

## Navigating Health Care Reform An Employer's Guide

UnitedHealthcare, May 2010

### Health Reform Implementation Timeline

Quick Reference Timeline	
<b>Effective Upon Enactment (3/23/10)</b>	Automatic enrollment*
<b>Effective 90 Days following Enactment</b>	<ul style="list-style-type: none"> <li>Temporary retiree reinsurance program</li> <li>High risk pool</li> </ul>
<b>Effective Plan Years Beginning on or After September 23, 2010</b>	<ul style="list-style-type: none"> <li>Adult children coverage to age 26</li> <li>Restricted annual limits on essential benefits (to be defined)</li> <li>No lifetime limits on essential benefits</li> <li>No preexisting condition exclusions for enrollees under age 19</li> <li>No rescissions (primarily individual and small group coverage)</li> <li>First dollar coverage for preventive care**</li> <li>Revised appeals process**</li> <li>Non-discrimination rules extended to insured plans**</li> <li>Emergency services without prior authorization/treated as in-network**</li> <li>Choice of providers (pediatrician and OB-GYN)**</li> </ul>
<b>January 1, 2011</b>	<ul style="list-style-type: none"> <li>No reimbursement for OTC Drugs unless prescribed</li> <li>Form W-2 reporting of value of benefits (for W-2 issued in January 2012 with respect to 2011)</li> <li>Long-Term Care program</li> <li>Increased penalty for non-medical HSA withdrawals</li> </ul>
<b>March 23, 2012</b>	<ul style="list-style-type: none"> <li>Uniform Explanation of Coverage</li> <li>4 page pre-enrollment coverage document sent outlining benefits and exclusions</li> <li>60-Day notice in advance of material modifications</li> </ul>
<b>January 1, 2013</b>	<ul style="list-style-type: none"> <li>Medicare tax increase for high-earners</li> <li>No deduction for retiree drug subsidy</li> <li>Cap on salary reduction Health FSA contributions (\$2,500 limit)</li> <li>Comparative effectiveness fee (policy years ending after November 30, 2012)</li> </ul>
<b>March 1, 2013</b>	Employer notification regarding exchanges
<b>January 1, 2014</b>	<ul style="list-style-type: none"> <li>State-based exchanges</li> <li>Free rider penalty</li> <li>No preexisting condition exclusions</li> <li>Employer certification of coverage</li> <li>Increased wellness program incentives (from 20%-30%)</li> <li>Employer notification regarding exchanges</li> <li>Individual mandate</li> <li>Free choice vouchers</li> <li>No annual limits</li> <li>Required coverage for clinical trials for life-threatening diseases</li> <li>90-Day limit on waiting periods</li> <li>Retiree reinsurance program ends if money has not already run out</li> </ul>

\* 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.

## COBRA Under the Act

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 the 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 children 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.

## 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 such limits are permitted. Starting in 2014, annual limits on essential benefits are prohibited.
- **Pre-existing condition prohibitions.** All group health plans are prohibited from applying pre-existing 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).

### **The next items apply to 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.
- **Grandfathered and collectively bargained plans.** Plans in existence on March 23, 2010 may be grandfathered from complying with certain requirements. The law does not specify what will cause a plan to lose grandfathered status. Therefore it is unclear whether plan design changes will cause a plan to lose grandfathered status. A collectively bargained plan is exempt from certain requirements until the last of the collective bargaining agreements under the plan expires. The law is currently unclear as to whether the collectively bargained arrangements convert to a normal grandfathered status upon expiration or if a different treatment is contemplated.

### **Market changes (2010 –year end 2013)**

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

## Market changes (2014 and beyond)

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

## Standardized benefit requirements – essential minimum benefits and standard offerings

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

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

- **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:** Also 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 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.
- **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.

## Retiree Medical

- **Retiree Reinsurance.** The law creates a temporary re-insurance 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 participant’s out-of-pocket costs (i.e., contributions, co-payments, co-insurance 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 HHS, 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.

## Subsidies to offset insurance premiums

*(only available for coverage purchased through the Exchange)*

- **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).

## Health plan assessments/taxes

- **Comparative Effectiveness Fee.** The law imposes a new comparative effectiveness research fee starting for plan years ending after September 30, 2012. Employers who sponsor self-funded plans must pay \$1 per participant for years ending in fiscal year 2013, and \$2 per participant thereafter. For years ending after September 30, 2014, the amount is indexed to national health expenditures. The fee phases out beginning in 2019.
- **High Value Health Plan (“Cadillac”) Tax.** Beginning 2018, excise tax of 40% on “high value” plans. The tax could be imposed on self-funded plan sponsors if the value of the employer-sponsored coverage (excluding stand-alone vision and dental benefits but generally including health FSAs, HRAs and HSAs) exceeds \$10,200 for individual and \$27,500 for family coverage. There are higher thresholds for qualified retirees and “high risk” professions (\$11,850 and \$30,950).
- **Medicare Tax.** Beginning in 2013, there is a 0.9 percent increase in Medicare taxes on wages in excess of \$200,000 for single individuals and \$250,000 for joint filers. Also, a 3.8% “unearned income Medicare tax is imposed on the same individuals.

## Glossary – Some Key Terms

<b>Donut hole</b>	The Part D “donut hole” is an out-of-pocket zone for Part D participants in a Part D programs that are 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.
<b>Effective date</b>	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.
<b>Essential health benefits</b>	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.
<b>Exchange</b>	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).
<b>Federal Poverty Level</b>	Established and available on the HHS Web site, and varies based upon family size.
<b>Free Choice Voucher</b>	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.
<b>HHS</b>	Health and Human Services. The Federal governmental agency overseeing many aspects of the law.
<b>High risk pool</b>	Temporary national high-risk pool created to provide health coverage to those with pre-existing medical conditions (effective not later than 90 days after enactment and ending January 1, 2014).
<b>Preventive coverage</b>	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 preventing care and screening (with respect to women) provided for in comprehensive guidelines supported by the HRSA.
<b>PPACA</b>	Patient Protection and Affordable Care Act (enacted March 23, 2010)