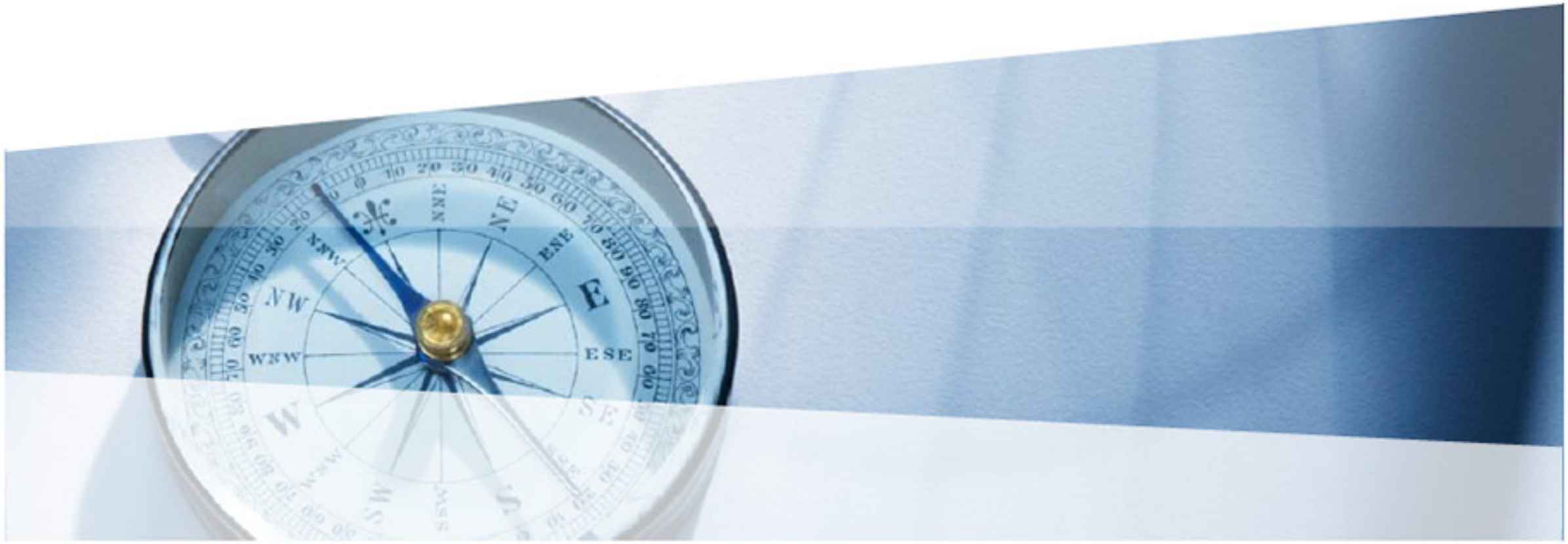
What IS Happening in 2015?



Group Health Plan Mandates & Employer Requirements in 2014

New Plan Design Requirements

- **90 day waiting period limitation**
  - **Employment-based orientation periods permitted**
- No pre-existing condition limitations for all enrollees
- No annual dollar limits on essential health benefits
- **Limits on in-network, out-of-pocket maximums (NGF)**
  - **In 2015, $6,600 for an individual, $13,200 for family coverage**
- Expansion of wellness incentives
- Coverage of 'routine patient costs' for items and services furnished to clinical trial participants (NGF)
- Provider nondiscrimination (NGF)
- **New preventive services (NGF)**

Taxes/Fees

- Patient-Centered Outcomes Research Institute (PCORI) fee
- **Transitional Reinsurance Fee**

Communications

- SBCs (on-going)
- W-2 reporting of health care costs (on-going)
- Exchange Notice (Oct. 2013; on-going for new hires)
- Non-mandated communications

90-Day Waiting Period Limitation

	Overview of Final 90-Day Waiting Period Rules
What is it?	• ACA prohibits waiting periods for medical coverage that exceed 90 calendar days (including weekends and holidays)
Who does it apply to?	• All plan sponsors, regardless of grandfathered status
When does it apply?	• Effective for plan years beginning on or after January 1, 2014
Two new provisions in final rules	**One month employment-based orientation period** • Plans can condition eligibility on completion of a "reasonable and bona fide employment-based orientation period" • Orientation period can't continue longer than one month after an employee starts in a position otherwise eligible for coverage • Begins on an employee's start date – whenever it occurs during a calendar month – and ends on the day before the corresponding date in the next calendar month **Treatment of rehires as newly eligible for coverage** • Employers can require that rehired employees once again meet the plan's eligibility conditions and then undergo a waiting period (no more than 90 calendar days) • Imposing this requirement must be "reasonable under the circumstances" – employers cannot use provision to avoid compliance with the waiting period rules

90-Day Waiting Period Limitation (cont.)

