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FAQs Issued on Several PPACA Provisions

On January 9, 2014, the Departments of Health and Human Services (HHS), Labor and Treasury issued FAQs to clarify Patient Protection and Affordable Care Act (PPACA) provisions related to several topics including:

- Preventive Services
- Cost-sharing Requirements
- Expatriate Health Plans
- Wellness Programs
- Fixed Indemnity Insurance
- Mental Health Parity

We have summarized the information in the FAQs and provided a link to the complete FAQs below.

Preventive Services (Q1)

For women who are at increased risk for breast cancer, medications that reduce the risk of breast cancer must be covered as preventive services with no cost-sharing. This applies to non-grandfathered individual and group plans for plan years beginning on or after September 24, 2014.

Cost-sharing Requirements (Q2 – Q5)

For plan or policy years beginning in 2014, the annual limitation on out-of-pocket costs applicable to non-grandfathered plans is $6,350 for self-only coverage and $12,700 for coverage other than self-only coverage. The annual cost-sharing limit applies only to Essential Health Benefits (EHBs). Since self-insured and large group health plans are not required to cover EHBs, those plans must make a good faith effort to use an EHB definition authorized by HHS for purposes of administering the cost-sharing limitation.

The FAQ clarifies that for plan years beginning on or after January 1, 2015, a group health plan may have separate out-of-pocket maximums for different benefits as long as the combined out-of-pocket maximum does not exceed the annual limit.

The FAQ also confirmed that out-of-network expenses and non-covered services such as cosmetic surgery are not required to be counted toward the plan's annual out-of-pocket maximum.

Expatriate Health Plans (Q6 – Q7)

It was previously announced that some PPACA provisions will not apply to insured expatriate plans for plan years ending on or before December 31, 2015. These FAQs extend the transitional relief for expatriate plans through December 31, 2016, and provide the following definition of an insured expatriate plan:

> An insured group health plan whose enrollment is limited to individuals who are expected to reside outside of their home country or outside of the United States for at least six months of a 12-month period and their covered dependents. The 12-month period can be within a single plan year or across two consecutive plan years.

Wellness Programs (Q8 – Q10)

Group health plans can provide wellness incentives, including premium surcharges and reductions, and some employers have a defined election period and process for their wellness programs. If a plan participant declines to participate in a wellness program during the employer-defined election period, the employer is not required to provide a mid-year opportunity for that individual to enroll in the wellness program and earn the reward. However, employers that allow mid-year elections can provide rewards, including prorated awards, for mid-year participants in the program.

If an individual's doctor indicates that an outcome-based wellness program is not medically appropriate for the individual and recommends an activity-only program instead, the plan must provide a reasonable alternative standard that accommodates the doctor's recommendation. However, the plan can have a say in which activity-only program meets the plan's requirement.

Plans must provide participants with a notice about the availability of reasonable alternative standards to meet wellness requirements. The sample language provided in the final regulations can be modified as long as it includes all the required content.

Fixed Indemnity Insurance (Q11)

Fixed indemnity group health insurance coverage that supplements other group health plan coverage and pays a specific dollar amount for hospitalization or an injury or illness is an "excepted benefit" and not subject to PPACA requirements. The FAQ expands the definition of fixed indemnity plans to include those that pay on a per-service basis in addition to those that pay on a per period basis.

Mental Health Parity (Q12)

Mental health parity legislation requires that cost-sharing and treatment limitations for mental health/substance use disorder services cannot be more restrictive than the requirements that apply to medical/surgical benefits. The FAQ clarifies the impact of mental health parity on individual and small group plans.

- Non-grandfathered individual policies – Must cover mental health/substance use disorder services and meet parity requirements for policy years beginning on or after January 1, 2014.
- Grandfathered individual policies – Are not required to cover mental health/substance use disorder services, but if these services are covered, parity requirements apply for policy years beginning on or after July 1, 2014.
- Non-grandfathered small group plans – Must cover mental health/substance use disorder services for plan years beginning on or after January 1, 2014 and meet parity requirements for plan years beginning on or after July 1, 2014.

- Grandfathered small group plans – Are not required to cover mental health/substance use disorder services or meet parity requirements.

Read the FAQs

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