



For your information[®]

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FAQs address OOP maximums, wellness benefits, expatriate plans and other ACA issues

The Departments have issued FAQs that address the implementation of several market reform provisions of the ACA, including out-of-pocket maximums, wellness programs, expatriate plans, and a new preventive care coverage requirement. The guidance includes significant new flexibility in allowing the out-of-pocket maximum to be split among coverages such as medical and prescription drugs. The guidance also expands the current transitional relief for expatriate plans, and extends the transition relief for an additional year. Employers will need to ensure that their health programs are in compliance with this new guidance.

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Background

On January 9, 2014 the Departments of Treasury, Health & Human Services (HHS), and Labor (the Departments) issued guidance in the form of [Frequently Asked Questions \(FAQs\)](#) on the implementation of the market reform provisions of the Affordable Care Act (ACA). This guidance addresses a wide ranging number of areas:

- Out-of-pocket maximums
- Wellness programs
- Expatriate plans
- New preventive coverage requirement
- Fixed indemnity insurance plans
- Mental health parity for individual and small group plans



Out-of-pocket maximums

Effective for plan years beginning on or after January 1, 2014, the ACA imposes annual out-of-pocket (OOP) maximums on the amount that an enrollee in a non-grandfathered health plan, including self-insured and large

group health plans, must pay for essential health benefits (EHB) through cost sharing. (See our [February 27, 2013 For Your Information](#).)

In 2014, the OOP limit is the same as the OOP limit for qualified high-deductible health plans (HDHPs) that are coordinated with health savings accounts (HSAs): \$6,350 for self-only coverage and \$12,700 for other than self-only. The 2014 limits will be indexed in future years. In [regulations](#) published on March 11, 2014, HHS has proposed 2015 OOP limits of \$6,600 for self-only coverage and \$13,200 for other than self-only. (Note that after 2014, these OOP limits will likely be different than those for HSA-qualified HDHPs.)

Previous guidance established a special transition rule for plans utilizing more than one service provider. For the first plan year beginning on or after January 1, 2014, such plans will be treated as satisfying the limit on out-of-pocket maximums if the following conditions are met:

- The plan complies with the out-of-pocket maximum for medical coverage (excluding, for example, prescription drug coverage).
- If the plan includes an out-of-pocket maximum on coverage that is not solely major medical coverage (for example, a separate maximum for prescription drugs), that out-of-pocket limit also complies with the maximums.

New guidance

The guidance confirms that the transition rule for plans that use more than one service provider only applies for the first plan year starting on or after January 1, 2014. However, the new guidance allows a plan's maximum OOP limit to be divided among different coverage categories of benefits so long as the combined amounts don't exceed the annual OOP limit. Importantly, the FAQ detailing this approach does not appear to be limited to plans with multiple service providers.

As an example, in 2014 a plan could have a \$3,000 self-only OOP maximum for medical benefits and a separate \$3,000 self-only limit for prescription drugs since the combined OOP of \$6,000 is less than the 2014 self-only limit of \$6,350. Note, a separate OOP limit for mental health and substance abuse benefits would violate the Mental Health Parity and Addiction Equity Act (MHPAEA).

The guidance also confirms that only expenses for EHB must be credited to the OOP maximum.

Buck comment. While self-insured and large group health plans are not required to cover EHB, these plans are prohibited from imposing annual or lifetime dollar limits on any EHB that are covered. Similarly, unreimbursed expenses for EHB may need to be credited to the OOP maximum. For example, if a plan wants to limit the coverage for services such as chiropractic care, acupuncture, autism, or infertility coverage, the plan may need to select a definition of EHB that does not include those services. The guidance confirms that a plan can use as a definition of EHB that "is one that has been authorized by the Secretary of HHS." One approach used by plans to define EHB is to select a state's definition of EHB. (See our [February 27, 2013 For Your Information](#).) This OOP guidance increases the need to define EHBs under a plan.

The FAQs confirm that cost sharing for the OOP limit includes:

- Deductibles, coinsurance, copayments, or similar charges for EHB
- Any other expenditure required that is a qualified medical expense under the Internal Revenue Code (Code) with respect to EHB covered under the plan

Cost sharing for the OOP limit does not include:

- Premiums
- Non-covered services
- Balance billing amounts for non-network providers
- Cost sharing for non-network providers

However, a plan can be designed to count any of the above expenses towards the OOP maximum.

Buck comment. Unaddressed in the guidance is the treatment of expenses, typically not credited towards the OOP limit, but incurred as a result of medical management techniques. Such expenses include increased costs imposed by the plan for using brand drugs instead of generic, using a retail pharmacy instead of mail order, failure to pre-certify hospital care, or failure to follow utilization management requirements. In prior guidance, HHS has stated that they “do not believe that the requirements pertaining to cost sharing would preclude issuers from engaging in reasonable medical management.” Additional guidance is needed.

