



Employee Benefits Law Information Memo

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Electronic Dispatch

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FEDERAL AGENCIES RELEASE FIFTH SET OF FAQs ON HEALTH CARE REFORM AND MENTAL HEALTH PARITY

On December 22, 2010, the Departments of Labor, Health and Human Services, and Treasury (collectively, the “Departments”) issued their fifth set of answers to several frequently asked questions (“FAQs”) about the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (“PPACA”). The FAQs also address 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 FAQs are described below.

FAQs

The Patient Protection and Affordable Care Act

The PPACA encompasses many different approaches to reducing the number of Americans with little or no health insurance coverage. The legislation includes mandates on employers, individuals, and providers, amendments to the Internal Revenue Code, and many other changes.

Cost Control for Preventive Care Benefits

The PPACA generally requires that group health plans cover recommended, in-network preventive services without any employee cost sharing. The Departments issued interim final regulations on July 14, 2010 addressing the requirement, but there have been lingering issues about a plan’s ability to control costs. The FAQs confirm that the PPACA allows plans to steer enrollees toward more cost-efficient service providers through value-based insurance designs (“VBID”). The FAQs provide an example of a permissible VBID. The PPACA would allow a group health plan to 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 outpatient hospital is a higher-value setting. The Departments add that further guidance is forthcoming.

Automatic Enrollment for New Employees

The PPACA requires employers with more than 200 full-time employees to automatically enroll new full-time employees in the employer’s health plan. However, the FAQs clarify that employers are not required to comply with this mandate until the Employee Benefits Security Administration promulgates regulations, which will be sometime before 2014.

Notice of Plan Modifications

The PPACA requires group health plans to provide 60 days notice to enrollees before making material modifications to the plan’s terms or coverage if they were not reflected in the most recent summary of benefits and coverage. However, the FAQs explain that employers are not required to comply with this mandate until the Departments issue standards for plans to follow for compiling and providing a summary of benefits and coverage.

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). The FAQs point out, however, that the PPACA permits varying coverage based on age that applies to all enrollees, including employees, spouses, and dependent children. An example in the FAQs suggests that a plan could charge a copayment for non-preventive care to *all enrollees* age 19 and over, but waive it for those under 19. However, it could not charge a copayment to *dependent children* age 19 and over, but waive it for those under 19.

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Grandfathered Health Plans

The PPACA provides that group health plans existing as of March 23, 2010, called “grandfathered plans,” are not subject to certain PPACA provisions as long as they do not make specific plan changes outlined in PPACA regulations. A plan that makes such changes would lose its grandfather status. The FAQs address the scenario where a grandfathered plan has a fixed cost-sharing requirement other than a copayment, such as a deductible or out-of-pocket spending limit, which is calculated based on a formula that includes a fixed percentage of an employee’s compensation. The FAQs conclude that, if the formula remains the same as it was on March 23, 2010, a compensation increase that causes a cost-sharing increase under the formula would not cause the plan to lose grandfather status, even where the cost-sharing increase exceeds the PPACA regulatory threshold.

Mental Health Parity and Addiction Equity Act of 2008

If plans provide mental health and substance use disorder benefits, the MHPAEA generally requires that financial requirements and treatment limitations for such benefits cannot be more restrictive than for medical and surgical benefits.

Small Employer Exemption

Group health plans subject to ERISA and the Internal Revenue Code are exempt from the MHPAEA as a “small employer” if they have 50 or fewer employees, preempting any State insurance law definition of small employer. The FAQs note, however, that for nonfederal government plans the PPACA applies, and it defines “small employer” as one that has 100 or fewer employees.

Increased Cost Exemption

The Departments explain in detail how the cost exemption works. The MHPAEA provides that if a plan makes changes to comply with the MHPAEA and incurs a 2% or greater cost increase in the first year the MHPAEA applies to it, or a 1% or greater cost increase in any year after the first year, then the plan is exempt from the MHPAEA the following year (that is, the year after the cost increase was incurred). The exemption lasts for one year, and then the plan must comply again. However, the plan could incur another cost increase of 1% or greater due to compliance-related changes and be exempt the following year. When calculating the cost increase percentage, the plan should include increases in the plan’s portion of cost sharing as well as non-recurring administrative costs (for example, adjusting computer software), which should be appropriately amortized. Plans must further demonstrate that cost increases are directly attributable to MHPAEA compliance rather than utilization or price trends, random claim experiences, or seasonal variations in claims processing. 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 their earlier 1997 regulations to claim the exemption.

Health Insurance Portability and Accountability Act of 1996

HIPAA regulations generally prohibit discrimination in eligibility, benefits, or premiums based on employee health. Where wellness programs require employees to meet a certain health standard (such as losing weight) to obtain a reward (such as lower premiums), they must satisfy HIPAA’s nondiscrimination requirements. There are five requirements: (1) the total reward cannot exceed 20% of the total cost of 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 alternative standard must be published in all plan materials. The PPACA incorporates these nondiscrimination rules, except that it changes the maximum reward from 20% of the total cost of coverage to 30%. The Departments intend to propose regulations before 2014 that implement this percentage change, as well as consider other nondiscrimination rules.

Independent Wellness Policies

The FAQs clarify that the nondiscrimination rules only apply to wellness programs that are part of a group health plan and not those that are operated independently as a separate employment policy. The FAQs list examples of independent programs, which include subsidizing healthier cafeteria food and gym memberships, providing pedometers (to encourage walking and exercise), and banning smoking in the workplace. Note, however, that these independent programs may still be subject to Federal or State nondiscrimination laws.

Meeting Health Standard as Condition of Reward

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. The FAQs provide two examples of programs that do not contain such a standard and thus are not subject to the nondiscrimination rules. In the first example, a group health plan offers, as part of its wellness program, an annual premium discount of 50% of the cost of coverage to employees that attend a monthly health seminar. The FAQs conclude that, because employees do not have to meet a health standard to obtain the discount, the nondiscrimination rules are inapplicable — including the rule limiting the reward amount to 20% of the cost of coverage. In the second example, a group health plan offers, as part of its wellness program, to reimburse employees for their monthly gym membership fee. The FAQs conclude that the nondiscrimination rules are inapplicable because the employees are not required to meet a health standard to obtain the reimbursement.

Application of the Nondiscrimination Rules

The FAQs provide an example of how to apply the nondiscrimination rules. The example is a group health plan that offers, as part of its wellness program, a discount of 20% of the cost of coverage to employees that achieve a cholesterol count of 200 or lower. The plan also states that if the employee has a health condition making it unreasonably difficult for them to satisfy the cholesterol count within a 60-day period, then the plan will create a reasonable alternative standard. The FAQs conclude that, although the plan requires employees to meet a health standard and is therefore subject to the nondiscrimination rules, it does not violate them because the total reward does not exceed 20% of the total cost of coverage, and the reward is available to all similarly situated individuals because it includes a reasonable alternative standard.

The FAQs provide useful guidance for employers seeking clarification on how and when various health care laws apply. A complete list of the FAQs can be found on the Employee Benefits Security Administration's website at www.dol.gov/ebsa.

If you have any questions about this memorandum, please contact any of the members of our Employee Benefits and Executive Compensation Practice Group listed below.

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