The Road to Reform

Preparing for health reform in 2013 and 2014
UnitedHealthcare recognizes that our American health system requires fundamental change to provide affordable, quality care. Health reform is a start but more is needed to address health care costs that are rising continually and a system where care is too variable. Innovative, value-oriented and outcome-focused approaches can help make the system work better for everyone.

At UnitedHealthcare, our goal is helping people live healthier lives.™ Through the use of best practices, UnitedHealthcare is working to build a better, more affordable health care system. We help make this happen by:

- Providing innovative and affordable choices in the health plans we offer
- Modernizing delivery of health care by development of tools and programs to make health care easier to understand and navigate
- Focusing on quality of service and simplicity of administration
- Informing and engaging your employees regarding their health to help them make healthier choices

The Affordable Care Act (ACA) brings significant changes to how Americans access and pay for health care. And while change is good, it can be challenging. 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. We are taking steps to ensure that UnitedHealthcare’s plan designs conform to the ACA’s mandates.

Changes in federal law are just one way to move toward a more modern health care delivery system. UnitedHealthcare is at the forefront of improving access to quality care, containing costs, using technology to increase transparency and changing the way the system pays for care. We understand that when physicians, insurance companies, employers, consumers and government bring their best ideas to the table, we can help improve access to quality and affordable care.
The Big Picture
The ACA is rolling out in phases that began in 2010 and extend through 2019. Generally, the provisions fall into one of these areas:
- Standards for minimum health benefit plan offerings
- Exchanges, also called Health Insurance Marketplaces
- Mandates for employers and individuals to provide or purchase health care coverage
- Premium credit or cost-sharing subsidies to qualified individuals to purchase coverage
- Taxes and fees
- Requirements that insurance companies spend a certain percentage of premium dollars on patient care
- Certain preventive care services covered without cost-share
- Insurance market reforms
- Expanded appeal rights for consumers
- Expanded Medicaid eligibility
- Changes to Medicare reimbursement

Keeping Your Grandfathered Plan
For employers who decided to “grandfather” their health benefit plan, some of the health reform changes may not apply. Grandfathering a plan means that you decided to keep the plan that you had in effect on March 23, 2010, and made no or only minimal changes as permitted by the grandfather rules. However, there are a number of changes that apply to all plans whether or not they are a grandfathered plan.
As we approach 2014, grandfathered plans may not have to implement a number of health reform law provisions, including:
- Rating restrictions such as adjusted community rating (small group plans only)
- Capping deductibles (small group plans only) and/or implementation of the ACA’s out-of-pocket limits
- Providing essential health benefits (small group plans only)
- Providing coverage for clinical trials
In general, plan changes that can cause loss of grandfathered status include eliminating certain benefits, increasing coinsurance, increasing fixed-dollar cost-sharing (copayments, deductibles and out-of-pocket limits) beyond allowed amounts, and the plan sponsor’s decrease in its contributions toward the cost of coverage by more than 5 percent below the contribution rate on March 23, 2010.
Employers that have chosen to maintain grandfathered status, you will need to satisfy the required notice and recordkeeping obligations for maintaining grandfathered status.
Five Things Employers Need to Know

As regulations, mandates and laws become effective over the next months and years, it’s important to know where to begin and what to focus on as you prepare your business and employees. Depending on your group size, some of these changes may involve changing your processes as well as updating plan documents and materials to comply with the new regulations. Read more below and on Page 6 in “On the Horizon” Here are five things employers need to know:

1. A number of taxes and fees related to the health reform law will affect employers. Several health reform fees will impact premiums and rates. Employers need to know who is responsible for submitting each fee and the effective dates.

2. Employers filing 250 or more W-2 Forms are required to report the cost of employees’ health benefit coverage on the employees’ W-2 Forms. The W-2 reporting requirement is informational only for the individual and does not mean that they will be taxed on these dollars.

