SEYFARTH SHAW

Health Care Reform Management Alert Series

New FAQs Clarify ACA Rules Relating to Out-of-Pocket Maximums, Preventive Services, Health FSA Carryovers, SBCs and COBRA Notices

Issue 81

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This is the eighty-first issue in our series of alerts for employers on selected topics in health care reform. (Click here to access our general summary of health care reform and other issues in this series) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

On May 2, 2014, the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury (collectively, the "agencies") jointly issued another series of Frequently Asked Questions (FAQs) regarding implementation of various provisions under the Affordable Care Act (ACA). The FAQs cover the following topics:

Out-of-Pocket Maximum

Background

For plan years beginning on or after January 1, 2014, non-grandfathered plans must limit participant out-of-pocket costs toward essential health benefits to an amount not in excess of certain inflation-adjusted thresholds (for 2014, $6,350 for self-only coverage, and $12,700 for family coverage). The agencies have yet to issue regulations on this topic but have issued a series of informal FAQs and have provided a good-faith interpretation standard pending regulations.

New Guidance

- Out-of-Network Costs. Plans are not required to count out-of-network costs toward the plan's out-of-pocket maximum. As such, to the extent a plan chooses to count out-of-network services toward the out-of-pocket maximums, the FAQs clarify that the plan is not required to count the balance billing (i.e., the amounts charged to participants over the plan's agreed-upon reimbursement rate) for those services not covered by an out-of-network provider toward the plan's maximum.

- Brand-Name Drug Costs. As noted above, only out-of-pocket expenses incurred for essential health benefits must count toward the plan's out-of-pocket maximum. Large insured plans and self-funded plans have certain leeway in defining essential health benefits. As such, the FAQs note that these types of plans could choose to exclude from the out-of-pocket maximum any expenses for brand-name drugs when a generic is available.
- Reference-Based Pricing. The FAQs noted that the agencies are considering how to address reference-based pricing (i.e., when a plan pays a fixed amount for a certain procedure and certain in-network providers accept that amount as payment in full while others do not). The agencies are concerned that this may be used as a subterfuge to carve out certain in-network expenses that would otherwise count toward the maximum. But, until the agencies issue additional guidance, the agencies will not penalize a plan for excluding from the out-of-pocket maximums expenses incurred by participants that are in excess of the reference-based pricing.
- Summary Plan Descriptions (SPD). The FAQs reiterated that an ERISA plan's SPD must explain which covered benefits will count toward the out-of-pocket maximum.

Preventive Services - Smoking Cessation Counseling

Background

Under the ACA, non-grandfathered plans need to cover certain preventive services at 100%, with no participant cost-sharing. A full list of preventive services that plans must cover is available at *www.healthcare.gov* and the list includes tobacco cessation counseling and intervention.

New Guidance

- The FAQs reiterated that plans may use reasonable medical management techniques to determine frequency, method, treatment or setting limitations for preventive services.
- While not specifically required, the agencies will consider a plan to be in compliance with the smoking cessation counseling recommendation if the plan covers:
    - Screening for tobacco use, and
    - For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage, without prior authorization, for:
        - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and
        - All FDA-approved tobacco cessation medications (including prescription and prescribed over-the-counter drugs) for a 90-day treatment regimen.
- Notably, this appears to create a safe harbor rather than a hard-and-fast rule. It remains to be seen how the agencies would react to a lesser offer of coverage.
- Moreover, plan sponsors had previously been concerned that the preventive service mandate, which includes treatment for certain mental health and substance abuse disorders, could more broadly subject the plan to the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements (which do not apply to plans that don't cover mental health/substance abuse services at all). Final regulations under the MHPAEA clarify that plans covering mental health/substance abuse services solely for the purpose of, and to the extent required by, the ACA, will not be subject to the entire panoply of MHPAEA requirements.

Health FSA Carryover and Excepted Benefits

Background

The ACA insurance market reforms (including those discussed above) only apply to "group health plans," and not to "excepted benefits." Most health FSAs will be considered an excepted benefit if the maximum reimbursement payable to an employee does not exceed the greater of:

1. Two times the employee's salary reduction election, or

2. $500 plus the amount of the participant's salary reduction election.

Guidance in 2013 by the Internal Revenue Service allows plans to carryover up to $500 of unused participant health FSA deferrals to be available to reimburse expenses incurred in the subsequent plan year.

New Guidance

The FAQs clarify that, for purposes of determining whether a health FSA constitutes an excepted benefit, the unused carryover amount is not treated as a reimbursement in excess of the employee's salary reduction in the carryover year.

Summary of Benefits and Coverage

Background

Group health plans are required to issue participants a uniform summary of benefits and coverage describing the terms of the plan during annual enrollment and during certain other events (such as a participant request or a mid-year change in the terms of coverage). For the first and second year of applicability, the agencies issued transition/enforcement relief indicating the agencies would focus on compliance assistance rather than enforcement for certain areas such as plans that issue the SBC electronically, plans that fail to issue an SBC, and plans providing expatriate coverage. (For a full list of the available forms of transition relief, see *http://www.dol.gov/ebsa/faqs/faq-aca19.html*.)

New Guidance

- The agencies announced that there will be no new template or uniform summary for the third year of applicability. This means that plans may continue to issue the SBC on the same template that they used for the second year of applicability.
- The agencies extended all forms of transition relief described in the link provided above. Most importantly, this includes the DOL's basic compliance assistance (rather than enforcement) stance when it comes to SBCs.

COBRA Model Notices

Background

In 2013, the DOL issued a revised model COBRA election notice that notified qualified beneficiaries of the coverage options that would become available through the Health Insurance Marketplaces or Exchanges.

New Guidance

Simultaneous with the issuance of the FAQs, the DOL issued updated versions of the model election notice, as well as the COBRA general notice that must generally be furnished to each covered employee within 90 days of becoming covered under a group health plan. The notices now reflect that the Marketplace is open and describes special enrollment rights in Marketplace coverage.

The DOL also issued a revised notice under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Employers that maintain a health plan in a state that provides premium assistance under a state Medicaid plan or a state child health plan must notify employees of the opportunities available for premium assistance. The CHIPRA model notice has also been updated to reflect the availability of Marketplace coverage.

The FAQs provide that the model notices can be found at *www.dol.gov/ebsa/cobra.html* and *www.dol.gov/ebsa/compliance_assistance.html*. Use if these model notices will be considered compliance with the COBRA notice content requirements.

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