

Navigating health care reform – An employer’s guide



The new federal health reform law focuses primarily on establishing new state-based mechanisms for obtaining 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 guarantee issue requirements, become effective in 2014. Other reforms, such as certain lifetime and annual limits and pre-existing coverage exclusions for enrollees (dependent or employee) up to 19, as well as a requirement to offer dependent coverage up to age 26, become effective during the first year of implementation. This guide is designed to assist our employer group customers by highlighting some of the changes made by the legislation, and setting out general timelines.

Please click

- ▶ **Health reform implementation timeline**
- ▶ **Market Changes**
- ▶ **Glossary**



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UHCEW484380-000

Next

Print

Exit

Health Reform implementation timeline



► Quick reference timeline

Effective upon enactment (3/23/10)

Automatic Enrollment*

Effective 90 days following enactment

- Temporary 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**
- Non-discrimination Rules Extended to Insured Plans**
- Emergency Services without prior authorization/treated as in-network**
- Choice of Providers (pediatrician and OB-GYN)**

January 1, 2011

- No Reimbursement for OTC Drugs unless prescribed
- Form W-2 Reporting of Value of Benefits (for W-2 issued in January 2012 with respect to 2011)
- Long-Term Care Program
- Increased Penalty for Non-Medical HSA Withdrawals

* The legislation does not set out a separate effective date (so effective on March 23, 2010), however as a practical matter, employers may not be able to comply until regulations are issued.

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



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UHCEW484380-000

Home

Back

Next

Print

Exit

Health Reform implementation timeline



► Quick reference timeline (continued)

March 23, 2012

- Uniform Explanation of Coverage
- 4-page pre-enrollment coverage document sent, outlining benefits and exclusions
- 60-Day Notice in Advance of Material Modifications

January 1, 2013

- Medicare Tax Increase for High Earners
- No Deduction for Retiree Drug Subsidy
- Cap on Salary Reduction Health FSA Contributions (\$2,500 limit)
- Comparative Effectiveness Fee (policy years ending after November 30, 2012)

March 1, 2013

- Employer Notification Regarding Exchanges

January 1, 2014

- State-based exchanges
- Free rider penalty
- No preexisting condition exclusions
- Employer certification of coverage
- Increased wellness program incentives (from 20%-30%)
- Employer notification regarding exchanges
- Individual mandate
- Free choice vouchers
- No annual limits
- Required coverage for clinical trials for life-threatening diseases
- 90-day limit on waiting periods
- Retiree reinsurance program ends if money has not already run out



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UHCEW484380-000

Home

Back

Next

Print

Exit

Market changes



► For plan years beginning on or after 9/23/10 (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 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 19.

Automatic Enrollment Process

Employers with more than 200 employees must automatically enroll all full-time employees as soon as they are eligible for coverage, and employees may opt out of coverage. [Note: The legislation does not set out an affirmative effective date, so technically, this provision is effective on 3/23/10, the date of enactment. However, as a practical matter, employers cannot comply until regulations are issued.]

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).



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UHCEW484380-000

Home

Back

Next

Print

Exit

Market changes



▶ Grandfathered plans

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 impacting “grandfather” status. Connect with your UnitedHealthcare representative to receive additional guidance on grandfather rules.

▶ Non-grandfathered plans

Preventive Care Coverage

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 appeals process is resolved (external review to be based on NAIC Model Act with minimum standards to be set by HHS).

Non-discrimination for Fully-Insured Plans

Insured group health plans may not discriminate in favor of highly compensated individuals under Internal Revenue Code Section 105(h). This provision previously applied to self-funded plans only, which is why most executive medical plans were funded on a fully-insured basis.

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.



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UHCEW484380-000

Home

Back

Next

Print

Exit

Market changes



▶ Market changes (2010 – year-end 2013)

Small Employer Health Insurance Credit

The law provides for tax credits to certain small businesses (no more than 25 full-time equivalent employees and not more than \$50,000 in average annual employee wages) that offer health benefits. The tax credits vary depending upon the tax-exempt status of the organization and the aggregate amount of employer contributions toward health benefits. The subsidy begins for taxable years beginning after 12/31/2009.

