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DOL Audits of Employer Group Health Plans on the Rise

Preparing for Audits of Compliance with PPACA, GINA, HIPAA, COBRA, Wellness Programs and More

THURSDAY, MAY 23, 2013

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

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U.S. Department of Labor Audits of Employer Group Health Plans

May 23, 2013

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DOL Audit Activity

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- We have recently been seeing a lot of Department of Labor (DOL) audit activity
- Typical Document Request includes:
  - Plan Document, SPD, Contracts with Insurers, Third Party Administrator Agreements, Bonding, etc.
  - Responsibilities of the Employer versus Employees with respect to allocation of costs/premiums/contributions
  - Health Insurance Portability Accountability Act (Certificates of Creditable Coverage, preexisting condition limitations, claim denials based on preexisting conditions, and procedures that comply with special enrollment rights, and appeal procedures)

DOL Audit Activity

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- Typical Document Request includes:
  - Women's Health and Cancer Rights Act (WHCRA) Notice
  - The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) Notice
  - Plan's rules for pre-authorization for a hospital length of stay in connection with childbirth
  - Written description of benefits mandated by WHCRA

DOL Audit Activity

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- Relatively Recent Document Request includes:
  - Plan's rules on Mental Health Benefits
  - Materials describing wellness programs or disease management programs

DOL Audit Activity

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- Affordable Care Act Requests:
  - Grandfathered status
  - Dependent Coverage to Age 26
  - Rescissions of coverage
  - Lifetime limits
  - Annual limits

DOL Audit Activity

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- Affordable Care Act Requests, if a plan is not grandfathered
  - Choice of provider notices- Right to designate any participating primary care provider, physician specializing in pediatrics or healthcare professional specializing in obstetrics or gynecology
  - Emergency services
  - Preventative services
  - Internal appeal process and external review
  - Independent Review Organization contracts

Legal Areas for Discussion

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- Affordable Care Act (ACA)
- Genetic Information Nondiscrimination Act of 2008 (GINA)
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Health Insurance Portability Accountability Act of 1996 (HIPAA)
- Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)

The Affordable Care Act (ACA)

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- The Patient Protection and Affordable Care Act (ACA)
  - H.R. 3590, signed into law by President Obama on March 23, 2010
  - Public Law (PL) 111-148
- The Health Care and Education Reconciliation Act of 2010
  - H.R. 4872, signed into law on March 30, 2010
  - PL 111-152
  - Made revisions to the ACA

Grandfathered Plans

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- Plans in effect as of March 23, 2010
- Examples of changes resulting in a loss of grandfathered status
  - Changing the plan to eliminate all or substantially all benefits to diagnose or treat a particular condition, or to eliminate benefits for any necessary element to diagnose or treat a condition
  - Increasing any percentage cost-sharing requirement (*e.g.*, coinsurance)
  - Increasing a fixed-amount cost-sharing requirement, other than a copayment (*e.g.*, a deductible or out-of-pocket limit), if the total percentage increase in the cost-sharing requirement exceeds the "maximum percentage increase" (the increase in the overall medical care component of the Consumer Price Index for All Urban Consumers [CPI-U] plus 15%)

Grandfathered Plans, Continued

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- **Examples of changes resulting in a loss of grandfathered status (continued)**
  - Increasing a fixed-amount copayment, if the total increase in the copayment exceeds the greater of: $5 increased by medical inflation measured from the grandfather date, or a total percentage measured from the grandfather date that is more than the sum of medical inflation plus 15%
  - Decreasing the employer or employee organization's contribution rate toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5%
    - The cost of coverage is determined in the same way the premium is calculated for COBRA continuation coverage purposes
  - Decreasing or imposing a new annual limit on the dollar value of benefits (however, plans with an existing lifetime limit are permitted to adopt an overall annual limit at a dollar value that is lower than the dollar value of the plan's lifetime limit, subject to agency rules regarding restrictions on annual limits)

