UBA PPACAAdvisor

Kaminsky & Associates, Inc.

AGENCIES ISSUE FINAL REGULATIONS, OTHER GUIDANCE THAT AFFECT SELF-FUNDED PLANS

Whistleblowing | Preventive Care |
Out-of-Pocket Limits | Minimum Value

Late last week the Department of Health and Human Services (HHS) and the Department of Labor (DOL) issued several more regulations on the Patient Protection and Affordable Care Act (PPACA). Some of the new rules affect all plans, while others only affect certain kinds of plans.

Whistleblowing/Prohibiting Retaliation

Impacts all self-funded plans beginning April 2013

PPACA prohibits employers (including insurers) from retaliating against an employee for reporting possible violations of PPACA to his employer or to the government, providing testimony about the possible violation or refusing to violate the law. It also prohibits retaliating or taking an unfavorable employment action against an employee because he or she received a premium tax credit. Unfavorable employment actions include firing or laying off, denying benefits, reducing pay or hours, denying overtime or promotion and making threats.

The government has now issued procedures that will be followed if an employee believes he or she has been retaliated against. The employee must file a complaint within 180 days after the claimed retaliation occurred. Complaints will be filed with and investigated by the Occupational Safety and Health Administration. (OSHA handles most whistleblowing complaints made with the Department of Labor.) If the complaint is found to be valid, the employer could be required to reinstate the employee, pay back wages, restore benefits, etc.

Preventive Care

Impacts all nongrandfathered self-funded plans now

The agencies have received many questions about the requirement to provide first-dollar preventive care. They have now issued a FAQ that clarifies that:

- While plans generally do not need to provide out-of-network preventive care if there are no in-network providers able to provide the needed preventive care service, out-of-network care must be provided at no cost
- Preventive over-the-counter drugs, such as aspirin for those at risk for heart attacks, must be covered at 100 percent only if the over-the-counter drug is actually prescribed
- Routine immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) must be covered without cost-sharing beginning with the plan year that begins one year after the recommendation is adopted by the Centers for Disease Control and Prevention (CDC)
- When a screening or immunization recommendation applies only to those who are "high risk," the attending provider is the one who determines if the person is high risk
- If a polyp is removed during a screening colonoscopy, the entire procedure must be covered without cost-sharing, as a preventive service
- The BRAC test itself, as well as genetic testing, must be covered at 100 percent if the attending provider determines the woman is at high risk for the BRAC mutation based on family history
- Required contraceptive coverage does not include male contraceptives
- Plans may not limit coverage to oral contraceptives and must cover IUDs, implants, sterilization, device removal, etc. Plans may impose reasonable management techniques, such as limiting first dollar coverage to generics unless use of the generic would be medically inappropriate for the individual. Over-the-counter contraceptives must be covered only if they are FDA-approved and prescribed by the woman's health care provider
- Annual HIV testing and triennial HPV DNA testing must be covered as part of well-woman care

Out-of-Pocket Limits

Impacts all non-grandfathered self-funded plans beginning with the 2014 plan year

The FAQ also talks about the out-of-pocket maximum requirements. Beginning with the 2014 plan year, plans may not have an out-of-pocket maximum that is larger than the allowed out-of-pocket limit for high-deductible health plans (HDHP) issued in connection with a health savings account. (The out-of-pocket limit includes the deductible, coinsurance and copays. For 2013, the HDHP out-of-pocket limit is $6,250 per person and $12,500 per family.)

The FAQ provides one year of transition assistance to plans that have separate major medical and prescription drug vendors. For the 2014 plan year only, those plans may apply the out-of-pocket limit separately to the major medical and prescription drug parts of coverage. Similar flexibility will not be available to plans with separate mental and nervous benefits, as the Mental Health Parity Act does not allow separate mental and nervous benefit limits.

Minimum Value

Impacts all self-funded plans as of the start of the 2014 plan year

Self-funded plans (regardless of size) will not be required to provide the ten "essential health benefits" or coverage at a "metal level" as some plans will be required to do. (The essential health benefits are coverage within these categories - ambulatory/outpatient, emergency, hospitalization, maternity and newborn care, mental health and substance use, prescription drugs, rehabilitative and habilitative services and devices -- e.g., speech, physical and occupational therapy, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including pediatric dental and vision care. Under the "metal level" requirements, a plan must be designed to cover 90 percent of covered costs - a "platinum" plan, 80 percent of covered costs -- a "gold" plan, 70 percent of covered costs -- a "silver" plan or 60 percent of covered costs -- a "bronze" plan).

However, self-funded plans will not be allowed to impose lifetime or annual limits on essential health benefits (see the previous paragraph for a description of these benefit categories). In addition, to avoid penalties employers with 50 or more full-time employees or full-time equivalent employees must offer plans that provide minimum value (an actuarial value of at least 60 percent). A proposed minimum value calculator has been released; it is at: Regulations and Guidance | cciio.cms.gov

Current year employer contributions to health reimbursement arrangements and health savings accounts are included in the minimum value calculation.

The agencies had said they planned to provide safe harbor minimum value plan designs, but there is still no time table for issuing those plan designs.

The text of the FAQs on out-of-pocket limits and preventive services is here:
FAQs About Affordable Care Act Implementation Part XII

The text of the interim final rule on PPACA whistleblowing and retaliation is here:
http://www.dol.gov/find/20130222/OSHA2013.pdf

28-Feb-2013

Kaminsky & Associates, Inc.

Kaminsky & Associates, Inc. I www.teamkaminsky.com I Ph: (419) 535-5502