Uniform Explanation of Benefits

By March 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 font, and should be written in a manner that is easy for the average participant to understand. The Secretary of HHS will provide a model notice in advance of the requirement.

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

By March 2013, employers must provide new and existing employees with information about the Exchange, such as information on employee eligibility for coverage under the Exchange, including “free choice vouchers” and premium credits.



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UHCEW484380-000

Home

Back

Next

Print

Exit

Market changes



▶ Market changes (2014 and beyond)

Reporting of Coverage

Beginning 2014, two new IRS reporting requirements apply to employers who offer group health coverage. First, employers who self-insure 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 and those required to offer free choice vouchers 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 must also be provided to full-time employees.

Temporary Risk Corridor Program

Between 2014 and 2016, HHS shall establish a mandatory risk corridor program, similar to Medicare Part D, for the individual and small group markets in which carriers with costs above 103% of "target" levels receive supplemental payments and carriers with costs below 97% of "target" levels make supplemental payments to HHS.

Waiting periods

Group health plans are prohibited from requiring waiting periods for coverage in excess of 90 days.



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UHCEW484380-000

Home

Back

Next

Print

Exit

Market changes



► Standardized benefit requirements – essential minimum benefits and standard offerings

Essential Health Benefits

Beginning in 2014, all health insurance in the individual and small group market (offered in or outside the Exchange) must include minimum essential benefits with coverage in the following categories: 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, and pediatric services, including oral and vision care.

- For plan years beginning in 2014, cost-sharing for all non-grandfathered plans is limited to HSA rules, and deductibles for small employers are not to exceed \$2,000 (single) and \$4,000 (family) unless employer contributions offset higher limits.

- For plan years beginning on or after September 23, 2010, non-grandfathered health plans are required to cover ER services as in-network without prior authorization. If services are provided out-of-network, the cost-sharing requirement is the same as if services were provided in-network.
- For plan years beginning in 2014, non-grandfathered health plans are also required to cover routine costs of phase I-IV clinical trials.

Wellness

The current HIPAA limitation on wellness rewards is increased from 20% to 30% (HHS can increase it to 50%).



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UHCEW484380-000

Home

Back

Next

Print

Exit

Market changes



► Employer coverage and reporting requirements/penalties for non-compliance

Premium Tax Credit

From 2010 to 2013, small employers with 25 or fewer employees and an average wage of \$50,000 or less are eligible for premium tax credits for two years of up to 35% of their contribution, if they contribute at least 50% of the total premium. Employers with 10 or fewer employees and average wages of \$25,000 or less will be eligible for the full credit. In 2014, the credits are limited to Exchange-based coverage and increase to 50% of contributions. Beginning in 2014, small employers will only be eligible for the credit for two years.

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 by CPI) or a penalty based on a percent of income (1% in 2014, 2% in 2015, and 2.5% 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% of income, individuals with incomes below the federal filing threshold, Native American tribe members, individuals with short coverage gaps of less than 3 months and individuals who experience hardship as determined by HHS.)

“Shared Responsibility” Fee

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 who 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).

Automatic Enrollment

Employers with more than 200 employees that offer coverage must automatically enroll new full-time employees with the opportunity to opt out.



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UHCEW484380-000

Home

Back

Next

Print

Exit

Market changes



► Employer coverage and reporting requirements/penalties for non-compliance (continued)

W-2 Reporting

Beginning with the 2011 calendar year (i.e., W-2's filed January 2012), employers must begin to report the "value" of employer-provided health coverage on an employee's W-2. The value may equal the COBRA cost minus the 2% administrative tack-on fee.

Free Choice Voucher

Employers who offer coverage and pay any portion of the cost of such coverage are required to provide a tax-exempt "free choice voucher" to certain employees to purchase coverage through an Exchange. The amount of the voucher is equal to the contribution the employer would have made to the plan to which the employer makes the highest contributions, based on the level of coverage (self-only or family) that the employee obtains through an Exchange. Qualifying employees are those whose household income is less than or equal to 400% of the federal poverty level, who do not participate in the employer health plan, and whose premium contribution for self-only coverage under the employer health plan if they did participate would be above 8% and less than or equal to 9.8% of their household income.

