The employer's share of the cost of the plan

ACA – Areas of Expected Employer Impact

Administrative: Employer Reporting Requirements, SBC

Final regulations published on 2/9/12 require that the Summary of Benefits and Coverage (SBC) for group health plans and individual health insurance coverage must be delivered to group health plans and participants at various points within the sales and renewal process beginning 9/23/12

The SBC must cover the following information:


Insurance Company 1: Plan Option 1

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

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual + Spouse | Plan Type: PPO

This is only a summary.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 person / $1,000 family. Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document 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 prescription drug coverage. There are no other specific deductibles.	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. For participating providers $2,500 person / $5,000 family. For non-participating providers $4,000 person / $8,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) 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?	Premiums, balance-billed charges, and health care that this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.[insert].com or call 1-800-[insert] for a list of participating providers.	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. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
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 on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-[insert] or visit us at www.[insert].com.

If you want more information about the items and terms used in this form, see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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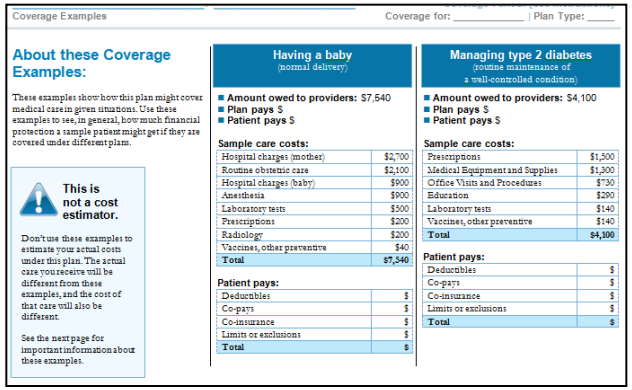

Coverage Examples

Coverage for: _____ | Plan Type: _____

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under 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 will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $
- **Patient pays** $

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	**$**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $
- **Patient pays** $

Sample care costs:

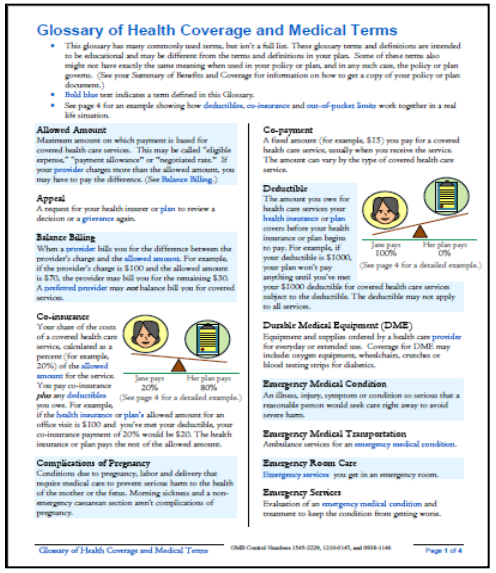
Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	**$**

Summary of Benefits and Coverage:
A uniform 4 page double sided document that describes the benefits and coverage under a plan including cost sharing requirements and any information regarding exceptions, reductions, or limitations.

Coverage Examples:
Examples of cost sharing under the plan for coverage of two common conditions: Having a baby and managing type 2 diabetes.


Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue 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 for covered services.

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.

Jane pays 20% | Her plan pays 80%
(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.

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

Jane pays 100% | Her plan pays 0%
(See page 4 for a detailed example.)

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 you get in an emergency room.

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

Glossary of Health Coverage and Medical Terms

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Page 1 of 4

Uniform Glossary: Provides definitions of health coverage and medical terminology used in the SBC. The glossary must be made available via link and via paper upon request (Made available via website link).

ACA – Areas of Expected Employer Impact

Administrative: Employer Reporting Requirements, SBC

Aetna is actively working to deliver a compliant SBC solution by the 9/23/2012 effective date. Aetna will support SBC generation for both Insured (as required by the law) and Self Funded customers (where requested).

SBC Production & Distribution Requirements: Insured vs. Self Funded Plans	
Insured Plans	**Self Funded Plans**
• **Insurer (issuer)** is accountable for providing the SBC to plan sponsor (for group plans), or individuals (in the Individual Market) • The **insurer (issuer)** and the **plan sponsor** are **jointly accountable** for providing the SBC to applicants, participants, and beneficiaries. – Either can satisfy requirement or both – Aetna will leverage employers as the primary distribution channel whenever possible – Some form of employer attestation regarding SBC distribution may be requested	• **Plan Sponsors** are accountable for generating and distributing the SBCs. Aetna does not have any regulatory obligation to produce and/or distribute SBCs for self-funded customers • While there is no regulatory requirement for Aetna to do so, Aetna will support ASC customers with SBC generation beginning 8/20/2012 • Aetna's support of ASC customers will include generation of SBCs and/or plan data validation (for active Aetna plans), but distribution will remain the employer's responsibility

ACA – Areas of Expected Employer Impact
Administrative: MLR

What has occurred YTD 2012?

- All rebate notices and checks, where applicable, were mailed by 8/1/2012, as required by law
- In total, more than 721,000 letters and ~184,000 checks with ~$106M in rebates were sent to Individual subscribers, Group policyholders and subscribers across 31 rebate eligible pools for Individual, Small Group and Large Group

What is coming next?

