

Fast Forward >> Bringing It Home

2014-15 Changes for Oxford Fully Insured Large Group Employers (51-99)

Employers will 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 brief summary covers several of the provisions and health plan changes that have the greatest impact to employers — Health Insurance Marketplaces, also called Exchanges, expansion of benefits, employer and individual mandates, reporting requirements, premium changes based on market changes and taxes and fees. Many of these 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 plan design offered, on average, employer groups are expected to see a substantial increase in costs.

Expanded Benefits and Other Benefit Requirements

Clinical Trials — For plans effective on or after January 1, 2014, all non-grandfathered health plans are required to cover certain routine patient costs incurred when participating in approved clinical trials. 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. 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.

Essential Health Benefits (EHB) No Limits — Each state has selected a benchmark plan and defined what benefits are considered essential. If a client covers a benefit deemed essential, that EHB cannot have annual and lifetime dollar limits. Groups may determine to remove coverage of an EHB. They may, however, add a duration limit in lieu of a dollar limit.

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 Oxford 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 — 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.

Integrated Health Reimbursement Account (HRA) — As part of the Internal Revenue Service (IRS) and Department of Labor integrated HRA guidance, stand-alone HRAs are no longer permissible and, for plan years that began on or after January 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 amount in the HRA is forfeited or the employee is permitted to permanently opt out and waive future reimbursements from the HRA.

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 maximum (OOPM)* 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 OOPM 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 effective 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](#).

Out-of-Pocket Maximum (OOPM) Changes — OOPM has new accumulation rules and ceiling. All non-grandfathered group health plans regardless of group funding or size must have an OOPM that limits overall out-of-pocket (OOP) costs on all EHB. All member cost-sharing applies, including co-payments, co-insurance 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.

- In-network OOPM caps for 2014 are \$6,350 single/\$12,700 family. Based on proposed rules, in 2015, those limits rise to \$6,600 single/\$13,200 family.
- For the first plan year that began on or after January 1, 2014, there is a one-year safe harbor available for plans that utilize more than one service provider to administer benefits. Under the safe harbor, the OOPM limits will be satisfied if the major medical coverage and other separately administered plans each limit the total amount of the OOPM for all coverage dollar amounts to the levels noted above.
- We are combining all EHB and non-EHB coverage into a single OOPM with new and renewing plans that began on or after January 1, 2014 for fully insured plans.
- 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. Flexibility is based on the size of the client and the platform you are on. Talk to your sales representative for more details.

Provider Scope of License (Provider Non-Discrimination)

— Effective for plan years that began on or after January 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.

- Does not require that group health plans or health insurance issuers contract with any health care provider willing to abide by their terms and conditions for participation.
- Does not prevent group health plans or health insurance issuers from establishing varying reimbursement rates based on quality or performance measures.
- Similar language is included in section 1852(b)(2) of the Social Security Act and implementing HHS regulations (Medicare Advantage plans).

*May also be referred to as maximum out-of-pocket or out-of-pocket limit.

Summary of Benefits and Coverage (SBC) — On September 23, 2012, issuers and employers were required to provide an SBC 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, should be written in a manner that is easy for the average participant to understand, and exactly follow the template and instructions for completion issued by HHS. SBCs for group health plans that began 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).

We will also make changes to the coverage calculator used to calculate the coverage examples in the SBC. For SBCs for ACIS/National Accounts clients, we will continue to use the online calculator provided by 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 the Coverage Calculator, which calculates the coverage examples based on our 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 effective on or after January 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 January 1, 2014 for grandfathered and non-grandfathered plans. 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.

Individual and Employer Mandates

Individual Mandate — On January 1, 2014, the ACA required individuals who are not exempt to either maintain MEC for themselves and any non-exempt 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 Marketplaces. 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 — and beyond, \$695 per uninsured person or 2.5 percent of household income over the filing threshold (whichever is greater).
- Going 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 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 Individual Marketplace 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.

Premium and Rating Changes

Rating Methodology — States have determined group size definitions based on average total number of employees (ATNE), full-time equivalents (FTE), or most commonly, eligible employees.

Prohibition of Preexisting Conditions Exclusion for All

Ages — Preexisting conditions exclusion must be removed for all members of all ages.

Guaranteed Availability of Coverage — Health insurance issuers, other than in the student health insurance market, are to offer coverage to and accept every employer or individual who applies for coverage in the group and individual market, subject to certain exceptions. Exceptions allow issuers to restrict enrollment in coverage to: 1) open and special enrollment periods, 2) employers with eligible individuals who live, work or reside in the service area of a network plan, and 3) situations involving limited network capacity and limited financial capacity.

Guaranteed Renewability of Coverage — Health insurance issuers, other than in the student health insurance market, must renew or continue in-force coverage in the group and individual market at the option of the plan sponsor or the individual with limited exceptions. Exceptions to this requirement include the failure to meet minimum participation or contribution standards.

Overview of Taxes and Fees Affecting Employers

There are several health reform taxes and fees. Those with fully insured plans will see these fees prorated into their premiums.

Insurer Fee — The permanent Insurer Fee is collected annually from health insurance issuers based on net written premiums. The Insurer Fee will fund premium tax subsidies for low-income individuals and families who purchase health insurance through Marketplaces.

Transitional Reinsurance Fee — The ACA imposes a fee 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. Employers with self-funded plans will submit their enrollment count and the Reinsurance Fee directly to the government. To assist our self-funded customers in determining their enrollment, we will provide a monthly membership summary report free-of-charge in early October for each medical plan we administer.

Patient-centered Outcomes Research Institute (PCORI) Fee —The temporary fee funds research that evaluates and compares health outcomes, clinical effectiveness, risks and benefits of medical treatments and services.

The table shows a summary of the taxes and fees.

Fee	Effective Date	Timing / Duration	Payment Cycle
PCORI Research Fee (\$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.	October 1, 2012	Temporary Began 2012 Phases out 2019	Fully insured: we 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).
Insurer Fee (About 3 percent of the total premium)	January 1, 2014	Permanent	Fully insured: we will pay no later than September 30 of calendar year. Included in the premium. Self-funded: N/A
Transitional Reinsurance Fee (About \$5.25 per member per month in 2014 and \$3.67 per member per month in 2015)	January 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 January 15 or in two installments January 15 and November 15 of the calendar year following the applicable benefit year.

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 Affordable Care Act (ACA) that take effect in 2015. Employers who provide minimum essential coverage (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 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).

- **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 October 1, 2013 and new employees within 14 days of their start date to inform them of their coverage options available through the Health Insurance Marketplaces. 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 under Notice to Employees of Coverage Options or the United for Reform Resource Center at uhc.com/united-for-reform/health-reform-provisions/health-benefit-exchanges.

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 \(CMS\)](http://www.cms.gov).

ICD-10 — ICD-10 will replace 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 will affect diagnosis and inpatient procedure coding but not current procedural terminology (CPT) coding for outpatient procedures.

Recent legislation has delayed the implementation date of ICD-10 until October 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 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.

We are 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.

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.

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.



For updates and more detailed information, please refer to the United for Reform Resource Center at uhc.com/united-for-reform.



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