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More Agency FAQs Issued on Health Care Reform

The agencies have jointly issued another set of FAQs (Part V) on the implementation of health care reform, mental health parity, and HIPAA nondiscrimination for wellness programs. Like FAQs I to IV issued earlier, these FAQs address a range of plan design and health reform implementation issues related to employer-sponsored coverage. The Department of Labor has updated its website to add links to the FAQs and other information on health reform. Among other things, the FAQs address the following:

- **Value-based insurance design for preventive care benefits** - Health reform generally requires that non-grandfathered group health plans provide coverage for recommended preventive services without cost sharing. These group health plans are permitted to use reasonable medical management techniques to control costs, including utilizing value-based insurance designs (VBID) that provide incentives for enrollees to utilize higher-value and/or higher-quality services or venues of care. The FAQ guidance confirms that this includes the use of copayments to steer patients towards a particular high-value setting, such as an ambulatory care setting, provided the plan accommodates any individuals for whom it would be medically inappropriate to have the preventive service provided in the high-value setting.
- **Automatic enrollment in health plans** - Under health reform, employers with more than 200 full-time employees are required to automatically enroll new full-time employees in the employer's health benefits plans and continue enrollment of current employees. The FAQs provide that until implementing regulations are issued, employers are not required to comply with the automatic enrollment requirement. It is expected that automatic enrollment rulemaking should be completed by 2014.
- **60-day prior notice for material modifications** - Health reform provides that by March 23, 2012, group health plan sponsors must provide a benefits summary during annual open enrollment and when someone first becomes eligible for coverage. The summary is required to be short, contain non-technical language and cover "essential health benefits" and other topics (under standards to be developed by March 23, 2011). Health reform also provides that if a group health plan makes any material modification in any of the terms of the plan involved that is not reflected in the most recently provided summary of benefits and coverage, the plan must provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective. The effective date of this provision has been unclear. The FAQs clarify that group health plans are not required to comply with the 60-day prior notice rule until they are required to provide the summary of benefits and coverage pursuant to the standards issued by the agencies (the agencies have not yet issued those standards).

- **Dependent coverage of children to age 26** - Health reform provides that the terms of a group health plan providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older). While this generally prohibits distinctions based upon age in dependent coverage of children, it does not prohibit distinctions based upon age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children. So, for example, the FAQs clarify that a plan may impose age-based rules regarding benefits and coverage (such as an increased copayment for physician visits for individuals over age 19) so long as the age-based rules apply broadly to all plan participants, including employees, spouses, etc., and are not limited in application to adult children above or below a specified age.
- **Grandfathered health plans** - The FAQ guidance provides that if a plan or coverage has a fixed-amount cost-sharing requirement other than a copayment (for example, a deductible or out-of-pocket limit) that is based on a percentage-of-compensation formula, the cost-sharing arrangement will not cause the plan or coverage to cease to be a grandfathered health plan as long as the formula remains the same as that which was in effect on March 23, 2010. Accordingly, if the percentage-of-compensation formula for determining an out-of-pocket limit is unchanged and an employee's compensation increases, then the employee could face a higher out-of-pocket limit, but that change would not cause the plan to relinquish grandfather status.
- **Mental Health Parity implementation** - The FAQs provide:
    - Confirmation that group health plans of small employers (50 or fewer employees, or 100 or fewer for nonfederal governmental plans) are exempt from the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
    - Clarification that MHPAEA requires that the criteria for medical necessity determinations made under a plan with respect to mental health or substance use disorder benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request.
    - Clarification that documents with information on the medical necessity criteria for both medical and mental health /substance use disorder benefits are plan documents, and under ERISA, must be furnished within 30 days of request.
    - Provision of an interim enforcement safe harbor for MHPAEA's increased cost exemption for plans that make changes to comply with the law and incur an increased cost of at least 2% in the first year that MHPAEA applies to the plan or at least 1% in any subsequent plan year. The exemption lasts for one year, generally after which the plan must comply again.
- **HIPAA nondiscrimination for wellness programs.** The FAQs provide clarification as follows:
    - Not all employment-based wellness programs are required to check for compliance with the HIPAA nondiscrimination provisions (if an employer operates a wellness program as an employment policy separate from its group health plan, the program may be covered by other Federal or State nondiscrimination laws, but it is not subject to the HIPAA nondiscrimination regulations).
    - If a wellness program is not based on an individual satisfying a standard that is related to a health factor, it does not have to satisfy the five criteria in the HIPAA nondiscrimination regulations.
    - In general, among other things, a wellness program subject to the HIPAA nondiscrimination regulations must be available to all similarly situated individuals, provide a reasonable alternative standard, and the reward must be limited to no

more than 20% of the total cost of coverage.

- The agencies intend to propose regulations that use existing regulatory authority under HIPAA to raise the percentage for the maximum reward that can be provided under a health-contingent wellness program to 30% before the year 2014 and are also considering what accompanying consumer protections may be needed to prevent these programs from being used as a subterfuge for discrimination based on health status. More guidance is expected early next year.

The agencies intend to issue further guidance on these and other health reform requirements in the future.

Employers are advised to continue to monitor health reform developments. Should you have questions about this or any aspect of federal health insurance reform, contact your Conner Strong account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong, visit our online Resource Center.

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