Grandfathered Plans, Continued

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- Sample DOL ACA audit requests
  - Copy of the grandfathered health plan status disclosure statement that was required to be included in plan materials provided to participants and beneficiaries describing the benefits provided under the plan
  - Records documenting the terms of the plan in effect on March 23, 2010 and any other documents necessary to verify, explain or clarify status as a grandfathered health plan (*e.g.*, documentation relating to the terms of cost sharing, contribution rate of the employer or employee organization towards the cost of coverage, annual and lifetime limits on benefits, or any contract with a health insurance issuer in effect on March 23, 2010)

Dependent Coverage Expansion

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- Coverage of adult children to age 26
  - Effective in 2011 for non-grandfathered plans (until 2014, grandfathered plans only required to offer coverage if child does not have other employer-sponsored coverage available)
  - Employer required to provide one-time enrollment opportunity and notice for individuals who previously lost or were denied coverage due to age but were now eligible for coverage
- Sample DOL ACA audit requests
  - Sample of each written notice describing enrollment opportunities relating to dependent coverage of children to age 26 utilized by the plan on or after September 23, 2010

Rescission of Coverage

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- No retroactive termination of coverage (except under limited circumstances)
  - Effective in 2011
  - Exceptions for intentional misrepresentation or fraud
- Sample DOL ACA audit requests
  - List of any participants or beneficiaries whose coverage has been rescinded, the reason for the rescission, and a copy of the written notice of rescission that was provided 30 days in advance of any rescission of coverage

Lifetime Limits

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- No lifetime dollar limits on essential health benefits
  - Effective in 2011
- Sample DOL ACA audit requests
  - Documents showing the lifetime limits, if any, applicable for each plan year beginning on or after September 23, 2010
  - Sample of each form of notice sent to participants or beneficiaries stating that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan

Annual Limits

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- **Phase out of annual limits on essential health benefits began in 2011, and annual limits on essential health benefits are totally prohibited beginning in 2014**
  - For plan years beginning on or after September 23, 2010, but before September 23, 2011, the limit was $750,000
  - For plan years beginning on or after September 23, 2011, but before September 23, 2012, the limit was $1.25 million
  - For plan years beginning on or after September 23, 2012, but before December 31, 2013, the limit is $2 million
    - Waiver process was available for plans and coverages that included “limited benefit” or “mini-med” plans
    - Intended for lower-cost coverage to part-time workers, seasonal workers, and volunteers who otherwise may not be able to afford coverage at all
- **Sample DOL ACA audit requests**
  - Documents showing the annual limits applicable for each plan year beginning on or after September 23, 2010, including any waivers

Choice of Providers

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- Participants must be allowed to choose primary care providers, pediatricians, obstetricians, and gynecologists
  - Effective in 2011 (non-grandfathered plans only)
- Sample DOL ACA audit requests
  - Copy of each form of choice of provider notice informing participants of the right to designate any participating primary care provider, physician specializing in pediatrics in the case of a child, or health care professional specializing in obstetric or gynecology in the case of women utilized by the plan on or after September 23, 2010, and a list of participants who received the disclosure notice

Emergency and Preventive Services

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- First dollar preventive care coverage and emergency care coverage without prior authorization
  - Effective in 2011 (non-grandfathered plans only)
- Sample DOL ACA audit requests
  - Copies of documents relating to any benefits with respect to emergency services in an emergency department of a hospital for each plan year beginning on or after September 23, 2010
  - Copies of documents relating to the provision of preventive services for each plan year beginning on or after September 23, 2010

Claims and Appeals

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- Increased internal claims and external review requirements
  - Effective in 2011 (non-grandfathered plans only)
- Sample DOL ACA audit requests
  - Copy of the plan's internal claims and appeals and external review processes
  - Samples of each form of adverse benefit determination, notice of final internal adverse determination notice, and notice of final external review decision, utilized by the plan on or after September 23, 2010
  - Any contract or agreement for an independent review organization or third party administrator providing external review

Requirements for 2014 and Beyond

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- **2014: Employer "Pay or Play" Coverage Mandate**
  - Only applies to all plans with 50 or more full time employees (FTEs)
  - Non-deductible excise tax applies for no coverage offered or coverage offered to less than 95% of full-time employees
    - Penalty if one FTE obtains a tax credit or cost sharing assistance is $2,000 per FTE in excess of 30 employees

