On the Horizon: Health Reform Changes

Employers will see an impact on the health coverage they offer their employees as a result of some of the changes under the Patient Protection and Affordable Care Act (ACA). This brief summary covers several of the provisions and health plan changes that have the greatest impact to employers. In addition, the ACA contains a number of fees and taxes as well as product and benefit requirements that will affect the cost of health care for employers during the next several years. While the exact cost may differ for each employer based on location and plan design offered, on average employers are expected to see a substantial increase in costs.

Overview of Taxes and Fees Affecting Employers

- **Patient-Centered Outcomes Research Institute Fee (PCORI)** – Beginning with plan years that end after Sept. 30, 2012, the ACA imposes a new fee on commercial health insurers and self-insured plans. This fee is $1 per covered life for the first year, $2 per covered life for the second year, and indexed to medical inflation thereafter. The fee helps to fund research on the comparative effectiveness of medical treatments conducted by the new Patient-Centered Outcomes Research Institute (PCORI).
- **Insurer Fee** – Collected from health insurance issuers based on certain net written health insurance premiums for fully insured groups. The new fee is expected to total $8 billion in 2014 for all insurers, increasing to $14.3 billion in 2018, and increasing by the rate of premium growth thereafter. Based on industry estimates, the impact on premium is approximately 2.3 percent. The Insurer Fee will fund premium tax subsidies for low-income individuals and families who purchase insurance through Health Benefit Exchanges.
- **Transitional Reinsurance Fee** – For years 2014 to 2016, the ACA imposes a fee on insurers 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 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 are permitted to increase these fees at their discretion. Based on industry estimates, the average projected cost is approximately $6 per member/per month in 2014, which then decreases each year for the subsequent two years.
- **Other Health Care Fees** – The ACA also generates new revenue through:
  - Annual fee on pharmaceutical manufacturers (2011) and excise taxes on medical devices (2013) may increase claim expenses to your plan.
  - Excise tax imposed (40 percent) on the value of health insurance benefits exceeding a specified threshold (2018).

Other Changes Affecting Small Group Employers

From 2012 through 2014 additional changes and impacts to coverage and requirements will also affect small group employers. Some of the more prominent include:

- **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 a Summary of Benefits and Coverage (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. In addition, the SBC includes coverage examples of common benefits scenarios for having a baby or managing Type 2 diabetes, which illustrate the cost of care covered by the plan. 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).
- **Adjusted Community Rating and Market Restriction** – Health insurance in the individual and small group markets will only be able to vary premiums by family size, geography, tobacco use and age. Other rating factors currently used such as gender, industry, group size, health status and medical history will be prohibited. The impact of age factors will be limited to a range of 3 to 1. Tobacco users may also have their premium varied by up to 50 percent higher than non-tobacco users. As a result of these changes, a significant number of employers will realize more substantial increases than under current requirements.
- **Employer Mandate** – Beginning in 2014 employers may be subject to a non-deductible excise tax penalty if they do not provide benefits to employees or if the benefit offering does not equate to Minimum Essential Coverage offering.

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- **Minimum Essential Coverage** – PPACA does not explicitly mandate an employer to offer employees acceptable health insurance. However, certain employers with at least 50 full-time *equivalent* employees will face penalties, beginning in 2014, if one or more of their full-time employees obtains premium tax credit through an exchange. An individual may be eligible for a premium credit either because the employer does not offer coverage or if the employer offers coverage that is either not "affordable" or does not provide Minimum Essential Coverage (MEC). An employer-sponsored plan that satisfies the ACA's reform requirements must:
  - Be affordable to the employee (premium may not exceed 9.5 percent of household income). The IRS, however, has issued a safe harbor allowing employers to substitute the employee's W-2 income for household income.
  - Provide minimum value, which is at least 60 percent of the total allowed cost of benefits.

  Employers will need to evaluate their offerings to determine whether they meet these minimum value requirements; if they do not, they will need to evaluate alternative plan options and/or the impact of paying assessments.
- **Essential Health Benefits (EHB) No limits** – Beginning in 2014, small group employers are required to provide Essential Health Benefits.
- **Deductible Caps** – Beginning 2014, plan design deductibles may not exceed a $2,000 (self-only) or $4,000 (other than self-only) annual limitation provided under the ACA.
- **Out-of-Pocket Maximum Changes** – Beginning 2014, all cost-sharing toward services including flat-dollar copays that are defined as Essential Health Benefits must accumulate to a plan's out-of-pocket maximum.
  - Beginning 2014, the out-of-pocket maximum for all plans will be capped at the same level at which HSA plans are capped. In 2013, these levels are $6,250 for single coverage and $12,500 for non-single coverage.
- **Prohibition of Pre-existing Condition Exclusions for All Ages –** Beginning in 2014, pre-existing condition exclusions must be removed for all members, not just those under age 19.
- **Guaranteed Issue and Renewability** – Issuers required to offer and accept to any individual, small or large group ALL products that are approved for sale in the market with limited exceptions.
  - Coverage must be renewed at the option of the plan sponsor or individual.
- **Other Benefit Requirements** – Employers will need to adjust plan design and offerings based on rules going into effect in 2012 through 2014.
  - Beginning August 2012, preventive benefits will be expanded for a number of services for women including additional screening, prenatal office visits, breast-feeding support and some contraceptives.
  - Beginning in 2013, employee salary reduction contributions to health FSAs will be limited to $2,500 per year, with indexed increases allowed in future years to adjust for inflation.
  - In late summer or fall (future guidance is expected on complying with this notice requirement), employers must provide written notice to current and new employees at the time of hire to inform them of the exchanges and the circumstances under which an employee may be eligible for a premium tax credit and a cost sharing reduction.

Modernizing Health 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 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 www.uhc.com/reform.

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This communication should not be considered legal advice. Questions regarding the application of ACA to your plan should be addressed to your benefits counsel.

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