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New Health Care Reform FAQs

Recently, the DOL, HHS and IRS (the "Departments") released new Health Care Reform Frequently Asked Questions ("FAQs"). The FAQs provide guidance on coverage of preventive services, cost-sharing limitations, and wellness programs.

Coverage of Preventive Services Includes Breast Cancer Risk Reduction Medications. Health Care Reform requires that non-grandfathered group health plans provide certain preventive care benefits without any cost sharing by participants. The FAQs clarify that, for plan years beginning on or after September 24, 2014, non-grandfathered group health plans must cover, without any cost sharing by participants, risk-reducing medications for women who are at an increased risk of breast cancer.

Cost-Sharing Limits. With respect to non-grandfathered group health plans, Health Care Reform imposes cost-sharing limitations and out-of-pocket maximums, which limit participants' overall out-of-pocket costs for essential health benefits ("EHBs"). Generally "cost-sharing" refers to amounts participants are required to pay, such as deductibles, coinsurance, copayments or similar charges. The annual maximum for 2014 is $6,350 for single coverage and $12,700 for family coverage.

A previous FAQ provided a one-year transition rule for plans that utilize more than one service provider (e.g., separate providers for major medical and prescription drugs). The transition rule generally allows plans to apply separate out-of-pocket annual maximums to each separately administered benefit.

- ***Transition Rule Expires in 2015.*** For plan years beginning on or after January 1, 2015, the transition rule will no longer apply; and plans will be required to apply one annual out-of-pocket maximum for all benefits, even if administered separately. However, the FAQs permit plans to use separate out-of-pocket limits across multiple categories of EHBs so long as all of the separate limits combined do not exceed the annual maximum.
- ***Premiums, Out-of-Network Costs, and Non-Covered Items or Services Do Not Count Toward the Out-of Pocket Maximum.*** Plans are not required to count employee premiums, out-of-network expenses, non-covered services (such as cosmetic procedures), or balance billing amounts for non-network providers towards the annual out-of-pocket maximum, but may choose to do so.

Wellness Programs. Health Care Reform increased the maximum permissible reward under a health contingent wellness program from 20% to 30% of the cost of coverage (or 50% for programs related to tobacco use) and imposed additional requirements on such programs.

- ***Opportunity to Qualify for a Reward May Be Annual.*** The FAQs clarify that, if a participant is given a reasonable opportunity to qualify for a reward or avoid a surcharge (for example, enrolling in a tobacco cessation program) at the time of enrollment, the plan is not required to provide another opportunity to earn the reward to an individual who declined the opportunity until the next annual enrollment.
- ***Physician Recommendations on Reasonable Alternative Standards.*** Health contingent wellness programs must offer a reasonable alternative for obtaining a reward to individuals that fail to meet the initial standard. Further, if the program is outcome-based, individuals must be offered an opportunity to involve their personal physician to develop an alternative that is medically appropriate. The FAQs clarify that, if a participant's physician recommends an alternative goal (for example, a weight reduction

program) as being medically appropriate instead of the plan's reasonable alternative, the plan must provide a reasonable alternative that accommodates the recommendation. However, the plan can have a say in which physician recommended alternative goal is used to satisfy the reward.

- ***Sample Notice Language.*** The previously issued final wellness program regulations (i) require plans to disclose to participants the availability of a reasonable alternative standard and physician involvement in all plan materials describing the wellness program, and (ii) provide sample language. The FAQs clarify that plans may modify this sample notice language so long as the notice includes all of the required content in the final regulations.

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