UBA PPACAAdvisor

Additional PPACA Details Released

On January 9, 2014, the Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Department of the Treasury (IRS) issued Frequently Asked Questions - Part XVIII that provides additional information about requirements in several areas.

Preventive Care

The requirement that non-grandfathered plans provide first dollar coverage at 100% includes a provision to update the list of services that must be covered. The FAQ announces that because the United States Preventive Services Task Force (USPSTF) now recommends that breast cancer risk-reducing medications, such as tamoxifen or raloxifene, be prescribed for women who are at increased risk for breast cancer and are at low-risk for adverse medication effects, those medications (which can be expensive) must be covered at 100% beginning with the first plan year that starts on or after September 24, 2014, (starting January 1, 2015, for calendar year plans).

The FAQ also clarifies that a plan may use reasonable limits on the frequency (but not the dollar amount) of preventive care that it will cover. If the USPSTF recommendations include a frequency, those guidelines should be followed. If there is no guideline, the insurer or health plan may impose a reasonable frequency limit.

Out-of-Pocket Limits

The FAQ clarifies that, for non-grandfathered plans, the out-of-pocket maximum:

- Must include deductibles, coinsurance and copayments for essential health benefits (EHBs). A plan may exclude benefits that are not EHBs from the out-of-pocket maximum if it wishes.
- Need not include premiums, costs for non-covered services, or costs for out-of-network services, although it may if it wishes.
- May be separated into different out-of-pocket maximums for different categories of services, but the total of all the separate out-of-pocket maximums cannot exceed the out-of-pocket maximum allowed by the Patient Protection and Affordable Care Act (PPACA), which is $6,350 for self-only coverage or $12,700 for family coverage for 2014.
  - This option may be helpful for plans with multiple vendors.
  - This technique may not be used to create a separate out-of-pocket maximum for mental health services because that would violate the Mental Health Parity Act (MHPA).

The FAQ also verifies that, to the extent a large group insured plan or a self-funded plan must consider EHBs, it may use any state's EHB benchmark plan. (Large group insured plans and self-funded plans do not have to offer coverage for the 10 EHBs, but they cannot impose lifetime or annual dollar limits on EHBs.)

Wellness Programs

The FAQ states that a plan that offers an annual opportunity to receive an incentive for non-use of tobacco is not required to offer a mid-year opportunity for an individual who was offered, but declined the original opportunity. For example, Jones Co. offers a non-smoker discount and an opportunity for smokers to enroll in a smoking cessation program for the next calendar year. Mary and John are both smokers. They decline to enroll in the smoking cessation program. John quits smoking in July and Mary asks to enroll in the non-smoker program in August. Jones Co. is not required to give John the non-smoker rate for the rest of the year (although it may if it wishes, on either a full or pro-rata basis). Jones Co. does not need to offer the non-smoker program, or the discount, to Mary (although it may if it wishes, on either a full or pro-rata basis).

The FAQ also says that if an employee's doctor states that an outcomes-based reasonable alternative is medically inappropriate for the employee, and the doctor suggests an activity-based alternative instead, the employer must accept the suggested alternative but has leeway on how the alternative is implemented. For example, Rachel exceeds the plan's body mass index (BMI) standard, and the plan's usual reasonable alternative is a percentage reduction in BMI. If Rachel's doctor advises that the reduction in BMI is medically inappropriate and suggests a weight reduction program instead, the plan must accommodate the weight loss program request, but it does have a say in which weight loss program Rachel must complete.

Mental Health and Substance Abuse Disorders

Coverage for mental health and substance use disorder services are an EHB, so non-grandfathered individual and small group policies must offer coverage for these services. Prior to PPACA, plans were not required to cover mental health and substance abuse, although the MHPA requirements applied to plans that offered this coverage. To coordinate the requirements of these two laws, the FAQ provides that plans that must offer EHBs need to offer coverage for mental health and substance use disorders beginning with the 2014 plan year, and that the EHB coverage must satisfy the applicable mental health parity rules. This will change slightly starting with the first plan year beginning on or after July 1, 2014, or as of January 1, 2015, for calendar year plans.

Expatriate Plans

Insured expatriate plans do not need to comply with most PPACA provisions. The FAQ clarifies that a plan is considered an insured expatriate health plan if enrollment is limited to employees and their covered dependents who are expected to reside outside of their home country or outside of the United States for at least six months of a 12-month period. The 12-month period can fall within a single plan year or across two consecutive plan years. Expatriate plans generally will satisfy requirements to obtain or offer minimum essential coverage.

Fixed Indemnity Policies (Individual Market)

A fixed indemnity plan does not need to meet most of PPACA's requirements and also is not considered minimum essential coverage for purposes of avoiding the individual or employer penalties. Historically, a plan must pay benefits on a fixed period basis to fall within the fixed indemnity exception. The FAQ says that a supplemental policy may qualify as a fixed indemnity policy even though it reimburses on a per service basis, or other basis than a fixed period, if:

- It is sold only to individuals who have other health coverage that is minimum essential coverage,
- There is no coordination between the benefits under the fixed indemnity policy and an exclusion of benefits under any other health coverage,
- The benefits are paid in a fixed dollar amount regardless of the amount of expenses incurred and without regard to the benefits provided under any other health coverage, and
- 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 responsibility requirements of PPACA.

Volunteer Firefighters

In a blog posted on January 10, 2014, the IRS stated that it intends to exclude volunteer firefighters and other volunteer emergency medical personnel from those who need to be considered "employees" under the employer-shared responsibility ("play or pay") requirements. It is not clear from the blog how much a volunteer emergency responder can be paid and still be considered an exempt volunteer. The IRS has promised to provide details in the final play or pay regulations, which it says will be released shortly.

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