Wellness programs

In June 2013 the Departments issued final regulations, effective for plan years starting on or after January 1, 2014, which implemented changes made by the ACA to wellness programs subject to the HIPAA nondiscrimination rules. (See our [July 16, 2013 For Your Information.](#))

New guidance

The FAQs provide additional guidance in several areas.

- A group health plan charges tobacco users, who do not enroll in a tobacco cessation program at the beginning of the plan year, a premium surcharge. If the group health plan provides participants with a reasonable opportunity to avoid the premium surcharge at beginning of the plan year, the plan is not required to offer participants another opportunity during the plan year to avoid the premium surcharge, and can require that participants wait until the next plan year. However, the plan can provide full or pro-rata rewards for mid-year enrollment in a wellness program.
- If a participant’s physician advises that an outcome-based standard is medically inappropriate for the participant, and recommends an activity-only program (e.g., weight reduction program) instead, the plan must provide a reasonable alternative standard that accommodates the physician’s recommendations

concerning medical appropriateness, but the plan has a say in which alternative program is provided. The guidance states that the “participant should discuss different options with the plan.”

Buck comment. While the discussion in the FAQs is specific to tobacco cessation and weight loss programs, the concepts discussed (mid-year enrollment and physician recommendations) should apply broadly to other wellness program designs.

- The final wellness regulations provided sample language for notifying participants of the availability of a reasonable alternative standard. The FAQs confirm that plans can modify the sample language to reflect the details of the specific wellness program as long as the notice includes all the required content from the regulations.

Expatriate plans

Recognizing the challenges that expatriate plans have in complying with many of the marketplace reform requirements of the ACA, in March 2013 the Departments issued guidance that provided a temporary exemption for insured expatriate plans from many of the ACA provisions for plan years ending on or before December 31, 2015. (See our [April 26, 2013 For Your Information](#).)

New guidance

This new guidance extends the temporary exemption by one year; to plan years ending on or before December 31, 2016. The guidance also states that the Departments will continue to consider “narrowly tailored guidance” that takes into account the ability of expatriate plans to comply with the ACA requirements. However, any new guidance that is more restrictive will not be applicable to plan years ending before 2017.

Expatriate plans that are eligible for the transition relief must:

- Be insured.
- Comply with the applicable requirements of ERISA, the Public Health Service Act, and the Code as in effect before the enactment of the ACA. This includes, for example, compliance with the Mental Health Parity and Addiction Equity Act, the HIPAA nondiscrimination rules, ERISA claims procedures, and any ERISA reporting and disclosure requirements.
- Limit enrollment to insureds for whom “there is a good faith expectation that such individuals will reside outside of their home country or outside the United States for at least six months of a 12-month period,

Required notice contents

A plan must disclose in all plan material describing a wellness program a notice of the availability of a reasonable alternative standard. The notice must include:

- The availability of a reasonable alternative standard to qualify for a reward, and if applicable the possibility of a waiver
- Contact information for obtaining a reasonable alternative standard
- A statement that the recommendations of an individual's personal physician will be accommodated

and any covered dependents.” The 12-month period can fall within a single plan year or across two consecutive plan years. (Prior guidance required the six months to be within a single plan year.)

Expatriate plans are minimum essential coverage

Coverage under an expatriate plan *is* generally considered “minimum essential coverage” for purposes of (1) determining employer satisfaction of the employer shared responsibility requirements (“play or pay” penalties), or (2) for satisfaction of the individual coverage mandate.

The March 2013 guidance exempted insured expatriate plans from many of the ACA requirements, including the prohibition of annual and lifetime dollar limits, coverage of preventive services with no cost sharing, and prohibition of pre-existing condition limitations. (See our [April 26, 2013](#) *For Your Information* for a list of additional exemptions.) The new guidance exempts expatriate plans from the following additional ACA requirements:

- Essential health benefit requirement
- Out-of-pocket maximum requirement
- Transitional reinsurance program and fees
- Risk adjustment and risk corridor programs

Preventive care services

The ACA requires all non-grandfathered health plans in the individual and group markets to cover preventive services without imposing cost-sharing requirements (e.g., copayments, coinsurance, or deductibles). In describing the types of preventive care that must be covered, the ACA uses guidelines developed by several different entities, including the United States Preventive Services Task Force (USPSTF). (See our [July 20, 2010](#) and [March 15, 2013](#) issues of *For Your Information*.) Plans are required to incorporate new preventive recommendations and guidelines made by the USPSTF and other federal agencies.

New guidance

On September 24, 2013, the USPSTF issued new recommendations for women who are at increased risk for breast cancer that included the prescribing of risk-reducing medications such as tamoxifen or raloxifene. The guidance confirms that for plan years beginning on or after September 24, 2014 (January 1, 2015 for calendar-year plans), non-grandfathered health plans are required to cover prescription medications designed to reduce the risk of breast cancer in women, without cost sharing, subject to reasonable medical management.

