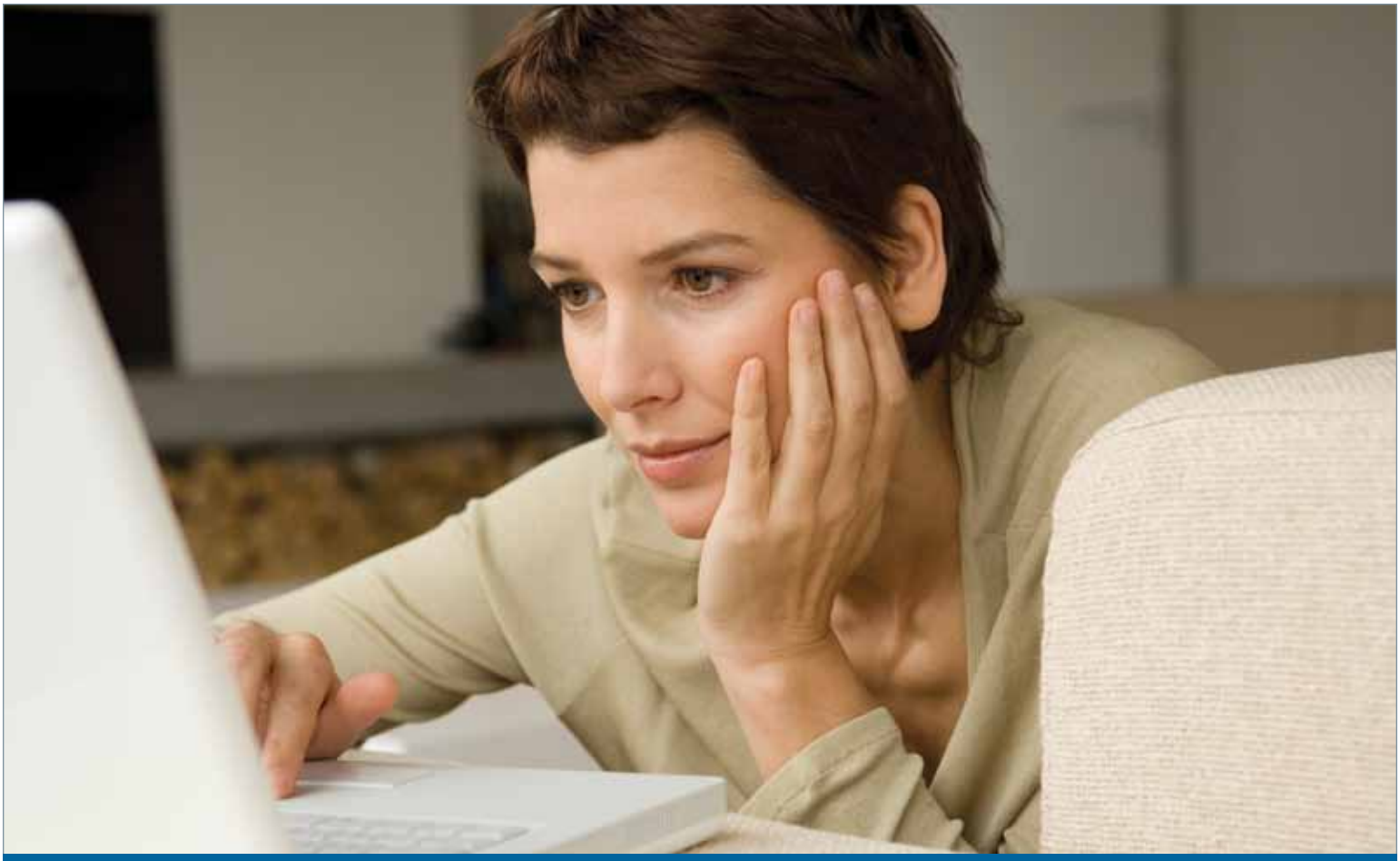

Navigating Health Reform

An employer's guide

Large Groups: 2012 – 2014

UnitedHealthcare®

3/26/13

Overview

The federal health reform law focuses primarily on establishing new state-based mechanisms for obtaining health care coverage and for establishing federal standards (implemented in coordination with states) to oversee benefit designs and costs of coverage. Many significant reforms, including Exchanges and guaranteed-issue requirements, become effective in 2014. Other reforms, such as certain lifetime and annual limits and preexisting coverage exclusions for enrollees (dependent or employee) up to age 19, as well as a requirement to offer dependent coverage up to age 26, became effective during the first year of implementation. This guide is designed to assist employers by highlighting some of the changes made by the legislation, and setting out general timelines.

