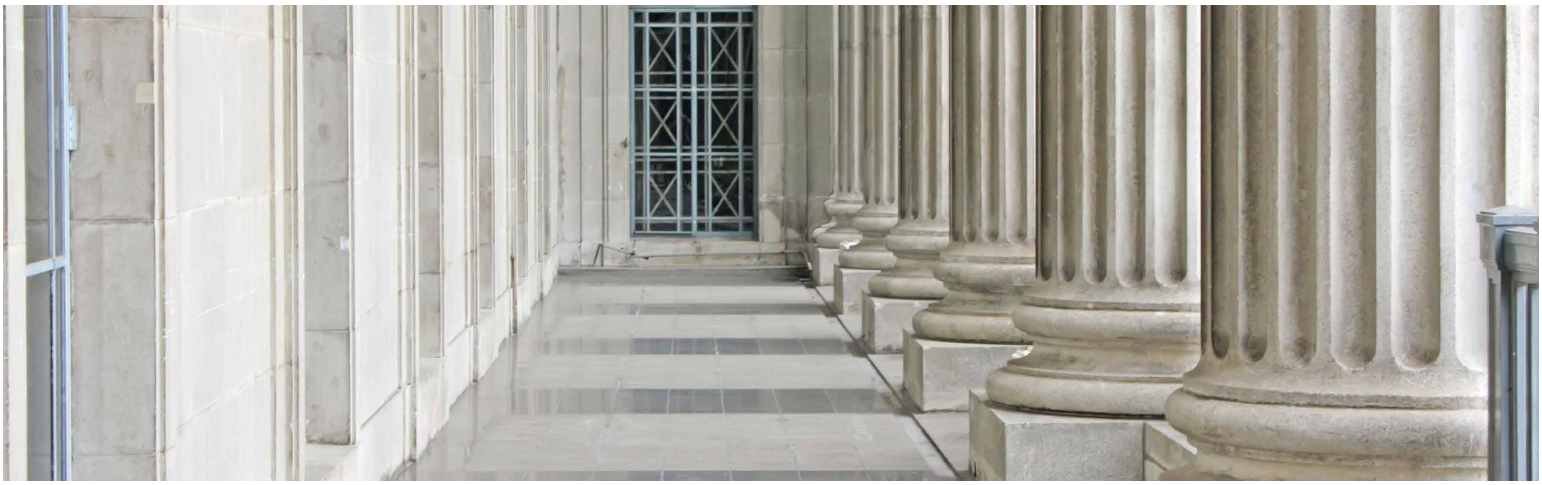
EMERSON, REID & Co.

Health Reform Update

Guidance Released on Several Health Care Reform Provisions



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The Departments of Labor, Health and Human Services and the Treasury issued guidance in the form of a final rule, and Frequently Asked Questions about certain provisions of the Affordable Care Act. Below are some of the highlights:

Cost-Sharing Limits

The ACA provides that for plan years beginning on or after January 1, 2014, group health plans may not impose cost-sharing that exceeds certain limitations for deductibles and out-of-pocket maximums. Specifically, the preamble to prior regulations states that the annual limit on deductibles of $2,000 for individuals and $4,000 for families for non-grandfathered insured health plans only applies to plans and issuers in the small group market. The preamble was silent as to out-of-pocket maximums. The final rule and FAQs confirm the following:

- The annual deductible limits under the ACA apply only to non-grandfathered plans and qualified health plans offered in the small group market. A plan may exceed the annual deducible limit if it cannot reasonably reach a given level of coverage (metal tier) without exceeding the deductible limit. This requirement does not apply to grandfathered plans, large insured plans or self-insured plans, although the Agencies acknowledge that they intend to engage in future rulemaking to establish annual deductible limits for self-insured and large group health plans.
- All non-grandfathered group health plans must comply with the ACA's annual limits on out-of-pocket maximums. These limits are the same as qualified high-deductible health plans (for 2013, these limits are $6,250 self-only/$12,500 family). Amounts will be adjusted annually for inflation. This requirement applies to all non-grandfathered plans, including large employer group health plans and self-insured plans.

