HUSCH BLACKWELL

Don't Let the Delay Fool You – Healthcare Reform is Alive and Well

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Some employers may have rejoiced when IRS Notice 2013-45 delayed until 2015 the implementation of the employer shared-responsibility penalties mandated by the Patient Protection and Affordable Care Act (ACA). Certainly, this delay is a win for employers; however, other healthcare reforms will demand the attention of health plan sponsors before January 1, 2014, including the requirement to send a notice to all employees by October 1, 2013.

- Notice of Exchange Availability

  Employers are required to provide a notice of exchange availability to all employees (even those who are not eligible for or enrolled in employer's health plan) by October 1, 2013. Thereafter, new employees must receive a copy of the notice within 14 days of their date of hire. This notice provides individuals with information regarding the availability of individual health insurance exchanges and subsidies. A model notice is available for employers that sponsor healthcare coverage here (also available in Spanish) and for employers that do not sponsor healthcare coverage here (also available in Spanish). Interestingly, a recently issued FAQ provides that there is no penalty for failing to send the notice. However, we recommend sending it.

- Prohibition on Annual Dollar Limits for Essential Health Benefits

  Health plans may not place an annual dollar limit on essential health benefits beginning with the 2014 plan year. Many plans are already complying with this rule, but other plans took advantage of transition rules that allowed them to impose annual limits through the end of the 2013 plan year. The expiration of this transition relief spells the end of traditional mini-medical plans, which generally provided a limited set of benefits with a low annual dollar limit.

  A recently issued Technical Release highlights the impact this and other healthcare reform rules have on health reimbursement arrangements (HRA), health flexible spending accounts (FSA) and employee assistance plans (EAP).

  - HRAs: The Technical Release provides that standalone HRAs and employer pay plans, which reimburse employees for all or a portion of individual insurance premiums, must comply with the restriction on annual limits and other healthcare reforms (e.g., coverage of preventive care without cost

sharing). This effectively ends standalone HRAs and employer pay plans. The guidance provides specific information regarding when an HRA is "standalone," but it generally means that participation in the HRA is not tied to participation in an employer's ACA-compliant major medical plan. Note that the HRA may be integrated with any employer plan that complies with the healthcare reforms (e.g., an HRA that is available to employees who are enrolled in ACA-compliant non-HRA group coverage through a spouse's employer). However, an HRA is standalone if it is used to purchase individual insurance on a healthcare exchange.

- FSAs: Health FSAs that are excepted benefits are not subject to the prohibition on annual dollar limits or most of the other healthcare reforms. A health FSA will be considered to provide only excepted benefits if the employer also makes available group health plan coverage that is not limited to excepted benefits and the health FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the health FSA for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election).

- EAPs: The prohibition on annual dollar limits and other healthcare reforms do not apply to EAPs, but only if the program does not provide significant benefits in the nature of medical care or treatment.

- Prohibition on Waiting Periods in Excess of 90 Days

  Health plans are not permitted to impose waiting periods in excess of 90 days beginning with the 2014 plan year. Health plans may still impose substantive eligibility provisions, provided that they are not designed to avoid compliance with the 90-day waiting period limitation. Substantive eligibility provisions include limiting eligibility to certain classes of employees (e.g., full time) or requiring new employees to complete a cumulative hours requirement of no more than 1,200 hours.

- Limits on Overall Cost Sharing

  The overall cost-sharing limits for plan years beginning in 2014 are the same as the maximum out-of-pocket expense limits for HSA-compatible high-deductible health plans. For 2014, this means the out-of-pocket maximum for nongrandfathered plans cannot exceed $6,350 for self-only coverage and $12,700 for other coverage.

  The definition of cost sharing that must be counted against the out-of-pocket maximum is more expansive than that which has commonly been used by many health plans and includes deductibles, coinsurance,

copayments, similar charges, and any other expenditure required for expenses relating to one of the 10 essential health benefits (e.g., expenses for prescription drugs, maternity and hospitalization).

