



# The Road to Reform

Preparing for health reform in 2013 and 2014





UnitedHealthcare recognizes that our American health system requires fundamental change to provide **affordable, quality care**. Health reform is a start but more is needed to address health care costs that are rising continually and a system where care is too variable. Innovative, value-oriented and outcome-focused approaches can help make the system work better for everyone.

At UnitedHealthcare, our goal is **helping people live healthier lives.**<sup>™</sup> Through the use of best practices, UnitedHealthcare is working to build a better, more affordable health care system. We help make this happen by:

- ▶ Providing innovative and affordable choices in the health plans we offer
- ▶ Modernizing delivery of health care by development of tools and programs to make health care easier to understand and navigate
- ▶ Focusing on quality of service and simplicity of administration
- ▶ Informing and engaging your employees regarding their health to help them make healthier choices

The **Affordable Care Act (ACA)** brings significant changes to how Americans access and pay for health care. And while change is good, it can be challenging. We want to help you understand health reform and let you know that you are not in this alone. We're with you every step of the way. We are taking steps to ensure that UnitedHealthcare's plan designs conform to the ACA's mandates.

Changes in federal law are just one way to move toward a more modern health care delivery system. UnitedHealthcare is at the forefront of improving access to quality care, containing costs, using technology to increase transparency and changing the way the system pays for care. We understand that when physicians, insurance companies, employers, consumers and government bring their best ideas to the table, we can help improve access to quality and affordable care.

## The Big Picture

The ACA is rolling out in phases that began in 2010 and extend through 2019. Generally, the provisions fall into one of these areas:

- ▶ Standards for minimum health benefit plan offerings
- ▶ State-based Health Benefit Exchanges (Exchanges)
- ▶ Mandates for employers and individuals to provide or purchase health care coverage
- ▶ Premium credit or cost-sharing subsidies to qualified individuals to purchase coverage
- ▶ Taxes and fees
- ▶ Requirements that insurance companies spend a certain percentage of premium dollars on patient care
- ▶ Certain preventive care services covered without cost-share
- ▶ Insurance market reforms
- ▶ Expanded appeal rights for consumers
- ▶ Expanded Medicaid eligibility
- ▶ Changes to Medicare reimbursement

## Keeping Your Grandfathered Plan

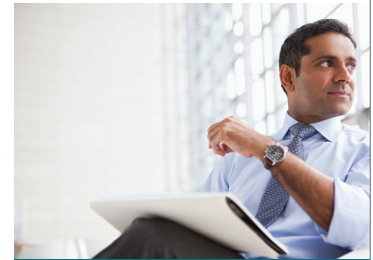
For employers who decided to “grandfather” their health benefit plan, some of the health reform changes are not required. Grandfathering a plan means that you decided to **keep the plan that you had in effect on March 23, 2010**, and made no or only minimal changes as permitted by the grandfather rules. However, there are a number of changes that apply to all plans whether or not they are a grandfathered plan.

As we approach 2014, **grandfathered plans will not be required to** implement a number of health reform law provisions, including:

- ▶ Rating restrictions such as adjusted community rating (small group plans only)
- ▶ Capping deductibles and/or implementation of the ACA’s out-of-pocket limits
- ▶ Providing **essential health benefits (small group plans only)**
- ▶ Providing coverage for clinical trials

In general, plan changes that can cause loss of grandfathered status include eliminating certain benefits, increasing coinsurance, increasing fixed-dollar cost-sharing (copayments, deductibles and out-of-pocket limits) beyond allowed amounts, and the plan sponsor’s decrease in its contributions toward the cost of coverage by more than 5 percent below the contribution rate on March 23, 2010.

So, if you have chosen to maintain grandfathered status, you will need to satisfy the notice and recordkeeping obligations that are required to maintain grandfathered status.



### GRANDFATHERED PLANS

Grandfathered status is, for the most part, indefinite and exists until otherwise lost. Of course, customers should continue to check regulations for changes in the grandfather rules.



