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REFORM Update

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Frequently Asked Questions (FAQs) were jointly prepared by the Departments of Labor, Health and Human Services, and Treasury (the Departments). The FAQs address a host of issues, including:

- New model COBRA notices
- Maximum out-of-pocket limits
- Coverage for preventive services
- Health flexible spending account (FSA) carryover and excepted benefits
- Summary of Benefits and Coverage (SBC) update

The FAQs were released to help all stakeholders understand the issues related to compliance with the various aspects of the Affordable Care Act (ACA).

New Model COBRA Notices

The Marketplace has brought a viable and perhaps less expensive coverage alternative to COBRA. However, COBRA-qualified beneficiaries are limited in when they can elect this coverage.

An individual who loses coverage as a result of a qualifying event will have the opportunity to elect Marketplace coverage within 60 days of the event. If the qualified beneficiary elects COBRA coverage instead, he or she can enroll in Marketplace coverage only during open enrollment for the Marketplace or when the maximum COBRA benefit period has been exhausted.

In 2013, the Department of Labor (DOL) amended the model COBRA election notice to add a paragraph explaining that the Marketplace may offer an affordable alternative to COBRA. This model language, however, did not communicate the specific rules that apply to Marketplace elections and COBRA coverage. As a result, the DOL released new model notice language for both the general notice and the election notice.

The general notice was previously called the initial COBRA notice. It must be furnished to each covered employee and covered spouse within 90 days of when coverage begins. (An earlier date may be required if a plan participant experiences a COBRA-qualifying event and the election notice is due before the end of the general notice's delivery timeframe.)

Employers are not required to use the model general notice. They can also modify it as they deem necessary. However, COBRA requires that certain elements be included in the general notice:

- The name of the plan, and the name, address and telephone number of someone whom the employee or spouse can contact with questions

- A general description of the continuation coverage available under the plan
- An explanation regarding how qualified beneficiaries should notify the plan of qualifying events or disabilities
- An explanation of the importance of keeping the plan administrator informed of current addresses
- A statement that the general notice does not fully describe COBRA and more information is available from the plan administrator or the plan's summary plan description (SPD)

Most employers will use the model notice language, but may modify it for their employees.

A new model election notice was also provided. The election notice offers the details of COBRA when an individual loses coverage and experiences a qualifying event.

The employer has 30 days to notify the plan administrator of a COBRA-qualifying event. The election notice must be provided within 14 days after the plan administrator receives notification of the event. The election notice is required to include:

- The name of the plan, and the name, address and telephone number of plan's COBRA administrator
- The qualifying event
- The qualified beneficiaries (by name or by status)
- An explanation of the qualified beneficiaries' right to elect COBRA coverage
- The date coverage will terminate if COBRA is not elected
- Instructions on how to elect COBRA coverage
- What will happen if COBRA is not elected or COBRA rights are waived
- What coverage is available for COBRA continuation, how long coverage can be continued and how it may be extended for disability or secondary qualifying events
- How COBRA coverage may be terminated prior to the maximum benefit period
- Premium payment rules including due dates and grace periods
- A statement of the importance of keeping the plan administrator informed of the current addresses of all qualified beneficiaries
- A statement that the election notice does not fully describe COBRA and more information is available for the plan administrator or the plan's summary plan description (SPD)

Both the model general and election notices were revised in early May. They now explain, in greater detail, the new coverage options available in the Marketplace and their interaction with COBRA.

Employers can find copies of the model notices at www.dol.gov/ebsa/cobra.html.

Maximum Out-Of-Pocket Limits

Non-grandfathered group health plans are subject to maximum out-of-pocket limits effective on the first day of the first plan year beginning on or after January 1, 2014. The out-of-pocket maximums are indexed annually. The amounts for 2014 and 2015 are as follows:

	2014	2015
Single	$6,350	$6,600
Family	$12,700	$13,200

The tricky part of the maximum out-of-pocket limits is that all cost-sharing associated with essential health benefits must accumulate toward the maximum.

These FAQs addressed unusual situations and what amounts should be credited to the annual out-of-pocket maximum:

