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Health Care Reform Management Alert Series

Agencies Issue FAQs on Cost-Sharing Limits, Wellness Programs, and Other Topics

Issue 75

By Jennifer Kraft and Kelly Pointer

This is the seventy-fifth 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 January 9, 2014, the Departments of Treasury, Health and Human Services and Labor (the "Agencies") jointly issued *FAQs* on a number of upcoming requirements under the Affordable Care Act, as described below.

BENEFITS COUNTED IN COST-SHARING LIMITS

What did we already know?

[✓] Applicable to Non-Grandfathered Plans Only

For plan years beginning on and after January 1, 2014, non-grandfathered group health plans cannot impose cost-sharing (deductibles, co-pays, and co-insurance) higher than the 2014 out-of-pocket maximum applicable to high-deductible health plans ($6,350 for self-only coverage and $12,700 for coverage other than self-only coverage), subject to adjustment in future years. For purposes of calculating the cost-sharing limitation, the Agencies acknowledged that coordination of a single limit across multiple providers (e.g. major medical and prescription drug) may be difficult and they provided a transition rule for the 2014 plan year. For details about the transition rule, see *Issue 52*.

What did we learn?

The Agencies confirmed that, beginning with the 2015 plan year, non-grandfathered plans and issuers will be required to apply the cost-sharing limits (also referred to as the out-of-pocket maximum) across all essential health benefits ("EHB").

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Accordingly, the transition rule described above will no longer apply after the 2014 plan year. Under the FAQs:

Cost-sharing must include:	Cost-sharing may (but is not required to) include:
• Essential health benefits • In-network benefits (that are EHB) • Covered benefits (that are EHB) • Deductibles • Copayments • Coinsurance	• Non-essential health benefits • Out-of-network benefits • Non-covered benefits • Premiums • Balance billing for non-network providers

(For more information on EHB, see Issues *46* and *53*).

Essential Health Benefits: To date, little guidance has been provided on defining "essential health benefits" for self-insured plans. The FAQs state that a self-insured plan will be considered to have used a permissible definition of EHB if the definition is one that is authorized by the Secretary of HHS and that the Agencies intend to use their enforcement discretion and work with large group market and self-insured plans that make a good faith effort to apply an authorized definition of EHB. This is consistent with guidance by the Department of Health and Human Services in the context of annual and lifetime limits.

A plan with multiple service providers may divide the out-of-pocket maximum among multiple categories of benefits rather than reconcile claims across multiple service providers. In other words, a plan may use separate out-of-pocket limits for different benefits, as long as the combined amount of any separate out-of-pocket limits does not exceed the annual limitation.

WELLNESS PROGRAMS

What did we already know?

[✓] Applicable to Grandfathered and Non-Grandfathered Plans

In June 2013, the Agencies issued final regulations on wellness programs. See *Issue 65*. Under the final regulations, the maximum permissible reward under a health-contingent wellness program is 30% of the cost of coverage (increased from 20% of the cost of coverage). The maximum permissible reward for a program designed to prevent or reduce tobacco use, however, is 50% of the cost of coverage. Wellness programs have other design requirements as well: participants must have a reasonable opportunity to qualify for the reward at least once per year, the program must allow alternative ways to achieve the reward in certain circumstances, and participants must be notified that alternatives are available.

What did we learn?

The FAQs provide that a plan with a tobacco surcharge is only required to offer the opportunity to qualify for the lower cost once per year. This means if a participant is a tobacco user and declines the opportunity to enroll in a tobacco cessation program at the beginning of the plan year, the plan is not required to remove the tobacco surcharge if the participant enrolls in a tobacco cessation program mid-year. The wellness program could, however, be voluntarily designed to provide the reward mid-year or to pro-rate the reward.