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Health reform implementation timeline

Quick reference timeline

Effective 90 days after enactment	▸ Early retiree reinsurance program ▸ High-risk pool
Effective plan years beginning on or after September 23, 2010	▸ Adult children coverage to age 26 ▸ Restricted annual limits on essential benefits (to be defined) ▸ No lifetime limits on essential benefits ▸ No preexisting condition exclusions for enrollees under age 19 ▸ No rescissions (primarily individual and small group coverage) ▸ First-dollar coverage for preventive care* ▸ Revised appeals process* ▸ Emergency services without prior authorization/treated as in-network* ▸ Choice of providers (pediatrician and OB/GYN)*
January 1, 2011	▸ No reimbursement from FSA, HRA, or HSAs for OTC drugs unless prescribed ▸ Annual rate review process begins ▸ Increased penalty for non-qualified HSA withdrawals
January 1, 2012	▸ Non-discrimination rules extended to insured plans* (implementation delayed until regulations are released) ▸ Appeals provision fully implemented* ▸ Patient-Centered Outcomes Research Institute (PCORI) fee ($1 per member per year). PCORI goes into effect for plan years ending after September 30, 2012. ▸ First medical loss ratio rebates paid by August 1 ▸ Women's extended preventive services with no cost-sharing.* Women's expanded preventive services are effective for the first plan year on or after August 1, 2012.
September 23, 2012	▸ Summary of benefits and coverage – four-page preenrollment coverage document sent outlining benefits and exclusions ▸ 60-day notice in advance of material modifications
January 1, 2013	▸ W-2 reporting on value of employer-sponsored plans (for 2012 plan year) ▸ Medicare tax increase for high earners ▸ No deduction for retiree drug subsidy ▸ FSA contributions cap ($2,500 limit) ▸ Patient-Centered Outcomes Research Institute (PCORI) fee increases to $2 per member per year in year two of the fee. Fee ends in 2019.
January 1, 2014	▸ State-based Exchanges ▸ Adjusted community rating (small groups only)* ▸ No preexisting condition exclusions ▸ Guaranteed issue and renewability** ▸ Employer certification of coverage ▸ Increased wellness program incentives (from 20 percent to 30 percent) ▸ Individual and employer mandates ▸ No annual limits ▸ Required coverage for clinical trials for life-threatening diseases* ▸ 90-day limit on waiting periods ▸ Annual insurer fee ▸ Transitional reinsurance fee

* Applies to non-grandfathered plans only. Grandfathered plans are exempt until the status is lost.
**Grandfathered aspects TBD.

Key health reform provisions implemented

(for plan years beginning on or after September 23, 2010; applies to grandfathered plans as well)

- **Adult Children Coverage.** Group health plans that provide dependent child coverage will be required to cover adult children until the age of 26. Grandfathered plans may exclude adult children who are eligible for coverage under another employer-based health plan (other than one of a parent) until 2014.
- **Restrictions on Lifetime and Annual Limits.** Group health plans may no longer set lifetime limits on "essential health benefits." It is possible that "restricted annual limits" on essential health benefits will be permitted until 2014 if the secretary of the Department of Health and Human Services (HHS) defines which of such limits are permitted. Starting in 2014, annual limits on essential benefits are prohibited.
- **Preexisting Condition Prohibitions.** All group health plans are prohibited from applying preexisting condition limits for children under age 19.
- **Policy Rescissions.** All group health plans and insurers are prohibited from rescinding coverage (except in limited acts of fraud or intentional misleading representation of facts).
- **Rate Review.** Process for annual review of individual and fully insured group plan rate increases that exceed a specified percent. Insurers are required to submit justification for specified increases. This does not apply to grandfathered or self-funded plans.
- **HSA, HRA, FSA.** Limitations on over-the-counter medications.
- **Increased penalties for non-qualified HSA withdrawals.**

(applies to non-grandfathered plans)

- **Preventive Care Services.** All group health plans are required to provide coverage for preventive services as defined in the new law, including current "A" and "B" recommendations of the U.S. Preventive Services Task Force, and are prohibited from imposing cost-sharing requirements on such items or services.
- **Internal/External Appeals.** Group health plans must have an "effective" internal and external appeals process for coverage determinations and claims, and must continue coverage until the appeals process is resolved.
- **Emergency Services.** Must be covered without prior authorization and treated as in-network.
- **Choice of Providers.** Must allow the plan member to designate a child's pediatrician as the primary care provider. May not require authorization or referral for a participating OB/GYN.

