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Employee Benefits & Executive Compensation ADVISORY ■

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Health Care Reform Update: Departments Issue New ACA FAQs on Preventive Services, Cost-Sharing Limits, Fixed Indemnity Insurance, Wellness Programs and Expatriate Health Plans

On January 9, 2014, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the "Departments") issued Part XVIII of the Frequently Asked Questions (FAQs) on Affordable Care Act (ACA) and Mental Health Parity Implementation. The Departments' ACA Implementation FAQs have been important sub-regulatory tools for divining regulatory intent on complicated, and continually evolving, issues. This advisory addresses FAQs Part XVIII related to ACA implementation, including guidance regarding preventive services, cost-sharing limitations, fixed indemnity insurance, wellness programs and expatriate health plans as they relate to group health plans.[1]

Preventive Services (FAQ 1)

Public Health Service Act (PHSA) § 2713 and the interim final regulations thereunder require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to provide benefits for, and prohibit the imposition of cost-sharing requirements with respect to, various preventive care services. The FAQs reiterate the position in the regulations that if the recommendation or guideline does not specify the frequency, method, treatment or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques to determine any coverage limitations.[2]

FAQ 1 provides updated guidance on the U.S. Preventive Services Task Force (USPSTF) "B" recommendation from September 24, 2013, regarding breast cancer. The USPSTF recommendation was that providers "engage in shared, informed decisionmaking" with women at increased risk for breast cancer about medications to reduce their risk, and offer to prescribe risk-reducing medications (such as tamoxifen or raloxifene) for women at increased risk for breast cancer and low risk for adverse side effects. FAQ 1 provides that for plan or policy years beginning on or after September 24, 2014, non-grandfathered group health plans and non-grandfathered health insurance coverage in the individual or group market are required to cover such medications for affected individuals without cost-sharing, subject to reasonable medical management.

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[1] The FAQs may be found at http://www.dol.gov/ebsa/faqs/faq-aca18.html.

[2] *See* 26 CFR 54.9815-2713T(a)(4), 29 CFR 2590.715-2713(a)(4) and 45 CFR 147.130(a)(4).

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Cost-Sharing Limitations (FAQs 2-5)

PHSA § 2707(b) provides that a non-grandfathered group health plan must ensure that any annual cost-sharing imposed under the plan does not exceed the limitations in ACA § 1302(c)(1) (relating to maximum out-of-pocket (OOP) costs) and ACA § 1302(c)(2) (relating to deductibles for small group market plans).[3]

Transition Rule for Separately Administered Benefits in Prior FAQs

This OOP requirement has caused some administrative issues where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on OOP costs. A previous FAQ (Part XII, FAQ 2) provided guidance on this issue for the first plan year on or after January 1, 2014. In that FAQ, the Departments indicated that they would consider the annual limitation on OOP costs to be satisfied if:

- the plan complies with the requirements with respect to its major medical coverage (perhaps excluding prescription drug or pediatric dental coverage) and
- to the extent that the plan or any health insurance coverage includes an OOP maximum on coverage that does not consist solely of major medical coverage (such as a separate OOP for prescription drug coverage) and that OOP maximum does not exceed the dollar amounts set forth in ACA § 1302(c)(1).

The updated guidance in FAQs Set XVIII does not extend this transition rule. Instead, the Departments have included guidance on the definition of essential health benefits, a discussion of how the OOP limit may be applied separately to different benefits and clarifications on how the OOP max applies to out-of-network (OON) items and services and OOP costs for non-covered items or services.

FAQ 2 Essential Health Benefits

The OOP maximum applies with respect to essential health benefits (EHBs). Plans are not required to apply the annual OOP maximum limit to benefits that are not EHBs. Large group plans and self-funded plans are not required to cover EHB, thus raising a question as to the definition of EHB that applies with respect to such plans for purposes of the OOP maximum.

FAQ 2 specifies that the Departments will consider self-insured group health plans or large group health plans to have used a permissible definition of EHB if the definition is one that is authorized by the Secretary of HHS (in other words, a state benchmark plan).[4] In addition, the Departments state that they intend to use their discretion and work with large group market and self-insured plans that make a good faith effort to apply an authorized definition of EHB. Note that this is the same approach the Departments indicate will apply with respect to large group and self-funded plans with respect to applying the prohibition on annual and lifetime dollar limits on EHB.

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[3] For plan or policy years beginning in 2014, the annual limit on OOP costs is $6,350 for self-only coverage and $12,700 for other than self-only coverage. This amount is increased for later plan or policy years based on increases in average health insurance premiums, as determined by the Secretary of HHS in accordance with ACA § 1302(c)(4).

