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UnitedHealth Group is pleased to bring you this issue of the Health Care Modernization News Flash to update you on health care issues under discussion in Washington, D.C. and in the states, and to share our perspectives on modernization of the health care system.

Our Perspective

UnitedHealth Group Comments on Enactment of Health Care Reform Bills

Following the enactment of the “Patient Protection and Affordable Care Act” and the “Health Care and Education Affordability Reconciliation Act”, UnitedHealth Group President and CEO Stephen Hemsley stated, “UnitedHealth Group is committed to ensuring that expanded access to quality care for millions of Americans is achieved and sustained over time. We remain concerned that any advances under the new law will be eroded by the unchecked rise of health care costs that were not adequately addressed in the legislation. We will continue to work with all stakeholders to tackle this complex but critical issue.” For years, UnitedHealth Group has focused on practical, proven and effective solutions to ensure accessible, affordable and quality coverage for all Americans. Throughout the federal health care reform debate, we engaged with government officials, policymakers and the health care community to improve health care from a whole-system perspective, offered constructive reform proposals, and provided data, insights and best practices from across our enterprise. We support many of the elements included in the new law, from the coverage expansions to the anti-fraud and abuse initiatives to the incentives for the promotion of prevention and wellness efforts. However, many of the reforms will only be sustainable if there’s an effective individual responsibility requirement and the accelerating cost burden on families and businesses is relieved. We know that the modernization of health care is just beginning. Controlling cost growth across the system is fundamental to creating a modern health system.

National Spotlight

President Signs Health Reform Bills

On March 30th, the President signed the “Health Care and Education Affordability Reconciliation Act” that passed both the House and Senate on March 25th. The “Health Care and Education Affordability Reconciliation Act” makes changes to the “Patient Protection and Affordable Care Act,” which was signed into law by the President on March 23rd. The CBO estimates that these two laws combined will cost \$940 billion over ten years and cover 32 million of the 54 million uninsured. Details of the newly enacted health reform bills include:

- **Financing of Health Reform:** A 40% excise tax is placed on “high value” employer-based plans (insured and self funded) valued at over \$10,200 for individuals and \$27,500 for families starting in 2018, with higher levels and adjustments for the age and gender of workers and for high risk occupations. Beginning in 2013, there is an increase in the Medicare FICA tax of 0.9% on income over \$200,000 for singles and \$250,000 for couples and a new 3.8% assessment is placed on unearned income for these income earners. Annual fees are placed on health insurers (a total of \$60 billion from 2014 to 2020 with exemptions for certain non-profit Medicaid and Medicare plans) and pharmaceutical companies (a total of \$28 billion from 2011 to 2020). Starting in 2013, a 2.9% sales tax is applied to medical devices, excluding eyeglasses, hearing aids, and other “general goods” purchased over-the-counter. The legislation also makes changes to HSA and FSA rules, increases the threshold for individual tax deductibility of medical expenses to 10%, sets a 10% tax on tanning bed services, reduces spending for the Medicare Advantage program, reduces provider payment rates under Medicare, and secures rebates for Medicaid and discounts for Medicare Part D from pharmaceutical companies.
- **Insurance Market Rules Effective Within Six Months of Enactment:** Several insurance market rules take effect for plan years starting on or after six months post enactment, including review of health plan premiums by state departments of insurance and HHS, prohibition of lifetime benefit limits and “restricted”

annual limits, a requirement that plans cover dependents to the age of 26, prohibition of waiting periods exceeding 90 days, a requirement that plans cover preventive services without cost-sharing, prohibition of pre-existing condition exclusions for children under 19, and prohibition of coverage cancellation or rescission except in cases of fraud. Prior to the implementation of new market rules in 2014, the legislation also establishes high risk pool provisions for individuals who can not obtain coverage due to health status and creates a reinsurance program for employer coverage of early retirees. Provisions related to lifetime and annual limits, dependent coverage, waiting periods, preventive services, and retiree reinsurance apply to insured and self funded plans.

