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INSURANCE BRIEF

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Ringing in the ACA

The deadline to enroll for coverage in the Marketplace Exchanges effective 1/1 has passed and it remains to be seen whether additional extensions will be given for premiums to be paid. But it is clear that the most significant changes under the Affordable Care Act (ACA) have now taken effect:

- No pre-existing condition exclusions;
- Guaranteed issue and renewability;
- No annual or lifetime limits on essential health benefits;
- Coverage for all adult children to age 26—including those that have employer coverage;
- Waiting periods limited to 90 days (60 days for CA residents);
- Out-of-Pocket limits must comply with limits for H S A qualified plans;
- Small group market reforms: deductibles capped at $2,000/$4,000; rating restrictions; essential health benefits required; and
- Individual Mandate

Just to list a few! All of the above are effective for plan years beginning on or after 1/1/14.

What's Next? Hoping for guidance on the fully-insured discrimination testing provision this year. Possibly we will also see the guidance for auto-enrollment for groups with 200+ full-time employees. Until received neither provision will be implemented.

Federal court rulings are expected on two cases challenging the availability of premium tax credits under the ACA. The U.S. Supreme Court will hear at least one case involving women's preventive services.

2015: The employer mandate will be effective for plan years beginning on or after 1/1/15. We would like to see guidance on how the fiscal year plan and original transition rules are affected by the delay of pay or play. For now it is safest to assume no additional transition relief will be provided.

2018: High-value plan excise tax (Cadillac tax). Time will tell how this may change!

Your SML Account Team is here to answer any ACA questions.

How to Stop Fretting and Start Writing Your Will *by Rocket Lawyer*

If putting your final wishes in writing is a lower priority than cleaning the mildew from your shower grout, you're not alone. A full 61% of Americans don't have a Will.

It took fear of flying to prompt Janeen and Luis Mesa to create a Will. Before they boarded a flight to Texas, Luis, a novice flyer, began to worry about what would happen if his daughter from a previous marriage was left on her own. "He wanted to make sure she was cared for until she was of age," said Janeen Mesa, of Oakland, CA.

Making a Will forces you to make some important decisions—such as choosing an executor, appointing a guardian for your children, and divvying up your assets.

But it's also helpful to remember that:

#1: You Can Have Fun With It Christa Cywinski, a preschool director in Philadelphia, PA, got her Will done with the help of food, drink and friends. "We started talking about all the things that would be good to get down on paper, so at our next supper club we agreed to lay out all our intentions," she said. "We had a lovely evening full of laughs, drank good wine, and got a little silly with details about memorial services, etc."

Making the big decisions may feel a little less daunting in an informal environment, in the company of people you love.

#2: Good-enough Sometimes Trumps Perfection If you've got a family full of artists and marine biologists rather than lawyers and CPAs, it doesn't mean you're out of luck in choosing an executor to administer your will. It's true that an executor's duties are heavy on legal and financial details: they may include distributing your assets and possessions; paying taxes and bills on your estate; making any court appearances, administering trusts, and—if you own a family business or sole proprietorship—handling your business succession.

"I always tell people the person they choose doesn't need to have a great deal of legal or financial savvy, but they do need to know when to get help and how to have a reasonably competent conversation with the helpers—usually a lawyer or accountant," says Amy Shelf, a San Francisco attorney.

You can use alternates as a way to involve more people in your Will, which means that:

#3: You Don't Always Need to Make One Choice Unlike choosing an executor—a job that, inevitably, will be filled by someone, someday—you choose guardians in the hope that they'll never be called on. A guardian comes into play when both biological parents or legal guardians die before a child reaches adulthood.

If your children have many special people in their lives, it can be difficult to choose one family member or friend over another. Naming alternates is a way to include a variety of people you love and trust, and to allow for changing circumstances—such as aging parents and evolving family situations.

#4: Choosing Heirs Doesn't Have To Be Complex, Unless You Want It to Be Naming heirs is the heart of your Will, but deciding who gets what can be another emotional hurdle to getting it done. Who should get the family china or grandpa's watch? Who gets the house? And, if you have a family business, who should inherit it?

Typically, your beneficiaries will be your spouse, children, other close family members, charities—or really anyone else you name. As for bequests—who gets what—there are several basic types: specific bequests, such as who gets the china; general bequests, which are made from the estate as a whole; and residual bequests, or whatever is left.

You can make your bequests as detailed as you like, such as having money paid out over time or putting restrictions on funds going to a prolific spender. But if you don't have a clear idea of how you want to split up your assets, you can require that your estate be divided equally between specific people (be forewarned, however, that this could make your Will more challenging to administer, especially if family members have their eyes on specific items). No matter what, it's still important to name your heirs, or the court will do it for you.

#5: It's Not Really Final Until It's Final Despite the name—Last Will and Testament—a Will is not something you write on a stone tablet. It's quite a flexible document that can be modified at any time with a Codicil, or rewritten entirely. In fact, estate planning attorneys recommend that you revisit your will every few years, especially if you go through major life events.

Janeen Mesa said she and her husband are updating their Wills for the third time since that flight to Texas. Their oldest daughter is now an adult, their two younger children are still minors, and their assets have grown—and grown more complex. While they took a DIY approach in earlier versions, the latest version took more planning, and assistance.

It's better to have something in writing than to wait for perfection. So stop worrying, and get started!

Contact your SML account specialist to learn about how Rocket Lawyer can help you and your employees with estate planning and other legal matters through company-sponsored legal plans. Rocket Lawyer has helped over 20 million people with their legal needs, from creating documents to getting connected to attorneys.

