SecureOne Benefit Administrators, Inc

Frequently Asked Questions: 2014 New Benefit Mandates for Self-Insured Plans

What new benefit mandates apply to self-insured health plans in 2014 and when do they take effect?

For plan years starting on or after January 1, 2014, new benefit mandates apply to self-insured health plans. As shown in the following chart, some of the new mandates apply to all plans whether or not they are grandfathered, while others apply only to non-grandfathered plans.

All Plans	Non-Grandfathered Plans
Remove all pre-existing condition limitations	Apply maximum out-of-pocket limits
No waiting periods exceed 90 days	Cover costs of clinical trial participants
Remove any annual dollar limits on essential health benefits	Provider non-discrimination rules
Offer coverage to dependents to age 26 with no limitations (if plan offers dependent coverage)	
Wellness (Preventative Services)	

Elimination of Pre-existing Condition Exclusions

What is the Affordable Care Act's prohibition on pre-existing condition exclusions?

A health plan (including a grandfathered plan) cannot deny coverage or otherwise limit or exclude benefits based on the fact that a condition was present before coverage became effective, regardless of whether the individual previously received diagnosis, care or treatment for the condition. This prohibition applied to enrollees under the age of 19 for plan years starting on or after September 23, 2010. Beginning with the first plan year that starts on or after January 1, 2014, the prohibition on pre-existing condition exclusions applies to all other enrollees regardless of age.

Does the prohibition on pre-existing condition exclusions come with any enhanced notice or disclosure requirements?

Although the Affordable Care Act does not impose any separate notice requirement on the elimination of pre-existing condition exclusions, employers will still need to update all applicable participant communications (including enrollment materials, the plan document, the summary plan description and any other plan summaries of benefits or coverage) to correctly describe the plan's terms. In addition, because no plan can impose any pre-existing conditions limitation after December 31, 2014, plans will no longer be required to provide an individual with a HIPAA Certificate of Creditable Coverage beginning in 2015.

90-Day Limit on Waiting Periods

What is the Affordable Care Act's new prohibition on waiting periods longer than 90 days?

Beginning with the first plan year that starts on or after January 1, 2014, no health plan (including a grandfathered plan) can use an eligibility condition based solely on a lapse of time longer than 90 days. In addition, a plan may no longer apply a waiting period longer than 90 days after an employee or dependent satisfies the plan's eligibility criteria before coverage becomes effective.

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How does the 90-day limit on waiting periods apply to variable hour employees?

If it can not be determined whether a newly-hired employee is expected to work full-time (or to regularly work a specified number of hours per stated period), the plan can use a reasonable period of time to determine whether an employee satisfies the plan's eligibility conditions. Like the rules for determining an employee's full time status under the employer shared responsibility provisions, a plan can use a measurement period for counting hours. However, the total time period before coverage becomes effective (including both waiting period and measurement period) cannot be longer than 13 months from the employee's start date, plus the time remaining until the first day of the next calendar month if the employee's start date is not the first day of a month.

Elimination of Annual Dollar Limits on Essential Health Benefits

How do the Affordable Care Act's prohibitions on dollar limits for essential health benefits apply to self-insured health plans?

Although self-insured plans are not required to cover "essential health benefits," those that do can not impose any annual or lifetime dollar maximums on those benefits. However, these plans are permitted to impose non-dollar limits such as day or visit limits, consistent with other guidance, on essential health benefits as long as they comply with other applicable statutory provisions. Additionally, self-insured plans may impose dollar limits on non-essential health benefits.

The prohibition on annual and lifetime dollar limits on essential health benefits applies to both grandfathered and non-grandfathered plans. The prohibition on lifetime dollar limits became effective in 2010. The complete prohibition of annual limits does not become effective until the first plan year beginning on or after January 1, 2014. Prior to the 2014 plan year, plans were permitted to phase in the elimination of annual limits on essential health benefits according to the following schedule:

Plan Years	Minimum Annual Limit
Beginning between September 23, 2010 but before September 23, 2011	$750,000
Beginning between September 23, 2011 but before September 23, 2012	$1,250,000
Beginning between September 23, 2012 but before January 1, 2014	$2,000,000
Plan year beginning January 1, 2014 and after	Unlimited

What are essential health benefits?

Essential health benefits are a core benefits package that must include, at a minimum:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Lab services
- Preventative and wellness services and chronic disease management
- Pediatric services (including oral and vision care)

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Each state is required to define essential health benefits for insured products. Self-insured plans can adopt any benchmark plan to define essential health benefits for purposes of the limits on annual and lifetime maximums. For example an employer based in California could define essential health benefits for purposes of lifetime and annual limits in accordance with the essential health benefits standards in the state of Texas. However, employer group health plans do not need to cover all essential health benefits.

How do these restrictions apply to account based plans?

Type of Account Based Plan	Application of Annual Dollar Limits
Stand-alone Health Reimbursement Arrangements (HRAs)	Restrictions on annual dollar limits apply**
Integrated HRAs*	Not applicable if the other health coverage when considered alone, complies with the prohibition on annual limits
Retiree-only HRAs	Not applicable
Healthcare Flexible Spending Arrangements (FSAs)	Not applicable because FSAs are generally exempt from these limit rules (but note that employee salary reduction contributions to health FSAs are specifically limited each year to $2,500 (indexed for inflation))
Medial Savings Accounts (MSAs)	Not applicable because these account based plans are not generally treated as group health plans
Health Savings Accounts (HSAs)	

*An HRA is not considered integrated unless the HRA is available only to employees who are covered by an employerôs group plan (either insured or self-insured) that satisfies the prohibition on annual limits on essential health benefits. An employer-sponsored HRA cannot be integrated with insurance policies purchased in the individual insurance market or with an employer plan that provides coverage through individual insurance policies.