- **Insurance Market Rules Effective in 2011:** The legislation sets up an 80% medical loss ratio (MLR) for individual and small group plans and an 85% MLR for large group plans. The definition of small group follows current state law until 2014, when small group is defined as 100 employees unless a state limits the definition to 50 employees before 2017. These requirements apply to insured health plans inside and outside of Exchanges, including “grandfathered” plans.
- **Insurance Market Rules Effective Starting in 2014:** Reforms that require guarantee issue and renewal during an open enrollment period, establish risk sharing mechanisms (partly funded by insured and self funded health plans), prohibit premium variations based on health status, and limit premium variation to tobacco use, age (3:1 band), geography, and family composition apply to individuals and small groups to size 100 (states may limit small groups to 50 and may increase beyond 100 with expanded Exchange eligibility starting in 2017). Annual limits and pre-existing condition exclusions are prohibited for insured and self funded plans. States can pass legislation to form “Health Care Choice Compacts” to allow the purchase of individual insurance across state lines.
- **Multi-State Plans and CO-OPs:** “Multi-State Plans” are created in 2014 to compete with private insurers in state Exchanges. The Office of Personnel Management (OPM) will enter into contracts and negotiate premiums and other conditions with at least two private health plans (health plans may voluntarily participate and at least one must be non-profit) to create Multi-State individual and small group plans to be offered in every state by 2017. Start-up funding is also provided to establish non-profit member-governed health plans (CO-OPs) in 2014 not currently in existence to compete with private insurers and Multi-State Plans in Exchanges. CO-OPs and Multi-State Plans must comply with the same rules as other plans in Exchanges. States are not required to establish CO-OPs.
- **State Exchanges:** State-based “Exchanges” are established in 2014 for individuals without access to affordable group coverage (and not eligible for Medicare or Medicaid), small groups to size 100 (states may limit small groups to 50 and may increase beyond 100 starting in 2017), and CHIP eligibles (beginning in 2015) if benefit and cost-sharing under a plan is certified as appropriate for the population. State Exchanges are designed to facilitate comparison shopping, enrollment, and subsidy administration and certify plans for participation that meet established standards and rules, including reasonable rate increases. Participation is voluntary.
- **Benefit Plans:** Beginning in 2014, individuals and small groups to size 100 (states may limit small groups to 50 and may increase beyond 100 with expanded Exchange eligibility starting in 2017) have a choice of up to five plan types including “Bronze” (60% actuarial value), “Silver” (70% actuarial value), “Gold” (80% actuarial value), “Platinum” (90% actuarial value) and “Young Invincible” (catastrophic plan available for adults under 30 and for those whom a Bronze premium would exceed 8% of income). Individuals between 133% and 200% of the federal poverty level without access to employer coverage would be enrolled in a state-negotiated “Basic Plan” where available. HHS establishes and updates benefit plan definitions through a public process, but states may establish additional benefit rules as long as additional subsidy costs are state paid. Out-of-pocket spending is limited to HSA limits for individual and group plans (insured and self funded). Wellness incentives up to 30-50% of the cost of coverage are allowed for group plans (insured and self funded).
- **Coverage Mandates, Penalties, and Subsidies:** Starting in 2014, individuals are required to have coverage through a “grandfathered” plan, a large group plan, a government program (Medicaid, Medicare, and the like), or through an individual or small group plan that meets minimum requirements (“Bronze” plan or “Young Invincible” plan for those under age 30), or pay a penalty. The penalty is the greater of a flat dollar amount (\$95 in 2014 phased-in to \$695 by 2016) or a percent of income (1.0% in 2014 phased-in to 2.5%

by 2016). Waivers of the penalty are allowed for Native Americans, those with religious objections, and individuals with a financial hardship defined as premiums exceeding 8% of income. Individuals up to 400% of the federal poverty level (\$88,000 for a family of four) are eligible for premium and cost-sharing subsidies for plans purchased through an Exchange. Employers are not required to offer coverage, but those with 50 or more full-time employees not offering coverage are required to pay a \$2,000 fee per employee obtaining a subsidized plan through an Exchange starting in 2014. Employers offering coverage must pay up to a \$3,000 fee per employee obtaining subsidized coverage through an Exchange. Employers may exempt 30 full-time employees from the penalty calculation. Those employers offering coverage must also provide tax-exempt “free choice vouchers” to qualifying employees (whose premium contribution would be between 8% and 9.5% of their income) to purchase coverage through an Exchange that is equal to the contribution the employer would have made to its own plan. Starting in 2010, low wage employers (average salary less than \$50,000) with 25 or less employees are eligible for up to a 50% premium credit for two years if they pay for at least 50% of the premium.

- **State Waivers:** States can seek a waiver from HHS starting in 2017 to adopt their own rules in lieu of the new federal standards related to benefit requirements, Exchanges, and coverage mandates as long as the state standards would result in similar outcomes and not increase the federal deficit.
- **Medicaid and the Children’s Health Insurance Program (CHIP):** Medicaid eligibility is expanded to 133% of the federal poverty level for all individuals in 2014 with full federal funding of the expansion until 2017 (95% in 2017 phased-down to 90% by 2020 and thereafter). For states that have already implemented a Medicaid expansion for childless adults and parents, state spending on this population is reduced by 50% in 2014 and over time state spending is reduced further to equal that of non-expansion states by 2020. Upon enactment, states are required to maintain existing Medicaid and CHIP eligibility. CHIP is extended to 2015. If a state exhausts its federal CHIP funding in any given year, CHIP eligibles may be moved into an Exchange. Beginning in 2015, states can enroll CHIP eligible children into private coverage through an Exchange if the benefits and cost-sharing are certified by HHS as similar to those under CHIP.
- **Medicare:** The payment structure for Medicare Advantage is changed by setting the 2011 Medicare Advantage payments at 2010 levels and phasing-in new payment levels ranging from 95% of fee-for-service Medicare payments in high-cost areas and 115% of fee-for-service Medicare payments in low-cost areas starting in 2012. Beginning in 2012, Medicare Advantage plans with high quality or an improvement in quality are eligible for payment bonuses. By 2014, Medicare Advantage plans are required have an 85% medical loss ratio. The Part D “donut hole” or coverage gap is closed by 2020 by reducing the gap by \$250 in 2010 and reducing coinsurance to 25% for brand and generic drugs. Starting 2011, pharmaceutical manufacturers provide a 50% discount for brand name drugs and a 7% discount for generic drugs purchased in the “donut hole” or coverage gap under Part D. The income subsidy exclusion for employers offering “qualified prescription drug plans” is eliminated in 2013. The legislation also links provider payments to quality outcomes, creates pilot programs for coordinated care delivery models, establishes a new “Innovation Center” to test and implement new provider payment methods, and changes payment incentives to reduce hospital acquired infections and preventable readmissions. Annual provider payment updates are reduced for Medicare Part A and B and an independent “Payment Advisory Board” is established to report on system-wide health care costs, access, and quality and recommend policy changes to slow the rate of national health care spending growth and limit the rate of growth in Medicare spending.

Watch for more information from UnitedHealth Group over the next few weeks and months on the provisions and implementation of the “Patient Protection and Affordable Care Act” and “Health Care and Education Affordability Reconciliation Act.”