Grandfathered plans. Health plans in existence on March 23, 2010, may be "grandfathered" from complying with certain requirements. On June 17, 2010, an Interim Final Regulation was published by the government and addresses what coverage changes may be made by an insurer or plan sponsor without affecting "grandfather" status. Contact your UnitedHealthcare representative to receive additional guidance on grandfather rules.

Scheduled changes 2012 through 2013

- **Summary of Benefits and Coverage.** By September 23, 2012, employers must provide a summary of benefits and a coverage explanation to all participants at the time of enrollment and each subsequent year during annual enrollment. Employers may provide the summary in paper or electronic form. The summary must be no more than four pages in length, a minimum of 12-point type, and should be written in a manner that is easy for the average participant to understand.
- **Summary of Material Modification Notice.** Employers must provide notice of any material modification to benefits 60 days in advance of the effective date of those modifications. Willful failure to comply with the summary of benefits requirement or summary of material modification notice will result in a fine of up to $1,000 per failure on a per-enrollee basis.
- **Employee Notice Requirements.** In late summer or fall (future guidance is expected on complying with this notice requirement), employers must provide new and existing employees with information about the Exchanges, including information on employee eligibility for coverage under the Exchanges, including premium credits.
- **Administrative Simplification Begins.**
- **FSA Statutory Limit.** Beginning January 1, 2013, a $2,500 contribution limit (indexed for inflation) is placed on employee salary reduction contributions to FSAs.
- **W-2 Reporting.** Employers filing 250 or more W-2 forms in the preceding calendar year (2011 for 2012 W-2 forms) are required to report to employees the total cost of their employer-sponsored group health plan coverage under the Patient Protection and Affordable Care Act. At this time, employers filing fewer than 250 W-2 forms in January 2013 do not need to report cost of coverage on W-2 forms. This transition relief will continue until further guidance is issued.

Scheduled changes 2014 and beyond

- **Waiting Periods.** Group health plans are prohibited from requiring waiting periods for coverage in excess of 90 days.
- **Reporting of Coverage.** Beginning in 2014, two new IRS reporting requirements apply to employers that offer group health coverage. First, self-funded employers must file an information return with the IRS (and provide a statement to covered individuals) identifying those employees and other individuals who were offered health care coverage and specifying the dates of coverage. If the coverage is insured, the return must be filed by the insurer and disclose the portion of the premium (if any) required to be paid by the employer. Second, employers with at least 50 full-time employees must file a return with the IRS certifying whether the employer offered to its full-time employees (and their dependents) the opportunity to enroll in health care coverage, including information about the employer's contribution to the cost of such coverage. A statement containing this information also must be provided to full-time employees.
- **Standardized Benefit Requirements – Essential Minimum Benefits and Standard Offerings for Small Group Plans in and out of Exchanges.** States to determine what definition of Essential Health Benefits will be in each state.
- **ICD-10 Code Adoption Begins.**

Employer coverage and reporting requirements/penalties for noncompliance

- **Employer Mandate.** Beginning in 2014, employers with at least 50 full-time employees that do not offer coverage must pay a fee of $2,000 multiplied by the total number of full-time employees (minus 30) if any full-time employee receives premium assistance through an Exchange; employers that do offer coverage must pay the lesser of $3,000 fee for each full-time employee who receives premium assistance through an Exchange or $2,000 per full-time employee (minus 30).
- **Minimum Essential Coverage.** Beginning in 2014, all U.S. citizens are required to have "minimum essential coverage" or pay the greater of a flat-dollar penalty ($95 in 2014, $325 in 2015 and $695 in 2016, indexed for inflation) or a penalty based on a percent of income (1 percent in 2014, 2 percent in 2015 and 2.5 percent in 2016 and thereafter). Waivers are allowed for specified individuals and circumstances (i.e., those with religious objections, individuals not lawfully present in the U.S., incarcerated individuals, individuals for whom required contributions for coverage exceed 8 percent of income, individuals with incomes below the federal filing threshold, Native American tribe members, individuals with short coverage gaps of less than three months and individuals who experience hardship as determined by HHS).
- **Automatic Enrollment.** Employers with more than 200 employees that offer coverage must automatically enroll new full-time employees with the opportunity to opt out.

