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- If you have an HDHP or HSA, your 2015 limits are now out!
- New COBRA notices, FAQs, and Exchange Special Enrollments…oh my!
- The birth of "Compliance Reminders"… where you find out more information about an existing rule and how it may affect your plan. This month: COBRA and an individual policy's effect on selecting Exchange coverage

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HEALTH SAVINGS ACCOUNT AND HIGH DEDUCTIBLE HEALTH PLAN LIMITS FOR 2015 RELEASED

The Internal Revenue Service (IRS) released the 2015 Cost-of-Living-Adjustments (COLA) for Health Savings Accounts (HSA) and High Deductible Health Plans (HDHP). Highlights are as follows:

Contribution and Out-of-Pocket Limits for Health Savings Accounts (HSA) and for High Deductible Health Plans (HDHP)

	2014	2015	Change
HSA contribution limit (employer + employee)	Individual: $3,300 Family: $6,550	Individual: $3,350 Family: $6,650	Individual: +$50 Family: +100
HSA catch-up contributions (age 55 or older) [1]	$1,000	$1,000	No change [2]
HDHP minimum deductible amounts	Individual: $1,250 Family: $2,500	Individual: $1,300 Family: $2,600	Individual: +$50 Family: +$100
HDHP maximum out-of-pocket amounts (deductibles, copays and other amounts, but not premiums)	Individual: $6,350 Family: $12,700	Individual: $6,450 Family: $12,900	Individual: +$100 Family: +$200

[1] Catch-up contributions can be made any time during the year in which the HSA participant turns 55

[2] Unlike other limits, the HSA catch-up contribution amount is not indexed; any increase would require statutory change

Under the Affordable Care Act (ACA), the Department of Health and Human Services (HHS) is required to use a methodology different from that which the IRS uses for HDHPs when calculating annual COLA adjustments. Therefore, starting in 2015, the two limits (HSA/HDHP inflation adjustments and annual increases in cost-sharing under the ACA's maximum out-of-pocket rules) will begin to differ as shown in the table below.

	2014	2015
ACA Out-of-Pocket Limits	Individual: $6,350 Family: $12,700	Individual: $6,600 Family: $13,200
IRS Out-of-Pocket Limits for HDHPs	Individual: $6,350 Family: $12,700	Individual: $6,450 Family: $12,900

Health Savings Account and High Deductible Health Plan Limits for 2015 Released (Continued)

Effective 2015 and beyond, the Premium Adjustment Percentage (PAR) will be used to calculate annual increases in cost-sharing under the ACA maximum out-of-pocket rules. These ACA rules limit participant cost-sharing under non-grandfathered group health plans for covered, in-network Essential Health Benefits (EHB).

Action Required

Employers with HDHPs and HSAs should ensure use of the appropriate limits beginning January 1, 2015. In addition, it is important to note that the PAR also applies to the employer mandate penalties, which could increase the penalty starting in 2015. Employers should keep an eye out for future adjustments and review their plan documents and communications materials to ensure appropriate limits are reflected.

For complete details, see IRS Revenue Procedure Notice 2014-30 at:

http://www.irs.gov/pub/irs-drop/rp-14-30.pdf

NEW EXCHANGE SPECIAL ENROLLMENT PERIODS AND HARDSHIP EXEMPTION

Recently the Centers for Medicare and Medicaid Services (CMS) issued a bulletin announcing new Special Enrollment Periods (SEP) available in Federally Facilitated Exchanges (FFE). In addition, another hardship exemption from the individual mandate penalty is now available in both FFEs and State-based Exchanges (SBE). Highlights are below.

Exchange Special Enrollment Period Offered in Relation to COBRA

In relation to COBRA, there is a limited SEP for individuals who are already eligible for or enrolled in COBRA coverage.

- Affected individuals will now have through July 1, 2014 to enroll in coverage through an FFE (Note: SBEs are encouraged to allow this new relief, but are not mandated to do so)

Special Enrollment Period for Individuals Whose Individual Policies Renew Outside of Exchange Open Enrollment

- Since consumers may have reasonably expected to have the option not to renew their non-calendar year individual market policies and to receive an SEP in an FFE outside of the OE period, at this time, HHS will provide an SEP (i.e., consumers may apply for coverage in an FFE up to 60 days before their plan terminates or up to 60 days after their plan's renewal date)
- If a Qualified Health Plan (QHP) is selected after the renewal date, coverage will be prospective based on the date of plan selection

New Exchange Special Enrollment Periods and Hardship Exemption (Continued)

Hardship Exemptions

- An additional hardship exemption is provided for all months prior to the effective date of coverage for those individuals who obtained Minimum Essential Coverage (MEC), effective on or before May 1, 2014, outside of the Exchange
  - Exemption available to those in a state with either an FFE or an SBE
  - Individuals are not required to submit an exemption application to the Exchange
- Individuals who enrolled in coverage through the Exchange prior to the close of the initial Open Enrollment (OE) period (March 31, 2014) are also eligible for a hardship exemption for the months prior to the effective date of coverage

No Action Required

Employers should be aware of the rules for SEPs and COBRA in order to assist employees with questions that may arise.

