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DOL Issues New FAQ on Multiple Topics

The most recently issued guidance from the DOL comes in the form of another set of "Frequently Asked Questions" (FAQs). FAQ XVIII addresses several issues related to the Affordable Care Act as well as implementation requirements under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) for plans in the individual and small group insurance markets. The guidance, which covers a wide range of subjects, addresses or provides clarification on the following topics:

Preventive Services
Generally under healthcare reform, non-grandfathered health plans are required to cover certain preventive services without imposing cost sharing requirements. See our update FAQs on Preventive Services and our latest update Contraceptive Coverage Mandate – Religious Objection Update for more information on preventive services requirements under healthcare reform.

Current guidance requires plans to cover, among other items, "evidenced-based items or services that have a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued on or around November 2009, which are not considered current." As of September 24, 2013 the USPSTF has changed their "B" recommendation regarding drugs that reduce the risk of breast cancer in women. In accordance with this recommendation, effective for plan years that begin on or after September 24, 2013, non-grandfathered health plans in both the individual and group market will have to provide coverage for such medications without cost-sharing, subject to reasonable medical management, for women who are at an increased risk for breast cancer.

Cost-Sharing Limitations
Effective for plan years on or after January 1, 2014, health plans are required to comply with cost-sharing limitations on essential health benefits (EHBs). Conner Strong & Buckelew's update Deductible Limits and Out of Pocket Maximums Begin in 2014 provides information about the out-of-pocket (OOP) maximum rules. The guidance in the recently issued FAQ clarifies that:

- "Overall" limits apply to plan years beginning on or after January 1, 2015. As such, non-grandfathered group health plans and group health insurance coverage must have an OOP maximum which limits overall OOP costs on all EHBs. This means that if a plan sponsor has multiple health plans, e.g., a medical benefit and a separate prescription drug benefit, an aggregate OOP maximum will apply to these benefits.

- Plans that have multiple service providers may divide the annual limit on OOP cost across the multiple benefits so long as the combined OOP maximum does not exceed the respective limitations for the year, under the rules. This offers an alternative to plan sponsors, carriers or service providers having to reconcile claims between multiple service providers.
- OOP expenses for service performed out-of-network and cost for non-covered items or services (such as cosmetic services) are not required to count toward the annual OOP limit.

The FAQ clarifies that the term "cost sharing" includes deductibles, coinsurance, copayments, or similar charges, and any other expenditure required of an individual which is a qualified “medical expense” with respect to EHBs covered under the plan. The term "cost-sharing" does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services. Nothing, however, prohibits a plan or issuer from counting such expenses toward the plan's annual maximum OOP limit.

Expatriate Health Plans

Additional clarification is provided regarding the definition of an insured expatriate plan for purposes of the temporary transitional relief available for certain expatriate plans. Details on the temporary relief were initially addressed in FAQ XIII. It’s confirmed in the FAQ that the Departments continue to consider providing additional guidance regarding insured expatriate plans, and to the extent that the new guidance is more restrictive than the guidance provided in FAQ XIII, the new guidance will not apply until the first plan year beginning on or after December 1, 2017.

Wellness Program

In June of 2013, the Department of Health and Human Services (HHS) issued new wellness rules effective for plan years beginning in 2014. Under the wellness rules, health contingent wellness programs (when the reward is based on satisfying a standard related to a health factor) must offer an alternative standard (or waiver) for participants unable to meet the standard. The new FAQ clarifies some of the new rules and provides that:

- Plans are not required to (but may) offer another alternative standard if a participant failed to meet an earlier alternative standard. In the example provided in the FAQ, under a wellness program in which smokers pay a premium surcharge, an opportunity to enroll in the tobacco cessation program (an alternative standard) was offered at the beginning of the plan year. A participant who is a tobacco user declined to participate in the tobacco cessation program but joined the program later in the plan year. The FAQ confirms that as long as the participant had a reasonable opportunity to enroll in the cessation program to qualify for the reward, the plan is not required to offer another opportunity to qualify for the reward in the same plan year. It is noted in the guidance that “nothing, however, prevents a plan or issuer from allowing rewards (including pro-rated rewards) for mid-year enrollment in a wellness program for that plan year.”
- In situations where a participant must meet a standard to qualify for a reward and the participant’s physician suggests an alternative standard, the plan must provide a reasonable alternative standard to accommodate the recommendations of the individual’s physician, but the plan may work with the participant in determining an appropriate alternative standard.
- Plans are permitted to alter the sample language provided in the final regulations regarding the notice of the availability of a reasonable alternative standard that must be disclosed to

plan participants under a health contingent wellness program. Modified language must still meet the content requirements described in the final regulations.

Fixed Indemnity Insurance

Current regulations provide that fixed indemnity plans under a group health plan that meet certain conditions are excepted benefits and as such do not have to comply with the provisions of healthcare reform. According to the DOL, this guidance has led to a "significant increase in the number of health insurance policies labeled as fixed indemnity insurance." Previously issued guidance (FAQ XI. question 7) reiterated that fixed indemnity policies must pay on a per-period basis and not on a per-service basis to be considered an excepted benefit. The latest guidance adds that insurance labeled as a fixed indemnity insurance that provides benefits other than on a per-period basis, may still qualify as an excepted benefit. Coverage that supplements other group health coverage, that does not meet the definition of fixed indemnity excepted benefits, may still qualify as a supplemental excepted health benefit. The FAQ refers readers to multiple governmental publications for more information on this complicated topic. The FAQ also explains that HHS intends to propose amendments that would allow fixed indemnity coverage sold in the individual market to be considered an excepted benefit if it meets the conditions outlined in the FAQ.

Mental Health Parity and Addiction Equity Act of 2008

In November 2013, final regulations on the MHPAEA were published which contained clarification on some provisions within the Affordable Care Act. See our update Final Mental Health Parity Rules Released for more information on the final regulations. Under healthcare reform, mental health and substance use disorder benefits are considered essential health benefits (EHBs), and non-grandfathered plans in the individual and small group markets are required to comply with the MHPAEA rules to satisfy the requirement to provided EHBs. General requirements under the MHPAEA for both non-grandfathered and grandfathered plans in the individual market as well as non-grandfathered plans in the small group market are described in the recently issued FAQ. Grandfathered plans in the small group market are not required to comply with the EHB provisions of healthcare reform or the MHPAEA.

Employers should carefully review the FAQs to determine if any of the guidance affects their plan design, benefit offerings, or administrative practices. If changes to the plan will occur as a result of the recently issued guidance, steps should be taken to properly document and communicate such changes if required.

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