FSA Statutory Limit

Beginning on January 1, 2013, a \$2,500 contribution limit (indexed to CPI-U) is placed on employee salary reduction contributions to FSAs.

Health Savings Account Penalty

Beginning on January 1, 2011, penalties for non-health-related distributions from HSAs increase from 10% to 20%.

Limitation on Over-the-Counter Reimbursements

Effective January 1, 2011, over-the-counter (OTC) medicines or drugs are not eligible for reimbursement under an FSA, HRA, or other employer-sponsored health plan, or to be treated as a qualified medical expense for distributions from an HSA, without a doctor's prescription. This requirement will not apply to eligible OTC medical items other than medicines or drugs (e.g., bandages or contact lens solution). NOTE: This limitation takes effect January 1, 2011 without regard to the plan year of the health FSA or HRA.



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UHCEW484380-000

Home

Back

Next

Print

Exit

Market changes



► Retiree Medical

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% 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 on 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 Health and Human Services, 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"). Under the health reform law, a Part D participant will receive a \$250 rebate

check for expenses within the donut hole beginning in 2010. Starting in January 2011, pharmacy manufacturers are also required to provide name brand drugs at a 50% 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% 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.



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UHCEW484380-000

Home

Back

Next

Print

Exit

Market changes



► Subsidies to offset insurance premiums (only available for coverage purchased through the Exchange)

Premium Tax Credit

From 2010 to 2013, small employers with 25 or fewer employees and an average wage of \$50,000 or less are eligible for premium tax credits for two years of up to 35% of their contribution, if they contribute at least 50% of the total premium. Employers with 10 or fewer employees and average wages of \$25,000 or less will be eligible for the full credit. In 2014, the credits are limited to Exchange-based coverage and increase to 50% of contributions. Beginning in 2014, small employers will only be eligible for the credit for two years.

Worksite Wellness Program

Health and Human Services is required to establish a grant program for worksite wellness programs not currently in existence for small employers with fewer than 100 employees who work 25 or more hours per week. \$200 million is appropriated for this 5-year grant program.

Individual Subsidies

Individuals with incomes between 100% and 400% 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 Exchange. Subsidies are not available for any coverage outside the Exchange. An employee with access to employer-based coverage is only eligible for a subsidy through the Exchange if the coverage is “unaffordable” (i.e., required share of the employee’s premium for self-only coverage exceeds 9.5% of his or her household income) or if the coverage does not satisfy a “minimum value” requirement (i.e., at least 60% of total allowed costs are paid by the plan).



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UHCEW484380-000

Home

Back

Next

Print

Exit

Glossary



► Some key terms

Donut hole

The 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 expended 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). For our calendar year customers, these provisions will be effective January 1, 2011.

Essential health benefits

The term is very broadly defined to include wide-open categories (i.e., hospitalization, laboratory services, mental health and substance use disorder services); therefore, we will need to seek guidance to understand which types of benefits are subject to an annual or lifetime limit.

Exchange

Requires each state to establish an American 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% actuarial value), silver plan (70% actuarial value), gold plan (80% actuarial value), and platinum plan (90% actuarial value).

Federal Poverty Level

Established and available on the HHS website, and varies based upon family size.



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UHCEW484380-000

Home

Back

Next

Print

Exit

Glossary



► Some key terms (continued)

Free Choice Voucher

A payment that an employer is required to make toward the cost of Exchange coverage for certain employees for whom the contributions to participate in the employer plan (self-only) exceeds 8% but does not exceed 9.8% of the employee's household income for the year.

HHS

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).

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) Additional preventive care and screening (with respect to women) provided for in comprehensive guidelines supported by the HRSA.

PPACA

Patient Protection and Affordable Care Act (enacted March 23, 2010)



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UHCEW484380-000

Home

Back

Print

Exit