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Health Agencies Release Guidance on Health Care Reform, Mental Health Parity and HIPAA Wellness Programs

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Over the last few months, the Departments of Labor, Health and Human Services, and Treasury (collectively, the "Departments") have issued Frequently Asked Questions ("FAQs") to address issues that have been raised about the Patient Protection and Affordable Care Act ("PPACA"). The latest set of FAQs , dated December 28, 2010, address several important issues including the application of "value-based insurance design" to control costs, and the effective dates for requirements regarding automatic enrollment and advance notice of material changes. In addition, the FAQs also provide guidance regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") nondiscrimination rules for wellness programs.

The Patient Protection and Affordable Care Act

Value-Base Insurance Design: The PPACA generally requires that group health plans cover recommended, in-network preventive services without employee cost sharing. A group health plan may use reasonable medical management methods to control costs. The FAQs confirm that plans may steer enrollees toward more cost-efficient service providers through value-based insurance designs ("VBID"). For example, a group health plan may have no copayment for preventive services performed at an in-network ambulatory surgery center, but have a $250 copayment for the same services performed at an in-network outpatient hospital, because the ambulatory center is a higher-value setting than the outpatient hospital. However, the plan must accommodate an individual who cannot use the ambulatory center because it is medically inappropriate, as determined by the patient's physician.

Automatic Enrollment for New Employees: The PPACA requires that employers with more than 200 full-time employees automatically enroll new full-time employees in the employer's health plan. The effective date of this provision was unclear. The FAQs clarify that employers will not be required to comply with automatic enrollment until the DOL develops rules, including rules to determine full-time employee status, which it expects to issue by 2014.

Notice of Plan Modifications: The PPACA requires that group health plans provide 60 days advance notice to enrollees of a material modification to the plan's terms or coverage. Employers are not required to comply with this mandate until the Departments issue further guidance.

Varying Coverage Based on Age: The PPACA provides that group health plans providing dependent coverage for children cannot vary such coverage based on age (except if they are 26 or older). While this generally prohibits distinctions based upon age in dependent coverage, it does not prohibit distinctions based on age that apply to all enrollees, including employees, spouses, and dependent children. For example, the FAQs provide that a plan could waive

a copayment for all enrollees under age 19, but require a co-payment for those over 18.

Grandfathered Health Plans: A grandfathered group health plan can lose its grandfather status if it impermissibly increases out-of-pocket expenses or deductibles. The FAQs clarify that where a grandfathered plan has a fixed cost-sharing requirement (other than a copayment) that is based on a percentage-of-compensation formula, an increase in cost sharing resulting solely from a compensation increase will not cause the plan to lose grandfather status as long as the formula remains the same as it was on March 23, 2010.

Mental Health Parity and Addiction Equity Act of 2008

The MHPAEA generally requires that financial requirements (e.g., co-insurance or co-payments) and treatment limitations (e.g., limits on the number of visits) imposed on mental health and substance use disorder benefits cannot be more restrictive than the predominant financial restrictions and treatment limitations imposed on medical and surgical benefits. The FAQs make the following clarifications:

Small Employer Exemption: Group health plans that are subject to ERISA will continue to be exempt from the MHPAEA as a "small employer" if the employer has 50 or fewer employees. The FAQs note, however, that nonfederal government plans are subject to the PPACA definition of "small employer," which applies to an employer that has 100 or fewer employees.

Disclosure Requirements: The FAQs clarify that a current or potential participant, beneficiary, and medical provider is entitled, upon request, to receive a copy of the group health plan's medical necessity criteria for mental health/substance use disorder benefits. Similarly, the FAQs emphasize that documents which disclose the medical necessity criteria for both medical/surgical benefits and mental health/substance use benefits are ERISA plan documents, and must be furnished within 30 days of a written request.

