

Health Care Reform Update

DOL Issues Additional Health Care Reform FAQs

The Departments of Labor, Health and Human Services and the Treasury (the Departments) have jointly issued a fifth round of frequently asked questions addressing issues under the Patient Protection and Affordable Care Act (PPACA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and wellness programs under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent regulations.

Following is a brief summary of a few highlights from this latest guidance; it is not exhaustive. For a copy of the FAQ, visit <http://www.dol.gov/ebsa/faqs/faq-aca5.html>.

PPACA

Value-Based Insurance Design in Connection with Preventive Care Benefits (Q1)

Effective the first plan year that begins on or after September 23, 2010, non-grandfathered group health plans must provide coverage for recommended preventive care services without cost-sharing. A list of the current recommended services is available at <http://www.healthcare.gov/center/regulations/prevention.html>.

Value-based insurance designs (VBIDs) are health plan designs that provide incentives for enrollees to utilize higher value and/or higher quality services or venues of care. The Departments intend to issue guidance that will better clarify how group health plans can utilize VBIDs for preventive care services.

Per a response to an FAQ, plans may use reasonable medical management techniques to control costs and to steer patients towards a particular high-value setting such as an ambulatory care setting for providing preventive care services, 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 having a mechanism for waiving an otherwise applicable copayment for the preventive services provided in a hospital.

Automatic Enrollment in Group Health Plans (Q2-3)

There have been a number of questions around the effective date of the automatic enrollment requirement. Briefly, 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 Department of Labor clarified that, until regulations are issued, employers are not required to comply with automatic enrollment.¹ The Department of Labor intends to issue regulations by 2014.

¹ Section 18A provides that employer compliance with the automatic enrollment provisions of that section shall be carried out "[i]n accordance with regulations promulgated by the Secretary [of Labor]."

60-Day Disclosure (Q4)

Many plan sponsors have had questions regarding the effective date of a new notice requirement that will require 60-day advance notice of any material modifications made to the health benefits plans. Briefly, the law requires health plans to provide a new 4-page summary of benefits. Once issued, plans must provide a 60-day advance notice of any material changes to that document.

The law provides that not later than March 23, 2011, the Departments must develop standards for use by group health plans and health insurance carriers in compiling and providing this summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan and, not later than March 23, 2012, plans and carriers must begin providing the summary pursuant to these standards.

The Departments state that group health plans and health insurance carriers are not required to comply with the 60-day prior notice requirement for material modifications until plans and carriers are required to provide the summary of benefits and coverage explanation pursuant to the standards issued by the Departments. The Departments have not yet issued the standards.

Note, an ERISA plan's responsibility to provide a summary of material modification or a summary of material reduction in covered services or benefits remains unaffected.

MHPAEA

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) supplemented the Mental Health Parity Act of 1996 (MHPA).² Generally, MHPAEA applies to employers with more than 50 employees and requires that the financial requirements and treatment limitations imposed on mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits. MHPAEA does not require plans to cover mental health and substance abuse disorders, but if such benefits are provided, MHPAEA will apply. Employers with 50 or fewer employees are exempt from the MHPAEA requirements.

Medical Necessity Determination (Q9-10)

MHPAEA and its regulations require that the criteria for medical necessity determinations made under the plan with respect to mental health or substance abuse disorder benefits must be made available by the plan administrator or health insurance carrier to any current or potential participant, beneficiary or contracting provider upon request. The documents must be furnished within 30 days of a request.

Increased Cost Exemption (Q11)

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 two percent in the first year that MHPAEA applies to the plan (the first plan year beginning after October 3, 2009) or at least one percent in any subsequent plan year (generally, plan years beginning after October 3, 2010). If such a cost is incurred, the plan is exempt for the plan year following the year the cost was incurred. Thus, the exemption lasts one year. After that, the plan is required to comply again; however, if the plan incurs an increased cost of at least one percent in that plan year, the plan could claim the exemption for the following plan year.

The Departments' interim final regulations implementing MHPAEA did not provide guidance for implementing the increased cost exemption. Accordingly, during an interim enforcement safe harbor until future regulatory guidance is effective, a plan that has incurred an increased cost of two percent during its first year of compliance can obtain an exemption for the second plan year by following the

² For group health plans, MHPAEA is effective for plan years beginning after October 3, 2009. Regulations on MHPAEA were issued February 2, 2010, and apply to plan years beginning on or after July 1, 2010.

exemption procedures described in the Departments' 1997 MHPA regulations, except that, as required under MHPAEA, for the first year of compliance the applicable percentage of increased cost is two percent and the exemption lasts only one year. Calculations of increased costs due to MHPAEA should include increases in a plan's share of cost sharing. Moreover, any non-recurring administrative costs (such as adjustments to computer software) attributable to complying with MHPAEA must be appropriately amortized. Plans applying for an exemption must demonstrate that increases in cost are attributable directly to implementation of MHPAEA and not otherwise to occurring trends in utilization and prices, a random claims experience that is unlikely to persist, or seasonal variation typically experienced in claims submission and payment patterns.

WELLNESS PROGRAMS AND HIPAA

HIPAA prohibits discrimination in eligibility, benefits, or premiums based on a health factor. An exception to the general rule is provided for certain wellness programs that discriminate in benefits and/or premiums based on a health factor.

HIPAA nondiscrimination regulations generally divide wellness programs into two categories. 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 without conditions under such rules ("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 seminar.

The second category of wellness programs under the final rules consists of programs that require individuals to satisfy a standard related to a health factor in order to obtain a reward ("standards-based 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). Although such a premium or benefit reward may discriminate based on a health factor, an exception permits such programs if the program provides the following safeguards:

- The total reward for such wellness programs offered by a plan sponsor is limited to 20 percent of the total cost of employee-only coverage under the plan. (However, if any class of dependents can participate in the program, the limit on the reward is modified so that the 20 percent is calculated with respect to the total cost of coverage in which the employee and any dependents are enrolled.)
- The program must be reasonably designed to promote health or prevent disease. For this purpose, it must: have a reasonable chance of improving health or preventing disease, not be overly burdensome, not be a subterfuge for discriminating based on a health factor, and not be highly suspect in method.
- 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) is disclosed.

Under the PPACA, the reward for standards-based wellness programs will increase to 30% in 2014. In this recent guidance, the Departments indicate their intent to propose regulations that will raise the percentage for the maximum reward under a standards-based wellness program to 30% before 2014. The

Departments are also considering additional consumer protections that many be needed to ensure that standards-based wellness programs are not used as a subterfuge for discrimination.

The Departments also included additional FAQs on HIPAA wellness programs in the guidance (see Q12-15).



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