compliance update

Introduction

On January 9th, 2014, the Department of Labor, Health and Human Services, and the IRS issued guidance in the form of a variety of Frequently Asked Questions, the 18th in a series of tri-agency guidance. These FAQs address a variety of issues as they relate to the Affordable Care Act ("ACA").

Preventive Care

The first FAQ deals with the requirement for employers to provide routine Preventive Care at no cost sharing to participants. Specifically, the ACA requires that non-grandfathered group health plans cover expenses of evidence-based services or items with an A or B rating in the current recommendations of the US Preventive Services Task Force. On September 24th, 2013, the USPSTF revised its B recommendation regarding medications for risk reduction of primary breast cancer in women. It now reads as follows:

> *"The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene."*

The ACA gives plans one year from the date of the change to implement the coverage – therefore, groups renewing on or after September 24, 2014, will have to incorporate these medications into its preventive care coverage without any cost sharing to the participant.

Cost Sharing Limits

The next four questions in the FAQ deal with the cost sharing limits that are applied to group health plans starting in 2014. The ACA limits group health plans maximum out of pockets to $6,350 for individual coverage, and $12,700 for any coverage other than individual coverage in 2014. Prior guidance allowed for an exception on these maximums in limited circumstances, which related to plans which used multiple service providers to track expenses, whose systems didn't tabulate the maximum out of pocket correctly.

The FAQs reiterate that the limited exception is only applicable for plan years in 2014, and that plans renewing on or after January 1, 2015 will have to strictly comply with the maximum out of pocket limits, even if multiple service providers are used.

The FAQs also confirm that out of network expenses do not have to be counted towards the maximum out of pocket, nor do they have to count expenses for non-covered items or services towards the maximum out of pocket. Finally, the agencies confirm that plans can have different maximum out of pocket limits on different categories of covered expenses, as long as the maximum out of pocket limit is not exceeded by any combination of expenses.

Expatriate Plans

Two FAQs are included with respect to Expatriate Plans, which had received prior transitional guidance from the agencies. The first gives clarification regarding what the agencies consider to be an expatriate plan:

> *"…an insured expatriate health plan is an insured group health plan with respect to which enrollment is limited to primary insureds for whom there is a good faith expectation that such individuals will reside outside of their home country or outside of the United States for at least six months of a 12-month period and any covered dependents, and also with respect to group health insurance coverage offered in conjunction with the expatriate group health plan. The 12-month period can fall within a single plan year or across two consecutive plan years."*

The second FAQ confirms that the agencies are still evaluating additional guidance regarding expatriate plans, and that any further guidance that is more restrictive than the current transitional guidance will not be effective for plan years that end on or before December 31, 2016.

Wellness Plans

Three FAQs regarding wellness plan details are provided in the guidance. While the questions are lengthy, the actual answers are straightforward. The first question deals with an employer who charges a tobacco surcharge, but offers a tobacco cessation program as well. Employees who complete the cessation program are given a discount on premiums. The scenario dealt with is an employee who initially declines to participate in the wellness program, but mid-year changes their mind and begins the cessation program. The FAQ confirms that the employer is not required in this scenario to provide the discount, as the employee didn't complete the required program throughout the year. Notably, the agencies confirm that an employer ***could*** offer the cessation program mid-year, or the discount mid-year, if they chose to, but they are not required to.

The second question deals with out-come based wellness programs and whether a participant's physician can deem the standard of obtaining the reward as inappropriate for the participant and recommend a different program. Reward-based wellness plans must accommodate for individuals for whom the standard for achieving the reward is not medically appropriate by their physician. The plan should work with the participant and the recommendation of the physician to determine an appropriate alternative.

The third question asks if plans and issuers are allowed to modify the sample language provided in the final regulations for Wellness Programs that satisfies the requirement of providing notice of the availability of a reasonable alternative standard. The FAQ confirms that "substantially similar language" can also be used to satisfy the notice requirement. It also continues to explain that the sample language provided to explain the details of a wellness program may also be modified, so long as all the required content is included as applicable.

Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that financial requirement and the treatment limitations placed on mental health and substance disorder benefits cannot be more restrictive that those of medical and surgical benefits. On November 13, 2013, the Departments published final regulations on MHPAEA to clarify and finalize the law's protections. The FAQ further clarifies the effect of the ACA on MHPAEA.

The ACA has made mental health and substance use disorder services one of the ten essential health benefits (EHB), thus supporting MHPAEA. Under the EHB rule, only small and individual non-grandfathered health plans had to comply with MHPAEA to satisfy the EHB requirement. The ACA, however, requires the whole individual market, both grandfathered and non-grandfathered plans, to comply with the protections of MHPAEA.

- **Non-Grandfathered Individual Market Coverage:** Policy years beginning on or after 1/1/2014, all non-grandfathered individual market plans that are not covered by the HHS transitional policy (which allowed states to extended individual and small group non-ACA compliant plans for an additional year) must have mental health and substance use disorder benefits that comply with the MHPAEA requirements that were issued in February 2010. The final regulations apply for policy years beginning on or after 7/1/2014.

- **Grandfathered Individual Market Coverage:** Grandfathered plans are still not subject to the EHB requirements and therefore are not required to cover mental health and substance use disorder benefits. However, to the extent that those benefits are covered, the coverage must comply with the requirements set forth in the final regulations for policy years beginning on or after 7/1/2014.
- **Non-Grandfathered Small Group Market Coverage:** Non-Grandfathered small group plans with plan years beginning on or after 1/1/2014 that are not covered by the HHS transitional policy must include mental health and substance use disorder benefits that comply with the interim MHPAEA guidance. Starting for plan years beginning on or after 7/1/2014, they must comply with the final regulations.

Grandfathered small group plans are not required to comply with either the EHB rule or MHPAEA.