Retiree medical – 2012 and beyond

- **Retiree Reinsurance.** The law creates a temporary reinsurance program for employers that provide health coverage for early retirees ages 55-64, helping to offset the cost of the coverage. This program would fund 80 percent of claims between $15,000 and $90,000 incurred by pre-Medicare early retirees, spouses, surviving spouses and dependents. Employers must use reimbursements to pay for increases in the employer's premiums or cost of benefits, or can use reimbursements to reduce participants' out-of-pocket costs (i.e., contributions, copayments, coinsurance or deductibles). The program will end January 1, 2014, or earlier if the $5 billion allocated in the statute for the program runs out. Plan sponsors are responsible for applying to the program and, if certified by HHS, submitting claims for reimbursement to HHS.
- **Medicare Part D Donut Hole.** Currently, Medicare Part D beneficiaries who exceed the prescription drug coverage limit are responsible for the cost of prescription drugs until the cost reaches a defined coverage limit ("donut hole"). As of January 2011, pharmacy manufacturers are required to provide name-brand drugs at a 50 percent discount to Part D participants in the donut hole. Eventually the discount will extend to generic drugs as well as name-brand and the discount will increase, reaching 75 percent by 2020. This will effectively eliminate the donut hole since the full price of those drugs will continue to be used for calculating the donut hole out-of-pocket amount.
- **Tax on Retiree Drug Subsidy.** The law eliminates the deductibility of retiree drug expenses to the extent of the Part D subsidy received by employers sponsoring creditable retiree drug programs for tax years beginning after December 31, 2012.

Subsidies to offset insurance premiums

(only available for coverage purchased through the Exchanges)

- **Individual Subsidies.** Individuals with incomes between 100 percent and 400 percent of the federal poverty level are eligible for sliding-scale premium and cost-sharing subsidies (in the form of refundable tax credits) to purchase coverage through the Exchanges. Subsidies are not available for any coverage outside the Exchanges. An employee with access to employer-based coverage is only eligible for a subsidy through the Exchanges if the coverage is "unaffordable" (i.e., required share of the employee's premium for self-only coverage exceeds 9.5 percent of his or her household income) or if the coverage does not satisfy a "minimum value" requirement (i.e., at least 60 percent of total allowed costs are paid by the plan).

Health plan assessments/taxes and fees

- **Patient-Centered Outcomes Research Institute (PCORI) Fee.** The law imposes a new comparative effectiveness research fee starting for plan years ending after September 30, 2012. Employers must pay $1 per member for years ending in fiscal year 2013, and $2 per participant thereafter. For years ending after September 30, 2014, the amount is indexed to national health expenditures. The fee phases out beginning in 2019.
- **Insurer Fee.** A fee collected from insurers to fund new premium tax credits available to low-income individuals and families purchasing insurance coverage through the Health Benefit Exchanges that start operation in 2014. The fee is based on net written premiums for fully insured groups. Private plans serving Medicare (under Part C and Part D) and Medicaid are also subject to this fee. The new fee is expected to total $8 billion in 2014 for all insurers, increasing to $14.3 billion in 2018, and indexed to premium trend thereafter. Based on industry estimates, the impact on premium is approximately 2.3 percent.
- **Transitional Reinsurance Fee.** For years 2014 to 2016, the Affordable Care Act imposes a fee on insurers and self-funded plans and then distributes the funds to insurers in the non-grandfathered individual market that disproportionately attract individuals at risk for high medical costs. The intent is to spread the financial risk across all health insurers to provide greater financial stability. The fee will be assessed on a per capita basis. The health reform law specifies the total amounts of the Reinsurance Fee that must be collected for the Reinsurance Program: $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016, totaling $25 billion. States may also charge a Reinsurance Fee. The impact of the Transitional Reinsurance Fee, based on the government rule and industry analysis, is about $6 per member per month for the first year
- **High-Value Health Plan ("Cadillac") Tax.** Beginning in 2018, an excise tax of 40 percent will be imposed on "high-value" plans. The tax could apply to self-funded plan sponsors if the value of the employer-sponsored coverage (excluding stand-alone vision and dental benefits but generally including health FSAs, HRAs and HSAs) exceeds $10,200 for individual coverage and $27,500 for family coverage. There are higher thresholds for qualified retirees and "high-risk" professions ($11,850 and $30,950).
- **Medicare Tax.** Beginning in 2013, there is a 0.9 percent increase in Medicare taxes on wages in excess of $200,000 for single individuals and $250,000 for joint filers. Also, a 3.8 percent "unearned income" Medicare tax is imposed on the same individuals.