## Five Things Employers Need to Know

As regulations, mandates and laws become effective over the next months and years, it's important to know where to begin and what to focus on as you prepare your business and employees. Depending on your group size, some of these changes may involve changing your processes as well as updating plan documents and materials to comply with the new regulations. Read more below and on Page 6 in "On the Horizon for 2013." Here are five things employers need to know:

- 1** A number of **taxes and fees** related to the health reform law will affect employers. Several health reform fees will impact premiums and rates. Employers need to know who is responsible for submitting each fee and the effective dates.
- 2** **Employers filing 250 or more W-2 forms will be required** to report the cost of employees' health benefit coverage on the employees' 2012 W-2 forms that are distributed in January 2013. The W-2 reporting requirement is informational only for the individual and does not mean that they will be taxed on these dollars.
- 3** Small groups can leverage **tax credits**. The Small Business Health Care Tax Credit is designed to encourage small businesses and small, tax-exempt organizations to offer health insurance coverage for their employees. UnitedHealthcare has developed a modeling tool (available at [uhc.com/reform](http://uhc.com/reform)) to assist employers and brokers in determining eligibility for the credit and estimating the potential credit amount. In **2014, the tax credit is increased** and available only to those employers who purchase insurance through a Small Business Health Options Program (SHOP) **Exchange**. You should seek advice from an accountant and attorney to determine how the credit may affect your specific situation.
- 4** **Exchanges** could affect how you offer coverage to your employees in the future. Although Exchanges are not in place until 2014, **you must provide all employees with information about Exchanges** (also called Health Benefit Exchanges), including employee eligibility to participate in an Exchange and available health insurance subsidies if the coverage you provide to employees is considered unaffordable by the ACA's guidelines.
- 5** There will be **coverage changes** based on benefit expansion or coverage limits. Small groups will be required to implement changes within the plans they offer, including:
  - ▶ Expanding coverage to their employees to include Essential Health Benefits (EHB) and Minimum Essential Coverage (MEC). This change affects employers with 50-plus average total number of employees (ATNE).
  - ▶ Ensuring that out-of-pocket limits do not exceed the limit as outlined by health savings accounts (HSAs). This change affects large groups as well.


### Essential Health Benefits

The categorization of a benefit as essential or nonessential does not indicate that the benefit will or will not be covered under your plan. All services (essential or nonessential) must meet all other requirements for coverage, including any cost-effective requirements and that the service or device must not be unproven, experimental or investigational.



## Looking Back

Here are key health reform changes that went into effect on or before **December 31, 2012:**

- ▶ Accountable Care Organization (ACO) requirements **[Definition]** 
- ▶ Appeals provision\*
- ▶ Dependent coverage up to age 26
- ▶ Limitation on Flexible Spending Account (FSA), Health Reimbursement Account (HRA) and Health Savings Account (HSA) coverage for over-the-counter medications
- ▶ **Medical Loss Ratio** (MLR) rebates
- ▶ Patient-Centered Outcomes Research Institute (PCORI) Fee
- ▶ Patient Protections\*
- ▶ Preexisting condition protections for persons under age 19
- ▶ **Preventive services** as well as an expanded list of women's preventive services with no cost-sharing\*
- ▶ Quality bonus began for Medical Advantage plans
- ▶ Removal of lifetime and per-beneficiary annual restricted dollar limits for EHB
- ▶ Summary of Benefits and Coverage (SBC), the Uniform Glossary and 60-day advance notice of material modifications

\*Not required of grandfathered plans

## On the Horizon for 2013

### Flexible Spending Account (FSA) Limits

Starting in 2013, there is a new maximum of \$2,500 that can be set aside in a health FSA. In subsequent plan years, this will change based on inflation. This change is in addition to no longer allowing health FSAs to be used for over-the-counter medications that became effective in 2011.

### Exchanges – Online Insurance Marketplace

Exchanges are intended to help individuals and small groups shop for, select and enroll in high-quality, affordable private health plans that fit their needs at competitive prices.

#### Public Exchanges

The ACA requires Exchanges to be established in each state by Jan. 1, 2014. If a state does not establish an Exchange, the federal government will step in and operate the Exchange. Between 2014 through 2016, only individuals and employers in the small group market are eligible to participate in an Exchange. In 2017, states may permit employers in the large group market to participate. Exchanges will open for business beginning Oct. 1, 2013, offering coverage beginning Jan. 1, 2014. Exchanges may be operated by the state or federal government or as a partnership between a state and the federal government. In 2014, small groups will be defined as businesses with up to 100 employees, although until 2016 a state may choose to limit the definition to businesses of up to 50 employees. The definition for large groups will remain as businesses with more than 100 employees.