Requirements for 2014 and Beyond

McDermott Will & Emery

- **2014: Employer "Pay or Play" Coverage Mandate**
  - Non-deductible excise tax for providing "unaffordable coverage" which means the employer offers health coverage to at least 95% of its full-time employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on an exchange and the coverage was unaffordable to that employee
    - Penalty of $3,000 per FTE who receives a federal subsidy capped at $2,000 per FTE in excess of 30 employees
    - Unaffordable coverage means (i) it exceeds 9.5% of the individual's household income (proposed regulations include a safe harbor); (ii) the employee falls within 100%-400% of the federal poverty level; and (iii) the plan's share of allowed costs under the plan is less than 60% (minimum value test)

Requirements for 2014 and Beyond, Continued

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- **2014: Notification of Exchange** – Employers are required to notify each employee at the time of hiring
  - The existence of the exchange;
  - That the employee may be eligible for a subsidy under the exchange if the employer's share of the total cost of benefits is less than 60%; and
  - That if the employee purchases a policy through the exchange, he or she will lose the employer contribution to any health benefits offered by the employer
- **2015: Employer Reporting of Health Insurance Coverage** – Every person who provides minimum essential coverage to an individual during a calendar year will have to file a special return
- **2018: Cadillac Tax** – A nondeductible 40% excise tax will be imposed on the value of high cost coverage in excess of $10,200 for single coverage and $27,500 for family coverage, indexed for inflation

Penalties

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- Pay or Play Penalties
- Cadillac Plan Penalties
- Employee Retirement Income Security Act (ERISA) Penalties
  - No specific penalties under ERISA, but participants, beneficiaries, and the DOL may use ERISA's civil enforcement provisions to file lawsuits against plan fiduciaries to enforce ACA requirements.
    - Lawsuits would be brought as a claim for breach of fiduciary duty for failure to comply with ACA
    - Claims for payment of benefits alleged to be due under the plan because of ACA could be potentially filed directly against the plan or plan sponsor, and the affected party could seek damages for unpaid benefits, interest, and attorney's fees

Penalties, Continued

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- **Internal Revenue Code (Code) Penalties**
  - Excise tax under Section 4980D of the Code for failure to meet market reforms under ACA
  - General formula for calculating the tax is $100 per day that the plan is not in compliance for each individual to whom the failure relates
    - Tax may be higher in limited cases where a failure is not corrected prior to a notice from the Internal Revenue Service (IRS) of examination of income tax liability or during the period of examination
    - Tax does not apply when failures were not discovered and would not have been discovered exercising reasonable diligence, or when failures occurred due to reasonable cause (and not willful neglect) and were timely corrected. For failures due to reasonable cause that are not timely corrected, a tax is imposed but the amount is limited, and the Secretary of the Treasury has discretion to waive all or part of the tax to the extent that the payment of such tax would be excessive relative to the failure involved

Penalties, Continued

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- **Internal Revenue Code (Code) Penalties**
  - Code requires employer sponsors of group health plans that are liable for the tax under Code Section 4980D to self-report by filing IRS Form 8928 (Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code). Failure to file the return and pay the excise tax on or before the employer's federal income tax return due date (without extension) may result in late payment penalties and related interest, unless the failure to timely file or pay is due to reasonable cause and not to willful neglect

GINA

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- Title I of GINA imposes health insurance genetic nondiscrimination requirements relating to underwriting, premiums and genetic testing
  - GINA prohibits group health plans and health insurers that offer health insurance coverage from:
    - Adjusting group health plan premium or contribution amounts on the basis of genetic information
    - Does not prohibit premium or contribution increases based on the manifestation of a disease or disorder of an individual enrolled in the plan