3. Small groups with no more than 25 employees can leverage tax credits. The Small Business Health Care Tax Credit is designed to encourage small businesses and small, tax-exempt organizations to offer health insurance coverage for their employees. UnitedHealthcare has developed a modeling tool (available at uhc.com/reform) to assist employers and brokers in determining eligibility for the credit and estimating the potential credit amount. In 2014, the tax credit is increased and available only to those employers who purchase insurance through a Small Business Health Options Program (SHOP) Exchange. You should seek advice from an accountant and attorney to determine how the credit may affect your specific situation.

4. Exchanges could affect how you offer coverage to your employees in the future. Although Exchanges are not in place until 2014, you must provide all employees with information about Exchanges, including employee eligibility to participate in an Exchange and available health insurance subsidies if the coverage you provide to employees is considered unaffordable by the ACA’s guidelines.

5. There will be coverage changes based on benefit expansion or coverage limits. Small groups will be required to implement changes within the plans they offer, including:
   - Expanding coverage to their employees to include Essential Health Benefits (EHB) and Minimum Essential Coverage (MEC). This change affects employers with 50 or more full-time employees and full-time equivalents.
   - Ensuring that out-of-pocket limits do not exceed the limit as outlined by health savings accounts (HSAs). This change affects large groups as well.

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**Essential Health Benefits**

The categorization of a benefit as essential or nonessential does not indicate that the benefit will or will not be covered under your plan. All services (essential or nonessential) must meet all other requirements for coverage, including any cost-effective requirements and that the service or device must not be unproven, experimental or investigational.
Looking Back
Here are key health reform changes that went into effect on or before December 31, 2012:

- Accountable Care Organization (ACO) requirements
- Appeals provision*
- Dependent coverage up to age 26
- Limitation on Flexible Spending Account (FSA), Health Reimbursement Account (HRA) and Health Savings Account (HSA) coverage for over-the-counter medications
- Medical Loss Ratio (MLR) rebates
- Patient-Centered Outcomes Research Institute (PCORI) Fee
- Patient Protections*
- Pre-existing condition protections for persons under age 19
- Preventive services as well as an expanded list of women’s preventive services with no cost-sharing*
- Quality bonus began for Medical Advantage plans
- Removal of lifetime and per-beneficiary annual restricted dollar limits for EHB
- Summary of Benefits and Coverage (SBC), the Uniform Glossary and 60-day advance notice of material modifications

*Not required of grandfathered plans
On the Horizon

Flexible Spending Account (FSA) Limits
Starting in 2013, there is a new maximum of $2,500 that can be set aside in a health FSA. In subsequent plan years, this will change based on inflation. This change is in addition to no longer allowing health FSAs to be used for over-the-counter medications that became effective in 2011.

Exchanges
Exchanges are intended to help individuals and small groups shop for, select and enroll in high-quality, affordable private health plans that fit their needs at competitive prices.

Public Exchanges
The ACA requires Exchanges, also called Health Insurance Marketplaces, to be established in each state by Jan. 1, 2014. If a state does not establish an Exchange, the federal government will step in and operate the Exchange. Between 2014 through 2016, only individuals and employers in the small group market are eligible to participate in an Exchange. In 2017, states may permit employers in the large group market to participate. Exchanges will open for business beginning Oct. 1, 2013, offering coverage beginning Jan. 1, 2014. Exchanges may be operated by the state or federal government or as a partnership between a state and the federal government. In 2014, small groups will be defined as businesses with up to 100 employees, although until 2016 a state may choose to limit the definition to businesses of up to 50 employees. The definition for large groups will remain as businesses with more than 100 employees.

Applicable employers must provide written notice to current employees by Oct. 1, 2013, and new employees within 14 days of their start date to inform them of their coverage options available through the new Exchanges. The U.S. Department of Labor shared a Model Notice employers may use to meet this requirement that can be found on the Department of Labor website at dol.gov/ebrsa/healthreform/index.html or the United for Reform Resource Center at uhc.com/united_for_reform_resource_center/health_reform_provisions/health_benefit_exchanges.htm. Employees meeting certain requirements who cannot afford the coverage provided by their employer may purchase a plan in the Exchange.

