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Milliman

CLIENT ACTION Bulletin
Employee Benefits

More Guidance Issued on Implementing the Affordable Care Act

SUMMARY **The federal agencies with regulatory authority under the Affordable Care Act (ACA) have released several new pieces of guidance in the past few months, including final and proposed rules, as well as "frequently asked questions" (FAQs) or similar informational resources. This *Client Action Bulletin* provides a broad overview of guidance from the Departments of Health and Human Services (DHHS), Labor (DOL), and Treasury (IRS) issued prior to April 1, 2013, as applied to group health plans beginning in 2014, when the health insurance exchanges are scheduled to become operational.**

DISCUSSION

"Essential Health Benefits" and "Minimum Value" Coverage Requirement

A DHHS final rule specifies the essential health benefits (EHBs) that nongrandfathered small group (covering up to 50 employees) insurance policies must cover. Although larger groups and self-insured group health plans need not satisfy the EHB requirement, neither may these plans impose any lifetime or annual limits on the EHBs that they do cover. The ACA's limits on annual deductibles and out-of-pocket expense limits also are integral to EHBs: nongrandfathered small group policies must limit deductibles to $2,000/$4,000 (single/family coverage) for EHBs. The separately released related FAQs explain that small group health insurance coverage may exceed the annual deductible limit if it cannot "reasonably reach a given level of coverage without exceeding the deductible limit." Nongrandfathered self-insured and large group plans may rely on the agencies' stated intention to apply the deductible limits imposed only on plans and issuers in the small group market until further guidance is issued. In addition, all nongrandfathered plans must comply with the out-of-pocket limits, set at the limits that apply to qualified high-deductible health plans (HDHP) for 2014. According to the new final rule and FAQs, the out-of-pocket limits include deductibles, copays, and coinsurance amounts, but do not include premiums, out-of-network expenses if the benefits are available in-network, or non-EHB expenses. A transition rule for the out-of-pocket expense limit applies, for the 2014 plan year only, if a group health plan uses multiple claims administrators covering different health benefits with separate out-of-pocket maximums.

The final rule outlines several ways to determine whether fully insured or self-insured large group plans comply with the ACA's minimum value (MV) coverage requirement. A failure to meet this requirement subjects the plan sponsor to excise tax penalties. Along with the final rule, the DHHS released design-based checklists, as well as an MV calculator, to determine if a plan provides an MV of at least 60%. Employers may obtain certification from an actuary only if the plan contains nonstandard features and neither the MV calculator nor the design-based checklists can be used.

The final rule clarifies that MV takes into account employer contributions to a health savings account (HSA) and amounts newly made available under a health reimbursement account (HRA) that may be used only for cost sharing (i.e., an "integrated" HRA). In addition, the final rule specifies coverage of mental health and substance use disorder services, as well as required compliance with the federal parity law by small group insurance policies beginning in 2014.

Other Regulations and Guidance

Other guidance from the federal agencies issued through the end of March 2013 implementing ACA provisions includes:

- A DOL self-compliance tool that group health plan sponsors, plan administrators, health insurance issuers, and others may use to determine compliance with some of the ACA's provisions affecting ERISA plans. The tool provides an informal explanation of the statutes and the most recent regulations and interpretations.

- A DHHS proposed rule on determining eligibility for, and granting exemption certificates from, the shared responsibility payment for individuals not maintaining minimum essential health coverage and designating other coverage as minimum essential health coverage. In addition, the IRS issued a proposed rule on the shared responsibility payment for individuals not maintaining essential coverage. The IRS also issued related FAQs addressing basic information on the individual shared responsibility provision, including who is affected, what is minimum essential coverage, the exemptions available, and reporting coverage.
- A DHHS notice containing the 2013 Federal Poverty Level (FPL) figures, which will be used to determine subsidies for health insurance purchased by low- and moderate-income people in the exchanges. Under the ACA, households with incomes between 100% and 400% of the FPL are eligible for refundable tax credits.
- A DOL interim final rule that protects employees from employer retaliation if they: report violations (or what they reasonably believe to be a violation) under the ACA; testify or participate in proceedings concerning such violations; or object to, or refuse to participate in, activities they reasonably believe to be a violation.
- A DHHS/DOL/IRS proposed rule addressing the application of the contraceptive coverage mandate to certain nonprofit religious organizations (e.g., nonprofit religious hospitals or higher educational institutions). Under the proposed rule, religious organizations no longer will be required to subsidize or directly provide contraceptive coverage for their employees, but insurance carriers or third-party administrators will be required to facilitate coverage and services at no cost to the plan participants.
- A DHHS final rule on HIPAA privacy, security, enforcement, and breach notification as modified by the Health Information Technology and Clinical Health Act and the Genetic Information Nondiscrimination Act. The final rule: expands the definition of "business associate" contracts; adopts higher penalties; expands requirements for covered entities' notice of privacy practices; and modifies individual rights concerning disclosures and access to protected health information.
- A DHHS final rule related to health insurance premiums, focusing on insurance market reforms applicable to nongrandfathered small group insurance. Reforms include the establishment of risk pools; fair premiums; guaranteed availability and renewability; rate increase disclosure and review requirements; and student health and catastrophic plan requirements.
- A DHHS proposed rule providing guidance on how states should handle eligibility determinations for Medicaid and other income assistance programs under the health insurance exchanges, beginning in January 2014. The rule requires individuals who apply for exchange coverage to provide information on their access to employer-coverage, and contemplates use of an application template that employees can take to their employers or that employers can complete and make available to employees.
- An IRS proposed rule providing guidance on the ACA's annual fee imposed on covered entities that provide health insurance. The fee is due by the a date specified by the Treasury Secretary, but in no event later than Sept. 30 of each calendar year in which it must be paid.
- A joint DOL/DHHS/IRS proposed rule implementing the ACA's maximum 90-day waiting period for new employees in group health plans or insurance.

ACTION Plan sponsors are advised to carefully review the various new rules and guidance for their effects on the group health coverage and insurance. Preparations to implement necessary changes should continue, with ongoing discussions with insurers, third-party advisors, and administrative and/or health service providers.

For additional information about any of the recent releases from the DOL, DHHS, and/or the IRS, or for assistance with analyses or compliance, please contact your Milliman consultant.