GINA

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- Title I of GINA imposes health insurance genetic nondiscrimination requirements relating to underwriting, premiums and genetic testing
  - GINA prohibits group health plans and health insurers that offer health insurance coverage from:
    - Requesting or requiring individuals or their family members to undergo genetic testing, subject to certain exceptions for:
      - Certain health care professionals providing services to the individual;
      - Determinations regarding payment; and
      - Research
    - Collecting genetic information:
      - For underwriting purposes; and
      - Prior to or in connection with enrollment

GINA Underwriting Definition

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- **The definition of underwriting under GINA is broader than activities relating to rating and pricing a group policy, and includes:**
  - Determining eligibility (including enrollment and continued eligibility) for plan benefits (including changes in deductibles or other cost-sharing) in return for activities such as completing a health risk assessment or participating in a wellness program
  - Calculating premium or contribution amounts (including discounts, rebates or payments in kind) for activities such as completing a health risk assessment or participating in a wellness program
  - Applying preexisting condition exclusions. Note that health care reform prohibits pre-existing condition exclusions effective for plan years beginning on or after January 1, 2014. For enrollees under 19 years old, this provision was effective for plan years beginning on or after September 23, 2010
  - Other activities relating to the creation, renewal, or replacement of benefits or coverage

GINA and Wellness Programs

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- GINA also defines genetic information as including family medical history
  - As a result, wellness programs that offer rewards for completing health risk assessments that request genetic information (including family medical history) violate the prohibition against requesting genetic information for underwriting purposes

GINA and HIPAA

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- GINA has now been incorporated into the final HIPAA Rule
  - Prohibits the use or disclosure of genetic information for underwriting purposes, even if a covered entity plan has the individual's written authorization to do so
  - Applies to all health plans subject to the HIPAA privacy and security rules other than long-term care insurance
  - Prohibition applies to all genetic information as of March 26, 2013, regardless of when or where the genetic information originated

MHPAEA

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- Applies to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements
- Also applies to health insurance issuers who sell coverage to employers with more than 50 employees

MHPAEA

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- If a group health plan includes medical/surgical benefits and mental health benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits
- If a group health plan includes medical/surgical benefits and substance use disorder benefits, the financial requirements and treatment limitations that apply to substance use disorder benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits
- Mental health benefits and substance use disorder benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits

MHPAEA

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- If a group health plan includes medical/surgical benefits and mental health benefits, and the plan provides for out-of-network medical/surgical benefits, it must provide for out-of-network mental health benefits
- If a group health plan includes medical/surgical benefits and substance use disorder benefits, and the plan provides for out-of-network medical/surgical benefits, it must provide for out-of-network substance use disorder benefits
- Standards for medical-necessity determinations and reasons for any denial of benefits relating to mental health benefits and substance use disorder benefits must be made available upon request to plan participants
- The parity requirements for the existing law (regarding annual and lifetime dollar limits) will continue and will be extended to substance use disorder benefits

HIPAA Portability

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- Limits on Pre-existing conditions
  - Up to 12 months for normal enrollment 18 for late enrollment
  - Significant Break in coverage
- Certificates of Creditable Coverage
  - Must be issued when someone loses coverage under the plan
- Prohibit discrimination against employees and dependents based on their health status
- Allow a special opportunity to enroll in a new plan to individuals in certain circumstances

HIPAA Portability

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- Limits on Pre-existing conditions
  - A plan may not impose a pre-existing condition if a participant had prior creditable coverage
  - Most plans use the standard method of crediting coverage.
    - COBRA, individual coverage, and group plan coverage all count towards creditable coverage
  - A participant receives credit for previous coverage that occurred without a break in coverage of 63 days or more
    - Any coverage occurring prior to a break in coverage of 63 days or more is not credited against a pre-existing condition exclusion period
  - Health Care Reform eliminated pre-existing conditions for all children under the age of 19, 2014 will eliminate pre-existing conditions for all

HIPAA Portability

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- Certificates of Creditable Coverage
  - Plan should contain procedures
  - Plans and insurers must furnish the certificate automatically to:
    - A participant/insured who is entitled to elect COBRA continuation coverage, at a time no later than when a notice is required to be provided for a qualifying event under COBRA
    - A participant/insured who loses coverage under a group health plan and who is not entitled to elect COBRA continuation coverage, within a reasonable time after coverage ceases
    - A participant/insured who has elected COBRA continuation coverage, either within a reasonable time after the plan learns that COBRA continuation coverage ceased or, if applicable, within a reasonable time after the individual's grace period for the payment of COBRA premiums ends
    - Upon request by a participant/insured