Increased Cost Exemption: If a plan makes changes to comply with the MHPAEA and those compliance changes cause its overall plan costs to increase by more than 2% in the first year the MHPAEA applies to it, or 1% in any subsequent year, then the plan is exempt from the MHPAEA the following year. The

FAQs clarify that, until the Departments issue regulatory guidance on how the increased cost exemption will be implemented, plans can follow the procedures outlined in 1997 regulations. When calculating the cost increases, the plan should include increases in the plan's portion of cost sharing, and must amortize non-recurring administrative costs. Plans applying for an exemption must further demonstrate that cost increases are directly attributable to MHPAEA compliance rather than utilization or prices, random claim experiences, or seasonal variation.

HIPAA Wellness Programs

HIPAA prohibits discrimination in eligibility, benefits, or premiums based on health factors. A wellness program which offers employees a reward (such as lower premiums) if they meet a certain health standard (such as losing weight) must satisfy the following nondiscrimination requirements: (1) the total reward cannot exceed 20% of the total cost of employee-only coverage; (2) the program must be reasonably designed to promote health or prevent disease; (3) the program must provide employees an opportunity to qualify for the reward at least once per year; (4) the reward must be available to all similarly situated employees (which means there must be a reasonable alternative standard for employees with a health condition that makes it unreasonably difficult for them to satisfy the original standard); and (5) the availability of the alternative standard is published in plan materials. The PPACA incorporates these nondiscrimination rules and, effective beginning in 2014, changes the maximum reward from 20% of the total cost of coverage to 30%.

Independent Wellness Programs: The FAQs clarify that only wellness programs that are part of a group health plan are subject to the nondiscrimination rules. Examples of wellness programs that are not part of a group health plan and, therefore, not subject to the nondiscrimination rules include: subsidizing healthier cafeteria food and gym memberships, providing pedometers (to encourage walking and exercise), and banning smoking in the workplace.

***No Health Standard*:** The FAQs explain that the nondiscrimination rules only apply to wellness programs that

require employees to meet a certain health standard to obtain a reward. For example, the nondiscrimination rules are inapplicable to a group health plan that gives an annual premium discount of 50% of the cost of coverage to employees who attend a monthly health seminar. A second example clarifies that an employer may have more than one wellness program, each of which provides a 20% award, as long as only one of the award programs is conditioned on satisfaction of a health standard.

Nondiscrimination Rules: The FAQs provide an example demonstrating application of the nondiscrimination rules to a wellness program that requires satisfaction of a health standard. In the example, a group health plan offers, as part of its wellness program, a discount of 20% of the cost of employee-only coverage to employees that achieve a cholesterol count of 200 or lower, and provides that if it unreasonably difficult for an employee to satisfy the cholesterol count within a 60-day period, then the plan will create a reasonable alternative standard that takes into account the employee's health condition. The FAQs conclude that the plan complies with the nondiscrimination rules because the total reward does not exceed 20% of the total cost of employee-only coverage, and because it includes a reasonable alternative standard, is treated as being available to all similarly situated individuals.

King & Spalding would be pleased to provide you with additional information and assist you with implementation of the myriad of health care reform changes under the PPACA, MHPAEA and HIPAA.

DOL Proposes New Disclosure Requirements for Qualified Default Investment Alternatives and Target Date Funds

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On November 30, 2010, the Department of Labor ("DOL") issued proposed regulations that will require plan fiduciaries to make additional disclosures to participants and beneficiaries with respect to qualified default investment alternatives ("Default Investments") generally and target date funds ("TDFs") specifically even where the TDFs are not one of a plan's Default Investments. To view these proposed regulations, click here.

Background

The Pension Protection Act of 2006 added a new Section 404(c)(5) to ERISA. This new section provided fiduciary relief for a plan fiduciary who takes action to invest a participant's self-directed individual account in specified Default Investments because the participant failed to make an investment election for his or her self-directed individual account. The DOL published final regulations implementing the provisions of Section 404(c)(5) of ERISA with respect to Default Investments on October 24, 2007 ("2007 Regulations"). A plan fiduciary who complies with the final regulations is not liable for any loss, or by reason of any breach, that occurs as the result taking action to make a Default Investment on behalf of participants who do not make an investment election.

One of the permissible Default Investments under the 2007 Regulations was an investment fund or model portfolio that changed its asset allocations and associated risk levels over time based on a participant's age, target retirement date, or life expectancy, now commonly referred to as a TDF.