[4] 45 C.F.R. § 156.100 provides that each state may select an EHB-benchmark plan according to various standards; it also states which plan is the default plan if the state does not make a selection. The list of benchmark plans can be found at Appendix A of 78 FR 12834, February 25, 2013, available at https://federalregister.gov/a/2013-04084.

FAQ 3 Dividing the OOP Limit

FAQ 3 clarifies that plans may divide the annual limit on OOP costs across multiple categories of benefits, rather than reconcile claims across multiple service providers, as long as the combined amount of any separate OOP limits applicable to EHBs under the plan does not exceed the annual OOP limit for that year under ACA § 1302(c). For example, plans may apply a separate limit to medical coverage and a separate limit to prescription drug coverage as long as the total limits do not exceed the maximum. In contrast, the one-year transition rule described above allows multiple types of coverage to independently meet the OOP maximum (for the 2014 plan year only). The FAQ makes it clear that there is some flexibility for plan sponsors to ensure that the OOP limits are met, without necessitating complicated monitoring of various service providers. Note, however, health plans must be careful not to implement separate OOP limits for different benefits in a way that violates the mental health parity rules.[5]

FAQ 4 Out-of-Network Benefits

Under applicable regulations, in the case of a plan with a network of providers, the OOP maximum applies only with respect to in-network services. FAQ 4 provides that a plan may, but is not required to, count OOP spending for out-of-network items and services toward the plan's annual OOP limit. Thus, plans with a network may choose whether or not to count out-of-network items or services against the OOP limit. In any case, however, in-network cost-sharing cannot exceed the OOP limit.

FAQ 5 Non-Covered Services

The term "cost-sharing" for purposes of the OOP maximum does not include spending for non-covered services, so such spending is not required to be counted against an OOP limit. Finally, FAQ 5 states that a plan may choose to count OOP spending for non-covered services toward the plan's annual maximum OOP costs.

FAQ 11 Fixed Indemnity Insurance

Fixed indemnity insurance provided under a group health plan meeting certain requirements is considered to be an excepted benefit under PHSA 2791(c)(3) (and the comparable Code and ERISA provisions), which makes it exempt from the ACA market reforms.[6] The FAQs note a "significant increase" in the number of policies labeled as fixed indemnity insurance. The Departments have expressed concern that some insurers are attempting to label too many types of policies—which, in the Departments' view, are effectively health insurance benefits—as fixed indemnity coverage, thus avoiding many of the rules the ACA was intended to implement. In an effort to address these concerns, the Departments stated in previous guidance (Part XI, FAQ 7) that in order for a fixed indemnity policy to be considered an excepted benefit, it must pay benefits on a per-period basis. Under this FAQ, a fixed indemnity policy that pays on a per-service basis does not meet the criteria for excepted benefits. Note that this limitation would not necessarily apply to other supplemental coverage such as accident or disability coverage, which is an excepted benefit under PHSA 2791(c)(1), limited scope vision or dental coverage, which is an excepted benefit under PHSA 2791(c)(2), or specified disease (e.g., cancer or some critical illness) coverage, which is also an excepted benefit under PHSA 2791(c)(3).

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[5] Regulations implementing the Mental Health Parity and Addiction Equity Act of 2008 prohibit a group health plan or health insurance coverage in the group or individual market from applying an OOP maximum to mental health or substance use disorder services in a classification that accumulates separately from any such maximum established for medical/surgical benefits in the same classification. Thus, plans and issuers may not impose an annual OOP maximum on all medical/surgical benefits in a classification and a separate annual OOP maximum on mental health and substance use disorder benefits in the same classification.

[6] Parallel citations are ERISA § 733(c)(3)(B) and IRC § 9832(c)(3)(B). Such coverage is exempt from the requirements of PHSA Title XXVII (requirements relating to health insurance coverage), ERISA part 7 (HIPAA and other healthcare-related provisions), and IRC chapter 100 (group health plan requirements).

FAQ 11 modifies the earlier FAQ by clarifying that insurance labeled as fixed indemnity that provides benefits other than on a per-period basis may qualify as excepted benefits under current law. Specifically, group health coverage that does not meet the definition of fixed indemnity excepted benefits may nonetheless qualify as supplemental excepted benefits coverage if it supplements other group health plan coverage.[7] This type of coverage includes Medicare supplemental (or "Medigap") coverage, TRICARE supplemental coverage and "similar supplemental coverage" provided under a group health plan that is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles.[8]

In addition, according to FAQ 11, HHS intends to propose amendments to 45 CFR § 148.220(b)(3)[9] to allow fixed indemnity sold in the individual health insurance market to be considered an excepted benefit if it meets the following conditions:

- It is sold only to individuals who have other health coverage that is minimum essential coverage within the meaning of Section 5000A(f) of the Code.
- There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage.
- The benefits are paid in a fixed dollar amount regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to an event or service under any other health coverage.
- A notice is displayed prominently in the plan materials informing policyholders that the coverage does not meet the definition of minimum essential coverage and will not satisfy the individual responsibility requirements of Section 5000A of the Code.

