

## FAQ – Market Reforms Implementation

### Value-Based Insurance Design in Connection with Preventive Care Benefits

Section 2713 of the Public Health Service Act (PHS Act) generally requires group health plans and group and individual health insurance issuers that are not grandfathered health plans to provide coverage for recommended preventive services without cost sharing. A complete list of the current recommended preventive services is available at [www.healthcare.gov/center/regulations/prevention.html](http://www.healthcare.gov/center/regulations/prevention.html).

The Departments will also develop guidelines to permit a group health plan or group or individual health insurance issuer to utilize value-based insurance designs. Generally speaking, value-based insurance designs (VBID) are health plan designs that provide incentives for enrollees to utilize higher-value and/or higher-quality services or venues of care. On or about the date of issuance of these FAQs, the Departments will be issuing a Request for Information on ways the Departments can encourage VBID in the context of preventive care services.

**Q1: My group health plan does not impose a copayment for colorectal cancer preventive services when performed in an in-network ambulatory surgery center. In contrast, the same preventive service provided at an in-network outpatient hospital setting would generally require a \$250 copayment. Is this permissible under PHS Act section 2713?**

Yes, this plan design is permissible. PHS Act section 2713 and its implementing regulations allow plans to use reasonable medical management techniques to control costs. The regulations the Departments issued to implement the preventive health benefits in the Affordable Care Act recognized the important role that VBID can play in promoting the use of appropriate, high value preventive services and providers. Plans may use reasonable medical management techniques 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 the otherwise applicable copayment for the preventive services provided in a hospital.

### Automatic Enrollment in Health Plans

**Q2: The Affordable Care Act amended the Fair Labor Standards Act (FLSA) by adding a new section 18A, requiring employers with more than 200 full-time employees to automatically enroll new full-time employees in the employer's health benefits plans and continue enrollment of current employees. What Agency is responsible for guidance under this new FLSA provision?**

The Secretary of Labor has delegated responsibility for FLSA section 18A rulemaking, and for regulations under new section 18B of the FLSA, Notice to Employees of Coverage Options, to the Employee Benefits Security Administration (EBSA) within the Department of Labor. EBSA and the Department of the Treasury will coordinate to develop the rules that will apply in determining full-time employee status for purposes of the amendments to the FLSA and the rulemaking by the Treasury Department under the Internal Revenue Code to develop the rules that will apply in determining full-time employee status for purposes of the amendments made by the Affordable Care Act to the Internal Revenue Code.

**Q3: When do employers have to comply with the new automatic enrollment requirements in section 18A of the FLSA?**

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].”

Accordingly, it is the view of the Department of Labor that, until such regulations are issued, employers are not required to comply with section 18A. The Department of Labor expects to work with stakeholders to ensure that it has the necessary information and data it needs to develop regulations in this area that take into account the practices employers currently use for auto-enrollment and to solicit the views and practices of a broad range of stakeholders, including employers, workers, and their families. The Department of Labor intends to complete this rulemaking by 2014.

**Disclosure under PHS Act section 2715(d)(4)**

**Q4: When are group health plans and health insurance issuers required to comply with the notice requirement in PHS Act section 2715 (d)(4), which generally requires a 60-day prior notice for material modifications to the plan or coverage?**

PHS Act section 2715 as added by the Affordable Care Act generally provides, among other things, that not later than 12 months after the date of enactment of the Affordable Care Act, the Departments must develop standards for use by group health plans and health insurance issuers in compiling and providing a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage and, not later than 24 months after the date of enactment, plans and issuers must begin to provide the summary pursuant to the standards.

PHS Act section 2715(d)(4) generally provides that if a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act (ERISA)) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer must provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

Accordingly, it is the view of the Departments that group health plans and health insurance issuers are not required to comply with the 60-day prior notice requirement for material modifications in PHS Act section 2715 (d)(4) until plans and issuers are required to provide the summary of benefits and coverage explanation pursuant to the standards issued by the Departments.<sup>(1)</sup> The Departments have not yet issued the standards.

### **Dependent Coverage of Children to Age 26**

**Q5: My group health plan normally 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. Is this permissible?**

Yes. The Departments' regulations implementing PHS Act section 2714 provide that the terms of a group health plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older). While this generally prohibits distinctions based upon age in dependent coverage of children, it does not prohibit distinctions based upon age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children. In this case, the copayments charged to dependent children are the same as those charged to employees and spouses. Accordingly, the Departments will not consider the arrangement described in this question (including waiver, for individuals under age 19, of the generally applicable copayment) to violate PHS Act section 2714 or its implementing regulations.

