BenefitsBulletin

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Final Rule Implementing Mental Health Parity Rules

On Nov. 8, 2013, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (the Departments) jointly issued a **final rule** implementing the Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA).

MHPAEA is a federal law that generally prevents group health plans and health insurance issuers that provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical and surgical coverage.

The final rule increases parity between mental health/substance abuse disorder benefits and medical/surgical benefits in group and individual health plans.

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IRS Modifies FSA "Use-or-lose" Rules

A big change to the rules governing health flexible spending accounts (FSAs) in 2014 was recently announced by the Internal Revenue Service (IRS).

FSAs are tax-advantaged accounts that reimburse employees for certain medical expenses, up to the amount contributed for the plan year. Health FSAs are commonly offered through a cafeteria plan to allow employees to make pre-tax salary reduction contributions to their FSAs. Employers may provide health FSA benefits in addition to employees' salary reduction contributions.

On Oct. 31, the IRS released **Notice 2013-71**, which relaxes the "use-or-lose" rule for health FSAs. Previously, any money put into a health FSA could not be carried over into the next year, although reimbursements were allowed to be paid for qualified expenses incurred in a "grace period" of up to two and a half months after the end of the plan year.

Under the relaxed rule, employers will now be able to allow participants to carry over up to $500 in unused funds into the next year. Any unused FSA amounts over $500 will be forfeited. This modification applies only if the plan does not also incorporate the grace period rule.

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"Use-or-lose" Rule Changes

This new carryover does not affect the $2,500 limit on salary reduction contributions. This means the plan may permit the individual to elect up to $2,500 in salary reductions in addition to the $500 that may be carried over.

For ease of administration, a cafeteria plan is permitted to treat reimbursements of all claims for expenses that are incurred in the current plan year as reimbursed first from unused amounts for the current plan year and, only after exhausting these current plan year amounts, as then reimbursed from unused carryover amounts from the preceding plan year.

To implement the new $500 carryover option, a cafeteria plan offering a health FSA must be amended to include the carryover provision.

Transition Relief for Cancelled Health Plans

Over the last few months, millions of Americans have received notices informing them that their health insurance plans are being cancelled because they do not comply with Affordable Care Act (ACA) reforms set to go into effect in 2014.

In response, the White House issued a transition policy for 2014. Under the new policy, individuals and small businesses that have received cancellation notices due to their coverage not meeting ACA standards may be able to keep their coverage for an additional year.

Under this transitional policy, outlined in guidance issued by the Department of Health and Human Services on Nov. 21, health insurance coverage in the individual or small group market that is renewed for a policy year starting between **Jan. 1, 2014, and Oct. 1, 2014** (and associated group health plans of small businesses), will not be considered to be out of compliance with specified ACA reforms if certain conditions are met.

The transition relief only applies with respect to individuals and small businesses with coverage that was in effect on Oct. 1, 2013. It does not apply with respect to individuals and small businesses that obtain new coverage after Oct. 1. All new plans must comply with the full set of ACA reforms.

However, this one-year reprieve will not be available to all consumers. Because the insurance market is primarily regulated at the state level, state governors or insurance commissioners will have to allow for the transition relief. A number of states have announced that they will not allow the transition relief exception. Also, health insurance issuers are not required to take advantage of the transition relief and renew plans, and many have expressed concern that the change could disrupt the new risk pool under the federal and state health insurance Marketplaces.

On Dec. 19, HHS **announced two new options** for individuals whose policies have been cancelled. Individuals who have been notified that their individual market policy will not be renewed are now eligible for a hardship exemption from the individual mandate, and may enroll in catastrophic coverage if it is available in their area. The hardship exemption is intended for individuals who have suffered a hardship affecting their ability to obtain coverage under a qualified health plan.

Catastrophic health plans are plans that are intended to protect the participants from very high health costs. They generally have lower premiums than comprehensive plans but require the policyholder to pay all medical costs up to a certain amount, usually several thousand dollars. Catastrophic plans offered through the Marketplace cover three primary care visits per year and offer free preventive care benefits.

In order to purchase this catastrophic coverage, individuals will need to complete a hardship exemption form and indicate that their current health insurance policy is being cancelled, and that they consider other available policies to be unaffordable.

Mental Health Parity Rules

According to the Departments, the final rule ensures that health plan features like copays, deductibles and visit limits are generally not more restrictive for MH/SUD benefits than they are for medical and surgical benefits. The final rule also includes specific additional consumer protections, such as:

- Ensuring that parity applies to intermediate levels of care received in residential treatment or intensive outpatient settings;
- Clarifying the scope of the transparency required by health plans, including the disclosure rights of plan participants, to ensure compliance with the law;
- Clarifying that parity applies to all plan standards, including geographic limits, facility-type limits and network adequacy; and
- Eliminating an exception to the existing parity rule that was determined to be confusing, unnecessary and open to abuse.

The new rule finalizes interim rules that had been in place since February 2010. But because it only applies to plan or policy years beginning on after July 1, 2014, plans and insurers must continue to comply with the interim final regulations until the new rule takes effect.

Also, the MHPAEA does not require large group health plans and their health insurance issuers to cover MH/SUD benefits. The MHPAEA's requirements apply only to large group health plans and their health insurance issuers that choose to include MH/SUD benefits in their benefit packages.

Reinsurance Fee Changes for 2015

Beginning in 2014, the Affordable Care Act (ACA) requires a three-year transitional reinsurance program to be established in each state. This program is intended to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation (2014 through 2016) when individuals with higher-cost medical needs gain insurance coverage. This program will impose a fee on health insurance issuers and self-insured group health plans.

On Nov. 24, the Department of Health and Human Services (HHS) published its **2015 Notice of Benefit and Payment Parameters Proposed Rule**, which addresses the reinsurance program. This rule contains the proposed reinsurance payment parameters and reinsurance contribution rate for the 2015 benefit year, as well as certain oversight provisions related to the operation of the transitional reinsurance program.

First, the proposed rule would exempt certain self-insured, self-administered group health plans from the ACA's reinsurance contribution requirement by redefining a "contributing entity." This change is proposed to be effective for the 2015 and 2016 benefit years and applies to self-insured, self-administered group health plans that do not use a third party administrator for core processing functions.

Second, HHS announced that the annual contribution rate for 2015 will be $44 per enrollee per year.

Finally, HHS modified the reinsurance payment schedule, effective for the 2014 benefit year. Under the 2013 rule, contributing entities were required to submit payment within 30 days of receiving an HHS notification of the required reinsurance contribution. The proposed rule would change the collection schedule, requiring payment of reinsurance contributions in two installments—one at the beginning of the calendar year following the benefit year and one at the end of that calendar year. For example, for 2015, the proposed rule would require the newly defined "contributing entities" to pay the $44 per enrollee in a $33 allotment in January 2016 and $11 in the fourth quarter of 2016.

Please contact your Brown & Brown Consulting representative for more information.