FAQS ADDRESS GROUP HEALTH PLANS COVID VACCINE INCENTIVES AND PLAN ELIGIBILITY

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The Department of Labor, Health and Human Services, and the Treasury came together recently to issue joint FAQs aimed at group health plans and wellness plans. These 5 FAQs address group health plan coverage requirements for qualifying coronavirus preventive services and vaccine incentives.

The first FAQ clarifies that group health plans and issuers must now cover COVID-19 vaccines and their administration, without cost sharing, immediately once the particular vaccine is authorized under an Emergency Use Authorization or approved under a Biologics License Application. Given all the guidance issued throughout the last 18 months, there was some reasonable confusion about when group health plans and issuers had to cover the cost of COVID vaccines without cost sharing. This FAQ clarifies that the no-cost sharing rule became effective January 5, 2021. Nonetheless, the no-cost sharing rule will only be enforced prospectively.

The final few FAQs address plan eligibility and vaccine incentives. Under ERISA and the Internal Revenue Code, health plans and issuers are generally prohibited from discriminating against a participant, beneficiaries, and enrollees in eligibility, premiums, or contributions based on a health factor. Hence, it follows – and this guidance confirms – that health plans and issuers may not discriminate in eligibility for benefits or coverage under a plan based on whether or not an individual receives a COVID vaccine.

Despite this, group health plans may offer participants a premium discount for receiving a COVID vaccine if the discount complies with the final wellness program regulations. The guidance explains that a premium discount for getting a COVID vaccine would be an activity-only wellness program that must comply with the following criteria in order to not be discriminatory:

1. The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year;
2. The reward for the activity-only wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed 30% of the total cost of employee-only coverage under the plan;
3. The program must be reasonably designed to promote health or prevent disease;

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4. The full reward under the activity-only wellness program must be available to all similarly situated individuals (which includes allowing a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition or medically inadvisable to satisfy the otherwise applicable standard); and
5. The plan or issuer must disclose in all plan materials describing the terms of an activity-only wellness program the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated.

Lastly, this guidance touches on how premium discounts and surcharges are treated for purposes of determining affordability of coverage. Luckily, these rules are fairly simple. For purposes of assessing liability for the employer shared responsibility payment, a premium discount is disregarded when determining whether coverage is affordable. Conversely, a surcharge is not disregarded for purposes of assessing liability for the employer shared responsibility payment.