### **Preexisting Condition Exclusions for Children in the Individual Market**

**Q6: Some States have expressed an interest in permitting issuers to screen applicants for eligibility for alternative coverage options before offering a child-only policy. Is this allowed?**

Yes, under certain circumstances, issuers may screen applicants for eligibility for alternative coverage options before offering a child-only policy, provided this practice is permitted under State law. 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) and group health insurance.

Screening may not be limited to programs targeted to individuals with a pre-existing condition, such as the state high risk pool or Pre-existing Condition Insurance Plan (PCIP). Note that Medicaid policy, under 42 U.S.C.A. § 1396a (25)(G), prohibits participating States from allowing health issuers to consider whether an individual is eligible for, or is provided medical assistance under, Medicaid in making enrollment decisions. Furthermore, issuers may not implement a screening process that by its operation significantly delays enrollment or artificially engineers eligibility of a child for a program targeted to individuals with a pre-existing condition. Additionally, the screening process may not be

applied to offers of dependent coverage for children given the new Affordable Care Act requirement of offering coverage to dependents up to age 26.

States are encouraged, subject to State law, to require issuers that screen for other coverage to enroll and provide coverage to the applicant effective on the first date that the child-only policy would have been effective had the applicant not been screened for an alternative coverage option. States are also encouraged to impose a reasonable time limit, such as 30 days, at which time the issuer would have to enroll the child regardless of pending applications for other coverage. Finally, nothing in this FAQ should be construed to relieve the issuer of its obligation to enroll a child applicant in coverage.

### **Grandfathered Health Plans**

**Q7: My plan terms include out-of-pocket spending limits that 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 such that the change exceeds the thresholds allowed under paragraph (g)(1) of the interim final regulations relating to grandfathered health plans, will my plan relinquish grandfather status?**

No. The Departments have determined that if a plan or coverage has a fixed-amount cost-sharing requirement other than a copayment (for example, a deductible or out-of-pocket limit) 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. Accordingly, if the percentage-of-compensation formula for determining an out-of-pocket limit is unchanged and an employee's compensation increases, then the employee could face a higher out-of-pocket limit, but that change would not cause the plan to relinquish grandfather status.

### **The Mental Health Parity and Addiction Equity Act of 2008**

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) supplemented the Mental Health Parity Act of 1996 (MHPA). Generally, MHPAEA 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.<sup>(2)</sup> For group health plans, MHPAEA is effective for plan years beginning after October 3, 2009. On February 2, 2010, the Departments published interim final rules on MHPAEA, which apply for plan years beginning on or after July 1, 2010.<sup>(3)</sup>

**Q8: After the amendments made by the Affordable Care Act, are small employers still exempt from the MHPAEA requirements? How is "small employer" defined?**

Yes, small employers are still exempt. Although there were changes to the definition of "small employer" for other purposes under the Affordable Care Act, ERISA and the Code

continue to define a small employer as one that has 50 or fewer employees. Accordingly, for group health plans and health insurance issuers subject to ERISA and the Code, the Departments will continue to treat group health plans of employers with 50 or fewer employees as exempt from the MHPAEA requirements under the small employer exemption, regardless of any State insurance law definition of small employer. For nonfederal governmental plans, the PHS Act was amended by the Affordable Care Act to define a small employer as one that has 100 or fewer employees.

**Q9: I am an in-network health care provider and one of my patients is having trouble getting benefits paid for a mental health condition or substance use disorder. Am I entitled to receive a copy of the criteria for medical necessity determinations made by the patient's plan or health insurance coverage?**

Yes. MHPAEA and its implementing regulations state that 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.