**See transition rules for amounts credited before 2014.

Grandfathered Plans' Coverage for Children Until Age 26

What changes to the Affordable Care Act's requirements to cover children until age 26 become effective in 2014?

Employer plans are not required to offer coverage of children. However, those that do cover children (defined for this purpose to include only sons, daughters, step children, adopted children, children placed for adoption and foster children) must offer coverage at least until the child reaches 26 years of age. Plans can no longer condition eligibility on the childôs status as a tax dependent or as a student, or impose any other residency or financial support conditions on the availability of coverage. This requirement applied to plans generally beginning in 2010. Before 2014, grandfathered plans were allowed to deny coverage to children if they were eligible for coverage under another employerôs plan. Beginning in 2014, grandfathered plans that offer coverage to children must remove any conditions related to eligibility for coverage under another employerôs plan.

Can plans continue to condition health coverage on support, residency, or other dependency factors for individuals under age 26 who are not an employee's sons, daughters, step-children, adopted children, children placed for adoption or foster children?

Yes. A plan can continue to impose limits on coverage for other individuals (such as grandchildren, nieces or nephews), such as a condition that the individual be a dependent for income tax purposes.

Out-of Pocket Limit Maximums

What are the Affordable Care Act's requirements for group health plans to set maximums on out-of pocket limits?

Beginning with the first plan year that starts after 2013, a non-grandfathered health plan must set out-of-pocket limits for participants no higher than $6,350 for self-only coverage and $12,700 for non-self-only or family coverage. Higher out-of-pocket limits can apply to out-of-network coverage. These amounts may increase in future years.

What participant expenses must count toward the out-of-pocket maximum?

Out-of-pocket expenses that count toward the maximum include deductibles, co-pays and coinsurance. Plans using more than one vendor to administer benefits have a one-year safe harbor; as long as the major medical coverage and the separately administered benefit (e.g., prescription drugs) are each subject to an out-of-pocket limit that complies with the maximum, the plan will be deemed to comply with the rule. However, the safe harbor is not available for mental health and substance abuse benefits ï mental health parity rules do not permit separate out-of-pocket limits to apply to those benefits.

Must self-insured group health plans set minimum or maximum deductible amounts?

No. Unlike certain insured group health plans, self-insured group health plans are not subject to rules on deductible amounts.

Coverage for Participation in "Approved clinical Trials"

What are the Affordable Care Act's new requirements for group health plans to provide coverage for certain individuals participating in "approved clinical trials"?

Beginning with the first plan year that starts after 2013, a non-grandfathered health plan cannot:

Deny an individual participation in an approved clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition;

Deny, limit or impose additional conditions on the planôs coverage for items and services furnished in connection with participation in the clinical trial if the items or services would ordinarily be covered under the plan if the individual were not enrolled in the clinical trial; or

Discriminate against an individual on the basis of his or her participation in the clinical trial.

For what individuals must a plan provide coverage for participation in "approved clinical trials?"

Coverage for participation in an ñapproved clinical trialò must be provided for any participant or beneficiary who is eligible to participate according to the clinical trialôs protocol, so long as the individual provides information establishing why his or her participation in the clinical trial is appropriate or a referring health care provider that is an in-network provider concludes that the individualôs participation in the clinical trial is appropriate.

What is an "approved clinical trial" for purposes of this requirement?

An ñapproved clinical trialò is a phase I, phase II, phase III or phase IV clinical trial conducted in relation t the prevention, detection or treatment of cancer or another life-threatening disease or condition that is likely to result in death unless the course of the condition is interrupted. In addition, the clinical trial must be a study or investigation conducted under a new drug application reviewed by the Food and Drug Administration (or be exempt fro having such an investigational new drug application) or the clinical trial must be approved or funded by specified government agencies.

Will the Departments be issuing regulations addressing required coverage of participation in approved clinical trials before this requirement becomes effective?

No. The Departments announced they do not expect to issue regulations in the near future. Until any future guidance is issued, group health plans are expected to implement the requirement to cover participation in approved clinical trials using a good faith, reasonable interpretation of the law.

Provider Non-Discrimination

What are the Affordable Care Act's requirements for group health plans not to discriminate against health care providers?

Beginning with the first plan year that starts after 2013, a non-grandfathered group health plan may not discriminate with respect to plan participation or coverage against any health care provider acting within the scope of that providerôs license or certification under applicable state law. However, this does not mean that a group health plan must contract with ñany willing provider.ò In addition, either the plan or HHS may set different reimbursement rates for providers based on quality or performance measures.

With the Departments be issuing regulations addressing requirements for group health plans not do discriminate against health care providers before this requirement becomes effective?

No. The Departments announced they do not expect to issue regulations in the near future. The Departments have state that ñto the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan é shall not discriminate based on a providerôs license or certification, to the extent the provider is acting within the scope of the providerôs license or certification under applicable state law. This provision does not require plans or issuers to accept all types of providers into a network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.ò