

# P4P ... Preparing for PPACA

*Session #21:*

**Hot Topics and Recent Developments**

**March 20, 2013**



AMERICAN BENEFITS  

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COUNCIL

# Overview

## Recent Guidance

- “Employer Shared Responsibility” 4980H – dependent coverage rules
- 90-day waiting period limits – recent proposed regulations
- “Out-of-pocket” (OOP) cost-sharing limits – clarification and safe harbor
- Health reimbursement arrangements (HRAs) – FAQ clarifications
- Preventive services – FAQ clarifications
- Temporary relief – insured expatriate plans

## Looking Ahead...

# 4980H(a) – Offering Requirement

- Statute: Must offer MEC to all “full-time employees (and their dependents)”
- NPRM:
  - “Dependent” = child up to age 26, not spouse
  - “Child” = IRC section 152(f) child, which includes:
    - Biological child
    - Adopted child
    - Foster child
    - Stepchild



# 4980H(a) – Offering Requirement

- Issues/questions for employers:
  - How is the applicable large employer complying with the adult child coverage requirement?
  - Adopted: “[A] legally adopted individual of the taxpayer, or an individual who is lawfully placed with the taxpayer for legal adoption by the taxpayer”
    - Can “lawfully placed” occur prior to formal adoption?
  - Foster: “[An individual who is placed with the taxpayer by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction”
    - What if state law terminates foster status at age 18?



# 4980H(a) – Offering Requirement

- NPRM provides special transition rule
  - No penalty if applicable large employer “takes steps” in 2014 to implement offer of required dependent coverage



# 90-Day Waiting Period Maximum

- PHSA Section 2708, as amended by PPACA
- NPRM issued on Monday
  - Proposed to be effective for plan years on or after January 1, 2014; can rely for 2014
- Follows pretty closely prior IRS Notice 2012-59
  - Can rely for 2014
- Remember:
  - Applies whether non-grandfathered
  - Applies to all employees whether FT, PT
  - Applies to employers of all sizes
  - 4980H **will** trump otherwise valid plan eligibility rules



# 90-Day Waiting Period Maximum

- 90 days = 90 days (not 3 months)
- Waiting period = eligibility rule based solely on passage of time
  - Waiting period does not equal eligibility rules based on job classification, sales targets, etc.
  - But CANNOT be subterfuge for 90-day rule
- Compliance is based on whether the employee can elect coverage on 91<sup>st</sup> day



# 90-Day Waiting Period Maximum

- Certain hours-based eligibility rules are okay
  - cumulative hours-of-service rules
    - Must be based on working no more than 1,200 hours TOTAL
    - One-time application only, i.e., NOT per year
  - Other hours-based rules (e.g., 120 hours per month)
  - Regarding variable hour employees not expected at hire to work requisite hours: deemed in compliance if:
    - Employee is eligible for enrollment no later than 13+ months from hire
    - No waiting period is imposed after measurement period that exceeds 90 days (e.g., 8 month measurement period and 4 month waiting period, 1+ month for enrollment)





# 90-Day Waiting Period Maximum

- Special rule for issuers - issuers can rely on employer information if:
  - Require employer representation regarding eligibility terms and waiting periods
  - No specific knowledge of impermissible waiting period
- Existing waiting periods are extinguished once rule applies if > 90 days
- No need to issue certificates of creditable coverage after 2014



# Out-of-Pocket Limit Clarification and Safe Harbor

- PHSA § 2707(b), applicable to non-grandfathered employer-sponsored plans, limits out-of-pocket maximums and deductibles, effective January 1, 2014
  - Future guidance will provide that only plans and issuers in the small group market will be required to comply with the \$2,000/\$4,000 deductible limit
  - All non-grandfathered group health plans must comply with the annual limitation on out-of-pocket maximums of \$6,250 self-only/ \$12,500 family (the same amounts that apply under Code § 223 for high deductible health plans/HSAs)



# Out-of-Pocket Limit Clarification and Safe Harbor

- Only for the first plan year beginning on or after January 1, 2014 a plan who uses multiple service providers will be *deemed* to satisfy the out-of-pocket requirement if:
  - The plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); *and*
  - *To the extent* the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), such out-of-pocket maximum does not exceed the applicable dollar amount



# Out-of-Pocket Limit Clarification and Safe Harbor

## ➤ Open issues:

- Whether future guidance will limit the out-of-pocket rule to essential health benefits
- Whether the out-of-pocket rule will apply to in-network and out-of-network benefits in the same manner
- Whether any caps on benefits above \$6,250/\$12,500 will be permissible.