For the complete regulations, go to: http://www.gpo.gov/fdsys/pkg/FR-2014-05-07/pdf/2014-10416.pdf

For the CMS Bulletin, go to: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SEP-and-hardship-FAQ-5-1-2014.pdf

FAQs ADDRESS OUT-OF-POCKET MAXIMUMS, PREVENTIVE SERVICES, UPDATED COBRA NOTICES, AND MORE

Prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments), are additional Frequently Asked Questions (FAQ) regarding implementation of various provisions of the Affordable Care Act (ACA). Highlights are below.

Updated COBRA and CHIPRA Model Notices

A Notice of Proposed Rulemaking with updated versions of the COBRA and CHIPRA model election notices was recently released. The updated notices note that the Exchange is open, and provide clarification on special enrollment rights for Exchange coverage. Revised notices include:

- COBRA General Notice: To be furnished to each covered employee (and their spouse if covered under the plan)
- COBRA Election Notice: To be furnished to qualified beneficiaries
- CHIPRA Notice: To be furnished to each employee residing in a state that provides potential opportunities currently available for premium assistance for the purchase of coverage under a group health plan

Some COBRA qualified beneficiaries may want to consider alternatives to COBRA continuation coverage, such as coverage that is available through the Exchange. COBRA qualified beneficiaries may be eligible for a premium tax credit (a tax credit to help pay for some or all of the cost of coverage in plans offered through the Exchange) and cost-sharing reductions (amounts that lower out-of-pocket costs for deductibles, coinsurance, and copayments). These factors may make Exchange coverage more affordable than COBRA. In some instances however, there is a gap between the loss of coverage and a participant's choice of COBRA or Exchange coverage. During that gap, individuals could incur significant claims. The hallmark of COBRA coverage is that it is retroactive to the date of the loss of coverage – it is designed to fill that gap. Exchange coverage, by contrast, applies prospectively only. Further guidance on this issue is expected.

FAQs Address Out-of-Pocket Maximums, Preventive Services, Updated COBRA Notices, and More (Continued)

Limitations on Cost-Sharing under the Affordable Care Act

Under recent guidance the DOL and HHS have addressed the extent to which certain items should count towards the annual limit on Out-of-Pocket (OOP) maximums for Essential Health Benefits (EHB). The limitation on OOP maximums generally applies to non-grandfathered plans beginning plan year 2014.

- Out-of-Network Spending
  - A plan is not required to, but may choose to count out-of-network spending towards the annual limit on OOP maximums. A plan that chooses to count an *insured's* out-of-network spending towards the OOP maximum may do so using any reasonable method (e.g., plans may count the participant's cost up to the Usual, Customary, and Reasonable amount (UCR) for a service)
- Brand Name Drugs (Large Group Market Coverage and Self-Insured Group Health Plans)
  - It is up to the plan to define EHBs. Meaning, a plan may define EHBs to include only generic drugs, if medically appropriate (as determined by the individual's personal physician) and available, and if it provides a separate option for electing a brand name drug at a higher cost-sharing amount. For these types of plans the Summary Plan Description (SPD) must identify which covered benefits are counted
- Reference-Based Pricing Structure (Large Group Market Coverage and Self-Insured Group Health Plans)
  - Yet to be decided upon; however, the Departments are particularly interested in implementing standards that these types of plans must meet to ensure a participant's access to appropriate and quality medical care

Coverage of Tobacco Counseling as a Preventive Service

Plans will be considered compliant so long as they use reasonable medical management techniques to determine any coverage limitation. For example, a plan would be considered in compliance with the requirement, if the plan covers without cost-sharing screening for tobacco use; and, for tobacco users, at least two cessation attempts (as defined by the FAQ) per year.

Health Flexible Spending Account (FSA) Carryover and Excepted Benefits

Carryover amounts are not taken into account when determining whether a health FSA satisfies the maximum benefit condition of the excepted benefit requirements (i.e., the carryover amount does not affect the maximum amount of salary reduction contributions a participant is permitted to make each plan year).

Summary of Benefits and Coverage (SBC)

Until further guidance is issued, the SBC template and sample completed SBC made available in April 2013 may be used after the second year of applicability (i.e., for plan years on/after January 1, 2015). In addition, previously issued enforcement and transition relief has been extended until further guidance is issued.

