Employee Benefits Advisory

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Departments of Labor and Health and Human Services Issue Joint Guidance under the Affordable Care Act and MHPAEA

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On December 23, 2010, the Departments of Labor and Health and Human Services (the "Departments") issued helpful new guidance under both the Patient Protection and Affordable Care Act of 2010, as amended (the "Affordable Care Act") and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The guidance—which is in the form of Frequently Asked Questions (FAQs)—is the fifth in a series of FAQs issued on the Department of Labor's website.[1] While the prior FAQs were limited to issues arising under the Affordable Care Act, this FAQ also tackles questions under MHPAEA. This client alert summarizes the important features of this latest guidance, which is referred to below as the "FAQ."

Affordable Care Act

Value-Based Insurance Design in Connection with Preventive Care Benefits

Public Health Service Act (PHSA) section 2713, as added by the Affordable Care Act, generally requires non-grandfathered group health plans and individual health insurance policies and contracts to provide coverage for recommended preventive services without cost sharing. This requirement is the subject of an interim final rule issued July 19, 2010, which, among other things, generally encourages plans to apply reasonable medical management techniques. The FAQ gives plans the green light to adopt value-based insurance designs (VBIDs), i.e., "health plan designs that provide incentives for enrollees to utilize higher-value and/or higher-quality services or venues of care."

The FAQ cites with approval the following VBID: A group health plan that imposes no copayment for colorectal cancer preventive services when performed in an in-network ambulatory surgery center *may* impose a copayment on the same services when provided at an in-network outpatient hospital setting, provided the plan accommodates any individuals for whom it would be medically inappropriate to have the preventive service provided in the ambulatory setting (as determined by the attending provider) by waiving the otherwise applicable copayment for the preventive services provided in a hospital.

Automatic Enrollment

Under an amendment to the Fair Labor Standards Act (FLSA), the Affordable Care Act requires employers with more than 200 full-time employees to automatically enroll new full-time employees and continue enrollment of current employees in the employer's health benefits plans. There is no effective date for this provision, which usually means that the provision is effective on enactment. But the law also requires that this rule will be applied "[i]n accordance with regulations promulgated by the Secretary [of Labor]." Most practitioners assumed that the rule would not take effect until the Departments issued the rules that the statute envisioned.

The Departments used the FAQ to advise that rulemaking under this provision has been delegated to the Departments' Employee Benefits Security Administration (EBSA). More to the point (at least from the perspective of employers and their advisors), the FAQ confirms that employers are *not* required to comply with the automatic enrollment requirements until regulations are issued. The Departments intend to issue this regulation by 2014.

Disclosure under PHS Act Section 2715(d)(4)

PHSA section 2715 as added by the Affordable Care Act requires group health plans to provide a summary of benefits and coverage explanation that "accurately describes the benefits and coverage under the applicable plan." As is the case with the automatic enrollment requirement, no effective date was specified. But the law directs the Departments to develop standards for use by group health plans and health insurance issuers in compiling and providing a summary of benefits and coverage explanation not later than 12 months after the date of enactment. This FAQ clarifies that "group health plans and health insurance issuers are not required to comply with the 60-day prior notice requirement for material modifications" until regulations are issued. (The regulators have not yet issued these standards.)

Dependent Coverage of Children to Age 26

An interim final rule issued under PHSA section 2714 (as added by the Affordable Care Act) clarifies that group health plans or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older). The FAQ posits (and approves of) a group health plan design feature under which the plan charges a copayment for physician visits that do not constitute preventive services. The plan charges this copayment to individuals age 19 and over, including employees, spouses, and dependent children, but waives it for those under age 19. According to the Departments, distinctions based upon age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children, are permitted. Here, the copayments charged to dependent children are the same as those charged to employees and spouses. Therefore, this arrangement does not violate PHSA section 2714.