In late summer or fall (future guidance is expected on complying with this notice requirement), employers must provide written notice to current employees and going forward, new employees, to inform them of the Exchanges and the circumstances under which an employee may be eligible for health insurance subsidies.

Employees meeting certain requirements who cannot afford the coverage provided by their employer may purchase a plan in the Exchange.

Employers with at least 50 full-time employees who decide not to offer a health benefit plan to their employees, and instead leverage the Exchange, are subject to penalties referred to as the employer mandate. Read more on Page 8 in "What's Coming in 2014."

#### Private Exchanges

Private exchanges are being established by a variety of different entities such as consulting firms and cooperatives. Private exchanges are available to all business segments and fully insured or self-funded groups of all sizes. Because private exchanges are operated by private entities, subsidies are not available to those purchasing health care insurance through a private exchange.

### Taxes and Fees

To fund several of the changes mandated by the health reform law, new fees will apply to health insurance issuers and self-funded plan sponsors. Based on the government rule and industry analysis for fully insured customers, in 2014 the cumulative impact of the health reform fees shows an increase in the premium by about 3.8 percent. For self-funded plan sponsors, it is about \$5 to \$6 per member per month.

- The **Patient-Centered Outcomes Research Institute (PCORI) Fee** applies to health insurance issuers and employers sponsoring self-funded group health plans. The temporary fee helps to fund research on the comparative effectiveness of medical treatments. Beginning with plan years ending on or after Oct. 1, 2012, the fee is \$1 per covered life for the first year, \$2 per covered life for the second year, and indexed to medical inflation in subsequent years. The fee began in 2012 and ends in 2019.

The PCORI fee is due by July 31 of the calendar year immediately following the last day of the plan year. So, the 2012 fee must be paid by July 31, 2013, regardless of renewal date.

- In the case of fully insured coverage, UnitedHealthcare is responsible for filing Form 720 and paying the required PCORI fee. The fee is rolled into the premium rates and is not called out separately on the invoice.
- Self-funded customers, as the plan sponsor, must file federal excise Form 720, and pay the fee directly to the IRS.
- The **Excise Tax**, also known as the Cadillac tax, begins in 2018, and imposes a 40 percent excise tax on the value of health insurance benefits exceeding a certain threshold. The thresholds are \$10,200 for individual coverage and \$27,500 for family coverage (indexed to inflation). The thresholds increase for individuals in high-risk professions and for employers who have a disproportionately older population.
- The **Pharmaceutical Manufacturer's Fee** is an annual fee that began in 2011 and is imposed on any manufacturer or importer of branded prescription drugs with sales of more than \$5 million.
- The following three fees under the ACA will be progressively incorporated into fully insured plan premiums and not called out separately on the invoice beginning Feb. 1, 2013, as renewals or new business cases begin and state regulatory approvals are received. Because groups with a February 2013 effective date will have one month of coverage subject to taxes and fees (January 2014), the fee for this month is included in the 2013 rates. Likewise, groups with a March 1 effective date will have two months of impact; groups with an April 1 effective date will have three months of impact; etc. The fees are prorated and spread over 12 months.
  - The **Insurer Fee**, also called the health insurance industry tax or **premium tax**, is an annual, permanent fee on health insurance issuers beginning in 2014. The Insurer Fee applies only to health insurance issuers, such as UnitedHealthcare. Therefore, it affects fully insured business only.

The fee will fund premium tax subsidies for low-income individuals and families who purchase health insurance through an Exchange. The amount of the Insurer Fee is determined by the market share of the health insurance issuer. It is based on its net written health insurance premiums in the previous year, with certain exclusions.

Although we have not received final federal guidance on the Insurer Fee, based on the government rule and industry analysis, the impact of the fee during the first year is about 2.3 percent of the premium.
  - The **Transitional Reinsurance Fee** is designed to stabilize non-grandfathered individual market plans (in and out of the Exchange). It is assessed on a per capita basis for both fully insured and self-funded members and applies to group and individual business. The Reinsurance Program will exist for the first three years of the Exchanges' operation (2014-2016).