If these requirements are satisfied, fixed indemnity insurance would no longer have to pay benefits solely on a per-period basis to qualify as an excepted benefit.

FAQ 11 notes that until HHS finalizes this change, HHS will treat fixed indemnity coverage in the individual market as excepted benefits for enforcement purposes if it meets the above conditions in states where HHS has direct enforcement authority. HHS also encourages states with primary enforcement authority to treat such coverage as an excepted benefit and will not consider a state to be not enforcing the individual market requirements if it does so.

Wellness Programs (FAQs 8-9)

The Departments issued final regulations regarding nondiscriminatory wellness programs on June 3, 2013.[10] Among other changes, these final regulations increased the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan from 20 percent to 30 percent of the cost of coverage and to 50 percent for wellness programs designed to prevent or reduce tobacco use. The final regulations also addressed

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7 This includes PHSA § 2722(c)(3) and 2791(c)(4), ERISA § 732(c)(3) and 733(c)(4), and IRC § 9831(c)(3) and 9832(c)(4).

8 26 CFR § 54.9831-1(c)(5), 29 CFR § 2590.732(c)(5) and 45 CFR § 146.145(c)(5).

9 This regulation addresses coverage only for a specified disease or illness (such as cancer), and hospital or other fixed indemnity coverage, as long as the coverage meets certain requirements regarding non-coordination of benefits.

10 For more in-depth information about the final wellness regulations, see Alston & Bird's Employee Benefits & Executive Compensation Advisory from October 23, 2013, at http://www.alston.com/advisories/ACA-update/.

reasonable design of health-contingent wellness programs and reasonable alternatives that must be offered to satisfy the rules. The new FAQs do not make any significant changes to these rules, but clarify the Departments' thinking on how often opportunities to enroll in the wellness plan must be presented, alternatives suggested by physicians and the language that must be provided to participants.

FAQ 8 confirms that if a participant is provided a reasonable opportunity to enroll in a wellness program (in the FAQ, tobacco cessation) at the beginning of a plan year and qualify for the award, the plan is not required to provide another opportunity to avoid any surcharge until renewal or reenrollment for coverage for the next plan year. However, a plan may choose to allow rewards, including pro-rated rewards, for mid-year enrollment in a wellness program.

FAQ 9 states that in the case of a participant whose physician deems an outcome-based wellness program to be medically inappropriate, the plan does not have to provide the specific alternative suggested by the physician. Instead, the plan must provide a reasonable alternative standard that accommodates the recommendations of the physician with regard to medical appropriateness. This FAQ notes that many programs may be reasonable for this purpose and a participant should discuss various options with the plan.

Finally, plans and issuers may modify the sample language provided in the final regulations provided that the notice includes all of the required content.[11]

Expatriate Health Plans (FAQs 6-7)

FAQ 1 of FAQs Part XIII provided guidance and transition relief regarding whether expatriate health coverage is subject to the ACA. The recent FAQs provide clarification on the definition of "insured expatriate health plan" and extend the transition relief for another year.

FAQ 6 provides that for purposes of this temporary transition relief, an insured expatriate health plan is an insured group health plan that limits enrollment to primary insureds for whom there is a good faith expectation that such individuals will live outside of their home country (or outside of the United States) for at least six months out of a year (not necessarily within a single plan year), along with any covered dependents. An insured expatriate health plan includes group health insurance coverage offered in conjunction with the expatriate group health plan. FAQ 6 also clarifies that the Departments will consider Title I, Subtitle D of the ACA to be satisfied if a plan and issuer of an insured expatriate health plan complies with the pre-ACA version of PHS Act Title XXVII; previous guidance had only mentioned ACA Title 1 Subtitles A and C. Finally, FAQ 6 notes that coverage provided under an insured expatriate health plan is generally considered to be minimum essential coverage under Code § 5000A.

Finally, the Departments state in FAQ 7 that any new regulation or guidance that is more restrictive with respect to plans or issuers will not be applicable to plan years ending on or before December 31, 2016, and plans may continue to rely on the temporary transitional relief of Part XIII, FAQ 1 at least through that time.

***This advisory was written by* John Hickman, Carolyn Smith *and* Stacy Clark.**

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[11] 45 CFR § 146.121(f)(6) (sample language), 45 CFR § 146.121(f)(3)(v) and (f)(4)(v) (required content for activity-only or outcome-based wellness programs, respectively). Additional sample language is located at 45 CFR § 146.121(f)(4)(vi).

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