Health Reform Checklist

for fully insured employers with 2-99 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 that your UnitedHealthcare plan conforms with Affordable Care Act (ACA) mandates that apply to small group plans. This checklist provides an overview to help employers address health plan changes required by the ACA.

2012 – 2013 Health Reform Provisions

- ☐ Small Business Tax Credit – Employers with fewer than 25 employees should check to see if they qualify for the Small Business Tax Credit. For tax years beginning in 2014, the credit will be available only to small businesses that purchase health coverage through a Health Benefit Exchange (Exchange). You should seek advice from an accountant and attorney to determine how the credit may affect your specific situation.
- ☐ 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.
- ☐ 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.
- ☐ Provide a Summary of Benefits and Coverage (SBC) – On or after Sept. 23, 2012, group health plans and health insurance issuers offering group or individual health insurance coverage are required to use standards in compiling and providing an SBC that accurately describes the benefits and coverage under the applicable plan or coverage. These standards ensure that information is presented in a clear and uniform format that helps plans and individuals better understand their health coverage and compare coverage options across different types of plans and insurance products. 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). There are variations on how the SBCs will be distributed. For some, we will distribute directly to the employees, and, for others, it will be the responsibility of the employer to distribute. If you are unsure of your responsibility for distribution, please contact your UnitedHealthcare representative.

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 small group plans. The following items become effective Jan. 1, 2014. Note: No action is required of you. We are providing this for informational purposes only.

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- ☐ We will be removing 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; however, grandfathered individual health plans are exempt from this requirement.
- ☐ We will make sure your plan provides Essential Health Benefits (EHB). The ACA requires all non-grandfathered small group employers to provide EHB.
- ☐ We will make sure that cost-sharing toward services will accumulate to your plan's out-of-pocket maximum, including flat-dollar copayments for services that are defined as EHB.
- ☐ Be aware of the Patient-Centered Outcomes Research Institute (PCORI) Fee – For plan years ending on or after Oct. 1, 2012, the Act imposed 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 following three fees under the ACA into fully insured plan premiums and will not be called out separately on the invoice 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.
    - 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.
- ☐ 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's provisions, 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.
- ☐ Annual limitation on plan deductibles is $2,000 single/$4,000 family. This applies to non-grandfathered small groups with the exception of 50-plus as they are not considered small group. There is an exception for leaner plans if you cannot "reasonably" meet the approved actuarial values with a $2,000 deductible.
- ☐ 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.

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.

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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. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.
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