Glossary – some key terms

"Donut hole"	The Medicare Part D "donut hole" is an out-of-pocket zone for Part D participants in a Part D program that is not sponsored by an employer. Part D does not pay for any prescription drugs once the participant has incurred $3,000 in drug expenses until the participant has spent an additional $7,000.
Effective date	The enactment date of the reform legislation is generally March 23, 2010. There are various effective dates within the legislation, and many are applicable for plan years beginning six months after enactment of the law (September 23, 2010).
ERRP	Early Retiree Reinsurance Program
Essential health benefits	The term is very broadly defined to include wide-open categories (i.e., hospitalization, emergency services; ambulatory patient services; maternity and newborn care; prescription drug coverage; rehabilitative and habilitative services and devices; preventive, wellness and chronic disease management; laboratory services; and mental health and substance use disorder services). Additional guidance is expected to understand which types of benefits are subject to an annual or lifetime limit.
Exchange	Requires each state to establish a Health Benefit Exchange, including a small business Exchange, by 2014. Each plan participating in an Exchange must meet standardized affordability, essential benefit and consumer protection requirements. Exchange plans must meet state benefits requirements and provide four plan levels: bronze plan (60 percent actuarial value), silver plan (70 percent actuarial value), gold plan (80 percent actuarial value) and platinum plan (90 percent actuarial value).
Federal poverty level	Established and available on the HHS website, and varies based upon family size
FSA	Flexible spending account
HHS	Department of Health and Human Services. The federal government agency overseeing many aspects of the law.
High-risk pool	Temporary national high-risk pool created to provide health coverage to those with preexisting medical conditions (effective not later than 90 days after enactment and ending January 1, 2014).
HRA	Health reimbursement arrangement
HSA	Health savings account
Preventive coverage	Under the preventive care coverage provision, plans are required to provide coverage for: (1) U.S. Preventive Services Task Force (USPSTF) recommendations of "A" or "B"; (2) Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC); (3) Evidence-informed preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and (4) Evidence-informed preventive care and screenings for women as per guidelines supported by HRSA.
PPACA	Patient Protection and Affordable Care Act (enacted March 23, 2010)

NOTES

Grandfathered Status

Working to Help Employers Keep Their Existing Coverage

What Does "Grandfathered" Status Mean?

Throughout the national debate on health care reform, Congress and President Obama promised employers **"if you like your health care plan, you can keep your health care plan...the government is not going to make you change plans under Health Reform."**

To keep your existing plan requires the group to maintain the health plan's status as a "grandfathered plan," which is not an easy task under the new health care reform regulations. At AAOA, our healthcare program qualifies for grandfathered status. We are working to maintain this status because the number of new benefit mandates, the complexity of administration and the cost for these changes remain unknown.

What are the Advantages?

Maintaining grandfathered status offers employers the strategic advantage of continuing coverage while evaluating the future effects of health care reform. An employer can always decide to buy a "mandated" plan; but once a group loses its grandfathered status; the group can never go back.

Some employers are currently insured with a company that has opted out, or has abandon "grandfathered" plans. For these employers, AAOA Healthcare offers an excellent alternative. AAOA will continue to provide members with options designed to meet employers changing needs.

What Happens When a Group Loses its Grandfathered Plan?

Plans that lose their grandfathered status face greater health care reform burdens. Depending upon the benefits under the existing plan, the loss of a plan's grandfather status may result in greater obligations to provide additional mandates at increased costs.

Why is Grandfathered Status Relevant?

- Grandfathered plans already qualify as "essential coverage" while new plans will be designed by federal agencies.

- Grandfathered plans will be able to continue the same preventive care benefits; new plans must offer the preventive services dictated by federal agencies.

- Grandfathered plans in Washington do not need to change their benefit appeals process, their emergency care benefits, or standards for network access.

- Grandfathered plans may require dependents under the age of 26 to seek out coverage under their own employer's health plan.

- Grandfathered plans may avoid the additional record keeping and reporting requirements of new plans.

All group plans must comply with some provisions of health care reform such as the lifting of certain lifetime and annual benefit limits; but, for Washington employers, many of the new federal consumer protections have been required for years. Why drop your "grandfathered" plan for an uncertain future when AAOA offers the certainty of high quality benefits at affordable prices?

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3/13 Large Employers 100+

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