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Newly Released FAQs on Healthcare Reform Issues

The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (Departments) jointly released a new series of Frequently Asked Questions (FAQs) addressing a variety of issues under the healthcare reform law, including questions about the out-of-pocket maximum, tobacco cessation programs, the treatment of health FSAs as excepted benefits, and an extension of enforcement relief for summaries of benefits and coverage (SBCs). See also our recent Update for information on the FAQs on COBRA Notice issues.

Limitations on Cost-Sharing: Effective for plan years on or after January 1, 2014, non-grandfathered health plans are required to comply with cost-sharing limitations on essential health benefits (EHBs). For plan years beginning in 2014, the annual limitation on out-of-pocket (OOP) costs is $6,350 for self-only coverage and $12,700 for coverage other than self-only coverage ($6,600 and $13,200 for 2015). Previous FAQs provided guidance on OOP maximums. The new FAQs address additional questions about OOP maximums.

- If an out-of-network (OON) provider charges an amount greater than the plan's allowed amount, a plan may count individual spending for the amount in excess of the allowed amount counted toward the OOP maximum. For example, if the plan covers 75% of the usual, customary, and reasonable amount (UCR) charged for services provided OON, and the participant pays the remaining 25% of UCR, plus any amount charged by the OON provider in excess of UCR, the 25% of UCR paid by the participant may reasonably be counted, in full or in part, toward the OOP maximum without including any amount charged above UCR paid by the participant.
- Large group market coverage and self-insured group health plans have discretion to define “essential health benefits” (EHBs), and may, for example, include only generic drugs, if medically appropriate and available, while providing a separate option (not as part of EHBs) of electing a brand name drug at a higher cost sharing amount. If, under this type of plan design, a member selects a brand name prescription drug in circumstances in which a generic was available and medically appropriate, the plan may provide that all or some of the amount paid by the member—such as the difference between the cost of the brand name drug and the cost of the generic drug—does not have to be counted towards the annual OOP maximum. For ERISA plans, the SPD must explain which covered benefits will not count towards an individual's OOP maximum.

Preventive Services - Tobacco Cessation programs: Generally under healthcare reform, non-grandfathered health plans are required to cover certain preventive services without imposing cost-

sharing requirements with respect to, among other things, services recommended by the U.S. Preventive Services Task Force (USPSTF). If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan can use reasonable medical management techniques to determine any such coverage limitations.

Among other things, the USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. According to the Departments, since evidence-based clinical practice guidelines can provide useful guidance for plans in determining coverage limitations, the Departments will consider a group health plan to be in compliance with the requirement to cover tobacco use counseling and interventions, if, for example, the plan covers, without cost-sharing:

- screening for tobacco use; and
- for those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for (a) four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization, and (b) all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Carryovers and Treatment of Health FSAs as Excepted Benefits: Most health FSAs are “excepted benefits” and are generally exempt from the Code's and ERISA's group healthcare plan requirements. Health FSAs generally constitute excepted benefits if the employer also makes available group health plan coverage that is not limited to excepted benefits for the year to the class of participants by reason of their employment, and the FSA is structured so that the maximum benefit payable to any employee participant in the class cannot exceed two times the employee's salary reduction election for the year, or if greater, cannot exceed $500 plus the amount of the participant's salary reduction election. The Departments recently modified the “use-or-lose” rule for health FSAs to allow, at the plan sponsor's option, participating employees to carry over up to $500 of unused amounts remaining at year-end in a health FSA to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year, provided that the plan does not also incorporate a grace period. The guidance also provided that the carryover does not affect the $2,500 maximum amount of salary reduction contributions that the participant is permitted to make.

The recent FAQ clarifies that unused carryover amounts remaining at the end of a plan year in a health FSA that satisfy the modified "use-or-lose" rule should not be taken into account when determining if the health FSA satisfies the maximum benefit payable limit prong under the excepted benefits rules.

Summary of Benefits and Coverage: Health plans must provide a summary of benefits and coverage (SBC) to members, using templates, instructions, and related materials authorized for implementing this disclosure requirement. On February 14, 2012, the Departments issued final regulations regarding the SBC. At the same time, the Departments published a notice announcing the availability of templates, instructions, and related materials authorized for implementing the disclosure provisions for the first year of applicability (for coverage beginning before January 1, 2014). An updated SBC template (and sample completed SBC) was made available in April 2013 for the second year of applicability. The new FAQs clarify that until further guidance is issued,

these updated SBC documents continue to be authorized. There are no changes to the uniform glossary or the "Why This Matters" language for the SBC. There are also no changes to the Instructions for Completing the SBC.

The new FAQ also clarifies that the Departments' basic approach to implementation, as stated in a previous FAQ, is: "[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. The Departments' approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law."

Employers should carefully review the FAQs to determine if any of the guidance affects their plan offerings. 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. Please contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220 with any questions. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.