Labor and Employment Alert: Employee Cost Sharing for Health Benefits and other Employee Benefits News

Related Professionals

Jennifer Bibart Dunsizer

Jolie N. Havens

Related Services

Employee Benefits and Executive Compensation

Labor and Employment

CLIENT ALERT | 2.28.2013

Summary: Recent government guidance addresses permissible employee cost sharing under your company's group health plan. This Vorys Client Alert summarizes what you need to know about out-of-pocket limits, annual and lifetime dollar limits, first dollar preventive care, and tobacco surcharges. To bring you up to date on other employee benefits news, this Client Alert also lists key dates for compliance with new HIPAA privacy regulations.

Deductibles and out-of-pocket limits

Small group health insurance policies will be subject to the following caps on in-network deductibles and out-of-pocket limits next year:

- The cap on deductibles will be $2,000 for single coverage and $4,000 for family coverage (indexed after 2014).
- The cap on out-of-pocket limits will be the highest out-of-pocket limits permitted for an HSA-compatible high deductible health plan. For 2013, those amounts are $6,250 for single coverage and $12,500 for family coverage (indexed for 2014 and later years).

The small group health insurance market is generally limited to employers with fewer than 50 employees.

Previously, there was a question as to whether the small group market caps would also apply to self-insured group health plans and health insurance policies sold to large employers. Recent final regulations by the Department of Health and Human Services (HHS) and Department of Labor (DOL) FAQs Part XII (posted February 20, 2013) resolve that question as follows:

- The cap on deductibles ***will not*** apply to self-insured group health plans and policies sold to large employers; but
- The cap on the out-of-pocket limit ***will*** apply to non-grandfathered self-insured group health plans and non-grandfathered policies sold to large employers. (Grandfathered plans and policies will be exempt while they continue to maintain grandfathered status.)

Only in-network essential health benefits (as defined by the applicable adjusted benchmark plan) need be counted toward the caps. Out-of-network deductibles and out-of-pocket limits are not capped by federal law (but, for insured plans, may be capped by state insurance law).

The cap on out-of-pocket limits presents a logistical problem for those plans where medical benefits are administered (or insured) by one entity and prescription drug benefits and other non-excepted benefits are administered by a different entity. The out-of-pocket limit is a cap on participant expenditures for all essential health benefits (e.g., the combination of medical benefits and prescription drug benefits) and, once reached, no further coinsurance or copays are permitted.

Transitional rule: Recognizing that the application of the out-of-pocket limit to all essential health benefits will require new and ongoing communications between vendors, the government provided a one-year transitional rule. For the first plan year starting on or after January 1, 2014, the out-of-pocket limit need only apply to medical coverage. However, if prescription drug coverage (or other non-excepted coverage) has a separate out-of-pocket limit, it cannot exceed the dollar amount then in effect. The out-of-pocket limit will have to apply to the combined benefits beginning in the following year.

Action items: If your company has a non-grandfathered health plan, check with your insurer, third party administrator and/or pharmacy benefit manager to confirm they will be building the systems needed to administer the out-of-pocket limit. Make a note to amend your plan documents accordingly.

Annual and lifetime dollar limits on essential health benefits

HHS declined to provide a uniform federal definition of essential health benefits. Instead, HHS allowed each state to select a benchmark health plan (with a default option for states that fail to make a selection). The specific benefits included in a state's benchmark health plan are, with some federally mandated adjustments, deemed to be the essential health benefits for all non-grandfathered individual and small group health insurance policies sold in that state.

Self-insured group health plans and health insurance policies sold to large employers (generally, employers with 50 or more employees) do not need to cover all essential health benefits. However, a self-insured group health plan or large group health insurance policy cannot impose annual or lifetime dollar limits on any essential health benefits that happen to be included in the plan or policy. What benefits are deemed to be essential for this narrow purpose (i.e., the prohibition on annual and lifetime dollar limits)? The preamble to the final regulations implies that HHS will permit the use of any benchmark plan (from any state) with the federally mandated adjustments. A list of the state benchmark plans and an explanation of the federally mandated adjustments is available at http://cciio.cms.gov/resources/data/ehb.html.

