

# Health Reform Checklist

for fully insured employers with 100+ employees

At UnitedHealthcare, 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 and are taking steps to ensure your UnitedHealthcare plan conforms with Affordable Care Act (ACA) mandates that apply to large group plans. This checklist provides an overview to help employers address health plan changes required by the ACA.

## 2012 – 2013 Health Reform Provisions

- Limit employee contributions to health flexible spending accounts (FSA).** Beginning in 2013, employee salary reduction contributions to health FSAs will be limited to \$2,500 per plan year, with indexed increases allowed in future years to adjust for inflation.
- Employers who file 250 or more employee 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. (This requirement is informational only and does not mean that employees will be taxed on these dollars.)
- Provide written notice about Health Benefit Exchanges (Exchanges).** 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 they may be eligible for health insurance subsidies.
- Assess health plan offerings.** Employers should begin assessing their health plan offerings to determine whether they meet the minimum value requirements that will become effective in 2014. If plans do not meet the requirements, employers will need to explore alternative plan options and/or the impact of paying assessments.

## 2014 Health Reform Provisions

Although the following provisions will not become effective until 2014, it is important for employers to know what is coming and what action is required to decide if any adjustments need to be made and be aware of what UnitedHealthcare will do for you.

### What Employers Need to Do

- Offer Minimum Essential Coverage (MEC)** – Employers will want to consider whether they need to make changes to the cost and quality of the coverage offered to avoid penalties that will apply if that coverage is considered unaffordable or low in value. Beginning in 2014, employers with 50-plus full-time employees 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 Coverage:** If an employer offers MEC 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.

An employer-sponsored plan that satisfies the ACA's reform requirements must:

- Be affordable to the employee, i.e., required share of the employee's premium for self-only coverage exceeds 9.5 percent of his or her W-2, Box 1 income.
- Provide minimum value, i.e., the plan must pay more than 60 percent of medical costs across a typical population.

### What Employers Need to Know

Rest assured that upon renewal, your plan will automatically be adjusted to comply with ACA provision requirements applicable to large group plans. The following items become effective January 1, 2014. Note: No action is required of you. We are providing this for informational purposes only.



- We will remove plan exclusions for those of any age with a pre-existing condition. This is an update to the provision from 2010 that did not allow exclusions for children under the age of 19 with a pre-existing condition. This applies to grandfathered and non-grandfathered plans.
- Be aware of the Patient-Centered Outcomes Research Institute (PCORI) Fee – For plan years ending on or after Oct. 1, 2012, the ACA imposes a fee, called the PCORI Fee, of \$1 per member per year on health insurance issuers and employers sponsoring self-funded group health plans. For fully insured plans, the temporary fee is rolled into the premium rates and is not called out separately on the invoice. The fee began in 2012 and ends in 2019.
- Be aware that UnitedHealthcare will start progressively incorporating the Insurer Fee and the Transitional Reinsurance Fee into premiums beginning Feb. 1, 2013, as renewals or new business cases begin and state regulatory approvals are received.
  - The **Insurer Fee** will be collected from health insurance providers based on net written premiums for fully insured groups. The annual fee is permanent and expected to total \$8 billion in 2014 for all insurers, increasing each year to \$14.3 billion in 2018, and indexed to premium trend thereafter. Based on the government rule and industry analysis, the impact on premium is approximately 2.3 percent in the first year.
  - The **Transitional Reinsurance Fee** will be collected from health insurance providers for years 2014 to 2016. The funds are distributed 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. Based on the government rule and industry analysis, the impact for the first year of the Transitional Reinsurance Fee is about \$5 to \$6 per member per month.
- Understand that out-of-pocket maximums for all non-grandfathered plans will be capped at the same level at which health savings account (HSA) plans are capped. In 2013, these levels are \$6,250 single/\$12,500 family.
- Understand that cost-sharing toward services must accumulate to a plan's out-of-pocket maximum, including flat-dollar copayments for services that are defined as Essential Health Benefits. (EHB). Large groups do not have to cover EHB services, but if they choose to do so, they are prohibited from having annual dollar limits and cost-sharing for EHB services and all services must accumulate to the plan's out-of-pocket maximum.
- Understand the delivery requirements for providing the Summary of Benefits and Coverage (SBC) to your employees. On or after Sept. 23, 2012, group health plans and health insurance issuers offering group or individual health insurance coverage are required to provide an SBC that accurately describes the benefits and coverage under the applicable plan or coverage. The final regulations require that the SBC be provided in several instances (upon application, by the first day of coverage if there are any changes, special enrollees, upon renewal, upon request and off-renewal changes). We will continue to ask employers to distribute SBCs to members.

## 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 the 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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