**Q10: I was denied benefits for mental health treatment by my plan because the plan determined that the treatment was not medically necessary. I requested and received a copy of the criteria for medical necessity determinations for mental health and substance use disorder treatment, and the reason for denial. I think my plan is applying medical necessity standards more strictly to benefits for mental health and substance use disorder treatment than for medical/surgical benefits. How can I obtain information on the medical necessity criteria used for medical/surgical benefits?**

Under ERISA, documents with information on the medical necessity criteria for both medical/surgical benefits and mental health/substance use disorder benefits are plan documents, and copies of plan documents must be furnished within 30 days of your request. See ERISA regulations at 29 CFR 2520.104b-1. Additionally, if a provider or other individual is acting as a patient's authorized representative in accordance with the Department of Labor's claims procedure regulations at 29 CFR 2560.503-1, the provider or other authorized representative may request these documents. If your plan is not subject to ERISA (for example, a plan maintained by a State or local government), you should check with your plan administrator.

**Q11: MHPAEA contains an increased cost exemption. How does a plan claim this 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 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 exemption procedures described in the Departments' 1997 MHPA regulations (62 FR 66932, December 22, 1997)(4), 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.

### **Nondiscrimination Based on a Health Factor and Wellness Programs**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended ERISA, the Code, and the PHS Act to add, among other things, provisions prohibiting 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. In 2006, the Departments published final regulations implementing these nondiscrimination and wellness provisions (HIPAA nondiscrimination regulations).(5)

The final 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 in the regulations 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.

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 ("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). Although such a premium or benefit reward may discriminate based on a health factor, an exception outlined in paragraph (f)(2) of the final rules permits such programs if the program provides the following safeguards:

1. 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.)
2. 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.
3. The program must give eligible individuals an opportunity to qualify for the reward at least once per year.
4. 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).
5. 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.

The Affordable Care Act added a new section 2705 to the PHS Act regarding nondiscrimination and wellness. Section 715(a)(1) of ERISA and section 9815(a)(1) of the Code incorporate section 2705 of the PHS Act by reference. PHS Act section 2705 largely incorporates the provisions of the Departments' joint final regulations with a few clarifications and changes the maximum reward that can be provided under a health-contingent wellness program from 20 percent to 30 percent. This change is effective in 2014.

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 percent before the year 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. Additionally, the following FAQs provide answers to frequently asked questions regarding wellness programs.

**Q12: Are all employment-based wellness programs required to check for compliance with the HIPAA nondiscrimination provisions?**

No. Many employers offer a wide range of programs to promote health and prevent disease. For example, some employers may choose to provide or subsidize healthier food choices in the employee cafeteria, provide pedometers to encourage employee walking and exercise, pay for gym memberships, or ban smoking on employer facilities and campuses. A wellness program is subject to the HIPAA nondiscrimination rules only if it is, or is part of, a group health plan. If an employer operates a wellness program as an employment policy separate from its group health plan(s), the program may be covered by other Federal or State nondiscrimination laws, but it is not subject to the HIPAA nondiscrimination regulations.

**Q13: My group health plan gives an annual premium discount of 50 percent of the cost of employee-only coverage to participants who adhere to a wellness program which consists of attending a monthly health seminar. Does this reward violate the HIPAA nondiscrimination regulations?**

No. This wellness program is not based on an individual satisfying a standard that is related to a health factor, so it does not have to satisfy the five criteria (set forth above) in the HIPAA nondiscrimination regulations. (The rule limiting the amount of the reward for health-contingent wellness programs to 20 percent of the cost of coverage applies only to programs that require satisfaction of a standard related to a health factor in order to qualify for the reward.)

**Q14: My group health plan gives an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists of giving an annual cholesterol exam to participants; participants who achieve a cholesterol count of 200 or lower receive the annual premium discount. The plan also provides 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. Does this wellness program violate the HIPAA nondiscrimination regulations?**

No. The wellness program is based on a health factor (achieving a cholesterol count of 200 or lower) and is subject to the HIPAA nondiscrimination regulations, including the five criteria described in paragraph (f)(2) of the regulations. In general, among other things, a wellness program subject to the HIPAA nondiscrimination regulations must be available to

all similarly situated individuals, provide a reasonable alternative standard, and the reward must be limited to no more than 20 percent of the total cost of coverage. The wellness program described above satisfies the requirement of being available to all similarly situated individuals because the plan provides a reasonable alternative standard and the premium discount is limited to 20 percent of the cost of employee-only coverage.

