Finance Committee Meeting

AGENDA

March 3, 2015

I. CALL TO ORDER

II. MATTERS BEFORE COMMITTEE

1. Approval - Insurance Plan Amendment

III. ADJOURN

Finance Committee Meeting

AGENDA

March 3, 2015

Item:

Approval - Insurance Plan Amendment

Department:

Additional Information:

Financial Impact:

Budgeted Item:

Recommendation / Request:

Viewing Attachments Requires Adobe Acrobat. Click here to download.

Attachments / click to download

- Plan Amendment
- Limit Guide

Cover Memo

Item # 1

Amendment 111–2015-01

Effective April 1, 2015

Plan Amendment to Plan Document and Summary Plan Description
of
City of Monroe Group Health Plan

1. **Page 6, in the Schedule of Benefits is changed to include the following highlighted information in italics and bold:**

	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
MAXIMUM PLAN YEAR BENEFIT AMOUNT	None (unlimited)	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR	Amounts applied to the Deductible for charges from Network Providers will be used to satisfy the Deductible for charges from Non-Network Providers and vice versa.	
Per Covered Person	$500	$1,000
Per Family Unit	$1,500	$3,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	Amounts applied to the Maximum Out-Of-Pocket Amount for charges from Network Providers will be used to satisfy the Maximum Out-of-Pocket Amount for charges from Non-Network Providers and vice versa. ***Prescription drug co-payments and coinsurance apply to a separate prescription drug maximum out-of-pocket amount.***	
Per Covered Person	$1,500	$3,000
Per Family Unit	$3,000	$6,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.		
Cost containment penalties		
Deductibles		
Prescription drug copayments and coinsurance		
Non-Covered Expenses		
Amounts that exceed the Allowable Charge or benefit maximums		

2. Under the Prescription Drug Schedule, the benefit is changed to include the following highlighted information in italics and bold:

PRESCRIPTION DRUG BENEFIT

Copayments are waived for medications that are considered to be for preventive care under the Affordable Care Act (see the recommendations and guidelines listed in the Schedule of Benefits above under preventive care).

PRESCRIPTION DRUG BENEFIT	
Prescription Drug Deductible Amount	Not Applicable
Prescription Drug Maximum Out-of-Pocket Amount, Per Calendar Year	***Per Person: $4,600*** ***Per Family: $8,700***
Generic Drugs	$20 Copayment
Formulary Brand Name Drugs	$40 Copayment
Non-Formulary Brand Name Drugs	$80 Copayment
PRESCRIPTION DRUG BENEFIT	
Mail Order Option (90 Day Supply)	
Generic Drugs	$40 Copayment
Formulary Brand Name Drugs	$80 Copayment
Non-Formulary Brand Name Drugs	$160 Copayment
Specialty Drugs (30 Day Supply) 20% up to a maximum co-insurance of $500 per prescription	
Generic Drug Incentive Daw 1: If the Physican requests a Brand Name drug, the Plan participant will be charged the Brand Name drug copayment plus the cost difference between the Brand Name drug and the Generic drug. If there is no Generic drug available, the additional fee will not be charged. Daw 2: If the Plan participant requests a Brand Name drug, the Plan participant will be charged the Brand Name drug copayment plus the cost difference between the Brand Name drug and the Generic drug. If there is no Generic drug available, the additional fee will not be charged.	

ACCEPTED:

by _____
City of Monroe

Date: _____

June 11, 2014

Latest Guidance on the Affordable Care Act's Rules for Out-of-Pocket Limits and Preventive Services Requirements

The Departments of Treasury, Labor, and Health and Human Services (HHS), which are responsible for implementing the Affordable Care Act[1] (collectively, the "Departments"), have published answers to two sets of frequently asked questions (FAQs).[2] The FAQs address two of the law's requirements for non-grandfathered plans: the new rules applicable to out-of-pocket limits and the preventive services requirement.

This *Capital Checkup* summarizes this guidance, which will help plan sponsors understand the law's requirements, especially as they begin the process of considering benefit changes for the 2015 plan year.

Out-of-Pocket Limits

Effective with the plan year beginning on or after January 1, 2014, non-grandfathered group health plans must comply with a new annual limit on cost sharing, also known as an out-of-pocket limit.[3] The maximums for the 2014 and 2015 plan years are noted in the table below.

The Affordable Care Act's Out-of-Pocket Limit, 2014 and 2015

	2014*	2015**
Individual Coverage	$6,350	$6,600
Family Coverage	$12,700	$13,200

* For 2014 only, the out-of-pocket limits are the same as the limits applicable to high deductible health plans paired with Health Savings Accounts (HSA).

** Starting in 2015, the out-of-pocket limits are no longer tied to HSA limits, but are calculated based on a percentage increase from the previous year. The percentage increase used this year was 4.2 percent (rounded).

The answers clarify the following rules for the 2015 plan year:

- Plan sponsors may have separate out-of-pocket limits on different categories of benefits (*e.g.*, medical and prescription drugs) as long as the combined amount of all such limits does not exceed the allowed amount. For example, a plan could cap a participant's out-of-pocket spending on medical expenses at $4,000 and drug expenses at $2,600, because those two limits added together do not exceed the allowed amount of $6,600.
- The out-of-pocket limit applies to in-network expenses only. A plan may limit a participant's out-of-network expenses, but is not required to do so.
- A plan sponsor is not required to count expenses for non-covered items or services toward the out-of-pocket limit.
- Reference pricing involves designs where a plan pays a fixed price for a particular procedure (*e.g.*, a knee replacement), which certain providers will accept as payment in full. The goal is to negotiate cost-effective arrangements with high-quality providers. Plans may have a reference-based pricing program where they do not count amounts above the reference price paid by participants toward the out-of-pocket limit. The plan would need to treat providers who accept the reference amount as the plan's only in-network providers and would have to use a reasonable method to ensure that it provides adequate access to high-quality providers. The Departments are seeking comments on these types of arrangements to help them provide additional guidance in the future. Comments are due by August 1, 2014.
- Generally, if a participant chooses a brand drug when a generic is medically appropriate, the plan does not have to count the amount paid by the patient (including the differential between brand and generic) toward the out-of-pocket limit.