Fast Forward » Bringing It Home

2014 - 2015 Changes for **Self-funded Employers**

Employers, including those who self-fund their health benefits, will continue to see an impact on the health coverage they offer their employees as a result of some of the changes under the Affordable Care Act (ACA). This summary covers several of the provisions and health plan changes that have the greatest impact to self-funded employers. In addition, the ACA contains a number of taxes and fees 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 the type of benefits offered, on average, employers are expected to see an increase in costs. Assess plan design and plan documents such as Summary Plan Descriptions (SPD) and plan benefits to determine whether they meet the minimum requirements that became effective in 2014.

Expanded Benefits and Other Benefit Requirements

Routine Patient Costs for Clinical Trials — For new and renewing plans effective on or after Jan. 1, 2014, all non-grandfathered health plans are required to cover certain routine patient costs incurred when participating in approved clinical trials. Coverage is for routine patient costs and care that would be a covered benefit even if the member was not a participant in a clinical trial, but not for the device, medication or data collection costs associated with the trial. Routine patient costs are covered even if the plan does not cover the clinical trial itself and are covered at the same benefit level as for any other illness, disease or condition. Clinical trial coverage beyond routine patient costs is not mandated by the ACA.

☐ *Review* SPDs and other plan documents to remove any limitations associated with routine patient costs in relation to clinical trials.

What is an approved clinical trial?
An approved clinical trial is one conducted in relation to the prevention, diagnosis or treatment of cancer or other life-threatening diseases or conditions and which has been approved or sponsored by one of a number of federal health-related agencies.

In addition, the trial for which routine patient costs must be covered, must be approved or sponsored by one of a number of federal agencies, including the National Institutes of Health, the Centers for Medicare and Medicaid Services and the Food and Drug Administration. This list is not all-inclusive.

What is UnitedHealthcare's approach?

- Coverage will include routine patient costs associated with preventive, therapeutic and diagnostic clinical trials.
- Coverage will include routine patient costs related to clinical trials covering "other life threatening conditions" in addition to cancer, cardiovascular and surgical musculoskeletal disorders of the spine, hips and knees.
- Coverage will include routine patient costs associated with Phase I, II, III and Phase IV trials.

Options
In addition to providing coverage for routine patient costs relating to cancer, cardiovascular or musculoskeletal diseases, self-funded customers may elect to provide coverage without diagnostic restriction. A plan may choose to offer greater coverage than ACA requires, including coverage for costs associated with trials relating to different conditions and conducted for different purposes. Generally, experimental, investigational and unproven services are excluded unless the patient's condition is life-threatening, as defined in the enrollee's benefit document.

Coverage for Adult Children to Age 26 including those that have employer coverage (formerly not required for grandfathered plans).

☐ *Include* coverage for all adult children until age 26.

Essential Health Benefits (EHB) No Dollar Limits — Self-funded employers are not required to provide EHB. If a client covers a benefit deemed essential, that EHB cannot have annual and lifetime dollar limits.

Self-funded employers may select any state or federal benchmark plan to serve as their guide for determining which benefits are defined as essential. This rule applies to both grandfathered and non-grandfathered plans.

☐ *Remove* annual and lifetime dollar limits for covered services defined as EHB.

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☐ *Select* a benchmark plan in order to determine which benefits are considered essential.

Religious Exemptions — Under the health reform law, certain religious institutions or employers with religious objections that offer insurance to their employees may be able to choose whether or not to cover contraception services. Contact your UnitedHealthcare representative if you have questions about these religious exemptions or find certification forms on the United for Reform Resource Center.

Flexible Spending Account (FSA) Contributions Reminder

For the taxable years beginning in 2015, the dollar limitation on voluntary employee salary reductions for contributions to health FSAs is $2,550. Also, an exception to the longstanding "use-or-lose" rule associated with FSAs now allows health FSAs to carry over up to $500; however, employers may specify a lower amount or not permit the carryover at all. The accumulated unused amount carried over plan year to plan year cannot exceed $500. Additionally, the same carryover limit must apply to all plan participants. Plan documents must be amended to include the carryover provision. An FSA carryover provision and an FSA grace period cannot be offered at the same time.

☐ *Determine* whether FSA carryover will be permitted. Amend plan documents as needed.

2015 Amounts for Health Savings Accounts (HSA)

The IRS issued the 2015 inflation adjusted contribution, deductible, and out-of-pocket spending limits for HSA. The limits are as follows:

For self-only coverage:

- The annual contribution limits may not exceed $3,350
- The annual deductible must be at least $1,300
- The annual out-of-pocket limits may not exceed $6,450

For family coverage:

- The annual contribution limits may not exceed $6,650
- The annual deductible must be at least $2,600
- The annual out-of-pocket limits may not exceed $12,900

Mental Health Parity — The final rules implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applies on the first day of the plan year that starts on or after July 1, 2014. There are two parts to the final rules: Financial Requirements and Treatment Limitations.