HIPAA Non Discrimination

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- **Discrimination Based on Health Status**
  - Plans and insurance companies may not establish rules for eligibility (including continued eligibility) based on health status related factors
  - These factors include:
    - Health status
    - Medical condition (physical or mental)
    - Claims experience
    - Receipt of health care
    - Medical history
    - Genetic information
    - Evidence of insurability
    - Disability
  - Plans generally may not require an individual to pay a premium or contribution that is greater than that for a similarly situated individual based on a health status related factor

HIPAA Special Enrollment

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- A plan is required to allow special enrollment for certain individuals to enroll in the plan without having to wait until the plan's next regular enrollment season
- Plans and insurers are required to provide special enrollment periods during which individuals who previously declined coverage for themselves and their dependents may be allowed to enroll (without having to wait until the plan's next open enrollment period)
  - A special enrollment opportunity occurs if an individual with other health insurance loses that coverage; or
  - If a person becomes a new dependent through marriage, birth, adoption or placement for adoption
  - A person must notify the plan of the request for special enrollment within 30 days after losing other coverage or within 30 days of having (or becoming) a new dependent

  If a person enrolls as a special enrollee, that person may not be treated as a late enrollee for purposes of any pre-existing condition exclusion period. Therefore, the maximum pre-existing condition exclusion period that may be applied is 12 months, reduced by your creditable coverage (rather than 18 months, reduced by creditable coverage)

WHCRA

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- The plan is required to provide (to an individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy) coverage for:
  - All stages of reconstruction of the breast on which the mastectomy was performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses
  - Treatment of physical complications at all stages of the mastectomy, including lymphedema

NMHPA

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- Requires plans that offer maternity hospital benefits for mothers and newborns to pay for at least a 48-hour hospital stay for the mother and newborn following childbirth
  - Requires plans that offer maternity hospital benefits for mothers and newborns to pay for at least a 96-hour hospital stay for cesarean births
  - Can be reduced if the attending provider, in consultation with the mother, decides to discharge earlier

HIPAA SPD and SMM Disclosure Rules

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- Effective for plan years beginning on or after January 20, 2001
  - Participants and beneficiaries must receive notice of material reductions in covered services (*e.g.*, reductions in benefits or increases in deductibles or copayments) generally within 60 days of adoption of the change. Previously, such material changes generally did not need to be disclosed until as late as 210 days after the end of the plan year in which the change was adopted
    - Note: Material Modification on or after January 1, 2011. If a group health plan or insurance company makes any material modification in terms of plan or coverage, and such modification is not reflected in the most recently provided summary of benefits and coverage, the plan or insurer must provide notice of the modification not later than 60 days prior to the date the modification becomes effective
  - Participants and beneficiaries must be informed that federal law prohibits plans from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections

HIPAA SPD and SMM Disclosure Rules (Continued)

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- Participants and beneficiaries must receive information regarding which DOL office they can contact for assistance or information regarding their HIPAA rights
- Participants and beneficiaries must receive information regarding the role of any issuer (*e.g.*, insurance company or HMO) with respect to the group health plan. The information disclosed must include the name and address of the issuer and what role it plays with respect to the plan (i.e., whether and to what extent the issuer guarantees benefits under a contract of insurance and the nature of any administrative services, such as claims administration)

HIPAA Administrative Simplification

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- Privacy
  - Compliance with privacy regulations by April 14, 2003 for large plans and April 14, 2004 for small plans
  - Updated Regulations effective September 23, 2013
- Electronic Transactions
  - Compliance with the standards for electronic transactions by October 16, 2003 (If a compliance plan is filed by October 15, 2002)
- Security
  - Compliance with security rules by April 21, 2005 for large plans and April 21, 2006 for small plans

