

# Fast Forward» Bringing It Home

## 2014-15 Checklist for Large Group Clients

Use this checklist to understand the changes that are coming in late 2014 and on into 2015 that may impact your group. The checklist below will review Affordable Care Act (ACA) provisions and provide details for other UnitedHealthcare business or program options.

Unless specifically noted, ACA provisions must be implemented upon 2014 new business effective date or upon your 2014 renewal date.

### Grandfathered Clients

Existing clients that previously signed the applicable grandfather form do not need to complete/submit a form this year. The grandfather forms are evergreen.

New grandfathered clients must sign the applicable grandfather form with their new business submission.

- For fully insured plans**, the plan sponsor — “Grandfather Status Attestation Form (for Fully Insured Key Account Groups)” applies.
- For self-funded plans**, the “Grandfather ASO Acknowledgement Form (for 100+ ASO Key Account Groups)” applies. The Acknowledgement form does not apply to national accounts.

### Cost-Sharing Provisions

The cost-sharing provision was introduced in 2014. The safe harbor component of this provision allowed clients that utilized a separate service provider to maintain a separate out-of-pocket maximum (OOPM) at the statutory OOPM level. In 2015, the safe harbor is expiring.

- ▶ The OOPM limit in 2015 will rise to \$6,600 single/\$13,200 family. The OOPM will be indexed yearly.
  - ▶ In 2015, customers have two choices for handling their in-network cost-sharing. Customers may apply their 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.
- Standard** – All cost-shares accumulate to a single OOPM.

- Optional by Market** – Separate OOPM for pharmacy (or other separate service provider). Talk to your UnitedHealthcare representative about your options.

For clients currently using another pharmacy vendor: Clients may also retain multiple in-network OOPM limits as long as when combined they do not exceed the levels listed previously. If carve-out pharmacy coverage continues and you want to accumulate to one OOPM, additional charges may be assessed to cover the technical linkage needed to support the cross-accumulation. You may consider moving to OptumRx because having both medical and pharmacy coverage with UnitedHealthcare will allow for a streamlined accumulation process. There will be no additional charge to cross-accumulate if your pharmacy coverage is with OptumRx on a direct basis.

### Embedded (Integral) Dental or Vision

Dental and vision benefits are subject to the ACA if they're embedded (integral), as defined by:

- For fully insured plans:** When enrolling in medical coverage, subscribers don't have the option to decline dental or vision, and these benefits are not issued on separate dental or vision insurance policies.
- For self-funded plans:** When enrolling in medical coverage, subscribers don't have the option to decline dental or vision.

**Note:** If an employer offers integral dental or vision benefits administered by another carrier, it is their responsibility to ensure that the total OOPM for all benefits satisfies the statutory requirements and that those benefits comply with all ACA rules.

## Reform implications:

1. Clients must determine if:
  - a. They will change their enrollment process to offer dental/vision separately.
  - b. They will pay in-network dental or vision essential health benefits (EHB) at 100 percent. This is not required, but it does eliminate the need to address OOPM for dental or vision.
  - c. They will retain a separate OOPM for embedded dental or vision, with the total of all OOPM limits not to exceed the statutory limits.
  - d. Cost-shares for all services will be accumulated to the medical out-of-pocket. This will likely require a data feed and include adult dental/vision in the medical OOPM, so we discourage using it for dental or vision.
  - e. They need to remove dollar limits from in- and out-of-network dental or vision EHB services.
  - f. They need to remove any exclusions or waiting periods from their embedded dental plan if these are based on pre-existing conditions.
2. Benefits must be incorporated into the Summary of Benefits and Coverage (SBC).
3. Other ACA impacts may also apply, such as expanded appeals rights, W-2 reporting, removing exclusions for pre-existing conditions and, if fully insured, Medical Loss Ratio (MLR). If you believe you have embedded dental or vision, please discuss your options with your UnitedHealthcare sales representative.

## 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 minimum essential coverage (MEC) that is affordable and meets minimum value requirements, or risk paying an excise tax (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 public Exchange 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.

## Mental Health Parity (MHP)

The final rules implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) will apply on the first day of the plan year that starts on or after July 1, 2014. There are two parts to the final rules: Quantitative and Non-Quantitative.

**Quantitative:** 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.) or treatment limits (day or visit limits, etc.) to MH/SUD that are more restrictive than the financial requirements or treatment limits that apply to medical/surgical benefits.