Pre-existing Condition Exclusions for Children in the Individual Market

The FAQ recognizes and expressly allows states to permit carriers to screen applicants for eligibility for alternative coverage options before offering a child-only policy, if allowed under applicable state law. This is an important concession on the part of the Departments, since it was feared that carriers would cease offering "child-only" polices in the face of a complete bar on medical underwriting. The FAQ does impose some limits, however. Screening is limited to circumstances in which *all* child-only applicants, regardless of health status, undergo the same screening process, and the alternative coverage options include options for which healthy children would potentially be eligible, such as the Children's Health Insurance Program (CHIP). The screening process may not be limited to programs targeted to individuals with a pre-existing condition, such as the state's high risk pool, nor may it be applied to offers of dependent coverage for children (in light of the Affordable Care Act requirement of offering coverage to dependents up to age 26).

Grandfathered Health Plans

The grandfather rules continue to be a source of confusion. This FAQ posits a plan term under which out-of-pocket spending limits (e.g., a deductible or out-of-pocket limit but not copayment) are based on a formula (a fixed percentage of an employee's prior year compensation). If the formula stays the same, but a change in earnings results in a change to the out-of-pocket limits, will the plan relinquish grandfather status? "No," say the Departments. If a plan or coverage has a fixed-amount cost-sharing requirement other than a copayment that is based on a percentage-of-compensation formula, that 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.

The Mental Health Parity and Addiction Equity Act of 2008

Generally, MHPAEA requires that the financial requirements and treatment limitations imposed on mental health and substance use disorder benefits under the group health plans of all employers (other than "small employers") cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits. The FAQ addresses the following questions under MHPAEA:

How is "Small Employer" Defined?

For nonfederal governmental plans, the Affordable Care Act amended the PHSA to define a "small employer" as one that has 100 or fewer employees. The FAQ explains that the definition of "small employer" under the Employee Retirement Income Security Act (ERISA)—i.e., an employer with 50 or fewer employees—has not changed. Therefore, group health plans of employers with 50 or fewer employees continue to be exempt from MHPAEA's requirements.

Access to Medical Necessity Determinations/Medical Necessity Standards

The FAQ notes that, under MHPAEA and its implementing regulations, the criteria for medical necessity determinations made under a plan or health insurance coverage with respect to mental health or substance use disorder benefits *must* be made available by the plan administrator or health insurance issuer to any current or potential participant, beneficiary, or contracting provider upon request. Similarly, ERISA requires plan administrators to provide copies of plan documents,[2] which include information on the medical necessity criteria for both medical/surgical benefits and mental health/substance use disorder benefits. (Since these rules are well-settled under current law, this FAQ appears to be intended to provide claimants with ready access to applicable law.)

MHPAEA Increased Cost Exemption

MHPAEA contains an increased cost exemption that is available 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 (i.e., the first plan year beginning after October 3, 2009) or at least 1% in any subsequent plan year (generally, plan years beginning after October 3, 2010). Interim final regulations implementing MHPAEA did not provide guidance for implementing the increased cost exemption. This FAQ fleshes out an interim enforcement safe harbor under which a plan that has incurred an increased cost of 2% during its first year of compliance can obtain an exemption for the second plan year by following the exemption procedures described in the Departments' 1997 MHPA regulations, with some minor modifications.

Non-Discrimination Based on a Health Factor and Wellness Programs

The FAQ includes a surprisingly comprehensive discussion of Health Insurance Portability and Affordability Act (HIPAA) rules prohibiting discrimination in eligibility, benefits, or premiums based on a health factor and the accompanying exception for certain "wellness programs" under a final regulation issued in 2006. The final regulations generally divide wellness programs into two categories.

1. First, programs that do not require an individual to meet a standard related to a health factor in order to obtain a reward are not considered to discriminate under the HIPAA nondiscrimination regulations and, therefore, are permissible. The FAQ refers to these as "participatory wellness programs." (Examples include a fitness center reimbursement program, a diagnostic testing program that does not base rewards on test outcomes, a program that waives cost-sharing for prenatal or well-baby visits, a program that reimburses employees for the cost of smoking cessation aids regardless of whether the employee quits smoking, and a program that provides rewards for attending health education seminars.)
2. The second category of wellness programs consists of programs that require individuals to satisfy a standard related to a health factor in order to obtain a reward. The FAQ calls these "health-contingent wellness programs." (Examples include a program that requires an individual

to obtain or maintain a certain health outcome in order to obtain a reward, such as being a non-smoker, attaining certain results on biometric screenings, or exercising a certain amount.) Health-contingent wellness programs must include the following safeguards:

- The total reward for the wellness programs offered by a plan sponsor must not exceed 20% of the total cost of employee-only coverage under the plan.
- The program must be reasonably designed to promote health or prevent disease.
- The program must give eligible individuals an opportunity to qualify for the reward at least once per year.
- The reward must be available to all similarly situated individuals. For this purpose, a reasonable alternative standard (or waiver of the original standard) must be made available to individuals for whom it is unreasonably difficult due to a medical condition to satisfy the original standard during that period (or for whom a health factor makes it unreasonably difficult or medically inadvisable to try to satisfy the original standard).
- In all plan materials describing the terms of the program, the availability of a reasonable alternative standard (or waiver of the original standard) must be disclosed.

Effective in 2010, the Affordable Care Act largely incorporates the provisions of the Departments' joint final regulations with a few clarifications; it also changes the maximum reward that can be provided under a health-contingent wellness program from 20% to 30%.

The Departments clarified the following items:

Scope of the Wellness Program Rules

Not all "wellness programs" are subject to the HIPAA wellness program rules. Recognizing that "employers offer a wide range of programs to promote health and prevent disease," the Departments said that "a wellness program is subject to the HIPAA nondiscrimination rules only if it is, or is part of, a group health plan." Therefore, for example, a program that provides or subsidizes healthier food choices in the employee cafeteria, provides pedometers to encourage employee walking and exercise, pays for gym memberships, or bans smoking on employer facilities and campuses is not a "wellness program" for HIPAA purposes. These programs may be covered by other federal or state nondiscrimination laws, but they are not subject to the HIPAA nondiscrimination regulations.

Premium Discounts that Exceed 20%

The rule limiting the amount of the reward for health-contingent wellness programs to 20% of the cost of coverage applies only to health-contingent wellness programs. Therefore, a group health plan may provide an annual premium discount of 50% of the cost of employee-only coverage to participants who adhere to a wellness program which consists of attending a monthly health seminar.

Health-contingent Wellness Programs Limits

Wellness program based on a health factor (e.g., achieving a cholesterol count of 200 or lower) are health-contingent wellness programs, which are subject to the HIPAA nondiscrimination regulations, including the five criteria described above. Thus, the program must be available to all similarly situated individuals and provide a reasonable alternative standard, and the reward must be limited to no more than 20% of the total cost of coverage. For example, a group health plan that gives an annual premium discount of 20% of the cost of employee-only coverage to participants who achieve a cholesterol count of 200 or lower satisfies this rule, provided that if it is unreasonably difficult or medically inadvisable to achieve the targeted cholesterol count within a 60-day period, the plan will make available a reasonable alternative standard that takes the relevant medical condition into account.

Combined Participatory Wellness Program and Health-contingent Wellness Program

Plans may maintain both participatory wellness programs and health-contingent wellness programs, provided that the reward under the health-contingent wellness component is limited to 20% of the cost of coverage and the component otherwise satisfies the five factors described above.

Conclusion

As is the case with the previous four FAQs, this most recent installment is both welcome and useful. The clarifications on automatic enrollment and the effective dates of benefits summaries are particularly important. The positions taken in the FAQs on these items reflect what many *thought* to be the rules. Having official word, however (even if only in sub-regulatory guidance), provides an important measure of comfort. The MHPAEA clarifications appear to have a different purpose. Anecdotal evidence (and, to a much more limited extent, our own experience) indicates that compliance with these rules was "spotty" at best. The Departments appear to have chosen this vehicle to call attention to the rules in a format that is likely to attract widespread attention.

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Endnotes

1 Click here for a copy. The previous FAQs were issued on September 20, 2010, October 8, 2010, October 12, 2010, and October 29, 2010.

2 ERISA § 104(b); 29 CFR 2520.104b-3.

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