Under another FAQ, a wellness program has an outcome-based reward, and a participant's doctor advises that a plan's standard for obtaining a reward is medically inappropriate for the participant. The physician suggests an activity-only weight

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reduction program instead. Responding to the question whether the plan can provide input as to the weight reduction program, the Agencies say yes; many different weight reduction programs may be reasonable for this purpose, and a participant should discuss different options with the plan.

Finally, the FAQs note that the regulations include several samples of language that could be used to notify participants that reasonable alternatives are available if they cannot perform the activity required by the program. The FAQs clarify that the sample language can be modified as long as it includes all of the required content.

OTHER ISSUES ADDRESSED

Preventive Service Benefits

For plan years beginning on or after January 1, 2014, non-grandfathered group health plans are required to cover immunizations and preventive care services specified by certain task forces and the Centers for Disease Control and Prevention without cost-sharing. See *Issue 10* and *Issue 25* for more information on required preventive coverage. Plans need to incorporate any changes to the required preventive coverage by the plan year that begins on or after one year after the date the recommendation or guideline is issued. On September 24, 2013, the United States Preventive Services Task Force issued new recommendations with respect to breast cancer. Non-grandfathered plans will be required to incorporate these recommendations into their preventive care coverage for plan years beginning on or after September 24, 2014 (so January 1, 2015 for calendar years).

Fixed Indemnity Plans[1]

"Excepted benefits" are generally exempt from the health reform requirements added by the Affordable Care Act ("ACA"). Excepted benefits include limited scope dental and vision coverage, some health care flexible spending accounts, fixed indemnity insurance arrangements and other supplemental coverage. As pointed out in the FAQ and in the media, there has been a significant increase in the number of health insurance policies labeled as fixed indemnity. In order for a fixed indemnity policy to be considered an excepted benefit, prior guidance indicated that the insurance must pay on a per-period basis (e.g. a fixed dollar amount per day) and not on a per-service or per-visit basis. The new FAQ provides that a fixed indemnity policy that provides coverage on a per-service basis may, in certain circumstances, qualify as excepted "supplemental coverage", or may be considered an excepted benefit under a new proposed standard which involves the policy being sold on the individual market, but only to those individuals who have other health coverage that is minimum essential coverage. Employers considering certain "skinny" plan designs or other policies that pay on a per-service or per-visit basis should be mindful of whether it qualifies as an "excepted benefit." If a group health plan is NOT an excepted benefit, it is subject to the ACA's prohibition on annual dollar limits on essential health benefits. In this case, including annual dollar limits (as most fixed indemnity plans do), could subject the employer to penalties. Employers considering these types of plan design are encouraged to consult with counsel.

Transition Relief for Expatriate Health Plans

Recognizing that plans providing coverage to expatriate employees can face unique challenges in satisfying ACA requirements, such as the requirement to cover preventive care services, temporary transitional relief for certain expatriate plans is available. See *Issue 59*. The Agencies clarified in the FAQs that the transitional relief is available to an insured group health plan where enrollment is limited primarily to 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 6 months of a 12-month period (and any covered dependents). The 12-month period can fall within a single plan year or across 2 consecutive plan years. The FAQs clarified the scope of the ACA that is covered by the transitional relief. Any subsequent guidance that is more restrictive will not be applicable to plan years ending on or before December 31, 2016.

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[1] A fixed indemnity plan, generally, is one that pays the insured a fixed dollar amount per day (or per other period) of hospitalization or illness regardless of the amount of medical expenses actually incurred.

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Mental Health Parity and Addiction Equity Act

The FAQs included a question and answer about the application of the Mental Health Parity and Addiction Equity Act to individual and small group market health insurance coverage. The Agencies' guidance on this issue will be discussed in a separate Alert.

Jennifer Kraft is a partner in Seyfarth Shaw's Chicago office. *Kelly Pointer* is an associate in Seyfarth Shaw's New York office. If you would like further information, please contact your Seyfarth attorney or Jennifer Kraft at *jkraft@seyfarth.com* or Kelly Pointer at *kpointer@seyfarth.com*.

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