Health Net

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Roadmap to Reform

Health care reform is about to hit Main Street as some of the biggest provisions take effect January 1, 2014. Health Net has the details large employers need to know now.

Information on the following provisions is current as of September 3, 2013. Questions? Please call your Health Net sales consultant anytime.

Annual Cost-Sharing Limits

Limits on how much people have to spend on their own health care take effect on January 1, 2014 or upon renewal or plan year for nongrandfathered plans. The annual cost-sharing — or out-of-pocket (OOP) expenses — is $6,350 for self-only and $12,700 for family coverage.

The limitation and cross-accumulation of cost-sharing applies to all covered plan services, including non-Essential Health Benefits and ancillary benefits. Transitional relief allows implementation to happen in two phases.

All medical services must cross-accumulate to this annual cost-sharing limit in 2014. However, cross-accumulation to benefits administered by third-party service providers may be delayed until 2015.

Health Net will delay cross-accumulation with pharmacy benefits for our nongrandfathered large group plans. This means that OOP limits for medical and for pharmacy benefits will be separate in 2014.

As always, we will encourage members to keep track of their receipts and let us know once they've met their annual OOP limit.

In addition, for nongrandfathered small group plans, the annual deductible may not exceed $2,000 for self-only coverage or $4,000 for family coverage (certain exceptions apply).

Employer Shared Responsibility

Certain situations will trigger a tax penalty if employer groups with at least 50 full-time (or full-time equivalent) employees do not provide health insurance to their employees.

This requirement was slated to take effect in 2014. However, under transitional relief, it will begin effective 2015. Under the final rules published February 2013:

- Minimum value standard: employer-sponsored health plans must cover at least 60 percent of covered costs.

- Definition of affordable coverage:
  - Employees pay less than 9.5% of their household income for their contribution of an employer-sponsored health plan.
  - Employers that offer more than one health plan: the affordability test applies to the lowest-cost option available to the employee as long as that option meets minimum value.

Employers can check minimum value using the calculator at:
http://www.cms.gov/cciio/index.html

Essential Health Benefits

There has been a lot of talk about Essential Health Benefits (EHBs). They are a set of services that all nongrandfathered individual and small group commercial health plans have to include effective January 2014.

Large group plans do not have to provide EHB coverage. However, if a large group plan currently provides coverage of an EHB, annual dollar limits are prohibited. For reference, the minimum EHB categories include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including dental and vision care

Actual services within each EHB category vary by state. Every state may define EHBs by choosing a benchmark plan.

Limits on Waiting Periods

The waiting period — or probationary period — is the period of time set by an employer before coverage becomes effective for a new employee enrolling into the group's health benefit coverage.

Group health plans and health insurance carriers that offering group coverage may not apply a waiting period that exceeds 90 days. California law sets the limit at 60 calendar days (AB1083).

The waiting period provision applies to grandfathered and non-grandfathered plans, and to fully insured and self-insured/ASO groups. It takes effect January 1, 2014 for new groups, and on or upon renewal for existing groups.

Medical Loss Ratio

Health insurance companies are required to:

- Report the proportion of premium dollars spent on health care costs and the quality of care.
- Pay rebates to policyholders if the share of premiums spent on clinical services and quality is less than:
  - 80% for plans in the individual and small group markets
  - 85% for plans in the large group markets

The MLR requirement began for coverage purchased in 2011 with any rebates due issued in 2012.

MLR is calculated based on a company's entire book of business, not by a specific plan or group.

Notice of Marketplaces

One of the responsibilities employers have under the Affordable Care Act is to notify employees about the health insurance marketplaces that will open in October 2013.

Employers of all sizes are required to provide the notification to employees at time of hire. The notice has to go to full-time and part-time employees. For all current employees, the original notification deadline was March 1, 2013. However, the Department of Labor (DOL) changed that deadline to no later than October 1, 2013, to coincide with the initial open enrollment period for the marketplace.

The written notification has to do three things:

1. Tell employees about the health insurance marketplaces;
2. State whether the employer offers a health plan that meets the minimum value standard; and
3. Explain that if the employee purchases a qualified health plan through the marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer.

The DOL has released model notices that employers can use to meet the requirement. There are versions for:

- Employers who offer a health plan to some or all employees: http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf
- Employers who do not offer a health plan: http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf

A COBRA model election notice (first link under the "For Employers" section): http://www.dol.gov/ebsa/COBRA.html

Taxes and Fees

Effective January 1, 2014, the ACA imposes new fees that will be collected to fund specific programs under health care reform law.

Health Insurance Tax (HIT)
This annual fee will fund premium subsidies for the health insurance marketplaces and Medicare expansion. It applies to health insurers, health maintenance organizations, and entities providing insurance under government programs (e.g., Medi-Cal).

HIT is based on insured net premiums written with first payment due in 2014. Total fee amounts increase in phases:

- $8 billion in 2014
- $11.3 billion in 2015 and 2016
- $13.9 billion in 2017
- $14.38 billion in 2018 (after 2018, the amount increases each year based on premium growth)

Transitional Reinsurance Contribution Fee
This fee supports the transitional reinsurance program established by each state to:

- Stabilize premiums for coverage in the individual market
- Minimize the effects of adverse selection

It applies to insured coverage and self-funded coverage and runs for three years: 2014-2016.

Patient-Centered Outcomes Research Institute (PCORI)
Already in effect is the PCORI fee, which applies to health insurance companies and plan sponsors of self-insured health plans. This fee is effective for plan or policy years ending on or after October 1, 2012 and before October 1, 2019.

The total amount is based on the average number of covered lives:

- $1 multiplied by the average number of covered lives for plan or policy years ending on or after October 1, 2012 and before October 1, 2013.
- $2 multiplied by the average number of covered lives for plan or policy years ending on or after October 1, 2013.
- Fee increases after October 1, 2014 are based on a formula that includes increases per capita amount of national health expenditures.

Wellness Programs

The U.S. Departments of Health and Human Services, Labor and the Treasury have set rules for employment-based wellness programs. The rules:

- Support participatory wellness programs
- Leverage workplace health promotion and prevention as strategy for reducing the burden of chronic illness, improve health and limit growth of health care costs
- Safeguard individuals against unfair underwriting practices that could otherwise reduce benefits based on health status
- Outline standards for nondiscriminatory “health-contingent wellness programs,” which generally reward individuals who meet a specific standard related to their health

The rules are designed to:

- Ensure flexibility for employers by increasing the maximum reward that may be offered under appropriately designed wellness programs, including outcome-based programs; and
- Protect consumers by requiring that health-contingent wellness programs be reasonably designed, be uniformly available to all similarly situated individuals and accommodate recommendations made at any time by an individual’s physician based on medical appropriateness.

The rules take effect for plan years beginning on or after January 1, 2014.