- The FAQs reaffirm that network plans are not required to count out-of-network services toward the out-of-pocket maximum. However, a plan that chooses to count out-of-network services in the out-of-pocket maximums may use any reasonable method to determine the approved amount for out-of-network services. For example, they can base the credit for out-of-network services on the reasonable and customary fee percentage. In cases where the provider sets an approved amount for out-of-network services, the approved amount can be used to determine cost-sharing. Plans are not required to count balance-billed amounts toward the out-of-pocket maximum if expenses incurred outside the network accumulate toward that maximum.
- Medical management programs have created confusion regarding what cost-sharing amounts should apply toward the out-of-network maximum. For example, it is common for a plan to include programs that strongly encourage the use of generic drugs. A plan may cover only generics when one is available and medically appropriate (as determined by a member's physician). The plan may cover a brand if it is medically necessary for a patient to use a brand instead of a generic prescription. In some cases, a patient may choose a brand and then pay the difference in cost between the generic and brand medications. In this situation, a plan is not required to apply the cost difference to the out-of-pocket maximum. The plan document must clearly explain which out-of-pocket costs will count toward the annual maximum. A plan must apply cost-sharing associated with essential health benefits. In this situation, a plan would list the option of a generic medication as an essential health benefit. A voluntary choice to select a brand drug would not be included as an essential health benefit.
- Some plans have adopted a reference-based pricing strategy to control costs. In this approach, plans set a fixed payment amount for a particular service, such as a knee replacement. The plan looks at the range of possible prices for the procedure and sets a maximum payment based on a prevailing price and quality incentives. A number of providers will accept the reference-based amount as payment in full. Others may not, and a balance-bill situation may occur for an essential health benefit. The Departments are looking for suggestions on how to handle this situation, in terms of what should be applied to the out-of-pocket maximum. For now, employers can apply the reference-based price to the out-of-pocket maximum.

The out-of-pocket maximum rules seem fairly straightforward. However, when a plan moves away from standard fee-for-service payment models, it gets more difficult to determine what should be applied to the out-of-pocket maximum.

Coverage for Preventive Services

Non-grandfathered health plans are required to cover specified preventive services with no member cost-sharing. The list of required preventive services is determined by the recommendations of a number of governmental agencies. One of the recommendations is that clinicians ask all adults about tobacco use. The clinician should provide tobacco cessation interventions to assist patients in quitting tobacco use.

Health plans were not sure what was meant by tobacco cessation interventions. The FAQs provide an example of a program that would meet the requirements:

1. Screening for tobacco use
2. For tobacco users, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt would include:
    a. Four tobacco cessation counseling sessions of at least 10 minutes' duration. Sessions can be telephonic, or individual or group counseling. Prior authorization cannot be required.
    b. All FDA-approved tobacco cessation medications (including both prescription and over-the-counter options) for a 90-day treatment regimen when prescribed by a health care provider. Prior authorization cannot be required.

The above services must be covered with no member cost-sharing to meet the preventive services requirement for non-grandfathered plans. Employers can always be more generous in covering therapies that help employees quit tobacco use.

Health FSA Carryover and Excepted Benefits

Excepted benefits are not subject to a host of regulations, including certain requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the ACA. Health FSAs are considered excepted benefits if they satisfy the following requirements:

1. The employer offers a group health plan that does not limit coverage to excepted benefits and is available to the same participants as the health FSA.
2. The arrangement is structured so that the maximum benefit payable to any plan participant cannot exceed:
    a. Two times the employee's salary reduction election for the plan year ***and***
    b. If greater, cannot exceed $500 plus the amount of the participant's salary reduction election

The FAQs address the new rules allowing a $500 year-end rollover from an FSA. They advise that the $500 rollover does not offset the annual $2,500 statutory maximum. They also confirm that the rollover amount is not used in determining if a health FSA is considered an excepted benefit. The rollover amount **would not be** used to calculate the maximum benefit payable as indicated above in the second bullet.

Summary of Benefits and Coverage (SBC) Update

An updated SBC template was made available to employers in April 2013. The new template was addressed in our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2013/Reform_Update_65.pdf.

These FAQs state that employers can continue to use the current template. They have made no changes to the template for 2014. The FAQs also advise that if a plan cannot reasonably describe benefits in a manner consistent with the template and instructions, the plan must still make their best effort to describe the benefits in a manner consistent with the template.

The FAQs extend the transitional relief that recognizes good faith compliance efforts. This means the Departments will enforce these rules with an emphasis on assisting group health plans, rather that imposing penalties. It is critical for plans to make good faith compliance efforts and not ignore the SBC requirement.

Concluding Thoughts

The government continues to provide useful, practical information to help employers comply with the many aspects of the ACA. Most employers will have to take action based on these new FAQs:

- Employers will need to update both the COBRA general notice and election notice to include more detail on health plan options in the Marketplace. If your plan uses a COBRA vendor, make sure the vendor is updating your plan notices with the new information.
- Employers should review how their health plan vendors are crediting various services to the out-of-pocket maximum. Most plans have medical management programs attached to the prescription drug benefit. It makes sense to question what cost-sharing amounts are being applied to the out-of-pocket maximum.
- Most health plans did not take action on covering tobacco cessation as a preventive care service. These FAQs clarify the minimum level of coverage that should be provided by non-grandfathered health plans.

Employers should continue to comply in good faith with the provisions of the ACA. The Departments will continue to release FAQs to clarify issues for employers.