Financial Requirements: Individual and group health plans that provide both medical/surgical benefits and mental health/substance use disorder (MH/SUD) benefits may not apply financial requirements (deductibles, co-insurance, co-payments, OOPM, etc.) to MH/SUD that are more restrictive than the financial requirements that apply to medical/surgical benefits. The final regulations provide a mathematical test that must be used to determine if the financial requirements will meet the parity requirements.

Based on the final rules, we have determined that our fully insured plans are compliant and will not require retesting at this time. Please note that we do anticipate the need to retest plans in 2016. The testing classifications will be updated for the 2016 plan portfolios to allow for greater cost-sharing flexibility for certain types of MH/SUD services. In the near future, the process of testing all plans for compliance and filing language to support paying some MH/SUD services on an intermediate basis will begin. More details will be available in mid-2015.

Treatment Limitations: Treatment limitations include benefit limits based on the scope or duration of treatment. Treatment Limitations fall into one of two categories, quantitative and non-quantitative. Quantitative Treatment Limitations include numerical limits such as episodes of coverage, day or visit limits.

Non-Quantitative Treatment Limitations are limits that apply in some other way to limit scope or duration of benefits, such as medical management techniques, medical necessity requirements, network participation and provider reimbursement, formulary design, etc.

For Treatment Limitations, there is no mathematical test to determine parity. Instead, for each classification of benefits, the application/operation of the treatment limits to a plan's MH/SUD benefits must be "manually" compared to such limits applying to medical/surgical benefits under the plan. We have developed a summary description of our standard non-quantitative treatment limits which can be used to help customers determine whether their plan's non-quantitative limits will meet the parity requirements under federal law. These summary descriptions are available at United for Reform Resource Center under Mental Health Parity.

☐ *Define* which conditions the plan will cover and which conditions will not be covered. Self-funded plans may be subject to mandates under the ACA that include coverage of mental health and substance use disorder treatment benefits.

☐ *Test* plans to ensure parity between mental health and medical portions of the plan.

Out-of-Pocket Maximum (OOPM) — OOPM has new accumulation rules and ceiling. All non-grandfathered group health plans regardless of group funding or size must have an OOPM which limits overall out-of-pocket (OOP) costs on all EHB. All member cost-sharing applies including copayments, coinsurance and deductibles. Plans are not required to apply the annual limitation on OOPM to benefits that are not EHB. For network plans, the OOPM applies to in-network services only.

- UnitedHealthcare combined all (EHB and non-EHB) coverage into a single OOPM with new and renewing plans that began on or after Jan. 1, 2014, for fully insured plans. In 2015, customers have two choices for handling their in-network cost-sharing. Customers may apply all in-network cost-sharing to a single common OOPM. They may also choose to establish separate OOPM for their separate service providers with the

total OOP not to exceed the maximum allowed for the year in question.

- In 2015, the OOPM limit for non-Health Savings Account (HSA) plans will differ from the OOPM limit for HSA plans. For plan years beginning in 2015, the OOPM limits for non-HSA plans will be $6,600 for single coverage and $13,200 for non-single coverage. The Internal Revenue Service has recently issued the final out-of-pocket limits for HSA plans in 2015. For plan years beginning in 2015, annual out-of-pocket limits for HSA plans are $6,450 single/$12,900 family.

☐ *Discuss* OOPM with clients, update benefit plans and related documents accordingly. Please note, should an employer choose to cross accumulate OOPM between separate service providers, significant lead time may be required. In addition, costs may be incurred.

Provider Scope of License (Provider Non-Discrimination) — Effective for plan years that began on or after Jan. 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law.

☐ *Check* SPDs and other plan documents for non permissible limitations on types of coverage arrangements. For example, limitations listed in SPDs or plan documents may state that for coverage of spinal manipulation, it must be performed by a chiropractor only. Another example could be that acupuncture must be performed by a licensed acupuncturist only. Limitations of this nature are no longer permissible under the plan. Employers are still permitted to exclude services under the plan.

Summary of Benefits and Coverage (SBC) — On Sept. 23, 2012, issuers and employers were required to provide a summary of benefits and coverage document to all participants at the time of enrollment and each subsequent year during annual enrollment. Employers may provide the SBC in paper form, or electronically if certain conditions are met. The summary must be no more than four double-sided 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. SBCs for group health plans, beginning in 2014 will include a statement on whether the plan meets minimum essential coverage (MEC) and meets minimum value (60 percent of costs of benefits for a population).

