P4P … Preparing for PPACA

Session #21:

Hot Topics and Recent Developments

March 20, 2013

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 91st 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