Minimum Value Calculator

An employer-sponsored plan provides a minimum value if the percentage of total allowed costs of benefits provided under the plan is no less than 60%. Consistent with previous guidance, the final rule will allow an employer to use the following tools to determine minimum value:

- A minimum value calculator, recently made available for informal external testing and use. For the minimum value calculator, instructions and methodology, visit http://cciio.cms.gov/resources/regulations/index.html. If necessary, the Department of Health and Human Services will issue a revised version of the calculator.
- Any safe harbor the agencies make available. It is expected that an array of design-based safe harbor checklists will be released and can be used to determine whether the plan provides a minimum value.

- An actuarial determination if the plan contains non-standard features that are not suitable for either of the above tools. Any actuarial determination must be made by a member of the American Academy of Actuaries.

The minimum value calculator provides an empirical estimate of the actual average spending by a wide range of consumers representative of those currently enrolled in self-insured plans. Once the date is entered, the calculator reports two things: whether the coverage provides a minimum value, and the value of the coverage for the minimum value purposes (e.g., a 60% minimum value, a 75% minimum value).

Employer contributions to an HSA and contributions newly made available under an integrated HRA may be used in the determination of minimum value. There is an option in the minimum value calculator to enter the employer's HSA and HRA contributions.

Some preliminary testing of the tool has shown that the vast majority of "common" employer plan designs will satisfy the minimum value requirement. We expect further guidance on this.

Preventive Coverage

Non-grandfathered group health plans and health insurance carriers offering group health insurance coverage must provide coverage for in-network preventive items and services and may not impose any cost-sharing requirements (such as copayment, coinsurance or deductible) with respect to those items or services. The preventive items and services can be found at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. The Departments published FAQs related to this health care reform requirement. Several things to note from the FAQs are:

- If a plan does not have any in-network providers to provide a particular preventive service, it cannot impose cost-sharing.
- Aspirin and other over-the-counter recommended items and services must be covered without cost-sharing only when prescribed by a health care provider.
- Contraceptive methods that are generally available over-the-counter, such as contraceptive sponges and spermicides are only required to be covered without cost-sharing if the method is both FDA-approved and prescribed for a woman by her health care provider.

- There is no required coverage relating to a man's reproductive capacity, such as for vasectomies and condoms.

For more in depth information about preventive coverage, visit the FAQs at http://www.dol.gov/ebsa/faqs/faq-aca12.html.

Expatriate Plans

The Departments recognize that expatriate group health plans may face special challenges in complying with certain provisions of the reform and have offered them transitional relief in the form of a Frequently Asked Question. An "expatriate health plan" is defined as an insured group health plan with respect to which enrollment is limited to primary insureds who reside outside of their home country for at least 6 months of the plan year and any covered dependents, and its associated group health insurance coverage.

The Departments have determined that, for plans with plan years ending on or before December 31, 2015, with respect to expatriate health plans, the Departments will consider the following requirements satisfied:

- No lifetime or annual limits
- Prohibition on rescissions
- Coverage of preventive health services
- Extension of dependent coverage
- Summary of benefits and coverage
- New nondiscrimination rule
- Quality of care reporting
- Medical loss ratios
- New appeals process
- Small group rate review
- Prohibition of preexisting condition exclusions
- Community rating for small group
- Guaranteed availability and renewability of coverage
- Essential health benefits package
- Prohibition on excessive waiting periods

Expatriate health plans must, as a condition of this transitional relief, comply with the pre-health care reform laws such as the mental health parity provisions, the HIPAA nondiscrimination provisions, the ERISA claims procedures, and any reporting and disclosure obligations under ERISA. The Departments note that coverage provided under an expatriate group health plan is a form of minimum essential coverage.

We will continue to advise you as further guidance develops.