In order for a fiduciary to take advantage of the relief provided under Section 404(c)(5), participants and beneficiaries must be provided an initial notice and an annual notice containing information about the plan's Default Investments. In addition to the notice requirement, fiduciaries must also provide certain investment-related information pursuant to Section 404(c) of the regulations.

Since the issuance of the 2007 Regulations, the DOL has continued to receive questions regarding the notice. The DOL issued a Field Assistance Bulletin in April 2008 that addressed these questions and indicated at that time, it was developing a regulation to establish disclosure requirements for all participant-directed individual account plans which would address how to satisfy the investment fee and expense disclosures.

On October 20, 2010, the DOL issued these final participant disclosure regulations which provide that the ERISA Section

404(a) fiduciary rules are satisfied only if certain plan and investment-related disclosures are made to participants in a participant-directed individual account plan ("2010 Regulations"). The 2010 regulations apply to all participant directed individual account plans even if such plans are not attempting to get ERISA Section 404(c) relief.

In addition, recent attention has been given to the increased use of TDFs. After public hearings and an extensive review of materials relating to TDFs, the DOL and the SEC published a joint Investor Bulletin to help educate investors and plan participants who intend to invest in TDFs, and the SEC issued proposed rules to address concerns regarding the potential for investor misunderstandings about TDFs. *[See K&S Compensation & Benefits Insights, August, 2010]*

Proposed amendments

The DOL has now issued proposed amendments to both the 2007 Regulations and the 2010 Regulations.

The proposed amendments amend the 2007 Regulations to more specifically describe certain investment-related information that must be included in the Default Investment notice to participants and beneficiaries, which is intended to complement the new investment-related disclosure requirements in the 2010 Regulations. For example, the proposed amendments require that the plan fiduciary provide to a participant or beneficiary comparable materials with respect to a participant's or beneficiary's investment in a Default Investment to the materials described in section 2550.404a-5(d)(3) and (4) of the 2010 Regulations. Further, the initial and annual Default Investment notices under the 2007 Regulations only require that the notice include "a description of the qualified default investment alternative, including a description of the investment objectives, risk and a return characteristics (if applicable), and fees and expenses attendant to the investment alternative".

To better conform these requirements to those of all participant-directed individual account plans under the 2010 Regulations, the proposed regulations would clarify that investment-related information for any Default Investment must include all of the following elements:

- the name of the investment's issuer;
- the investment's objectives or goals;
- the investment's principal strategies (including a general description of the types of assets held by the investment), and the principal risks (as required by the applicable SEC form);
- the investment's historical performance data (e.g., 1, 5 and 10 year returns) and, if applicable, any fixed return, annuity, guarantee, death benefit, or other ancillary features; as well as a statement indicating that an investment's past performance is not necessarily an indication of how the investment will perform in the future;
- the investment's attendant fees and expenses, including: any fees charged directly against the amount invested in connection with an acquisition, sale, transfer of, or withdrawal (e.g., sales loads, sales charges, deferred sales charges, redemption fees, surrender charges, exchange fees, account fees, and purchase fees); any annual operating expenses (e.g., expense ratio); and any ongoing expenses in addition to annual operating expenses (e.g., mortality and expense fees); and
- with respect to a TDF,
    - an explanation of the asset allocation, how the asset allocation will change over time, and the point in time when the investment will reach its most conservative asset allocation, including a chart, table, or other graphical representation that illustrates such change in asset allocation over time and that does not obscure or impede a participant's or beneficiary understanding of the information explained;
    - if the TDF name includes a particular date (like a TDF for 2030), an explanation of the age group for whom the investment is designed, the relevance of the date, and any assumptions about a participant's or beneficiary's contribution and withdrawal intentions on or after such date; and
    - if applicable, a statement that the participant or beneficiary may lose money invested in the TDF,

including losses near and following retirement, and that there is no guarantee that the investment will provide adequate retirement income.

The proposed regulations will also amend the 2010 Regulations to include in the participant or beneficiary disclosure (in an appendix) the above three elements with respect to TDFs.