Mental Health Parity Final Rules

On November 13, 2013, the Departments of Labor , Health and Human Services and Treasury issued final regulations implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). They also issued a new set of FAQs addressing implementation of MHPAEA as amended by the Affordable Care Act (ACA).

Background: The MHPAEA requires group health plans to provide parity between mental health or substance use disorder benefits and medical/surgical benefits. This applies to annual and lifetime dollar limits, deductibles, co-payments, co-insurance, out-of-pocket maximums and number of visits, or days of coverage. Interim final regs were issued in 2010 with which group health plans currently comply.

Effective Date: The MHPAEA regs apply to group health plans for plan years beginning on or after July 1, 2014.

Key Provisions: *Interaction with Lifetime and Annual Limit Prohibitions.* The final regs clarify that aggregation of annual and lifetime limits on mental health/substance use disorder benefits is only allowed on those benefits which are not essential health benefits (EHBs). This is true for both grandfathered and non-grandfathered plans.

Small Employer Exemption. Consistent with previous FAQ guidance the final regs reiterate that under the MHPAEA's small employer exemption the Departments will continue to exempt group health plans of employers with 50 or fewer employees. However, under ACA all insured, non-grandfathered small group plans are still required to cover EHBs in compliance with the MHPAEA regulations.

Interaction with Preventive Services Mandate. Included in the ACA preventive services to be covered without cost-sharing are alcohol misuse screening and counseling, depression counseling, and tobacco use screening. The final regs clarify that a group health plan providing these benefits solely to comply with the preventive services mandate is not required under MHPAEA to provide additional mental health/substance use disorder benefits. Group health plans will be relieved to know that they are not required to offer coverage for a broader range of mental health/substance use disorder benefits.

Tiered Networks and Other Sub-classification. The final regs retain the requirement that parity with respect to financial requirements and treatment limitations is determined separately for each of six classifications: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs. They also add that plans may create sub-classifications to address plan designs that have two or more network tiers of providers. For example, an in-network tier of preferred providers with more generous cost-sharing than a separate in-network tier of participating providers. The final regs make it clear that plans may not use sub-classifications not specifically permitted by the regs.

Guidance on Scope of Coverage for "Intermediate Services". The final regs address parity in the scope of services that must be covered and how certain services fit into the classifications. They clarify that a plan must assign covered intermediate mental health/substance use disorder benefits to the existing six classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a plan classifies medical care in skilled nursing facilities as inpatient benefits, then it must treat covered mental health care in residential treatment facilities as inpatient benefits.

Applicability to EAPs. The final regs confirm that EAPs are excepted benefits if they do not provide significant benefits in the nature of medical care or treatment. The Departments are developing a significant-benefits test and until released determination can be made using a reasonable, good faith interpretation.

Please contact your SML Account Team if you have any questions about how this impacts your policy.

Self-Funded Excepted Benefits Relief

The Department of Labor, Department of Health and Human Services, and the Internal Revenue Service (the Agencies) have done it again. Another holiday surprise! The Federal Register published a proposed rule regarding HIPAA's Excepted Benefits Rule on December 24, 2013.

Background: Under HIPAA Regulations currently in effect, insured limited scope vision and dental plans are considered Excepted Benefits. However self-funded dental and vision plans must meet two additional requirements to be considered Excepted Benefits:

- Employee must elect the coverage separately from any medical plan; and,
- Employee must contribute toward the cost of coverage (i.e. employee contribution requirements).

If these additional conditions are not met, then the plans would be subject to the Affordable Care Act (ACA). For calendar year group health plans, the self-funded plan must include minimum essential benefits and meet other standards specified in IRC Section 9815 as of January 1, 2014 or be subject to a $100/day per participant penalty. Fiscal year health plans become subject to these rules on the first day of the 2014 plan year. The requirements under IRC Section 9815 include in part: no lifetime or annual limits, no preexisting condition limitations, preventive care at no cost, no excessive waiting periods and additional notice requirements. Plenty of reasons to want to be excepted!

Key Provision: The proposed rule eliminates the need for an employee contribution for a self-funded, limited scope dental or vision plan as a requirement to be considered an "Excepted Benefit."

Employees still must be given the option to elect the coverage on a freestanding basis, separately from the election to participate in medical coverage. If the self-funded dental and medical coverage is offered on a combined basis, the dental or vision plan will become subject to ACA, including the preexisting condition limitations and elimination of annual or lifetime maximums. It's worth noting that certain dental procedures are subject to preexisting condition limitations such as the five-year replacement rule and the one-tooth extraction requirements.

Effective Date: Plan years beginning on or after January 1, 2015. However, the Agencies will consider limited scope dental and visions plans, as well as EAPs, as meeting the conditions of these proposed regulations through 2014 or later, pending the release of final regulations. In the event the final regulations are more restrictive than these proposed regulations, the final regulations will not become effective prior to January 1, 2015. In other words, these proposed regulations are in effect for 2014!

Healthy San Francisco Solution: Although relevant to only clients with employees working in San Francisco, this proposed ruling can help achieve compliance with the San Francisco Health Care Security Ordinance (HCSO). The HCSO accepts contributions to an HRA reimbursing only dental and vision as meeting the health care expenditure requirement. As of January 1, 2014, stand-alone HRA's cannot reimburse medical expenses. Employers who are interested in this limited HRA solution should contact their SML Account Teams.