Based on the final rules, UnitedHealthcare has determined that its 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.

Self-funded clients are responsible for ensuring plans are in compliance with the final MHP rules. Note that unless a client makes significant changes to their current plan, retesting will not be required until 2016. If a client would like to retest, OptumInsight is available to retest for a fee. Self-funded clients may decide to make the 2016 changes today, as they are not constricted by filings.

**Self-funded client** wants to retest their plan.

**Self-funded client** wants to make the 2016 changes today.

**Non-quantitative:** For non-quantitative limitations, there is no mathematical test. For each classification of benefits, the application/operation of these limits to a plan's MH/SUD benefits must "manually" be compared to such limits applying to medical/surgical benefits under the plan. A non-quantitative treatment limitations worksheet is available to facilitate review of these benefits if the plan contains more stringent requirements.

## Reporting Requirements

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.

**NEW! Section 6055** reporting is the required reporting to the IRS of information relating to covered individuals that have been provided minimum essential coverage (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).

**NEW! 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 employee.

## Taxes and Fees

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.

- ☐ **Fully insured clients:** Health plans will see health reform fees prorated into their premiums over 12 months.

### Self-funded clients

- ☐ Self-funded clients are responsible to pay the Patient-centered Outcomes Research Institute (PCORI) Fee. 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.
- ☐ **NEW!** The Transitional Reinsurance Fee payment is due no later than Jan. 15, 2015, for self-funded clients making one payment (\$63 per covered life). For clients that wish to split their payment into two installments, the first payment (\$52.50 per covered life) is due no later than Jan. 15, 2015, and the second payment is due no later than Nov. 15, 2015 (\$10.50 per covered life).

The IRS provides several counting methods to determine membership (covered lives). While self-funded clients are in a better position than UnitedHealthcare to determine their membership, in late 2014, UnitedHealthcare will provide a membership count. It is important that clients compare this count with other counting methods. Calculating the membership directly affects the amount of the Reinsurance and PCORI Fees payment, so it must be performed carefully. Ultimately, the client decides the method to calculate its membership and determine the amount owed.

The table shows a summary of the taxes and fees:

Fee	Effective Date	Timing / Duration	Payment Cycle
<b>PCORI Research Fee</b> (\$1 per member per year the first year, increasing to \$2 per member per year in the second year and \$2.08 in the third year and then indexed to medical inflation thereafter.	Oct. 1, 2012	Temporary  Began 2012 Phases out 2019	Fully insured: UnitedHealthcare will pay by July 31 (calendar year following end of plan year). Included in the premium. Self-funded: July 31 (calendar year following end of plan year).
<b>Insurer Fee</b> (About 3.6 percent of the total premium)	Jan. 1, 2014	Permanent	Fully insured: UnitedHealthcare will pay no later than September 30 of calendar year. Included in the premium. Self-funded: N/A
<b>Transitional Reinsurance Fee</b> (About \$5.25 per member per month in 2014 and \$3.67 per member per month in 2015)	Jan. 1, 2014	Temporary Three years (2014-2016)	Fully insured: Fee is based on federal fees. Included in the premium. Self-funded: Fee may be paid in one or two payments. Pay in full Jan. 15 or in two installments Jan. 15 and Nov. 15 of the calendar year following the applicable benefit year.

## Women's Health Preventive Contraception Coverage Benefits

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.

## Summary of Benefits and Coverage (SBC)

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 November 3, 2014 will use UnitedHealthcare's Coverage Calculator, which calculates the coverage examples based on UnitedHealthcare product standards specific to the benefit package. Some of the changes include:

- Deductible - Ability to not apply services as appropriate to the annual deductible, i.e., office visits or services that assess a flat-dollar co-payment
- Per Occurrence Deductible (POD) - Will have the ability to assess the POD as part of the calculation, as appropriate

Fully insured and self-funded clients who use a third-party provider to administer prescription or mental health benefits may continue to provide multiple SBCs to their employees. For example, an SBC can be provided from UnitedHealthcare for medical coverage and the third-party prescription administrator can provide the prescription coverage SBC.

- Does client want to include carve-out pharmacy/mental health benefits on the medical SBC? Please note additional charges may apply if UnitedHealthcare is asked to combine carve-out pharmacy or mental health benefits on the medical SBC.