Action Required

Employers should ensure they are using the latest COBRA and CHIPRA notices. Employers should also be aware that the Paperwork Reduction Act Statement need not be included in the provided notice.

Additionally, employers with self-insured and large group health plans that wish to exclude certain items from counting towards the plan's OOP maximum will need to clearly define these terms in their plan documents and, for ERISA plans, communicate them in their SPDs.

For the complete FAQ, go to: http://www.dol.gov/ebsa/faqs/faq-aca19.html#footnotes

COMPLIANCE REMINDERS...

Individual Policies, COBRA and the Exchange

Individual Policies:

- *Individual market Open Enrollment (OE) periods must be based on a calendar policy year (for non-grandfathered coverage) with policy year beginning on January 1 and ending on December 31 of each year*
- *Enrollment in individual coverage through the Exchange during OE is not considered a Qualifying Event (QE) for dropping group coverage*

Exchange Open Enrollment & COBRA Severance

- *Individuals may enroll during the annual OE period and during Special Enrollment Periods (SEP)*
    - *During OE: an individual can voluntarily drop COBRA coverage in favor of coverage through the Exchange, even if the COBRA coverage has not expired. In this case, an individual also may be eligible for a premium tax credit*
    - *Outside of OE: an individual, whose COBRA coverage expires, will qualify for an SEP and may also be eligible for a credit; an individual who voluntarily drops coverage will not qualify for an SEP*

Exchange Special Enrollment Option

Individuals that experience a QE may be able to change existing or enroll in new coverage within 60 days from the QE (group open enrollment is not considered a QE). Special enrollment is allowed where:

- *Dependent coverage is discontinued; or,*
- *Contributions to dependent coverage are discontinued*
    - *Individuals may enroll in coverage through the Exchange during an annual open enrollment period and during SEPs*

QUESTION OF THE MONTH

Q1: We changed the maximum waiting period under our calendar-year self-insured health plan to no more than 60 days to comply with health care reform. But the plan continues to impose some benefit-specific waiting periods for a period of up to six months. Is our plan design compliant with legal requirements?

A1: Your plan's general 60-day waiting period would comply with health care reform's prohibition on "excessive" eligibility waiting periods (which generally limits waiting periods to 90 days, effective for plan years beginning on or after January 1, 2014). However, as explained below, benefit-specific waiting periods (which typically make certain benefits available to participants only after they have been covered under the plan for a certain period of time) raise additional compliance issues.

Health care reform's maximum 90-day eligibility waiting period appears to apply to coverage under the plan as a whole, rather than to specific benefits, and does not expressly prohibit benefit-specific waiting periods. However, the final regulations contain an anti-abuse rule, which prohibits a plan from imposing eligibility conditions that are designed to avoid compliance with the 90-day waiting period limitation. For example, a plan that imposes several benefit-specific waiting periods in excess of 90 days may be found to violate this anti-abuse rule—even if its overall waiting period is shorter than 90 days.

Apart from health care reform's prohibition on excessive waiting periods, plans need to consider whether benefit-specific waiting periods comply with other legal requirements, such as nondiscrimination requirements under HIPAA and the Americans with Disabilities Act (ADA), and limits on preexisting conditions exclusions (PCEs) under HIPAA and health care reform. We provide general guidelines below, but it would be wise to review your specific plan design with legal counsel.

Question of the Month (Continued)

HIPAA's nondiscrimination rules do not prohibit plans from excluding or limiting benefits for a specific disease or condition so long as the exclusion or limitation applies uniformly to all similarly situated individuals (e.g., participants in a certain employment classification). Benefit exclusions or limitations generally are permissible under the ADA so long as coverage is equally available to the disabled and nondisabled. Thus, these nondiscrimination rules should not prohibit a benefit-specific waiting period so long as it is not directed at certain individuals due to their health status or disability. Generally speaking, a waiting period that targets a particular illness or disability shortly after a claim related to the illness or disability is submitted (e.g., a plan adopts a waiting period for HIV treatment shortly after receiving a claim for an HIV medication) is more likely to violate HIPAA's nondiscrimination provisions, the ADA, or other nondiscrimination laws. On the other hand, a waiting period for a service that is used to treat a wide variety of conditions (such as chiropractic services) generally would not impermissibly discriminate.

Remember, also, that HIPAA restricts PCEs—and health care reform prohibits PCEs entirely for plan years beginning on or after January 1, 2014. A benefit-specific waiting period would not violate the PCE limitations if it applies regardless of whether the treated condition was present before the first day of coverage. But some benefit-specific waiting periods can be "hidden" PCEs, since their primary effect is to exclude coverage for individuals whose conditions existed before they were enrolled in the plan (e.g., a 12-month waiting period for pregnancy benefits).

Source: EBIA Thomson Reuters