The 2007 Regulations already require that "an explanation of where the participants and beneficiaries can obtain investment information concerning the other investment alternatives available under the plan." Under the proposed rules, this requirement is expanded to allow the participants and beneficiaries to also obtain additional investment information concerning *the Default Investment and the other investment alternatives.* In

addition, the Default Investment disclosure must include a description of the right of a participant invested in a Default Investment to redirect those investments, including a description of fees and limitations that may apply if the participant wants to redirect the investment and an explanation of where additional information may be obtained.

Effective date

The DOL proposes that the amendments contemplated in the proposed regulations will be effective 90 days after publication of the final rule in the Federal Register.

What's to come

The DOL has stated it intends to publish a series of tips intended to assist plan fiduciaries in obtaining and evaluating relevant information when selecting and monitoring TDFs as investment options for participant-directed retirement plans. Further, the DOL is reexamining the electronic disclosure standards that govern the furnishing of notices under the 2007 and 2010 Regulations and will be issuing proposed regulations on electronic distribution in the near future.

King & Spalding continues to monitor guidance issues on Default Investments and TDFs and electronic disclosures. We will be happy to discuss the proposed rules described above with you.

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IRS Delivers Two December Gifts: Notices 2011-1 and 2011-5

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Prior to the end of 2010, the Internal Revenue Service ("IRS") released two notices providing additional guidance on two new health plan-related requirements under the Patient Protection and Affordable Care Act of 2010, and the Worker, Retiree and Employee Recovery Act of 2010 (together, "PPACA"). IRS Notice 2011-1

provided welcome relief to employers sponsoring insured, non-grandfathered group health plans that offer enhanced features to executives, while IRS Notice 2011-5 provided additional flexibility regarding the continued use of certain debit cards to purchase over-the-counter ("OTC") medicines or drugs. Both of these Notices are discussed in greater detail below.

Notice 2011-1

PPACA requires, among other things, that insured group health plans (which are not grandfathered) satisfy the nondiscrimination requirements of Section 105(h)(2) of the Internal Revenue Code (the "Code"), as early as January 1, 2011, for calendar-year plans. In addition, PPACA stated that rules "similar to" the rules contained in paragraphs (3) (requiring that such group health plan's eligibility classifications not discriminate in favor of "highly compensated individuals"), (4) (requiring that benefits offered under such group health plan not discriminate in favor of "highly

compensated individuals"), and (8) (applying "controlled group" rules) of Section 105(h) of the Code would apply to such group health plans. PPACA also imposes penalties on an employer sponsoring an insured, non-grandfathered group health plan that does not comply with the new nondiscrimination requirements, including an excise tax of $100 per day, per individual discriminated against, during the period the plan is noncompliant. Prior to PPACA, the nondiscrimination requirements of Section 105(h) of the Code applied only to self-insured plans; further, the only penalty for a self-insured plan's noncompliance with the Section 105(h) nondiscrimination rules was the loss of the tax benefits relating to such plan by the "highly compensated individuals."

Notice 2011-1 delays required compliance by insured, non-grandfathered group health plans with PPACA's nondiscrimination rules (as well as enforcement by the IRS, the Department of Labor ("DOL") and the Department of Health and Human Services ("HHS")) until the effective date of future guidance (which has not yet been released) that will address how rules "similar to" Code Sections 105(h)(3), (4) and (8) apply to such plans.

Notice 2011-1 states that the delay was prompted by public comments received by the IRS regarding confusion about application of the nondiscrimination rules to insured, non-grandfathered group health plans, and about how such rules will interact with provisions of PPACA that take effect after 2013, such as the state exchanges, employer and individual responsibility, and premium tax credit provisions. Notice 2011-1 also seeks public suggestions for resolution of specific issues raised by PPACA's nondiscrimination rules, including:

- the determination of what constitutes nondiscriminatory benefits under Section 105(h)(4) of the Code, and what is included in the term "benefits" (for example, it is unclear whether the rate of employer contributions toward the cost of coverage is a "benefit" that must be provided on a nondiscriminatory basis);

- whether the IRS, the DOL and HHS have the authority to provide for an alternative method of compliance with PPACA's new rules, that would involve only an "availability of coverage" test; and

- the possible use of the Code Section 414(q) definition of "highly compensated employees" for purposes of the nondiscriminatory classification test instead of the definition of highly compensated individuals under Code Section 105(h)(5) (which could lower the number of "highly compensated individuals," thereby making PPACA's rules easier to comply with).

