Year End Gifts – More Guidance for Health Reform Implementation

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Additional guidance continues to be released impacting implementation of the Patient Protection and Affordable Care Act, including the fifth set of FAQs issued jointly by the Internal Revenue Service (IRS), Department of Labor (DOL) and Department of Health and Human Services (HHS). This alert will provide a brief overview of recent guidance.

Finally, confirmation that automatic enrollment, 60-day prior notice and insured plan non-discrimination requirements are NOT yet effective

As you may recall, we previously highlighted an ongoing debate about the effective date for certain mandates. Recent guidance confirms our position that the following mandates are not yet effective:

- Automatic enrollment into health plans is not required for employers with more than 200 full-time employees until regulations have been issued. The FAQs state "The DOL intends to complete this rulemaking by 2014."

- The requirement to provide 60-day prior notice of any material changes to information described in the standardized summary of benefits and coverage explanation is not effective until the standardized summary is required (i.e., not earlier than March 2012).

- With the express endorsement of the three agencies, IRS Notice 2011-1 provides that the new non-discrimination rules for insured group health plans will not take effect until the first plan year beginning some period of time after regulations or other administrative guidance has been issued. Additional comments are being solicited on the application of the non-discrimination rules to both insured and self-insured plans.

Coverage of adult children can conform to adult coverage

The FAQs confirm that a plan may make distinctions based upon age that apply to all coverage under the plan. In FAQ #5, the three agencies stated that a plan does not violate PPACA when it imposes copayments on all individuals ages 19 and older (including employees, spouses and adult children) but waives copayments for children under age 19.

FSA / HRA debit cards can be used to purchase some prescribed OTC drugs

The IRS has relaxed the position taken in earlier guidance that had required the use of a paper-based claims

reimbursement process for purchases of prescribed over-the-counter drugs. In IRS Notice 2011-5 the IRS provides guidance on systems that would allow participants to use their health care flexible spending account (FSA) and health reimbursement account (HRA) debit cards to purchase prescribed over-the-counter medicines. Generally, participants may continue to use an FSA or HRA debit card to purchase over-the-counter drugs at retail and mail-order pharmacies, so long as they obtain a prescription for the drug, the prescription is presented to the pharmacist, and the drug is dispensed by the pharmacist and given an Rx number. There are other rules for vendors with health care merchant codes and "90% pharmacies."

Debit cards may not be used to purchase prescribed over-the-counter drugs from vendors not described above. Instead, these purchases must be submitted for reimbursement.

Most employers will need to review the new process with their insurer or third-party administrator and then communicate the changes to their employees (since most employers have already told employees that they could not use their debit card for over-the-counter drugs).

Clarification on preventative care (non-grandfathered plans)

The FAQs confirm that a plan can still use medical management techniques to control costs. FAQ #1 approved a plan design that covered a cancer screening without charge if the test is performed in an in-network ambulatory surgery center, but charged a copayment if the test was performed in an in-network hospital setting.

The DOL also issued a request for information about the strategies used by plans to steer employees toward high-value settings, how the "high-value" is determined and available consumer protections to ensure participants have adequate access to quality care.

Stay tuned for further regulation of medical management techniques.

Clarification of rules for wellness programs

Several FAQs address wellness programs. The FAQs reiterate that HIPAA's non-discrimination limitations on standards based wellness programs only apply to programs inside a plan that require satisfaction of a health factor to qualify for the reward. Programs that are separate from the group health plan, like subsidized healthy food choices in the employee cafeteria or paid gym memberships, are not subject to the HIPAA nondiscrimination rules. Also exempt from the rules are programs not tied to satisfaction of a standard, like premium reductions for attending monthly health seminars or completion of health risk assessments.

The FAQs confirm that the exempt wellness programs are excluded when reviewing the compliance of a standards based program. So an employer that provides two incentives that provide an aggregate premium discount in excess of 20% can still

comply with the requirements so long as any standards based program remained below the threshold. The FAQs also noted that the three agencies intend to issue guidance "early next year" on consumer protections that may be needed to prevent standards based wellness programs from being used as a subterfuge for discrimination based on health status.

Confirmation that "Small Employers" are still exempt from the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) mandates

FAQ #8 confirms that plans sponsored by employers with 50 or fewer employees (100 for non-federal governmental employers) will continue to be treated as exempt from the MHPAEA mandates. However, insured plans continue to be subject to state insurance mental health parity requirements.