The impact of the Transitional Reinsurance Fee, based on the government rule and industry analysis, is about \$5 to \$6 per member per month for the first year.
  - A **Risk Adjustment Fee** of about \$1 per member per year is assessed on issuers of risk-adjusted plans in the non-grandfathered individual and small group markets, whether in or out of the Exchanges. The permanent fee helps fund the administrative costs of running the Risk Adjustment Program. The program is intended to protect health insurance issuers of risk-adjusted plans, such as UnitedHealthcare, against adverse selection by redistributing premiums from plans with low-risk populations to plans with high-risk populations. The Risk Adjustment Fee begins in 2014.

Definition RAF



## What's Coming in 2014

### Employer Mandate, Requirements and Penalties

Beginning in 2014, employers with 50-plus full-time employees and full-time equivalents may be subject to a penalty if they do not offer affordable Minimum Essential Coverage (MEC). The penalty is calculated as follows:

- **Employers Not Offering Coverage:** If an employer does not offer MEC and one or more full-time employees receive a premium credit or cost-sharing subsidy through the Exchange, the penalty is \$2,000 per year per full-time worker. When calculating the penalty, the first 30 full-time workers are subtracted from the payment calculation.
- **Employers Offering Unaffordable Coverage:** If an employer offers MEC but the employee contribution exceeds 9.5 percent of household income, and one or more full-time employees receive a premium credit or cost-sharing subsidy through the Exchange, the penalty is \$3,000 per employee who receives a premium credit or cost-sharing subsidy.

### Individual Mandate

In 2014, most individuals who can afford coverage will be required to purchase health insurance or pay a penalty. The penalty for 2014 will be \$95 or 1 percent of the individual's income, whichever is greater and will rise for 2015 and 2016. Individuals who earn up to 400 percent of the federal poverty level may be eligible for federal subsidies to help them purchase insurance from the Exchange.

### Adjusted Community Rating

Adjusted community rating (ACR) rules will apply to non-grandfathered individual and small group insurance markets effective for plan years (policy years in the individual market) beginning on or after Jan. 1, 2014.

Under the ACA provision, the use of actual or expected health status or claims experience to set rates for premiums is prohibited. Other rating factors such as age, geographic area and tobacco use may be used to vary premiums, within certain limits.

The only groups not affected by the rating changes are self-funded groups and grandfathered plans along with large fully insured groups in most states.

### Removal of Preexisting Conditions

For plan/policy years beginning on or after January 2014, the health reform law will remove any restrictions on preexisting conditions for individuals of all ages. Therefore, coverage may not be denied for preexisting conditions nor will individuals with preexisting conditions be charged more. This is an update to the provision from 2010 that did not allow exclusions for children under the age of 19 with a preexisting condition. This applies to grandfathered and non-grandfathered plans; however, grandfathered individual health plans are exempt from this requirement.



ABC Company is a large group, fully insured, non-ERISA, non-governmental employer. ABC's 100 employees are covered by a non-grandfathered health plan. Eligible retirees of ABC Company are covered under a retiree plan. In anticipation of health reform provisions coming during 2013, the company developed the following approach to stay informed of health reform changes and, when necessary, communicate any changes to employees that may affect them:

Month	Health Reform Mandate	ABC Company Actions
<b>December 2012</b>	The Retiree Drug subsidy paid to ABC Company is now considered taxable income.	ABC Company must declare the Retiree Drug subsidy paid to it on its 2013 tax return.
<b>January 2013</b>	Starting Jan. 1, 2013, health care FSA contributions will be limited to a maximum of \$2,500. The limit will be adjusted according to the consumer price index (CPI) starting in 2014.	ABC Company must update its plan documentation to reflect the changes to the FSA contribution limit.
	Employers who filed 250 or more W-2 forms in the previous year are required to report to employees the cost of employer-sponsored health benefit coverage on their W-2 forms. Companies need only share the cost of coverage for those to whom it issues a W-2 form.	Because ABC Company filed 100 employee W-2 forms in 2011, it is not required to report the cost of its health benefit coverage on employees' 2012 W-2 forms.  <b>Note:</b> Even though employers are not required to notify their employees about W-2 reporting, to reduce the number of questions that may arise once the W-2 forms are distributed, it may be a good idea to communicate this information to employees that the requirement is informational only and does not mean that the cost of employer-provided coverage will be subject to income tax.
<b>March 2013</b>	As part of the employer mandate, ABC Company carefully evaluated its health plan and premiums and has decided to continue to offer coverage to its employees.	Because ABC Company's health plan is affordably priced and offers slightly more than the essential health benefits outlined in the ACA, the company decided that it was <b>more cost-effective to continue offering coverage instead of paying the penalties described in the employer mandate.</b>
<b>April 2013</b>	ABC Company renews its health plan.	The company's premium increases. Because ABC Company has an April 2013 effective date, it will have three months of coverage that will include the Insurer Fee and the Reinsurance Fee that are effective January 2014. The fees are prorated, so they are spread over 12 months of the company's premiums. The nominal PCORI fee of \$1 per member for the first year was already rolled into the premium.
<b>July 2013</b>	ABC Company received written notice that its group was eligible to receive rebates as set forth by the guidelines of <b>Medical Loss Ratio (MLR).</b>	ABC Company's policyholder is required to issue a written notice to relevant group plan subscribers about the rebate. The policyholder is obliged to use ABC's portion of the rebate attributable to the premium paid by ABC's subscribers in one of the following three ways: <ul style="list-style-type: none"> <li>▪ To reduce the subscribers' portion of the annual premium for the following policy year for all subscribers covered under any group health policy offered by the plan;</li> <li>▪ To reduce the subscribers' portion of the annual premium for the following plan year for only those subscribers covered by the policy on which the rebate was based;</li> <li>▪ Provide a cash refund to subscribers covered by the policy on which the rebate was based.</li> </ul>
<b>Late Summer or Fall</b>	ABC Company's employees will be eligible to participate in the Exchange beginning in 2014. Beginning in 2017, states may permit employers in the large group market to participate.	Employers are required under the law to notify employees in late summer or fall (future guidance is expected on complying with this notice requirement) of the availability of Exchanges in 2014. An employee communication was issued regarding the availability of the Exchanges and that ABC Company will be eligible to participate in the Exchanges beginning 2014 through 2016.
<b>November 2013</b>	ABC Company's employees have made their health insurance plan choice for the upcoming year.	As required by law, ABC Company has chosen the option to issue an <b>electronic copy</b> (instead of a paper copy) of the <b>summary of benefits and coverage (SBC)</b> to all participants enrolling in the health plan following the mandated formatting guidelines.



## **Questions employers may want to discuss with their tax adviser or legal counsel with the employer mandate in mind:**

- 1.** How does our product portfolio measure up to the minimum value requirements that will become effective in 2014?
- 2.** Do we offer affordable health care according to the definition in the employer mandate?
- 3.** How is our prescription drug coverage?
- 4.** Should we continue to offer coverage but change what we offer to suit the ACA's guidelines?
- 5.** Does it make more sense to pay the penalty of \$2,000 per full-time employee per year minus the first 30 full-time employees than to offer employer-sponsored health coverage?



## We Can Help

It's important to help your employees understand the health reform changes that affect them now. Take advantage of UnitedHealthcare's **online tools** to communicate changes or create programs for your employees: Health Care Lane,<sup>SM</sup> *Healthy Mind Healthy Body*® e-newsletter, member portals, videos from the award-winning "Health Care Reform Demystified" video series and the interactive health and wellness communications plan builder.



## Questions?

[www.SteveShorr.com](http://www.SteveShorr.com) 310.519.1335

Talk with your **broker** or account representative, who can address your specific concerns. We're here to help you:

- ▶ Stay updated on ongoing policy changes through our e-newsletters and special websites dedicated to health reform news
- ▶ Find the most affordable health benefit plans
- ▶ Talk about health reform with your employees
- ▶ Refer to the United for Reform Resource Center for updates and more detailed information at **[uhc.com/reform](http://uhc.com/reform)**.

Interactive Version - with working links from UHC



## Modernizing Health Care

As one of the largest participants in the health care system, we know firsthand the significant challenges our nation faces in improving access to quality care and managing costs for all Americans. We are actively working across the nation with states and the federal government to support broader access to health care coverage while lowering health care costs for our customers and helping to improve delivery of care.

UnitedHealthcare is committed to moving toward a modernized care delivery system, ensuring that changes in health care are made as effectively as possible for the health of the American people.

Please refer to the United for Reform Resource Center for updates and more detailed information at [uhc.com/reform](http://uhc.com/reform).



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310.519.1335

The content provided is for informational purposes only and does not constitute medical advice. Decisions about medical care should be made by the doctor and patient. Always refer to the plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the ID card.

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