HCR ALERT!

Wednesday, January 22, 2014

New Affordable Care Act Frequently Asked Questions (FAQs) Released

On January 9, 2014, the Departments of Health and Human Services (HHS), Labor and Treasury ("the Departments") published FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation, which address several Affordable Care Act (ACA) topics including coverage of preventive services, limitations on cost-sharing, expatriate health plans, wellness programs, fixed indemnity insurance and the Mental Health Parity and Addiction Equity Act. This alert summarizes key information presented in these recent FAQs.

Coverage of Preventive Services

In general, the ACA requires that non-grandfathered health plans must provide coverage without participant cost-sharing for services recommended by United States Preventive Services Task Force (USPSTF) with a rating of A or B; immunizations recommended by CDC Advisory Committee on Immunization Practices; and children and women's care guidelines supported by HHS.

On September 24, 2013, the USPSTF issued new recommendations with respect to breast cancer, revising its recommendation regarding medications for risk reduction of primary breast cancer in women. The USPSTF now recommends that clinicians engage in shared, informed decision-making with women who are at increased risk for breast cancer about medications to reduce their risk and, for women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.

Non-grandfathered health plans will be required to cover such medications for applicable women without cost-sharing (subject to reasonable medical management) as of plan or policy years beginning one year after the date the recommendation or guideline was issued (as of plan or policy years beginning on or after September 24, 2014).

Limitations on Cost-Sharing

In general, as of plan years beginning on or after January 1, 2014, the ACA requires that non-grandfathered health plans cannot impose participant total out-of-pocket (OOP) cost-sharing for covered Essential Health Benefits (EHB) that exceeds the OOP limitations permitted for high-deductible health plans ($6,350 for self-only coverage and $12,700 for other coverage in 2014, indexed annually thereafter). For the first year of applicability, where a health plan utilizes more than one service provider to administer benefits (e.g., separate medical and pharmacy benefit administrators), plans are considered compliant if the medical coverage complies with the OOP

limit requirement and, to the extent that the carved-out non-medical benefit has a separate OOP limit, it separately does not exceed the maximum dollar amount for high-deductible plans.

After the first year of applicability, the OOP limit for all EHB combined cannot exceed the maximum dollar amount for high-deductible plans for that year. However, plans may structure a benefit design using separate OOP limits for different benefits, provided the combined amount of the separate OOP limits does not exceed the limit for that year.

These recent FAQs also re-confirm that plans do not have to apply expenses for out-of-network and non-covered services to the OOP maximum.

Expatriate Health Plans

A previous FAQs document provided guidance and temporary transitional relief regarding the extent to which expatriate health coverage is subject to provisions of the ACA for plan years ending on or before December 31, 2015. These recent FAQs extend the transitional relief for expatriate plans through December 31, 2016 as well as provide clarification regarding the definition of an insured expatriate health for the purpose of this transition relief. The clarified definition is:

An insured expatriate health plan is an insured group health plan with respect to which enrollment is limited to primary insureds for whom there is a good faith expectation that such individuals will reside outside of their home country or outside of the United States for at least six months of a 12-month period and any covered dependents, and also with respect to group health insurance coverage offered in conjunction with the expatriate group health plan. The 12-month period can fall within a single plan year or across two consecutive plan years.

Wellness Programs

In general, as of plan years beginning on or after January 1, 2014, the ACA allows an increase in the maximum permissible reward under a health-contingent wellness program from 20% to 30% of the cost of coverage or 50% for programs designed to prevent or reduce tobacco use. These recent FAQs clarify that if a plan participant declines to participate in a wellness program during the employer-defined election period, but chooses to join the wellness program mid-year; the employer is not required to provide a mid-year opportunity for that participant to earn the reward. Employers may, at their discretion, prorate awards for mid-year participants if they so choose.

These recent FAQs also clarify that if an individual's doctor indicates that an outcome-based wellness program is not medically appropriate for the individual and recommends an activity-only program instead, the plan must provide a reasonable alternative standard that accommodates the doctor's recommendations, but the plan can have a say in which program of those meeting the requirement, is offered.

In addition, these recent FAQs confirm that the sample notification language provided in the final regulations regarding the reasonable alternative standard may be modified to reflect the details of a specific wellness program, provided the notice includes all of the required content described in the final regulations.

Fixed Indemnity Insurance

A previous FAQs document provided guidance indicating that, in order for a fixed indemnity policy to be considered an excepted benefit (and therefore generally exempt from most ACA requirements), it must pay benefits on a per-period basis (rather than a per-service basis). These recent FAQs indicate that fixed indemnity policies that do not pay on a per-period basis may, nonetheless, qualify as supplemental excepted benefits. HHS intends to propose amendments that would allow individual fixed indemnity policies to be considered excepted benefits if a policy meets the following conditions:

- It is sold only to individuals who have other coverage that is Minimum Essential Coverage (MEC)
- There is no coordination between provision of benefits and an exclusion of benefits under other health coverage
- Benefits are fixed dollar amounts regardless of amount of the expenses incurred and without regard to benefits provided under other health coverage
- A notice is prominently displayed in plan materials indicating the coverage does not qualify as MEC and does not satisfy the individual mandate.

Until HHS finalizes this rulemaking, it will treat fixed indemnity policies as excepted benefits for enforcement purposes if it meets the conditions above (in States where HHS has direct enforcement authority.)

Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 Impact on ACA

On November 13, 2013, the Departments published final regulations on the MHPAEA, which, in general, requires that the financial requirements (such as coinsurance) and treatment limitations (such as visit limits) imposed on mental health and substance use disorder benefits cannot be more restrictive than the predominant requirements that apply to medical/surgical benefits. These recent FAQs, which specifically address the MHPAEA's effect on ACA regulations, confirm the following:

- In order to satisfy ACA EHB provisions, non-grandfathered individual and small group market plans must cover mental health and substance use disorder services for policy years beginning on or after January 1, 2014 and must comply with MHPAEA for policy years beginning on or after July 1, 2014.
- All individual health insurance plans must comply with MHPAEA for plan years beginning on or after July 1, 2014, regardless of grandfathered status.

- Grandfathered small group market plans do not have to comply with either the ACA EHB provisions or MHPAEA.

ADDITIONAL PPACA REGULATIONS & GUIDANCE ISSUED IN THE LAST 3 MONTHS

Nov. 2013: HHS Announces Transition Policy Regarding Individual Policies Not Complying with ACA Requirements
Nov. 2013: IRS Issues Final Rules on Additional Medicare Tax & FAQ
Nov. 2013: IRS Issues Notice Regarding Procedural Guidance for Carrier Payment of Health Insurance Providers Fee
Nov. 2013: IRS Issues Final Regulations on Health Insurance Providers Fee
Nov. 2013: HHS Issues Proposed Regulations on Transitional Reinsurance Fee and Other Misc. ACA Items and Fact Sheet
Nov. 2013: HHS Announces One-Year Delay of Online SHOP Enrollment
Dec. 2013: HHS Issues Interim Final Rule Extending Exchange Enrollment Deadline for 1/1/13 Coverage
Dec. 2013: Agencies Issue Proposed Regulations on Excepted Benefits
Jan. 2014: Departments Issue FAQs on Preventive Services, Cost-Sharing Limits, Expatriate Plans, Wellness Programs, Fixed Indemnity Insurance and MHPAEA

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