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Legal Developments Affect Open Enrollment for 2016

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Several legal developments affect the designs of group health plans in 2016. This brief refresher of those developments may be helpful to employers whose open enrollment is just around the corner.

1. ***New preventive care services.*** Starting in 2016, calendar year plans must cover additional preventive services that were recommended in 2014. Employers must offer a required preventive service or item without cost-sharing starting in the plan year that begins after the first anniversary of the date the coverage requirement is issued. The additional preventive services recommended by the US Preventive Services Task Force are available here. The complete list of preventive services that are currently required to be covered is available here. The preamble to recently published final regulations indicates the federal government intends to update the Healthcare.gov website to include (a) the dates that each preventive item or service was recommended and (b) new recommendations and guidelines.

2. ***Clarifications of required coverage for certain preventive services and items*.** Plans must implement the following clarifications to their coverage of preventive items and services:

- For plan years beginning on or after July 10, 2015, at least one form of contraception in each of the FDA-approved contraceptive methods for women (currently 18) must be covered. Because oral contraceptive methods, the vaginal contraceptive ring, the contraceptive patch, and emergency contraception are each separate methods, this means that a plan or issuer may not impose cost sharing on the ring or the patch. Within each method, plans may use reasonable medical management techniques, such as imposing cost sharing on some items to encourage an individual to use other items. However, the management techniques must have an exceptions process that is accessible, transparent, and expedient. In addition, an attending provider's recommendation for a particular FDA-approved item must be permitted to override the plan's management techniques.

- Sex-specific recommended preventive services, such as mammograms or pap smears, must be covered regardless of an individual's gender — for example a transgender individual who is recorded as a male by the plan — if the individual's attending provider determines that the service is medically appropriate.

- If a colonoscopy is scheduled and performed as a preventive screening procedure for

colorectal cancer, the plan may not impose cost sharing on anesthesia services performed in connection with the colonoscopy that were recommended by the attending provider.

- A plan must cover without cost sharing recommended genetic counseling and testing for breast cancer susceptibility genes (BCRA 1 or BCRA 2) for women who are at risk for harmful mutations in these genes based on their own personal history of non-BCRA-related breast or ovarian cancer and any other family history of cancer, as long as the woman is currently asymptomatic and cancer-free.

3. ***New out-of-pocket limits for family coverage.*** Starting in 2016, a plan must pay 100% of essential health benefit expenses that an individual enrolled in family coverage (*e.,* coverage for more than one person) incurs in excess of the statutory out-of-pocket limit for self-only coverage ($6,850 for 2016), even if the family has not yet incurred aggregate costs exceeding the out-of-pocket maximum for family coverage ($13,700 for 2016). For example, if a family of four enrolls in family coverage and the employee incurs $10,000 in qualifying out-of-pocket expenses, the plan must pay $3,150 — the difference between $10,000 and the $6,850 out-of-pocket limit for self-only coverage — even though the family has not yet met the collective $13,700 out-of-pocket limit for family coverage. It is possible that the agencies will revisit this requirement and perhaps delay the effective date in response to questions that Congressional leaders have recently posed about the statutory authority for the requirement. More information regarding the new out-of-pocket limit for family coverage is available here.

4. ***Proposed EEOC regulations would impose limits on incentive for participatory programs.*** The Equal Employment Opportunity Commission (the "EEOC") has proposed regulations that would extend incentive limits to "participatory" wellness programs that involve disability-related inquiries or medical examinations. As discussed in our earlier post, the proposed regulations may require changes to other employer wellness programs. Because it is uncertain whether the EEOC will adopt a prospective effective date for the regulations, employers should consider the proposed regulations in designing their wellness programs for 2016.

5. ***Final regulations on summaries of benefits and coverage ("SBCs").*** Starting for plan years beginning on or after September 15, 2015, if a plan administrator contracts with a third party to provide the SBC, the plan administrator will not be relieved of responsibility for satisfying the SBC requirements unless the plan administrator monitors the third party's performance and, in the event of noncompliance, either (a) corrects the noncompliance if the plan administrator has all information necessary to make the correction; or (b) discloses the noncompliance to affected participants and beneficiaries and takes steps to avoid future violations. Other amendments adopted in the recently published final regulations largely codify previous guidance and clarifications to the SBC requirements. Plan administrators may continue using the existing SBC template until the agencies finalize the proposed SBC template issued at the end of 2014. The new template, which is expected to be released in January 2016, will not apply before plan years beginning in 2017. A summary of proposed changes to the SBC template is available here.

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