UnitedHealthcare will also make changes to the coverage calculator used to calculate the coverage examples in the SBC. For SBCs for ACIS/National Accounts clients, UnitedHealthcare will continue to use the online calculator provided by The Department of Health and Human Services (HHS) and enter the customer's benefits into the tool based on its plan design. For SBCs for ACIS/Key Accounts and all other platform clients, SBCs created on or after Nov. 3, 2014 uses UnitedHealthcare's Coverage Calculator, which calculates the coverage examples based on UnitedHealthcare product standards specific to the benefit package.

- **Summary of Material Modification Notice.** Issuers and employers must provide enrollees with 60 days' advance notice of any mid-year material modification to benefits if the change modifies the most recently issued SBC.

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.

Waiting Period (90-day limit) — For plan years that began on or after Jan. 1, 2014, all group health plans – including grandfathered and non-grandfathered, must have a waiting period for new employees that does not exceed 90 calendar days. Renewing customers with already-compliant waiting periods will see no changes. An employer group may have different types of member waiting periods as long as they do not exceed the 90-day limit. In creating such classifications, groups should consult their legal counsel to ensure there are no discrimination concerns. Employers may require a reasonable and employment-based orientation period of one month before the new hire is eligible and subject to the 90-day waiting period.

Wellness Programs — The final wellness programs rules were issued on June 3, 2013, and are effective for plan years that began on or after Jan. 1, 2014. The rules essentially increase the maximum reward permissible under a health-contingent wellness program offered in connection with a group health plan from 20 percent to 30 percent of the cost of coverage and up to 50 percent for wellness programs that are designed to reduce or prevent tobacco use. The rules also divide health-contingent-wellness programs into two subcategories (activity-only programs and outcome-based programs), provide clarifications regarding the reasonable design of these programs and the reasonable alternatives that must be offered in order to avoid prohibited discrimination. This provision may impact your incentives or communication materials.

☐ *Review and update* programs and plan documents as needed.

Individual and Employer Mandates

Individual Mandate — As of Jan. 1, 2014, the ACA required individuals who are not exempt to either maintain MEC for themselves and any nonexempt family members or include an individual shared responsibility payment with their federal income tax return. The health insurance required must be MEC or an individual would pay a potential penalty for noncompliance. For this individual mandate, coverage may be obtained through government programs such as Medicare or Medicaid; employer or individual insurance market; or Exchanges. If individuals do not elect coverage offered by their employer, do not have other coverage and do not meet one of the narrow exceptions, there will be a tax penalty based on an 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 — $695 per uninsured person or 2.5 percent of household income over the filing threshold (whichever is greater).
- 2017 and forward, the penalties will be increased by the cost-of-living adjustment.

Employer Mandate — The employer mandate applies to applicable large employers (ALEs) with 50 or more full-time employees (including full-time equivalents). It requires ALEs to either offer full-time employees and their dependents MEC that is affordable and meets minimum value requirements, or risk paying a penalty. The penalty goes into effect in 2015 for employers with 100 or more full-time employees and full-time equivalents, and 2016 for most employers with 50-99 full-time employees and full-time equivalents (so long as they qualify under transition relief). A penalty would generally apply if an employee applied to the Health Insurance Marketplaces (also called Exchanges) and was deemed eligible for a subsidy either because the employee did not receive an offer of MEC or the coverage the employer offered did not meet minimum value or affordability requirements. **MEC** includes coverage from one of the following sources:

- Medicare
- Medicaid or the Children's Health Insurance Program (CHIP)
- TRICARE
- Veteran's health program
- An employer's plan
- Health insurance plan purchased through the Marketplaces
- Individual health insurance coverage purchased outside of the Marketplaces
- A health plan in effect prior to 2014

Minimum value means the health plan pays at least 60 percent or more of the plan's total allowed benefit costs anticipated for a standard population.

Pre-existing Conditions Exclusion

Prohibition of Pre-existing Conditions Exclusion for All Ages — In 2014 and forward, pre-existing condition exclusions must be removed for all members of all ages.

☐ *Remove* plan exclusion for those of any age with pre-existing conditions.

Overview of Taxes and Fees Affecting Employers

There are several health reform taxes and fees mandated by the ACA. Employers with self-funded plans will submit applicable health reform fees directly to the government, and those with fully insured health plans will see fees prorated into their premiums.