Employers with 50 or more full-time employees and full-time equivalents who decide not to offer a health benefit plan or a plan that provides minimum essential coverage to their employees, and instead leverage the Exchange, are subject to penalties referred to as the employer mandate. Read more on Page 8 in “What’s Coming in 2014.”

Private Exchanges
Private exchanges are being established by a variety of different entities such as consulting firms and cooperatives. Private exchanges are available to all business segments and fully insured or self-funded groups of all sizes. Because private exchanges are operated by private entities, subsidies are not available to those purchasing health care insurance through a private exchange.
Taxes and Fees

To fund several of the changes mandated by the health reform law, new taxes and fees will impact premium rates. For fully insured customers, the cumulative financial impact of the health reform fees in 2014, based on the government rule and industry analysis, shows an increase in the premium of about 3.8 percent. The nominal PCORI research fee is included in the premiums, and UnitedHealthcare will start progressively incorporating the Transitional Reinsurance Fee and the Insurer Fee beginning Feb. 1, 2013, as renewals or new business cases begin and state regulatory approvals are received. A footnote acknowledging the Transitional Reinsurance and Insurer Fees will appear on 2-50 quotes and renewal packages as early as July 1, 2013 rate effective dates, and on 51-plus quotes and renewal rate exhibits as early as Feb. 1, 2013 rate effective dates. Timing of the footnote depends on state-specific regulatory filings and approvals. Fully insured large groups' renewals (100-plus) will show taxes and fees as line items on rate justifications.

• The Patient-Centered Outcomes Research Institute (PCORI) Fee applies to health insurance issuers and self-funded group health plans. The temporary fee helps to fund research on the comparative effectiveness of medical treatments. Beginning with plan years ending on or after Oct. 1, 2012, the fee is $1 per member for the first year, $2 per member for the second year, and indexed to medical inflation in subsequent years. The fee began in 2012 and ends in 2019. The PCORI Fee is due by July 31 of the calendar year immediately following the last day of the plan year. So, the 2012 fee must be paid by July 31, 2013, regardless of renewal date.
  – In the case of fully insured coverage, UnitedHealthcare is responsible for filing Form 720 and paying the required PCORI Fee. The fee is rolled into the premium rates and is not called out separately on the invoice.
  – Self-funded customers, as the plan sponsor, must file federal excise Form 720, and pay the fee directly to the IRS.

• The Insurer Fee is collected from health insurance issuers based on certain net written health insurance premiums for fully insured groups.
  The permanent 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 about 2.5 percent.
  The Insurer Fee will fund premium tax subsidies for low-income individuals and families who purchase insurance through Exchanges.

• The Transitional Reinsurance Fee is designed to stabilize non-grandfathered individual market plans (in and out of the Exchange). It is assessed on a per capita basis for both fully insured and self-funded members and applies to group and individual business. The Reinsurance Program will exist for the first three years of the Exchanges' operation (2014-2016). The impact of the Transitional Reinsurance Fee, based on the government rule and industry analysis, is about $5 per member per month for the first year.

• 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.
**Individual Mandate**

Beginning in 2014, the health reform law requires most individuals to have health insurance for themselves and their spouses or dependents. The requirement is for each individual to have minimum essential coverage (MEC) or pay a potential penalty for noncompliance. Coverage may be obtained through government program such as Medicare or Medicaid; employer or individual insurance market; or Health Insurance Marketplace (exchange). The individual mandate penalty is 1 percent of income for 2014 and is capped for a family at 300 percent of the individual penalty. It increases to 2 percent of income in 2015 and then 3 percent of income in 2016, indexed to inflation in future years. If individuals do not elect coverage offered by their employer and do not have other coverage, in 2014 there will be a tax penalty based on the individual's income. Please consult a tax advisor with questions.

- **2014** – $95 per uninsured person or 1 percent of household income over the filing threshold (whichever is greater)
- **2015** – $325 per uninsured person or 2 percent of household income over the filing threshold (whichever is greater)
- **2016** – and beyond, $695 per uninsured person or 2.5 percent of household income over the filing threshold (whichever is greater)
- **2017** – going forward, the penalties will be increased by the cost-of-living adjustment.