Comments on Notice 2011-1 must be submitted by March 11, 2011. Click here to access a copy of Notice 2011.

Notice 2011-5

PPACA revised the definition of "medical expenses" for employer-provided accident and health plans, including health flexible spending arrangements ("health FSAs") and health reimbursement arrangements ("HRAs"), to cover only prescribed medicines and drugs (including OTC medicines and drugs) and insulin. Accordingly, Notice 2010-59, which was released by the IRS in September 2010, explained that after December 31, 2010, OTC medicine or drugs (except for insulin) were not "medical expenses" unless such medicines or drugs were prescribed. In addition, Notice 2010-59 stated that OTC medicines or drugs could not be purchased with health FSA and HRA debit cards after January 15, 2011 (other than at "90% pharmacies," in which at least 90% of the store's income derives from eligible healthcare expenses).

IRS Notice 2011-5 modifies Notice 2010-59, as it applies to the use of health FSA and HRA debit cards for reimbursement of expenses for OTC medicine or drugs, by allowing health FSA and HRA debit cards to be used after January 15, 2011 to purchase OTC medicine or drugs at drug stores and pharmacies, non-health care merchants that have pharmacies, and mail order and web-based vendors that sell prescription drugs, so long as (i) prior to the purchase, (1) a prescription (as defined in Notice 2010-59) for the OTC medicine or drug is presented to the pharmacist, (2) the OTC medicine or drug is dispensed by the pharmacist in accordance with applicable laws and regulations, and (3) an Rx number is assigned; (ii) the pharmacist or other vendor retains a record of the Rx number, the name of the purchaser (or person for whom the prescription applies), and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements; (iii) all of the records described above in (ii) are available to the employer or its agent upon request; (iv) the debit card system will not accept a charge for an OTC medicine or drug unless an Rx number has been assigned; and (v) the additional rules for the use of health FSA or HRA debit cards contained in other IRS guidance and in

the relevant Treasury Regulations are satisfied. Where the above requirements are satisfied, Notice 2011-5 states that the debit card transaction will be considered fully substantiated at the time and point-of-sale.

Notice 2011-5 also provides that debit card transactions with vendors having health-care related "Merchant Codes" (e.g., physicians, dentists, vision care offices, hospitals, and other medical care providers) will be considered fully substantiated at the time and point-of-sale if they meet requirements (ii) (other than the requirement to retain the Rx number), (iii) and (v) of the above-listed requirements. Notice 2011-5 further provides that the substantiation rules of Notice 2010-59 continue to apply to 90% pharmacies, and that for all providers and merchants other than those discussed in Notice 2011-5, health FSA and HRA debit cards may not be used to purchase OTC medicines or drugs (other than insulin) after January 15, 2011. Notice 2011-5 is effective for health FSA and HRA debit card purchases of OTC medicines or drugs made after January 15, 2011. Click here to access a copy of Notice 2011-5.

King & Spalding would be happy to assist you in understanding the effects of Notices 2011-1 and 2011-5 on your company's group health plans.

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Update on Fee Disclosure Regulations

In July 2010, the DOL published interim-final regulations under ERISA Section 408(b)(2) requiring plan service providers to disclose certain information to plan fiduciaries to assist plan fiduciaries in understanding the reasonableness of fees being charged for plan services and assess potential conflicts of interest that might affect the quality of those services. We reported on those regulations in the August 2010 Compensation and Benefits Insights. The rules were originally scheduled to take effect in July 2011, but the DOL recently extended the applicability of those rules until January 1, 2012. To view this extension, click here. The new disclosure requirements will continue to apply to plan contracts or arrangements for services in existence on or after July 16, 2011.

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