Fixed indemnity insurance

The ACA requirements generally apply only to group health plans that are subject to the HIPAA portability rules. Benefits that are excepted from HIPAA requirements are also excepted from the ACA's group health plan mandates and insurance market reforms. Therefore HIPAA excepted benefits — such as limited scope dental and vision plans, most health flexible spending arrangements (FSAs), and fixed indemnity plans — are not subject to the ACA's mandates and insurance reforms, including the prohibition on annual and lifetime dollar limits on EHBs.

Guidance released in January 2013 reiterated that for a fixed indemnity plan to be an “excepted benefit” it must pay a fixed dollar amount per day (or per other period) of hospitalization or illness, regardless of the amount of expenses incurred. The guidance noted an increase in the number of health insurance policies characterized as “fixed indemnity coverage” that base the amount of payment on the type of procedure or item (e.g., doctors’ visits covered at \$50 per visit, surgical procedures covered at different dollar rates per procedure, and/or prescription drugs covered at \$15 per prescription). The Departments stated that policies paying on a per-service basis are not hospital indemnity or other fixed indemnity coverage, and are therefore not excepted benefits. Such coverage would be subject to the ACA requirements including the prohibition on annual and lifetime dollar limits. (See our [February 21, 2013 For Your Information](#).)

New guidance

HHS intends to propose amendments to current regulations that will allow fixed indemnity coverage sold in the individual market that provides benefits on a per-service basis to be considered excepted benefits if the following conditions are met:

- It is sold only to individuals who have other health insurance coverage that is minimum essential coverage.
- There is no coordination between the provision of benefits and an exclusion of benefits under any other 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 mandate.

Until the rules are finalized, HHS will treat fixed indemnity coverage in the individual market meeting these requirements as excepted benefits in states where HHS has direct enforcement authority over the individual market. HHS also encourages states with primary enforcement authority over the individual market to treat this coverage as excepted benefits.

Fixed indemnity plans are not minimum essential coverage

Coverage under a fixed indemnity plan is not considered “minimum essential coverage” for purposes of (1) determining employer satisfaction of the employer shared responsibility requirements (“play or pay” penalties), or (2) for satisfaction of the individual coverage mandate.

Buck comment. Fixed indemnity and hospital indemnity plans are often offered as supplemental coverage by employers to employees enrolled in HDHPs with an HSA or health reimbursement account (HRA). However, coverage under a plan other than certain “permitted insurance” will cause an individual to become ineligible to contribute to an HSA. Permitted insurance includes fixed indemnity plans that provide benefits as a fixed amount per day (or per other period) of hospitalization. But permitted insurance does not include fixed indemnity plans that provide benefits on a per-service basis, and enrollment in that coverage would make the individual ineligible to make HSA contributions.

Mental health benefits

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally requires group health plans that offer mental health and substance use disorder benefits to cover those benefits on terms that are no more restrictive than they are for medical and surgical benefits. However, the MHPAEA does not require that health plans cover mental health and substance use disorder benefits. Final regulations under the MHPAEA were issued in November 2013 and generally become effective for plan years beginning on or after July 1, 2014. (See our [January 14, 2014 For Your Information.](#))

The ACA builds on the MHPAEA and requires that all non-grandfathered health plans in the individual and small group market cover mental health and substance use disorder services as one of the ten EHB categories. The ACA also extended the MHPAEA protections to the entire individual market, including both grandfathered and non-grandfathered coverage.

New guidance

The guidance clarifies the effect of the ACA on parity:

- ***Non-grandfathered individual and small group market coverage.*** For policy or plan years beginning on or after January 1, 2014 all non-grandfathered coverage must include coverage for mental health and substance use disorder benefits that complies with the MHPAEA requirements, unless the coverage is subject to the HHS transitional policy. If so, insurers are allowed to renew coverage in the individual and small group markets for 2014 that would not otherwise be legally compliant under the ACA. (See our [November 14, 2013 For Your Information.](#))
- ***Grandfathered individual market coverage.*** Grandfathered individual coverage is not subject to the EHB requirements and therefore is not required to cover mental health and substance use disorder benefits. However, to the extent that mental health and substance use disorder benefits are covered under the policy, coverage must comply with the MHPAEA requirements for policy years beginning on or after July 1, 2014.
- ***Grandfathered small group market coverage.*** Grandfathered small group market coverage is not subject to either the EHB or MHPAEA requirements.

In closing

Employers with non-grandfathered group health plans will need to comply with the new guidance on out-of-pocket maximums and preventive services. The out-of-pocket maximum guidance provides valuable design flexibility. But employers who have not done so already will need to select a definition of essential health benefits to administer the out-of-pocket maximum. The additional guidance on wellness programs and expatriate plans also provides further flexibility.

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