HIPAA Privacy Basics

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- Covered Entities may use/disclose protected health information (PHI) only to the minimum extent necessary
- Covered Entities must have written privacy policies
- Covered Entities must train and audit in connection with such policies
- Individuals have the right to review and amend PHI
- Individuals have the right to an accounting of PHI
- Individuals have the right to a Privacy Notice
- Authorizations necessary for other than treatment, payment and health care operations
- Breach Notice provisions apply

HIPAA Business Associates

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- A person who is not under the direct control of the covered entity and who performs functions or activities on behalf of the covered entity involving the use or disclosure of PHI
- Business Associate contracts must have been entered into on the later of the privacy effective date or for new relationships, September 23, 2013

HIPAA Electronic Transaction Basics

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- Covered entities that conduct one or more of the previously mentioned transactions electronically are required to do so using the HIPAA prescribed standards and formats

HIPAA Security Basics

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- The security rules require covered entities to:
  - Ensure the confidentiality, integrity, and availability of all EPHI the covered entity creates, receives, maintains, or transmits
  - Protect against any reasonably anticipated threats or hazards to the security or integrity of such information
  - Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required by the rule
  - Ensure compliance with the rule by its workforce

COBRA

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- COBRA is a federal law that requires most employers maintaining group health plans to offer covered employees, and their covered family members, the opportunity to pay to continue coverage under an employer health plan where coverage would otherwise end
- Employers are responsible for following the guidelines outlined under COBRA if they:
  - Have 20 or more employees the previous calendar year; and
  - Offer group health benefits

Length of COBRA Coverage

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EVENT	***WHO RECEIVES COVERAGE?***	***DURATION***
Termination of Employment	▪ Covered Employee ▪ Spouse (of Covered Employee) ▪ Dependent Children (of Covered Employee)	18 Months

Length of COBRA Coverage

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EVENT	*WHO RECEIVES COVERAGE?*	*DURATION*
Death of Covered Employee	•Spouse (of Covered Employee) •Dependent Children (of Covered Employee)	36 Months
Divorce or Legal Separation of the Covered Employee & Spouse	•Spouse (of Covered Employee) •Dependent Children (of Covered Employee)	
Employee Entitled to Medicare	•Spouse (of Covered Employee) •Dependent Children (of Covered Employee)	
Loss of Dependent Status	•Dependent Children (of Covered Employee)	

COBRA

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- Have good Policies and Procedures relating to Notice to Qualified Beneficiaries
  - Keep addresses on file
  - A qualified beneficiary's right to elect COBRA remains open until expiration of the election period (a minimum of 60 days after the later of the date that coverage is lost or the date that a COBRA election notice is provided)
  - Address to “Employee and his or her dependents, as applicable”

COBRA

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- **Have good Policies and Procedures relating to Notice to Plan**
  - Under the IRS COBRA regulations, a group health plan is "not required to offer the qualified beneficiary an opportunity to elect COBRA" if notice of the qualifying event is not provided within the 60-day period
    - The DOL's COBRA regulations do not specifically deal with the consequences of a late qualifying event notice except to state that the initial notice must disclose an "explanation of the plan's requirements regarding the responsibility of a qualified beneficiary to notify the administrator of a qualifying event"
  - The DOL's COBRA regulations require plans to disclose (in the election notice but not in the initial notice) the plan's requirements regarding the responsibility of qualified beneficiaries who are receiving COBRA coverage to provide notice to the plan administrator of a second qualifying event
    - The DOL's regulations state that plans must disclose the consequences of failing to provide these notices

COBRA

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- **Have good Policies and Procedures relating to Timely Payment**
  - A qualified beneficiary's COBRA coverage may be terminated, subject to grace periods and other special rules, “as of the first day of any period for which timely payment is not made” with respect to the qualified beneficiary
  - A plan can either
    - Continue coverage during a payment grace period (subject to retroactive cancellation if no payment is made); or
    - If the plan allows retroactive reinstatement, cancel coverage and retroactively reinstate it upon payment of required premiums
    - Claims incurred during a payment's grace period need not be paid until any required payment for coverage has been made