### Health Plan Identifier (HPID)

The requirement to obtain a Health Plan Identifier (HPID) was delayed until further notice by the [Centers for Medicare and Medicaid Services \(CMS\)](#).

### Certificate of Coverage (COC) and Summary Plan Description (SPD) with Medical Necessity

- Medical necessity is aimed at promoting care that is medically appropriate and proven effective. The medical necessity option requires a prior authorization for certain services. As long as a member stays in-network, it is the responsibility of the participating providers to submit the prior authorization. A list of services that require prior authorization will be included in the members' plan documentation. Ask your sales representative for marketing collateral to share with your employees to help them understand how medical necessity works.

State product strategy may dictate a move to a plan with prior authorization. Your UnitedHealthcare sales representative will provide you with the details you need.

For self-funded clients, we now have the ability to add medical necessity to earlier SPD years – talk to your UnitedHealthcare sales representative for more details.

### Cost-Effective Solutions



There are some alternative solutions that are cost-effective and may help reduce costs for both fully insured and self-funded clients.

**Prior authorization for radiology and cardiology** – Starting January 2014, prior authorization for certain advanced outpatient imaging procedures and cardiology services will be available for members in self-funded plans. Coverage documents must be amended to support medical necessity. For radiology and cardiology services, this transition helps to assess and control cost and utilization, while promoting safety and quality consistent with evidence-based clinical guidelines. The radiology/cardiology prior authorization will automatically be included for fully insured clients on a prior-authorization COC.

- Self-funded plan would like to adopt prior authorization for radiology and cardiology.
- Ancillary charge prescription drug option** – This new pharmacy option is available to fully insured and self-funded clients on our large group platform. How does it work? When a higher-tier covered prescription drug is dispensed at the member's or the provider's request, an extra charge may apply if there is a chemically equivalent generic drug available at a lower-tier cost. When a member chooses the higher-tier drug, the member will pay the difference between the higher-tier drug and the lower-tier drug as well as the additional difference between the applicable co-payment and/or co-insurance for the higher-/lower-tier prescription drug.
- Consider OptumRx if you currently carve out pharmacy benefits** – With OptumRx, we have consolidated our pharmacy benefit services to better meet our clients' needs now and in the future. This will enhance our ability to engage members, improve health outcomes and better manage total health care costs. Having both medical and pharmacy coverage with UnitedHealthcare will allow for a streamlined accumulation process. If carve-out pharmacy coverage continues, additional charges may be assessed to cover the technical linkage needed to support the cross-accumulation.

The following cost-effective solutions apply to **self-funded clients only**:

- Value-based Contracting** – A value-based payment incentive 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 a value-based payment incentive program provides the best path to better health, better care and lower costs – for everyone. Value-based payment incentive programs are the way we do business today. In fact, our 8 million fully insured members participate

in value-based payment incentive arrangements in the markets where the opportunity exists. All new self-funded membership is included in these arrangements and starting with Feb. 1, 2014, renewal dates self-funded clients will be opted in to this program as well. 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 clients will recognize the benefits in bottom-line savings and healthier employees.

Your UnitedHealthcare sales representative will be able to provide more details during your 2014 or Jan. 1, 2015 renewal discussion.

- Advanced analytics and recovery services (AARS)** takes our baseline recovery services that you get today and adds a retrospective look back at claims. This service requires additional time, human intelligence and enriched information gathered from multiple data sources. We then leverage large-scale analytics to identify closed claims warranting further research.

With AARS, we will charge a 24 percent fee for this service but *only* if we are able to recover any savings. By not taking advantage of this service, you could be “leaving money on the table” by not recovering lost dollars.

- Claim-related fees** – Moving forward, all self-funded clients are encouraged to pay claim-related fees for the following programs through their bank account: Shared Savings, Facility R&C and Value-Based Pricing. The benefit will be an improved billing experience due to simplification of the payment process (one less payment to request through accounts payable) and reduced reminder calls from UnitedHealthcare.
- In addition, UnitedHealthcare also offers the option of paying for a package of supplemental services (i.e., NurseLine<sup>SM</sup>/Care24) via the bank account when billed as a separate line item on your invoice.

- Complete a “Claim-Related Fees Authorization” form** to pay these claim-related fees through the bank account.

### Fast Forward to Modernized 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.



**For updates and more detailed information** please refer to the **United for Reform Resource Center** at [uhc.com/united-for-reform](http://uhc.com/united-for-reform).

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