- Notice of MLR Information
  - This will be mailed to policyholders and subscribers that were in pools where we met the MLR requirements so no rebates were issued
  - As of 9/11/12, all Notice of MLR Information mailings have been completed
- Notice of Rebate
  - This will be mailed to ***new employees*** that were added in 2012 and are still active as of 8/1/12 in plans that received a rebate for the 2011 experience year

ACA – Areas of Expected Employer Impact
Impacts of Taxes, Fees & Penalties

Patient Centered Outcome Research Fee

- Sponsors of self-funded health plans and insurers will contribute $1 per participant covered under each self-insured health plan or health insurance policy for plan years ending during fiscal year 2013 and $2 per participant thereafter. The $2 amount will be adjusted in the future for increases in health care spending.
- The fee does not apply to plan years or policy years ending after ***September 2019***

Reinsurance

- A temporary program that offsets a portion of the adverse selection entering the insurance marketplace operated at the state level in 2014+
- This ACA provision will become ***effective in 2014***

Health Insurer Fee

- Entities that provide health insurance coverage to a "United States health risk" are subject to an annual fee, the amount of which will be determined by Treasury
- This will be ***effective in 2014*** and required annually thereafter

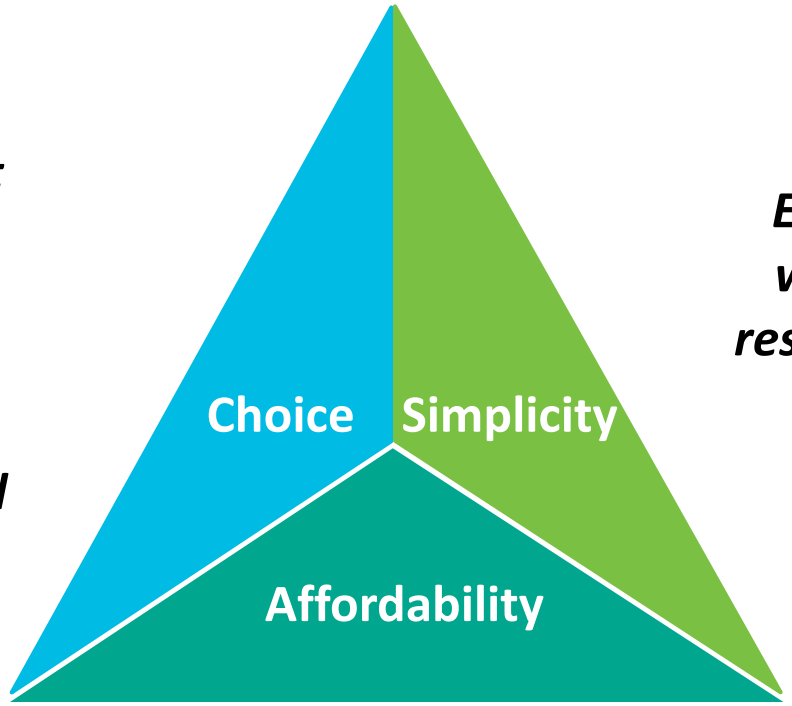
Cadillac Tax

- Insurers and Group Health Plan of employer-sponsored coverage will be taxed on policies costing more than $10,200 for individual coverage and $27,500 for family coverage ***beginning in 2018***
- Taxes will be 40% of the total premiums that exceed the threshold (listed above)

How Aetna is Preparing

Aetna Will Continue to Advocate for Sustainable Health Care Solutions

Consumers are best served by a competitive marketplace that lets them keep what they have and encourages private sector innovation



Empower consumers with technology and resources that make the health care system easier to use

Reform only works if individuals and families can purchase health benefits that meet both their health and financial needs

Developing solutions that lead to an improved *and* sustainable Health Care delivery system

Technology	Accelerated adoption of Health Information Technology (ActiveHealth, Medicity)
Quality/ Affordability Movement	Opportunity to increase quality and improve affordability (e.g., Provider payment reform, Network strategies)
Delivery System Infrastructure	New collaboration models between health plans and providers (e.g. Accountable Care Organizations)
More Engaged Consumers	Empowering consumers to get and stay healthy through tools, information and incentives (e.g. Mobile Apps, Personal Health Records, Payment Estimator, Wellness programs)

Health Care Reform Tools and Resources

Aetna has developed a range of tools and resources to assist our customers in understanding the potential impacts of the ACA and identify the best course of action.

Your Health Reform Connection

Aetna has invested significantly in freely available online resources to provide customers with the latest legislative updates, analysis and impacts of Health Care Reform.

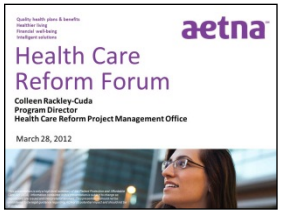
Customer Impact Analysis

Aetna has conducted a comprehensive analysis of the administrative, medical cost, tax and penalty impacts across our customer segments.

Employer HCR Modeling Tool

The tool focuses on key 2014 – 2018 health care reform provisions impacting employers and identifies the potential course of action by estimating financial impacts.

Broker, Consultant, & Customer Webinars



Aetna continues to provide educational and training sessions for our customers to ensure they are armed with the most current information on Health Care Reform.

Take Home Messages

- Aetna remains focused on transforming the health care delivery system such that all Americans have a choice of affordable, simple health care options
- Aetna remains committed to fostering compliance with the ACA and helping our customers achieve the same
- As constructive advocates for the people who use our services, we continue to work with HHS, NAIC and other agencies to shape regulations and avoid unintended consequences
- We all have a role to play; get and stay informed

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