Action item: If your group health plan includes dollar limits on a specific benefit, you should plan to remove the dollar limit or find an adjusted benchmark plan that does not cover that specific benefit.

First dollar preventive care

A non-grandfathered group health plan must provide first dollar coverage (i.e., no cost sharing imposed on the participant) for four categories of preventive care:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

These lists were compiled as guidelines for health care providers. When applied as instructions for first dollar reimbursement of services and supplies however, the lists can be ambiguous. The government clarified some of these ambiguities in FAQs Part XII (posted February 20, 2013). For example, when recommended by the USPSTF, first dollar coverage is required for:

- Over-the-counter items such as aspirin if (but only if) prescribed by a health care provider.
- The removal of polyps during a colonoscopy.
- Genetic testing for breast cancer susceptibility.

Tobacco use and wellness programs

If your company has a health-contingent (also known as a "standard-based") wellness program, you know that employees who fail to meet specified health standards can be charged higher contributions for health coverage (assuming the program meets specified conditions and you apply certain employee protections). Currently, the contribution differential cannot exceed 20% of the cost of coverage. Starting with the 2014 plan year, the contribution differential can be as much as 30% of the cost of coverage plus another 20% (for a maximum of 50%) where the additional 20% is based on tobacco use.

There is a new wrinkle: HHS recently published final regulations defining "tobacco use" for purposes of premiums for health insurance to be sold on the public exchanges. "Tobacco use" is defined as the use of tobacco on average of four or more times per week within no longer than the past six months. Needless to say, this definition is not consistent with what is typically used in wellness programs today. HHS, IRS and DOL previously indicated the intention to coordinate provisions applicable to tobacco users for purposes of premiums in the public exchanges and employer-sponsored wellness programs. Therefore, it is possible that your program will have to use the same definition of tobacco use in order to apply the full 50% premium differential.

Action item: Check back for developments before planning 2014 tobacco users surcharge.

OTHER EMPLOYEE BENEFIT NEWS

Protected health information (PHI)

If your company has a self-insured group health plan, you probably know that protected health information (individually-identifiable health information collected for purposes of administering health benefits) must be handled and protected in accordance with federal privacy rules (known as the HIPAA privacy rules). Recent revisions to those rules may require that you:

- Revise policies and procedures for breach notification by September 23, 2013. In the event of a breach of protected health information, a specified series of steps must be taken including notice to affected individuals and HHS. The new rules make significant changes to the process for determining whether an inappropriate use or disclosure of protected health information is in fact a breach. Specifically, an inappropriate use or disclosure of protected health information is *presumed* to be a breach unless the health plan (i.e., a person acting on behalf of the health plan) or business associate demonstrates that there is a low probability that the PHI has been compromised. Employees who are responsible for group health plan administration should be trained on the revised policies and procedures.
- Update your health plan's notice of privacy practices and distribute it to plan participants by November 22, 2013. If your next open enrollment mailing will not be until after November 22, 2013, you have another option: If you post the revised notice of privacy practices to a website maintained by the company for employee benefit matters by September 23, 2013, then you don't need to distribute the revised notice of privacy practices until the next open enrollment mailing to plan participants.
- Amend business associate agreements by September 23, 2014. Your existing business associate agreements should be reviewed for compliance with the final rules in advance of this deadline (or in connection with any earlier renegotiation of the relationship).
- Update your health plan's risk analysis. A health plan (like other entities subject to the HIPAA privacy rules) must perform an analysis of the risks to the protected health information for which it is responsible. If you have not reviewed your health plan's risk analysis in the past year (or after the last change to health plan administration), consider doing so in connection with these other updates. An up-to-date risk analysis is a must in the event of an HHS audit of your privacy practices.

Notice of exchanges postponed

One provision of the Affordable Care Act calls for a notice of the public exchanges to be distributed to employees in March 2013. Recognizing that not much useful could be said about the exchanges next month, the government deferred the notice pending further guidance. It is expected to be back on the schedule in late summer or fall.

* * *

This alert is a summary and cannot include all details that may be relevant to your situation. As always, please contact us if you want more information on these developments or other employee benefits matters.