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Volume 34 | Issue 09 | January 25, 2011

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

The Federal Departments responsible for implementing PPACA have released Part V of their FAQs providing sub-regulatory guidance on the law's provisions. In addition, they provide guidance relating to mental health parity and to HIPAA wellness programs.

Background

Over the last few months, the Departments of Health and Human Services (HHS), Labor (DOL) and the Treasury (Treasury) (collectively, the Departments) have issued Frequently Asked Questions" (FAQs), intended to address issues that have been raised as a result of the passage of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA). The Departments posted FAQs Part I on the DOL website on September 20, 2010 (see our September 22, 2010 *For Your Information*); FAQs Part II on October 8, 2010 and Part III on October 13, 2010 (see our October 18, 2010 *For Your Information* covering both Parts II and III): and FAQs Part IV on October 29, 2010 (see our November 2, 2010 *For Your Information*).

The Departments posted the latest set of FAQs, Part V, on December 28, 2010. In addition to addressing issues related to PPACA, the Part V FAQs also include guidance with respect to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and with respect to wellness programs under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Health Care Reform

Value-Based Insurance Design (VBID). In the absence of guidance, a group health plan may use reasonable medical management methods to control costs. Thus, a plan may charge a co-payment in one setting but not in another if waiving the co-payment is a method the employer uses to control costs. For example, a plan may provide that the co-payment is waived if a participant uses an ambulatory care center. However, for this to be permitted, the employer must accommodate the individual who cannot obtain care at the ambulatory care center because it would be medically inappropriate, as determined by the patient's physician. On December 28, 2010, the Departments issued a request for information on VBIDs and the preventive care requirements of PPACA.

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Automatic Enrollment. Employers with more than 200 full-time employees who offer a health plan must automatically enroll their employees in the plan and provide an opportunity for an employee to opt out of coverage. The FAQs set out in writing what the DOL staff has been saying in speeches – employers do not have to comply with the automatic enrollment requirement until the DOL promulgates regulations, which it expects to issue by 2014.

> ***BUCK COMMENT.*** *Health plan automatic enrollment raises different and additional issues than the existing 401(k) plan automatic enrollment, including what the default option should be.*

Material Modifications. PPACA requires group plans and insurance issuers to provide benefit summaries and coverage explanations to participants starting no later than 24 months after PPACA's March 2010 enactment. To provide employers with sufficient time to draft the summaries and explanations, PPACA requires the DOL to issue guidance within a year after PPACA's enactment. PPACA also requires plans and issuers to provide summaries of any material modifications within 60 days before a modification becomes effective. The FAQs provide that plans and issuers are not required to comply with the 60-day material modification notice requirement until the Departments issue the summary notice guidance.

Age 26. For children under age 26, coverage cannot vary based on age for children under age 26 (see our May 13, 2010 For Your Information). Plans may not charge more for the coverage merely because a covered child is over age 18. The FAQs note that the law does not prohibit a charge based on age that applies to all coverage. For example, a plan could provide no co-payments for all covered persons under age 19, whether they are employees, spouses, or dependents, and require co-payments for all persons over age 18.

Grandfathered Health Plans. The interim final regulations on grandfathered health plans (see our June 23, 2010 For Your Information) provide generally that a plan can lose grandfathered status if a participant's possible out-of-pocket expenses or deductibles increase. The FAQs clarify that an increase resulting merely from a participant receiving a compensation increase in a plan that requires higher-paid employees to pay more out-of-pocket than lower-paid employees would not eliminate the plan's grandfathered status.

Mental Health Parity and Addiction Equity Act

The MHPAEA prohibits group health plans from imposing any financial requirements (e.g., co-insurance or co-payments) or treatment limitations (e.g., limits on number of visits) on mental health or substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations imposed on medical and surgical benefits. On February 2, 2010, the Departments issued interim final regulations (see our March 2, 2010 *For Your Information* under MHPAEA that apply for plan years beginning on or after July 1, 2010 (January 1, 2011 for calendar year plans). The FAQs make the following clarifications:

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- **MHPAEA Disclosure.** Under MPHAEA and the implementing regulations, in-network medical care providers, current or potential participants, and beneficiaries are entitled to receive a plan's medical necessity criteria for mental health/substance benefits upon request.
- **ERISA Disclosure.** Plans must make plan documents available to participants, beneficiaries, and authorized representatives within 30 days of a request. This requirement applies to the medical necessity criteria for both medical/surgical benefits and mental health/substance benefits.
- **Cost Exemption.** A group health plan may elect to be exempt from the parity requirements if compliance causes its overall plan costs to increase by more than 2% in the first year of applicability or 1% in any subsequent year. The interim MHPAEA regulations do not address how to measure the 2% and 1%. The FAQs provide that plans should use the procedures set forth in the Departments' 1997 interim final regulations under the Mental Health Parity Act of 1996 (MHPA), adjusted to reflect the changes made by MHPAEA. Increased costs include an increase in a plan's share of cost-sharing. In addition, any non-recurring costs must be appropriately amortized. Plans must demonstrate that the increased costs are attributable directly to implementation of MHPAEA and not to increased utilization or prices, a random claim experience, or a typical seasonal variation.

BUCK COMMENT. *Although the FAQs provide the procedures for calculating the cost increase are those under the MHPA regulations, MPHAEA limited the exception's availability to every other year. This makes the cost exemption impractical as employers would have to comply in alternate years.*

HIPAA Wellness Programs

HIPAA prohibits discrimination on the basis of a health factor. The Departments' 2006 final HIPAA regulations provide a limited exception for wellness program benefits and premiums. Among the criteria for the exception is that the reward not be in excess of 20% of the cost of single coverage (if dependents are covered as well, the incentive can reflect the cost of dependent coverage). PPACA increases the 20% to 30% but not until 2014. In the FAQs, the Departments clarify the following:

- **30% Incentive.** The Departments 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 2014. The Departments are also considering what accompanying consumer protections may be needed to prevent the program from being used as a subterfuge for discrimination based on health status.
- **No Health Standard.** The HIPAA nondiscrimination tests do not apply to a wellness program if the wellness program does not require the participant to meet a health standard for the reward. Thus, HIPAA does not prohibit an employer from having two 20% awards as long as only one of the award programs is conditioned on a health standard.

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***BUCK COMMENT.** The FAQs do not address other open questions about award programs, such as how the Americans with Disabilities Act affects award programs.*

Conclusion

The Departments continue to publish guidance incrementally in the interest of providing information as quickly as possible. The FAQs, while not receiving the same deference as regulations, provide sub-regulatory guidance as to how the Departments will be interpreting and applying PPACA and related laws. It is likely that final regulations will incorporate the information in the sub-regulatory guidance.

Buck's consultants are available to assist you in assessing the impact of this guidance on your plans.

This FYI is intended to provide general information. It does not offer legal advice or purport to treat all the issues surrounding any one topic.

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