# FAQs Part XI

- Recent agency FAQ guidance (Part XI) threatens stand-alone HRAs
  - The Agencies concluded that a stand-alone HRA open for any 213 expense (an “open” HRA) is impermissible due to annual/lifetime cap prohibition
    - Only integrated open HRAs will be allowed
  - Agencies clarified that an open HRA used to purchase individual policy benefits does not satisfy the no-annual-cap prohibition because not integrated
  - The Agencies have further clarified what it takes for an HRA to be integrated



# Preventive Care Women's Health

- Under PHSA § 2713, non-grandfathered plans must cover “recommended” preventive services at 100% without cost sharing
- HHS adopted women's preventive care guidelines that non-grandfathered plans are required to cover at 100% for plan years starting on or after 8/1/12
  - Coverage for contraceptives has raised many questions
  - Clarification provided in FAQs issued on 2/20/13



# Preventive Care Women's Health

- Well-woman visits
- Screenings for gestational diabetes
- HPV testing
- Counseling for STDs
- Counseling & screening for HIV
- All-FDA approved contraceptive methods & counseling (exemption for certain religious employers)
- Breastfeeding support, supplies & counseling
- Screening & counseling for interpersonal & domestic violence



# Preventive Care Women's Health

- Plan must cover contraceptives for women at 100% (no male contraceptive coverage required)
  - Coverage for *generic* oral contraceptives rather than *brand* permissible, with exceptions
  - Must cover “full range” of FDA-approved methods, including barrier methods, hormonal methods and implanted devices
  - Must cover services related to devices (follow-up, management of side effects, counseling for continued adherence and removal)
  - OTC contraception items are only required to be covered if FDA-approved and prescribed





# Preventive Care Women's Health

- Administrative challenges
  - Application of reasonable medical management in limiting services (for example, must all pre-natal well women visits be covered? What limits on breast-feeding equipment and supplies are permissible?)
  - Physicians have discretion to determine additional visits necessary, generic birth control not appropriate, etc. and this must then be covered at 100%
  - Difficult to communicate evolving guidelines in SPD
  - “Clarifications” in law may require mid-year changes



# Other Recent Guidance

- Insured expatriate plans – FAQs (XIII)
- Temporary Transition Program fees – final rules
- “Whistleblower” Interim Final Regulations



# Looking Ahead

- Employer reporting under PPACA sections 6055 and 6056
- Possible changes to FSA use-or-lose rule
- MHPAEA final regulations – gun violence prevention initiative



# For more information: www.americanbenefitscouncil.org

The screenshot displays the American Benefits Council website. At the top, the logo and tagline "SHAPING THE WORLD OF CORPORATE BENEFITS POLICY" are visible. A navigation bar includes links for "ABOUT THE COUNCIL", "OUR ISSUES", "NEWS ROOM", "PUBLICATION LIBRARY", "RESOURCES", "CONTACT US", and "MEMBERS ONLY". A search bar and "Site Map/Index" link are also present. The main content area is divided into three columns: "SPOTLIGHT ON:" featuring a news item about PPACA Pay-or-Play Rules, "LATEST NEWS" with a summary of PPACA reporting requirements, and "JOIN US!" with membership information. Below this is a "FOLLOW US ON TWITTER" section. The "OUR ISSUES" section is highlighted with a red circle and lists categories: HEALTH (Health Care Reform (PPACA), General & Misc. Items), RETIREMENT (Defined Contribution/401(k) Plan Reform, Defined Benefit Plans & PBGC, Hybrid Plans, Financial Reform/Swaps, Investment Advice, Retirement Plan Administration, Miscellaneous Retirement), and OTHER ISSUES (Tax Reform, Deficit Reduction & Federal Budget, International Issues, Electronic Disclosure, Executive Compensation, Fiduciary Issues, Flexible Workforce/Worker Classification).

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**SPOTLIGHT ON:**

**PPACA Pay-or-Play Rules Released; Council Summary Available**

Treasury and IRS have issued [proposed regulations](#) and a set of [questions and answers](#) addressing the "shared responsibility" provisions for employers under the health care law. The Council's [comprehensive summary of the regulations](#) is now available.

[details ▶](#)

**LATEST NEWS**

**Summary of PPACA reporting requirements under tax code sections 6055, 6056**

Now available is the first part of the Council's [Benefits Brief summary](#), prepared by Crowell and Moring LLP, describing a number of new tax reporting requirements imposed by the Patient Protection and Affordable Care Act (PPACA).

This brief details these reporting requirements for employers, as well as additional obligations that apply as part of an exchange's enrollment of individuals in exchange-based coverage. Part Two of the series will cover the issuance of anticipated proposed regulations.

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**OUR ISSUES**

**HEALTH**

**Health Care Reform (PPACA), General & Misc. Items**

- Employer Shared Responsibility
- Market Reforms & Adult Child/Age-26 Coverage
- Preventive Care & Value-Based Design
- Quality Improvement & Delivery Reform
- Essential Benefits
- Tax & Revenue Issues
- Grandfathered Plans
- Claims and Appeals
- Summary of Benefits & Coverage
- Information Reporting/W2
- Health Insurance Exchanges
- State Innovation
- Medical Loss Ratio & Mini-Med Plans
- Automatic Enrollment

**RETIREMENT**

**Defined Contribution/401(k) Plan Reform**

- Automatic Enrollment
- Investments
- Plan fees
- Taxation of Retirement Plans/Limits

**Defined Benefit Plans & PBGC**

- Funding Reform
- PBGC Deficit & Premiums

**Hybrid Plans**

**Financial Reform/Swaps**

- Business Conduct Standards

**Investment Advice**

**Retirement Plan Administration**

**Miscellaneous Retirement**

**OTHER ISSUES**

**Tax Reform, Deficit Reduction & Federal Budget**

**International Issues**

- FACTA Issues
- FBAR Issues
- Puerto Rico Plans

**Electronic Disclosure**

**Executive Compensation**

- Non-Qualified Deferred Compensation
- Code Section 409(A), 457(A), 162(m) issues
- Say-on-Pay

**Fiduciary Issues**

**Flexible Workforce/Worker Classification**

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