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BENEFITS MARKETPLACE

Nineteenth Set of FAQs on the ACA Issued

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Issued date: 05/14/14

Frequently asked questions ("FAQs"), prepared jointly by the Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, the "Departments"), were issued with respect to various Affordable Care Act ("ACA") requirements, including their effect on COBRA and CHIPRA notices.

Updated Cobra And Chipra Notices

The DOL issued updated versions of the COBRA model[1] general notice and model election notice that reflect that the Marketplace is now open and that better describe special enrollment rights in Marketplace coverage. They are available at: www.dol.gov/ebsa/cobra.html.

In addition, proposed regulations[2] issued last week indicate that the model notices will no longer be contained as an appendix to the regulations, but solely on the DOL's website.

The DOL issued a revised CHIPRA notice[3] with similar updates related to Marketplace coverage, available at: http://www.dol.gov/ebsa/compliance_assistance.html.

The model notices are available in modifiable, electronic form.

Out-Of-Pocket Maximum Requirements

Background

Effective the first plan year that begins on or after January 1, 2014,[4] all non-grandfathered group health plans must comply with annual cost-sharing limitations on out-of-pocket maximums[5] that are the same as the limits that apply to HSA-qualified high deductible health plans.

With respect to an out-of-network provider, the amount in excess of the allowed amount (also known as balance billing) does not have to count toward the out-of-pocket maximum.

Large group market coverage and self-insured group health plans have discretion to define "essential health benefits." For small, insured, non-grandfathered health plans, additional requirements apply as they must provide the essential health benefit package.

Balance Billing

In the FAQs, the Departments indicate that a plan that chooses to count out-of-network spending towards the out-of-pocket maximum may use any reasonable method for

doing so. For example, if the plan covers 75% of the usual, customary, and reasonable amount ("UCR") charged for services provided out-of-network and the participant pays the remaining 25% of UCR plus any amount charged by the out-of-network provider in excess of UCR, the 25% of UCR paid by the participant may reasonably be counted, in full or in part, toward the out-of-pocket maximum without including any amount charged above UCR paid by the participant.

Generic drugs

In the FAQs, the Departments indicate that a plan may include only generic drugs toward the out-of-pocket maximum, if medically appropriate (as determined by the individual's personal physician) and available, while providing a separate option (not as part of essential health benefits) of electing a brand name drug at a higher cost sharing amount. If, under this type of plan design, a participant or beneficiary selects a brand name prescription drug in circumstances in which a generic was available and medically appropriate (as determined by the individual's personal physician), the plan may provide that all or some of the amount paid by the participant or beneficiary (e.g., the difference between the cost of the brand name drug and the cost of the generic drug) is not required to be counted towards the annual out-of-pocket maximum. For ERISA plans, the SPD must explain which covered benefits will not count towards an individual's out-of-pocket maximum.

In determining whether a generic is medically appropriate, a plan may use a reasonable exception process. For example, the plan may defer to the recommendation of an individual's personal physician, or it may offer an exceptions process meeting the requirements of 45 CFR 156.122(c).

Reference-based pricing

If large group market coverage or self-insured group health plan has a reference-based pricing structure,[6] the Departments invite comment on the application of the out-of-pocket limitation.

Until guidance is issued and effective, the Departments will not consider a plan or issuer as failing to comply with the out-of-pocket maximum requirements because it treats providers that accept the reference amount as the only in-network providers, provided the plan uses a reasonable method to ensure that it provides adequate access to quality providers.

Coverage Of Preventive Services

Background

A non-grandfathered group health plan must provide coverage for in-network preventive items and services, as determined by U.S. Preventive Services Task Force (USPSTF) recommendations, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services.

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Plans may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified in the recommendation or guideline regarding that preventive service.

Tobacco cessation

The Departments will consider a group health plan or health insurance issuer to be in compliance with the requirement to cover tobacco use counseling and interventions, if, for example, the plan or issuer covers without cost-sharing:

1. Screening for tobacco use; and

2. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:

    - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and

    - All Food and Drug Administration ("FDA")-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

These are examples only. It is possible to satisfy this preventive care mandate without offering all of the items listed above, but employers so doing should consult with counsel.

Health FSA Carryover And Excepted Benefits

Background

Excepted benefits provided under a group health plan or health insurance coverage generally are exempt from HIPAA and ACA market reform requirements. Health FSAs generally constitute excepted benefits if:

1. The employer also makes available group health plan coverage that is not limited to excepted benefits for the year to the class of participants by reason of their employment;

    and

2. The arrangement is structured so that the maximum benefit payable to any employee participant in the class cannot exceed:

    - Two times the employee's salary reduction election for the arrangement for the year; or

    - If greater, cannot exceed $500 plus the amount of the participant's salary reduction election).

Health FSAs may now allow up to $500 of unused amounts remaining at the end of a plan year in a health FSA to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year, provided that the plan does not also incorporate a grace period.

Effect of carryover on excepted benefits determination

The FAQs indicate that unused carry over amounts are not taken into account when determining if the health FSA satisfies the maximum benefit payable limit prong under the excepted benefits regulations.

Summary Of Benefits And Coverage

Background

The ACA requires a 4-page summary of benefits and coverage ("SBC") and uniform glossary to be provided to plan participants.

The Departments will not impose penalties on plans and carriers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the requirements.

Template

The template issued last year continues to apply. For the template, visit: http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html.

Enforcement relief

The enforcement relief continues to apply; the Departments' approach to implementation continues to be marked by an emphasis on assisting (rather than imposing penalties on) plans that are working diligently and in good faith to understand and come into compliance with the new law.

For the FAQs, visit: http://www.dol.gov/ebsa/pdf/faq-aca19.pdf.

[1] *Although the use of model notices is not required, the DOL will consider use of the model notices, appropriately completed, to constitute compliance with COBRA's notice content requirements.*

[2] *http://www.gpo.gov/fdsys/pkg/FR-2014-05-07/pdf/2014-10416.pdf*

[3] *Health plans should send annual notice to employees in states that provide Medicaid or SCHIP premium assistance.*

[4] *For the most part, this will be gauged on a calendar-year basis because out-of-pocket limits run on a calendar-year basis.*

[5] *This is also referred to as an annual limitation on cost-sharing.*

[6] *Reference-based pricing means the plan pays a fixed amount for a particular procedure (for example, a knee replacement), which certain providers will accept as payment in full.*