**Adjusted Community Rating**

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 provision, 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.

The only groups not affected by the rating changes are self-funded groups and grandfathered plans along with large fully insured groups in most states.

**Removal of Pre-existing Condition Exclusions**

For plan/policy years beginning on or after January 2014, the health reform law will remove any restrictions on pre-existing conditions for individuals of all ages. Therefore, coverage may not be denied for pre-existing conditions nor will individuals with pre-existing conditions be charged more. 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.

**Employer Mandate, Requirements and Penalties**

Beginning in 2015, employers with 50 or more full-time employees and full-time equivalents may be subject to a penalty if they do not offer medical coverage to full-time employees that provides minimum essential coverage, is affordable and meets minimum value requirements. If the employer does not offer coverage, or the coverage is deemed unaffordable and does not provide minimum value, full-time employees may obtain health insurance through an Exchange and qualify for a premium credit or subsidy. The penalty would apply if an employee applied to the Exchange and was deemed eligible for a subsidy either because the employer did not offer minimum essential coverage OR the coverage the employer offered did not meet minimum value or affordability requirements. While voluntary compliance with the mandate is encouraged for 2014, the penalty does not go into effect until 2015.

The penalty is calculated as follows:

- **Employers Not Offering Coverage:** If an employer does not offer any health benefits coverage or medical coverage that provides MEC and one or more full-time employee or dependent(s) qualifies for a premium tax credit or cost-sharing reduction through the Exchange, the annual penalty is $2,000 per full-time employee. When calculating the penalty, the first 30 full-time employees are subtracted from the payment calculation. This penalty is assessed per full-time employee for each month an employer does not offer coverage, or minimum essential coverage, to its employees.

- **Employers Offering Unaffordable Coverage:** If an employer offers MEC but the full-time employee's contribution is deemed unaffordable and does not provide minimum value, full-time employees may obtain health insurance through an Exchange and qualify for a premium credit or cost-sharing reduction. The annual penalty of $3,000 per full-time employee would apply if an employee applied to the Exchange and was deemed eligible for a subsidy. This penalty is assessed per full-time employee who receives a premium tax credit or cost-sharing reduction for each month the employee qualifies for such assistance.
ABC Company is a large group, fully insured, non-ERISA, non-governmental employer. ABC’s 100 employees are covered by a non-grandfathered health plan. Eligible retirees of ABC Company are covered under a retiree plan. In anticipation of health reform provisions coming during 2013, the company developed the following approach to stay informed of health reform changes and, when necessary, communicate any changes to employees that may affect them:

<table>
<thead>
<tr>
<th>Month</th>
<th>Health Reform Mandate</th>
<th>ABC Company Actions</th>
</tr>
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<tbody>
<tr>
<td>December 2012</td>
<td>The Retiree Drug subsidy paid to ABC Company is now considered taxable income.</td>
<td>ABC Company must declare the Retiree Drug subsidy paid to it on its 2013 tax return.</td>
</tr>
<tr>
<td>January 2013</td>
<td>Starting Jan. 1, 2013, health care FSA contributions will be limited to a maximum of</td>
<td>ABC Company must update its plan documentation to reflect the changes to the FSA</td>
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<td>$2,500. The limit will be adjusted according to the consumer price index (CPI) starting</td>
<td>contribution limit.</td>
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<td>in 2014.</td>
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<td></td>
<td>Employers who filed 250 or more W-2 Forms in the previous year are required to report</td>
<td>Because ABC Company filed 100 employee W-2 Forms in 2011, it is not required to</td>
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<td>employees the cost of employer-sponsored health benefit coverage on their W-2 Forms.</td>
<td>report the cost of its health benefit coverage on employees’ 2012 W-2 Forms. Note:</td>
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<td>Companies need only share the cost of coverage for those to whom it issues a W-2 Form.</td>
<td>Employers are not required to notify their employees about W-2 reporting. Once the</td>
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<tr>
<td>March 2013</td>
<td>As part of the employer mandate, ABC Company carefully evaluated its health plan and</td>
<td>W-2 Forms are distributed, they may want to communicate to employees that the</td>
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<td>premiums and has decided to continue to offer coverage to its employees.</td>
<td>requirement is informational only and does not mean that the cost of employer-</td>
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<td>April 2013</td>
<td>ABC Company renews its health plan.</td>
<td>provided coverage will be subject to income tax.</td>
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<td>July 2013</td>
<td>ABC Company received written notice that its group was eligible to receive rebates as</td>
<td>ABC Company’s policyholder is required to issue a written notice to relevant group</td>
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<td>set forth by the guidelines of Medical Loss Ratio (MLR).</td>
<td>plan subscribers about the rebate. The policyholder is obliged to use ABC’s portion</td>
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<td></td>
<td></td>
<td>of the rebate attributable to the premium paid by ABC’s subscribers in one of the</td>
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<td>following three ways:</td>
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<td>• To reduce the subscribers’ portion of the annual premium for the following policy</td>
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<td>year for all subscribers covered under any group health policy offered by the plan;</td>
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<td>• To reduce the subscribers’ portion of the annual premium for the following policy</td>
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<td>year for only those subscribers covered by the policy on which the rebate was based;</td>
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<td>• Provide a cash refund to subscribers covered by the policy on which the rebate</td>
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<td>was based.</td>
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<td>By Oct. 1, 2013</td>
<td>ABC Company’s employees will be eligible to participate in the Exchange beginning in</td>
<td>An employee communication was issued based on the Model Notice of Coverage Options</td>
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<td>2014. Employers are required under the law to notify employees by Oct. 1, 2013, of the</td>
<td>released by the Department of Labor (<a href="http://www.dol.gov/esa/pdf/FLSAwithplans.pdf">http://www.dol.gov/esa/pdf/FLSAwithplans.pdf</a>)</td>
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<td>availability of Exchanges in 2014.</td>
<td>regarding the availability of the Exchanges and that ABC Company will be eligible to</td>
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<td>Beginning in 2017, states may permit employers in the large group market to participate.</td>
<td>participate in the Exchanges beginning 2014 through 2016.</td>
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<tr>
<td>November 2013</td>
<td>ABC Company’s employees have made their health insurance plan choice for the upcoming</td>
<td>As required by law, ABC Company has chosen the option to issue an electronic copy</td>
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<td>year.</td>
<td>(instead of a paper copy) of the summary of benefits and coverage (SBC) to all</td>
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<td>participants enrolling in the health plan following the mandated formatting</td>
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<td>guidelines.</td>
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</table>
Questions employers may want to discuss with their tax advisor or legal counsel with the employer mandate in mind:

1. How does our product portfolio measure up to the minimum value requirements that will become effective in 2014?
2. Do we offer affordable health care according to the definition in the employer mandate?
3. How is our prescription drug coverage?
4. Should we continue to offer coverage but change what we offer to suit the ACA’s guidelines?
5. Does it make more sense to pay the penalty of $2,000 per full-time employee per year minus the first 30 full-time employees than to offer employer-sponsored health coverage?
We Can Help

It’s important to help your employees understand the health reform changes that affect them now. Take advantage of UnitedHealthcare’s online tools to communicate changes or create programs for your employees: Health Care Lane,® Healthy Mind Healthy Body® e-newsletter, member portals, videos from the award-winning “Health Care Reform Demystified” video series and the interactive health and wellness communications plan builder.

Questions?

Talk with your broker or account representative, who can address your specific concerns. We’re here to help you:

▶ Stay updated on ongoing policy changes through our e-newsletters and special websites dedicated to health reform news
▶ Find the most affordable health benefit plans
▶ Talk about health reform with your employees
▶ Refer to the United for Reform Resource Center for updates and more detailed information at uhc.com/reform.
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 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.