Transitional Reinsurance Fee — The ACA imposes a fee for years 2014 to 2016, on health insurance issuers and self-funded plans and then distributes the funds to issuers 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 fee will be assessed on employees, spouses and dependents for the first nine months of the calendar year regardless of plan year or renewal date. In 2014, the cost is $5.25 per member per month or $63 per member per year in 2014. In 2015, the fee is $3.67 per member per month or $44 per member per year. In 2016, the amount is to be determined. Employers with self-funded plans will submit their enrollment count and the Reinsurance Fee directly to the government.

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.

Timeline: 2014 (year one payment timeline):

- Nov. 15, 2014 — Enrollment counts due to the HHS. CMS extended the filing deadline from until December 5. They did NOT extend the payment deadline.
- Dec. 15, 2014 — HHS will invoice health plans (self-funded client).
- Jan. 15, 2015 — The due date for making the first payment, if paying in two installments. Last day to make the full payment, if paying in one installment.
- Nov. 15, 2015 — The due date for making the second installment of the 2014 payment.

Counting Methods: Four member counting methods may be used to determine fee amount:

1. **Form 5500**
2. **Snapshot Method** — Count the total number of covered lives on a single day in a quarter and divide the total by the number of dates on which a count was made.
3. **Snapshot Factor** — For self-only coverage, determine the sum of: (1) the number of participants with self-only coverage, and (2) the number of participants with other than self-only coverage multiplied by 2.35.
4. **Actual Count Method** — Add the total number of lives covered for each day of the first nine months of the benefit year and divide that total by the number of days in those nine months of the benefit year.

While self-funded clients are in a better position than UnitedHealthcare to determine their membership, in early October 2014, UnitedHealthcare will provide a monthly membership summary reporting free-of-charge for each medical plan we administer using the Snapshot Method. and Snapshot Factor It is important that clients compare this count with other counting methods. Calculating the membership directly affects the amount of the Reinsurance payment, so it must be performed

carefully. Ultimately, the client decides the method to calculate its membership and determine the amount owed.

Patient-centered Outcomes Research Institute (PCORI) Fee — The ACA imposed a temporary Patient-centered Outcomes Research Institute (PCORI) Fee funds research that evaluates and compares health outcomes, clinical effectiveness, risks and benefits of medical treatments and services. The fee is effective 2012 to 2019 and increased from $1 to $2 per member per year for policy or plan years ending Oct. 1, 2013, through Sept. 30, 2014. The PCORI Fee is indexed to medical inflation thereafter. Employers with self-funded plans will submit the PCORI Fee directly to the government, and those with fully insured health plans will see fees prorated into their premiums.

The counting methods for determining your membership count for the PCORI Fee are the same as the Reinsurance Fee.

☐ *Understand* the PCORI fee increases from $1 per member per year in year one to $2 per member per year in year two. Employers must complete Form 720 and pay the fee directly to the IRS. Third parties may not file Form 720 or pay the fee to the IRS on behalf of plan sponsors.

Reporting Requirements

Employer Coverage Reporting — On March 10, 2014, the U.S. Department of the Treasury and IRS published final rules to implement the information reporting provisions for insurers and certain employers under the ACA that take effect in 2015. Employers who provide MEC during a calendar year are required to report to the IRS certain information about individuals covered by MEC and also to provide a statement to those individuals.

- **Section 6055** reporting is the required reporting to the IRS of information relating to covered individuals that have been provided MEC by health insurance issuers (issuers), certain employers, and other entities that provide MEC. A statement disclosing MEC information must also be furnished to responsible individuals (i.e., subscriber).
- **Section 6056** reporting is the required reporting to the IRS of information relating to offers of health insurance coverage by employers that sponsor group health plans. A statement disclosing information about the offer of coverage must also be furnished to full-time employees.

Marketplace Notification — Applicable employers should have provided written notice to employees by Oct. 1, 2013. The U.S. Department of Labor shared a Model Notice employers may use the "Model Notice to Employees of Coverage Options" to meet this requirement that can be found on the Department of Labor website at dol.gov/ebsa/healthreform/index.html or the United for Reform Resource Center at uhc.com/united-for-reform/health-reform-provisions/health-benefit-exchanges

☐ *Provide* written notice to new employees within 14 days of their start date to inform them of their coverage options available through the Exchanges.

Health Plan Identifier (HPID) — On Oct. 31, 2014, the Centers for Medicare and Medicaid Services (CMS) announced a delay, until further notice, of the requirement to obtain a Health Plan Identifier (HPID).

ICD-10 — ICD-10 replaces ICD-9 codes used by physicians and health care professionals to record and identify diagnoses and procedures for purposes of claims payment and reporting. ICD-10 affects diagnosis and inpatient procedure coding but does not affect current procedural terminology (CPT) coding for outpatient procedures.