**Q15: My group health plan offers two different wellness programs, both of which are offered to all full-time employees enrolled in the plan. The first program requires participants to take a cholesterol test and provides a 20 percent premium discount for every individual with cholesterol counts under 200. The second program reimburses participants for the cost of a monthly membership to a fitness center. If I participate in both wellness programs and receive both rewards (the 20 percent premium discount and the reimbursement for the cost of a fitness center membership), is my plan violating the HIPAA nondiscrimination regulations?**

No. In this scenario, the first program is subject to the requirements of the HIPAA nondiscrimination regulations because the premium discount reward is based on an individual satisfying a standard that is related to a health factor (having a cholesterol count under 200). Therefore, the first program must meet the five criteria in the regulations, including the 20 percent limit on the amount of the reward. The second program is not based on an individual satisfying a standard that is related to a health factor, so it does not have to satisfy the five criteria in the regulations.

Furthermore, it is permissible to offer both programs at the same time because the rule limiting the amount of the reward for health-contingent wellness programs to 20 percent of the cost of coverage only applies to programs that require satisfaction of a standard related to a health factor.

As previously noted, 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 percent before the year 2014 and 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. More guidance is expected early next year.

## **U.S. Department of Health and Hospitals Answers on Market Reforms**

**Q16: Do the early market reforms apply to conversion policies?**

Yes, conversion policies are individual coverage and, therefore, the ACA requirements apply to them, unless there is a statutory exception (i.e., guarantee availability).

**Q17: Do the early market reforms apply to retiree-only plans?**

The early market reforms apply to all group plans unless the group plan has less than 2 active employees in the plan.

**Q18: Are individual market issuers prohibited from underwriting children's premiums regardless of age based on health status?**

No, individual market issuers may base premiums on health status as permitted under state law.

**Q19: For children under age 19, are individual market issuers prohibited from imposing pre-existing condition exclusions, or denying coverage because of a pre-existing condition?**

Yes, individual market issuers are prohibited from imposing pre-ex condition exclusions or denying coverage due to a pre-ex condition for those under age 19.

**Q20: For children age 19 and over, are individual market issuers prohibited from imposing pre-existing condition exclusions or denying coverage because of a pre-existing condition?**

No, individual market issuers may impose a pre-ex condition exclusion or deny coverage to for someone 19 or over (even up to age 26), if permitted by state law.

**Q21: May an individual market issuer that has an open enrollment period during which it enrolls children under age 19 with pre-existing conditions, medically underwrite during the rest of the year and decline to enroll children under age 19 with pre-existing conditions outside of the open enrollment period?**

No, individual market issuers may not impose a pre-ex condition exclusion or deny coverage to anyone under age 19 at any time during the year.

**Q22: Are plans prohibited from changing issuers after March 23, 2010 in order to maintain grandfathered status?**

Groups in group plans may change carriers after November 15, 2010, and retain grandfathered status provided the policy purchased from the new carrier is not "significantly" different from the old policy, as defined by federal regulation (see summary attached).

Groups that changed carriers with an effective date for the new coverage between March 23, 2010, and November 15, 2010, lost their grandfathering status.

Enrollees in individual plans may not change carriers and retain grandfathered status.

**Q23: If a grandfathered plan wants to change carriers, may it require the new carrier to offer it a plan identical to its previous plan under the former carrier?**

The new carrier must ensure that the new policy does not contain “significant” changes to the old policy that would violate the standards set forth in federal regulations.

**Q24: If a group health plan changes issuers after March 23, 2010, but the changes are not effective until after November 15, can the plan retain its grandfathered status?**

The group can retain grandfathered status as long as the change was not effective between March 23 and November 15, 2010.

**Q25: If a group health plan changes issuers and the new policy increases cost sharing more than is permitted under paragraph (g)(1) of the interim final regulations, can the plan maintain grandfathered status?**

No, the new policy must fit within the parameters set forth in federal regulation to retain grandfathered status.

**Q26: Can states require fully-insured grandfathered plans to comply with provisions in the ACA that the ACA says do not apply to grandfathered plans?**

Yes, they can!! The ACA does not prohibit states from implementing or enforcing stricter state protections.

**Q27: Some of the recommendations and guidelines of USPSTF, CDC and HRSA do not definitively state the scope, setting, or frequency of the items or services to be covered. States continue to ask if issuers can use reasonable medical management techniques to determine any coverage limitation under the plan.**

Yes, if the scope, setting or frequency are not clearly defined, then the issuers can use reasonable medical management techniques, as permitted by state law.