Special Open Enrollment Offered to COBRA QBS and New ACA FAQs and COBRA Model Notices Released

Issue Date: May 2014

Individuals currently on COBRA have been offered a special one-time open enrollment period on the Federally Facilitated Marketplace. New FAQs, released by the Department of Labor (DOL), Health and Human Services (HHS), and the Treasury (IRS), clarify certain requirements in regard to the annual out-of-pocket maximum, coverage for preventive services, health FSA carryover, and summary of benefits and coverage (SBC). In addition, the DOL released notice of new proposed rules requiring plans to modify COBRA notices to inform COBRA qualified beneficiaries (QBs) of the availability of coverage and possible subsidies/cost-sharing through the Marketplace, as well as providing updated model COBRA notices and the CHIPRA notice to better describe the Marketplace and enrollment rights.

One-Time Special Enrollment Period for Individuals on COBRA

HHS also released guidance May 2 that created a one-time special enrollment period on the Federally facilitated Marketplace for individuals currently on COBRA. The special enrollment period was created because HHS felt that changes to existing COBRA notices may not have been made in time for many COBRA QBs to take advantage of the regular public Marketplace annual open enrollment period. This special enrollment period runs through July 1, 2014. The HHS guidance specifically mentions the special enrollment period in regard to the federally facilitated Marketplaces, but we expect that most, if not all, state-based Marketplaces will also extend these same special enrollment rights.

Employers should consider taking full advantage of this special open enrollment opportunity and aggressively communicate it to existing COBRA QBs. Since COBRA QBs are generally higher risk individuals, it is in the employer's interest to reduce the number of COBRA QBs covered by the employer plan. Many COBRA QBs may find that they can obtain more affordable individual coverage though the public Marketplace, especially if they qualify for subsidized coverage. Finally, the employer may not be able to rely on a third-party COBRA administrator to implement aggressive steps to reduce the number of COBRA QBs, since it is not necessarily in the administrator's best interest to see that number reduced.

COBRA/CHIPRA Model Notices

COBRA QBs may find more attractive and/or more affordable coverage through the public (Federal or State) Marketplace. The DOL released notice of new proposed rules (scheduled to be released May 7), as well as updated model notices for the COBRA general notice and election notice and the CHIPRA notice to better describe the Marketplace and enrollment rights. These proposed rules and the model notices were also addressed in the FAQs.

The updated model general notice and model election notice are available on the DOL website at www.dol.gov/ebsa/cobra.html and the model CHIPRA notice is available at http://www.dol.gov/ebsa/compliance_assistance.html. Although use of the model notice is not required, until rulemaking is finalized and effective, DOL will consider use of the model notices available on its website, appropriately completed, to constitute compliance with the notice content requirements of COBRA. There are no changes as to when and how such notices need to be provided.

Annual Out-of-Pocket Maximum

All non-grandfathered group health plans are required to comply with cost-sharing limitations in regard to out-of-pocket (OOP) maximums on essential health benefits. In 2014, these out-of-pocket maximums are $6,350 for self-only and $12,700 for family coverage. In 2015, the amounts will be $6,600 for self-only

coverage and $13,200 for family coverage. The FAQs clarify the following in regard to the annual out-of-pocket maximum:

- "Balance Billing" from out-of-network providers may, but is not required to, be counted toward the annual OOP maximum.
- Additional costs associated with brand name prescriptions when generic drugs were available and medically appropriate are not required to be counted toward the annual OOP maximum.
- Comments were requested on reference-based pricing (for example, a plan that sets a fixed reimbursement level for a particular procedure). Until guidance is issued, plans that utilize reference-based pricing will not be considered out of compliance if they treat providers who accept the reference amount as the only in-network providers, provided the plan uses a "reasonable" method to ensure that it provides adequate access to providers. In this case, balance billing by providers who do not accept the reference pricing would not need to be counted toward the OOP maximum. Additional guidance is expected that may tighten this rule somewhat.

Preventive Services

Non-grandfathered group health plans are required to provide certain preventive services without imposing any cost-sharing. The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. The FAQs clarify that a plan will be considered in compliance if, for example, the plan or issuer covers, without cost-sharing screening for tobacco use, and for those who use tobacco products, at least two tobacco cessation attempts per year.

Health FSA Carryover – Excepted Benefit Status

In order for a health FSA to maintain excepted benefit status, it must satisfy two conditions:

- *Maximum Benefit Condition.* The maximum benefit payable under the health FSA to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the health FSA for the year (or, if greater, the amount of the participant's salary reduction election for the health FSA for the year plus $500).
- *Availability Condition.* Other non-excepted group health plan coverage (e.g., major medical coverage) must be made available for the year to the class of participants by reason of their employment.

The FAQs provide clarification that the carryover amount (up to $500), if an employer chooses to implement the new health FSA carry over option, will not be taken into account when determining the maximum benefit amount for purposes of excepted benefit status.

Summary of Benefits and Coverage (SBC)

Plan administrators (for self-funded groups) and plan administrators and insurers jointly (for fully insured groups) are required to provide all participants and beneficiaries with an SBC to describe the "benefits and coverage under the applicable plan or coverage." The SBC must be accompanied by a uniform glossary. Templates and guidance were previously provided for the 1st and 2nd year of applicability.

The FAQs clarify that the SBC template provided in April 2013, available at http://cciio.cms.gov or http://www.dol.gov/ebsa/healthreform, remains valid until further guidance is issued. In addition, the enforcement guidance and transition relief previously provided via FAQs for the 1st and 2nd year of application of the SBC and Uniform Glossary requirements (e.g. circumstances in which an SBC may be provided electronically, penalties for failure to provide the SBC or uniform glossary, providing information about MEC and MV without changing the SBC template) are extended until further guidance is issued.

Summary

The special enrollment period for individuals on COBRA is good news for employers with large number of COBRA QB on the employer plan. And overall, the FAQs and proposed rules do not provide any "new" requirements, but rather address and clarify several questions in regard to existing requirements. The

FAQs are available at http://www.dol.gov/ebsa/faqs/faq-aca19.html#footnotes. The notice of proposed rules is available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-10416.pdf.