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May 2013 ACA Roundup

The end of April and beginning of May, 2013 have seen a variety of new significant pieces of ACA regulatory action.

Updated SBC FAQs and Template

The Departments of Labor, Health and Human Services, and the IRS ("the agencies") have jointly published a new set of FAQs regarding the Summaries of Benefit and Coverage ("SBC") which are applicable for coverage beginning on or after January 1, 2014, and before January 1, 2015. Among the updates are:

- An updated SBC template (available at http://www.dol.gov/ebsa/healthreform/index.html), which incorporates an additional clarification as to whether the plan provides "minimum essential coverage" and satisfies the "minimum value" standard.
- Employers can remove the line item regarding whether the plan has an Annual Limit as plans renewing on or after January 1, 2014 are no longer allowed to have annual limits.
- Extension of the SBC Safe Harbor – the Agencies are again going to give plan sponsors another year of relaxed SBC enforcement relief, acknowledging that the 2013 to 2014 transition is going to cause potential issues, and they are currently more concerned with assisting employers to get them into compliance than with enforcing penalties for non-compliance.

There were no other changes, and the Agencies acknowledged that if it is administratively burdensome to add the minimum essential coverage and minimum value lines to the SBCs for 2014, employers would not face enforcement penalties for failure to add them.

New 2014 HSA Plan Design and Contribution Limits

The annual COLA adjustments for HSA plan design parameters and contribution limits have been published.

2014 Limits	
Minimum Individual Deductible	$1,250
Minimum Family Deductible	$2,500
Maximum Individual Out-of-pocket Limit	$6,350
Maximum Family Out-of-pocket Limit	$12,700
Maximum Individual HSA Contribution	$3,300

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Maximum Family HSA Contribution	$6,550
Catch Up Contribution	$1,000

Of note here is the maximum out-of-pocket amounts, as these are also the maximum out-of-pocket limits that any group health plan can have starting on the first renewal on or after January 1, 2014.

As expected, the catch-up contribution for HSA account holders aged 55 and older has not changed.

Proposed Regulations on Minimum Value for Employer Shared Responsibility

In a rather technical publication, the IRS has clarified many of the issues employers face with respect to ensuring their group plans meet the required 60% actuarial Minimum Value ("MV") parameter of Shared Responsibility (the so-called play-or-pay mandate). Many of these proposed regulations are built from prior guidance issued in 2011 and 2012. The topics covered discussions on which populations and benefits are used to determine MV, how employer HSA and/or HRA contributions affect MV, the treatment of wellness incentives, and methods for determining the MV percentage.

Population and Benefits used to Determine MV Percentage

The proposed regulations would determine the MV Percentage using the anticipated spending for a standard population (developed by HHS based on typical self-insured health plans) and taking into account all benefits provided by the plan that are included in any one of the EHB-benchmark plans.

Determining MV Percentage

The guidance restates that employers must use the previously available MV calculator to help determine whether their plan meets the 60% requirement, but allows them to make adjustments based on any actuarial analysis of plan features that don't appear in the calculator. Alternatively, employers will be allowed to use a safe harbor plan design to meet the requirement. The final safe harbor designs were not published in this guidance – future guidance will include them – the preamble to the guidance did give three examples, as follows:

- $3,500 integrated medical and drug deductible, with 80 percent co-insurance, and a $6,000 maximum out-of-pocket limit.
- $4,500 integrated medical and drug deductible, with 70 percent co-insurance, a $6,400 maximum out-of-pocket limit, and an employer $500 contribution to an HSA.

- $3,500 medical deductible, $0 drug deductible, 60% co-insurance for medical expenses, 75% co-insurance for prescription drugs, a $6,400 maximum out-of-pocket limit, and drug co-pays of $10/$20/$50 for Tier 1, 2 and 3 drugs respectively, with 75% coinsurance for specialty drugs.

HSA and HRA Contribution Treatment

The guidance confirms that employer contributions to employee HSAs would count towards satisfying the MV percentage – that is, since HSA funds can be used to offset out-of-pocket medical expenses, those contributions in essence reduce the employee's exposure to expenses and therefore increases the plan's actuarial value.

HRA contributions that can be used only for reimbursement of medical expenses likewise increase the plan's actuarial value, while HRA contributions that are used to help pay an employee's premium contribution do help an employer satisfy the "affordability test" (the requirement that ensures the employer is making their plan available on an affordable basis to employees) but would not increase the plan's actuarial value.

Finally, the guidance states that additional regulations are anticipated that will help an employer determine whether their HRA is "integrated" with the health plan, a requirement for HRAs beginning in 2014.

Wellness Incentives

The guidance indicates that wellness programs that provide a premium reduction cannot take the premium reduction into account when measuring the plan's affordability, unless the premium reduction is the result of complying with an employer's smoking cessation program. In other words, if an employer sponsors a wellness program in which employees who participate (by completing a health risk assessment, for example) get a $50 monthly reduction in the cost of coverage, that reduced premium contribution cannot be used as the baseline to ensure that the employee did not spend more than 9.5% of their Box 1, W-2 wages on employee-only coverage. The only exception to this rule is if the reward is for participation in a program designed to reduce or prevent tobacco usage.

FAQs on Annual Limit Waivers, Clinical Trials, Health Care Provider Nondiscrimination, and Transparence in Coverage Reporting

This set of FAQs addresses specific issues that do not apply to all employers.

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Annual Limit Waivers

Some plans were granted special waivers in 2010 that allowed them to maintain an annual limit on certain benefits for plan or policy years that ended before January 1, 2014. This FAQ reiterates that the waivers were approved for the plan or policy year that was in place in 2010, and that changing the plan or policy year in 2013 (such as moving it to a December 2013 renewal) will ***not*** change the expiration date of the waiver.

Clinical Trials

This FAQ relates to the requirement that non-grandfathered plans cover an individual's participation in certain approved clinical trials, nor deny coverage of routine patient costs for items and services furnished in connection with the trial, or discriminate against an individual based on their participation in the trial. The Agencies have stated that they do not intend to issue new regulations until after January 1, 2014 on this requirement, and that employers are expected to follow a good faith, reasonable interpretation of the law with respect to this requirement.

Healthcare Provider Nondiscrimination

For plan or policy years beginning in 2014, employer group health plans and health insurers may not discriminate, with respect to plan participation or coverage, against any health care provider acting within the scope of that provider's license or certification under applicable state law. The FAQ explains that HHS does not intend to issue regulations before the provision's effective date and that until further guidance is issued, plans and insurers subject to the provision are expected to follow a good faith, reasonable interpretation of the law. The FAQ also reiterates that the provision does not require plans or insurers to accept all types of providers into a network, and it does not apply to provider reimbursement rates.

Transparency in Coverage Reporting

Under health care reform, health insurers seeking to offer qualified health plans (QHPs) in an Exchange (also known as a Marketplace) are required to report certain information (such as claims payment policies and practices) to governmental entities and make it available to the public. A comparable reporting requirement is also extended to employer group health plans and other health insurers. Because QHP insurers will not have certain required data (such as enrollment information) until the first year of operation of their QHPs, the FAQ clarifies that QHP insurers need not begin reporting until after a QHP has been certified for one benefit year. Furthermore, the FAQ adds that the reporting requirements will become applicable to other group health plans and insurers no sooner than when the QHP reporting requirement becomes effective.