	Overview of Final 90-Day Waiting Period Rules
Key clarifications	Final rules include key clarifications: • Eligibility conditions unrelated to the passage of time – such as meeting sales goals, completing certain training, or earning a certain amount in commissions – can apply before a waiting period starts • 90-day limit begins to run only *after* an individual has met those other eligibility terms
What are time-related eligibility conditions?	There are two types of time-related eligibility conditions: • A "cumulative hours of service" rule permits a plan to condition eligibility on an employee having worked a certain number of cumulative hours – capped at 1,200 hours – before a waiting period starts • A "13 month" rule allows employers to satisfy the waiting period rules by offering a variable-hour employee coverage effective by the first of the month after 13 full months of employment – the same deadline to avoid employer shared-responsibility assessments
What are penalties for non-compliance?	• Excise tax starts at $100 a day "per individual to whom the failure relates" • Separate from any Employer Shared Responsibility assessments • Coverage offers that comply with the 90-day waiting period limits may not satisfy the conditions to avoid employer shared responsibility assessments (and vice versa); see next slide

Out-of-pocket Maximums

- Non-grandfathered group health plans must limit annual in-network out-of-pocket costs with respect to essential health benefits

Plan years beginning in	Self-only limit	Coverage other than self-only limit
• 2014	$6,350	$12,700
• 2015	$6,600	$13,200

- Plans may divide the limit among categories of benefits (e.g., prescription drug and major medical) provided the combined amount does not exceed the applicable limit
  - Perhaps can also divide the limit among different types of cost-sharing for the same benefits (such as coinsurance and copays)
- Plans not required to include spending for out-of-network benefits and/or non-essential health benefits in applying the maximum
- Guidance addresses OOP costs attributable to a referenced-based pricing structure and OOP costs for brand name Rx drugs when generics are available
- Also need to consider HSA/HDHP maximum out-of-pocket rules
  - For 2015: $6,450 self-only / $12,900 other than self-only

New Preventive Services

- In-network preventive services rated A or B by USPSTF must be covered at no cost for non-grandfathered plans.

US Preventive Services Task Force

- New for 2015 plan years:

- Hepatitis C virus screening
- HIV screening
- Intimate partner violence screening
- Alcohol misuse screening
- Breast cancer prevention medications
- Lung cancer screening
- Breast & ovarian cancer risk assessment & genetic testing/ counseling

New Preventive Services (cont.)
Recent Guidance on Tobacco Use Interventions

Safe harbor for tobacco use interventions that comply with preventive care rules

1. Screening for tobacco use.

2. For those who use tobacco products, <u>at least two tobacco cessation attempts per year</u>, including coverage for:
   - Four tobacco cessation counseling sessions of at least 10 minutes each *per attempt* (including telephone, group, and individual counseling).
   - All Food and Drug Administration (FDA)-approved tobacco cessation medications for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.
     - Includes both prescription and over-the-counter medications

Transitional Reinsurance Fee
Overview

Purpose	• To stabilize premiums in the individual insurance market, and to provide federal gov't revenue.
Paid by	• "Contributing entities," which includes self-insured and fully-insured major medical plans.
Applies to	• Plans providing "major medical benefits"; that is, plans with a 60% minimum value. • For 2015 and 2016, does not include self-funded, self-administered plans.
Based on	• Covered lives, including employees, spouses, children, domestic partners, and COBRA qualified beneficiaries. • Counting methods similar to PCORI fee (actual count, snapshot count, snapshot factor, Form 5500); generally, only use data through September of calendar year.
Timing	• Begins in 2014 and sunsets in 2016; paid in Jan. and Nov. of following calendar year
Pay to	• Mechanism for payment is www.pay.gov.

	2014	2015	2016
Fee PMPY	$63.00	$44.00	$25.00*
1st Installment	$52.50	$33.00	TBD
2nd Installment	$10.50	$11.00	TBD

*Mercer estimates calculated based on 200M estimated covered lives.

Transitional Reinsurance Fee (cont.)

- Paid annually by the "contributing entity."
  - **Insured plans**: insurance providers (carriers will likely build this fee into renewal pricing).
  - **Self-insured plans**: the plan sponsor, although TPA/ASO may transfer the fee on behalf of the plan sponsor if the TPA/ASO contractually agrees to do so.
  - Entity may choose to pay annual fee in two (unequal) installments or single payment.
- Generally, must calculate & pay fee on a calendar year basis, even if non-calendar year plan
- Important 2014 and 2015 dates and deadlines:

Autumn 2014	By November 15, 2014	By first selected payment date (no later than January 15, 2015)	By second selected payment date (no later than November 15, 2015)	Autumn 2015
Determine covered lives count, prepare supporting information. Submitter registers on Pay.gov unless already has Pay.gov account	Using online form, submit covered lives count, select payment date(s), supply banking information, upload supporting information Form calculates payment amount.	Ensure bank account has enough money for payment. HHS "pulls" payment from account on selected date.	Ensure bank account has enough money for second payment (if applicable). HHS "pulls" payment from account on selected date.	Repeat the process for 2015 TRF. May elect to use different counting methods, different payment dates, etc.