Fast Forward

Preparing for health reform in 2013 and 2014

The Affordable Care Act (ACA) brings significant and sweeping changes to how Americans access and pay for health care. And while change is good, it can be challenging. We are navigating these changes together. Our goal at UnitedHealthcare is simple: to help you understand what health reform means to you and your employees.

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. ***Get started here.***

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To learn about all of the provisions, go to **uhc.com/reform** or scan this code:

Focusing on Key Changes:

Expanded Benefits. Rating Changes. New Taxes and Fees.

The ACA is built around dozens of provisions. We are focusing on three main categories: provisions that will expand benefits, change rating criteria and levy new or increased taxes and fees.

Expanded Benefits

The health reform law defines certain categories of benefits as Essential Health Benefits (EHB) as outlined below. Small groups are required to include these benefits in their plan designs. Large and self-funded groups are not required to offer EHB, however, if they do include them, annual and lifetime dollar limits must be removed.

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

- The two largest changes are the introduction of pediatric dental and vision and habilitative coverage. Habilitative coverage is a health service that allows a patient to acquire a functional skill that should be present but is absent due to sickness or injury.
- Preventive services with no cost were expanded to include women's preventive services, such as contraceptives, prenatal and expanded screenings.
- Employers will be required to provide coverage for essential health benefits that has a minimum actuarial value of 60 percent.
- The actuarial value thresholds are tied to benchmark plans selected by each state. Note that state definitions of EHB will vary and may require product adjustments.

Coverage Changes

There are new out-of-pocket-maximum (OOPM) accumulation rules and deductible ceilings.

1. OOPM ceiling at Health Savings Account (HSA) level: likely $6,400 single/$12,800 family in 2014 (indexed to inflation)
   - All cost-sharing (for EHB) must accumulate to OOPM
   - This applies broadly to all plans, individuals, all group sizes, all funding approaches
2. Small group deductible ceiling: $2,000 single/$4,000 family
   - These limits will be indexed to inflation
   - The deductible ceiling does not apply in the individual market

Coverage Level Requirements

Plan coverage requirements are limited to the "metallic" coverage levels for individual, small group and Exchanges. Exchanges are required to offer at least one Silver and one Gold plan. Plans must be plus or minus two percent of the target.

Plan Type	% of the actuarial value of the covered benefits
BRONZE	60%
SILVER	70%
GOLD	80%
PLATINUM	90%

Rating Changes

The ACA calls for a move to adjusted community rating, which means the use of actual or expected health status or claims experience to set group premiums is prohibited. Beginning with plan years on or after Jan. 1, 2014, other rating factors such as age, geographic area and tobacco use may be used to vary premiums, within certain limits. These rules are still proposed and subject to change before becoming final law. In addition, there is now:

- Prohibition of excluding pre-existing conditions for all ages
- Guaranteed availability of coverage
- Guaranteed renewability of coverage
- No medical underwriting
- Single risk pool
- Index rate
- Plan level adjustments to index rate
- Rate increase review and notifications
- Catastrophic plans for specific populations

The only groups not impacted by the rating changes are self-funded groups and grandfathered plans along with large fully-insured groups in most states. For more information on adjusted community rating, please go to **uhc.com/reform** or scan this code:

New Taxes and Fees

Several health reform fees will impact premiums and rates. Employers need to know who is responsible for submitting each fee and the effective dates.

Five of the key new fees are noted here:

1. **PCORI Fee** (funds the Patient-Centered Outcomes Research Institute) — This temporary fee assists patients, clinicians, purchasers and policy-makers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings. The fee began in 2012 and ends in 2019.
2. **Insurer Fee** — This annual permanent fee on the health insurance sector, allocated by market share, funds Health Benefit Exchange subsidies. The fee is assessed on net written health insurance premiums, with certain exclusions.
3. **Transitional Reinsurance Fee** — This temporary fee is effective 2014 through 2016 and 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 ASO members. Applies to group and individual business.
4. **Risk Adjustment Fee** — The Risk Adjustment Program is intended to protect health insurance issuers of risk-adjusted plans, such as UnitedHealthcare, against adverse selection by redistributing premiums from plans with healthier populations to plans with unhealthier populations. In other words, it helps level the playing field. The permanent fee helps fund the administrative costs of running the program. The modest fee will be rolled into premium rates and will not be called out separately on the invoice.
5. **Excise Fee (Cadillac Tax)** — Applies to insurers and employers who offer rich benefit coverage.

Fee	Due on	Applies to	Estimated value
PCORI Fee	July 31 of the calendar year immediately following the last day of the plan year	FI and ASO – groups and individual ASO employers must make payment themselves	$1 pmpm first year increasing to $2 pmpm second year; indexed to medical inflation in subsequent years
Insurer Fee	Sept. 30 of calendar year	FI groups and individual carriers	$8 billion 2014 to $14.3 billion in 2018
Transitional Reinsurance Fee	Jan. 15 of the calendar year following the benefit year	FI and ASO ASO payable annually	$12 billion (2014) $8 billion (2015) $5 billion (2016)
Risk Adjustment Fee	Fee and calculation on June 30 of the calendar year following the benefit year. The first RA calculation is to be completed (will result in payments or charges) by June 2015 for the 2014 benefit year.	Issuers of risk-adjusted plans in the non-grandfathered individual and small group markets in and out of the Exchanges	Less than $1 per member per year; total estimated collections of $20 million per year
Excise Fee (Cadillac Tax)	2018	FI and ASO	40% of value of employer-sponsored coverage exceeding $10,200 individual/$27,500 family; indexed by cost of living in subsequent years

The Role of Health Benefit Exchanges

Health Benefit Exchanges, also called Health Insurance Exchanges, are marketplaces unique to each state where individuals and small groups can shop for health plans at competitive rates. States can also form regional Exchanges.

Although Exchanges are not in place until 2014, you must provide all employees with written notice about Exchanges by March 2013 to current employees and, going forward, new employees, about 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.

Employer Mandate, Requirements and Penalties

Employers with 50-plus full-time employees (or equivalent) are required to offer minimum essential health coverage or risk a penalty of $2,000 per employee for each employee over 30 employees.

For details on the employer mandate, please go to **uhc.com/reform** or scan this code:

If coverage is not affordable or does not provide minimum value as defined by the ACA, then employers risk a penalty of $3,000 per employee receiving a subsidy in the Exchange.

Help Your Employees Understand Their Role in Health Reform

It's important to help your employees understand the health reform changes that impact them now. Take advantage of UnitedHealthcare's online tools to communicate changes or create programs for your employees: Health Care Lane®, *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.

Fast Forward to Modernized Care

As one of the largest participants in the health care system, we know first-hand the significant challenges our nation faces in improving access to quality care and managing costs for all Americans. We are focused on providing more accountability, more health improvement and more engagement … essentially, more of what matters.

We're working to solve the big problems by focusing on these three areas – accountability, health and engagement – because we know how important they are to the health of your employees and your bottom line.

To learn more and stay current with the latest information, use **uhc.com/reform** as your reliable resource.

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