On April 1, 2014, legislation delayed the implementation date of ICD-10 to Oct. 1, 2015.

The new codes have an expanded format to encompass greater detail within the code and more specific information about the diagnosis. The table below shows the difference between the number of ICD-9 and ICD-10 procedure and diagnosis codes as well as the change in character format of those codes.

Diagnosis Codes	ICD-9	ICD-10
# of codes	13,000	68,000
Format	3 – 5	3 – 7
Procedure Codes	**ICD-9**	**ICD-10**
# of codes	3,000	87,000
Format	3 – 4	7

ICD-10 is the International Classification of Diseases, 10th Edition, and is the update of sign and symptom codes developed by the World Health Organization.

UnitedHealthcare is on track to be ICD-10 code-ready. We have engaged more than 10,000 providers across the country to share industry-informative materials as well as our transition plans.

☐ *Analyze* any plan design or plan document impact. Wherever an ICD-9 code exists, it will need to be changed to an ICD-10 code. The majority of our employer benefit plans do not contain ICD-9 codes. However, if the employer plan or plan documents contain diagnosis codes, action will be needed.

W-2 Reporting — Employers must report the cost of employees' health benefit coverage on the W-2 Forms that are distributed in January for the prior tax year (only applies to employers that file 250 or more employee W-2 Forms). The requirement is informational only and coverage is not subject to income tax. Employers that produce fewer than 250 W-2s for employees are currently exempt from this requirement.

Value-Based Contracting

Value-based payment program — A value-based payment program is an arrangement with health care providers that rewards for lower costs, better quality and greater efficiencies. A value-based environment pays for value and holds providers accountable for the outcomes of the care they provide.

UnitedHealthcare believes the transition to value-based payment programs provides the best path to better health, better care and lower costs – for everyone. Value-based payment programs are the way we do business today. In fact, our 8 million fully insured members participate in value-based payment arrangements in the markets where the opportunity exists. In addition, all new self-funded membership is included in these arrangements. Value-based contracting supports payment reform, which is part of the ACA through provider payment programs such as accountable care organizations (ACO) and patient-centered medical homes. When network providers are paid for performance, self-funded customers will recognize the benefits in bottom-line savings and healthier employees.

Definitions

Integrated Health Reimbursement Account (HRA) — As part of the recent Internal Revenue Service (IRS) and Department of Labor integrated HRA guidance, stand-alone HRAs are no longer permissible and, for plan years beginning on or after Jan. 1, 2014, can only be offered when combined with a medical plan. Integrated HRAs must also permit a member to opt out of the HRA through an annual open enrollment. An HRA is considered integrated with a group health plan if, under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out and waive future reimbursements from the HRA.

Preventive Care — A non-grandfathered group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for and shall not impose any cost-sharing requirements for preventive coverage (as defined by the ACA). Details as to UnitedHealthcare's approach to preventive care can be found in our Preventive Coverage Determination Guidelines (CDG). The Preventive CDG defines the services, diagnoses, age, gender and other requirements for ensuring that specific services are paid with preventive benefits.

Private Exchange — Private exchanges have been in place for several years. However, with increased interest in private exchanges for active employees and retirees, a number of private exchanges are being established by a variety of different entities such as consulting firms and cooperatives. Private exchanges are available to 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.

Health Insurance Marketplaces — Also called Exchanges, they are online Marketplaces in each state where people can research, compare and enroll in health insurance plans offered by health insurers. There are two types of Marketplaces within each state. One is the Individual Marketplace, where individuals can shop for insurance. The other is for small business employers, called the Small Business Health Options Program (SHOP).

UnitedHealthcare Marketplace — UnitedHealthcare's private sector, single-carrier health plan proprietary Marketplace where employers can make health benefits available to their employees via an easy-to-use plan selection and enrollment tool. Here are some of the many benefits to employers:

- UnitedHealthcare data integrated from prior health and claim history to help members choose appropriate plans based on needs.
- Greater client value – meets objectives without sacrificing control over plan design and ability to influence population health
- Control – employers retain control over plan designs, ancillary offerings and other strategic decisions.
- Actionable information – access to comprehensive reporting along with information specific to the population.
- Health solutions, communications and tools that can be used across an entire employee population.
- An integrated and consistent member experience – member ID cards, portal and tools, and customer service are all an integrated part of the UnitedHealthcare Marketplace.

Contact your account representative for more information on the UnitedHealthcare Marketplace.

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 uhc.com/united-for-reform.

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