For the 2014 plan year only, plans that utilize multiple service providers to help separately administer benefits (such as one third-party administrator for major medical coverage and a separate pharmacy benefit manager) are not required to integrate the expenses under the separately administered benefits for purposes of the out-of-pocket maximum if (i) the major medical portion of the plan complies with the out-of-pocket maximums discussed above and (ii) to the extent an out-of-pocket maximum applies to the separately administered coverage, it complies with the out-of-pocket maximums discussed above.

- Transitional Reinsurance Fee

  Enrollment data necessary to calculate the first transitional reinsurance fee applicable to insurers and self-funded major medical plans must be provided to the Department of Health and Human Services (HHS) by November 15, 2014. HHS will notify the plan of the amount of the contribution for the year by the later of December 15, 2014, or 30 days after receiving the plan data. The fee is due 30 days after notification. The fee is currently set at $5.25 per covered life per month in 2014. The fee will be higher in 2015 and 2016 and is eliminated in 2017. The reinsurance fee is designed to help stabilize premiums in the state and federal healthcare exchanges.

- Coverage for Clinical Trials

  Nongrandfathered health plans must provide coverage for the routine patient costs associated with certain approved clinical trials for the prevention, detection or treatment of cancer or other life-threatening conditions and diseases for plan years beginning on or after January 1, 2014. Generally, the entity providing the trial will cover most drugs and services related to the trial; however, the health plan is required to cover all items and services that would normally be covered by the plan for someone who is not enrolled in a clinical trial (e.g., temporary hospitalization or monitoring). To help mitigate costs, plans may require participants in clinical trials to utilize available in-network providers that are participating in the clinical trial.

- Prohibition on Pre-existing Conditions

  Health plans are prohibited from delaying coverage for anyone with a pre-existing condition for plan years beginning on or after January 1, 2014. This rule already applies to children but is expanded to include adults. It is important to note that any pre-existing condition limitation that began in the 2013 plan year must be waived when the 2014 plan year begins, even if the full length of the waiting period has not expired.

- Coverage for Adult Children to Age 26

  Generally, health plans providing dependent coverage must permit children of eligible employees to remain covered to age 26 regardless of the child's marital, student or tax-dependent status. For plan years beginning prior to January 1, 2014, a special transition rule applied to grandfathered health plans that permitted the exclusion of adult children of eligible employees who were eligible for healthcare coverage through another employer. For plan years beginning on or after January 1, 2014, the rule requiring coverage for adult children to age 26 applies to grandfathered health plans. Grandfathered plans must provide a special enrollment right for any adult children who were excluded under this transition rule.

- W-2 Reporting

  Employers are reminded that the requirement to report the full cost of health coverage on employee's W-2s continues in 2014 (for 2013 W-2s).

- Lookback Measurement Periods for Variable Hour Employees

  Even though employer shared-responsibility penalties have been delayed to 2015, large employers (those with 50 or more employees) may still need to track the hours of their variable hour employees in 2013 and 2014 to determine full-time status for employees in 2015. Proposed regulations implementing the shared-responsibility penalties set forth a complex lookback measurement period to determine which employees are "full time" (i.e., averaging 30 or more hours per week) and must therefore be offered health coverage to avoid penalties. Many employers will benefit from using the maximum 12 month lookback measurement period, but doing so generally requires employers to begin tracking hours in late 2013.

- Essential Health Benefits Required for Small Group Employers

  Beginning with the 2014 plan year, nongrandfathered fully insured small group health plans (i.e., plans sponsored by employers with fewer than 50 employees) are required to offer the following "essential health benefits:"

  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care

- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs o Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

- Maximum Deductible for Small Group Employers

  Beginning with the 2014 plan year, the deductible for nongrandfathered fully insured small group health plans (i.e., plans sponsored by employers with fewer than 50 employees) cannot exceed $2,000 for self-only coverage and $4,000 for other coverage.

What This Means to You

Despite the delay for employer shared-responsibility penalties, other penalties apply for failing to comply with ACA provisions that demand plan sponsor's attention prior to January 1, 2014. Accordingly, plan sponsors should closely review their plans and make any necessary amendments to ensure compliance and avoid penalties.

Contact Information

For additional information, please contact your Husch Blackwell attorney.

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