Strafford

presents

New Mandates for Group Health Plans: GINA, MHPA, HITECH, MSP Reporting and More

Navigating Plan Compliance Demands and Avoiding Federal Excise Tax

A Live 90-Minute Teleconference/Webinar with Interactive Q&A

Today's panel features:

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Wednesday, April 14, 2010

The conference begins at:

1 pm Eastern

12 pm Central

11 am Mountain

10 am Pacific

You can access the audio portion of the conference on the telephone or by using your computer's speakers.
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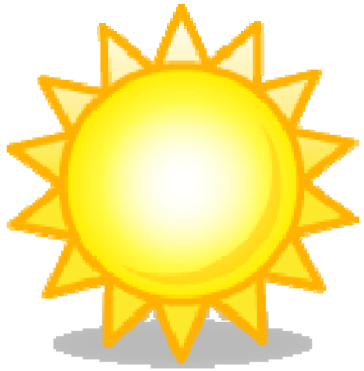
Hot Topics for Health Plans (including Health Care Reform)



Cheryl Risley Hughes
Christy Tinnes

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Issues to Watch . . .

- Health Care Reform
- Mental Health Parity
- HITECH Act
- COBRA Subsidy
- MSP Reporting
- GINA
- CHIPRA
- Michelle's Law
- New Excise Tax Rules

Health Care Reform: *Overview*

- Insurance Market Reforms – beginning 2011
- Exchanges – beginning 2014
- Individual Mandate – beginning 2014
- Employer Mandate – beginning 2014
- Excise Tax – beginning 2018

Health Care Reform: *"Near-Reforms" (2011 Plan Year)*

Applicable to insured & self-funded plans, beginning plan years 6 months after enactment – even for grandfathered plans -

- No annual or lifetime limits on "essential benefits" (Secretary may allow some annual limits prior to 1/1/14).
- Must cover adult child to age 26 (prior to 1/1/14, n/a if child eligible for other employer coverage).
- No pre-existing condition exclusions for enrollees under age 19.
- HSA, FSA, HRA cannot reimburse over-the-counter drugs (unless prescribed).

Health Care Reform: *"Near-Reforms" (2011 Plan Year)*

Applicable to insured & self-funded plans, beginning plan years 6 months after enactment – but not for grandfathered plans -

- Must cover preventive care without cost-sharing.
- Must cover OB-GYN without referral or prior authorization.
- 105(h) nondiscrimination rules extend to insured benefits.
- Appeals & External Review.
- Must allow emergency services without prior authorization and regardless whether participating provider.
- Must allow participant to designate pediatrician as child's primary care provider.

Health Care Reform: *Later Reforms – 2014*

Applicable to insured & self-funded plans, beginning 2014 -

- No pre-existing condition exclusions (even grandfathered plans).
- Waiting period no longer than 90 days (even for grandfathered plans).
- Rating limitations.
- Guaranteed access/renewability.
- Must cover clinical trials.
- Wellness program reward increased to 30%.
- Limits on cost-sharing ($5,000 individual / $10,000 family).

Health Care Reform: *Employer Mandate (2014)*

- Applies to employers with at least 50 full-time employees.
- Must pay fee if any employee receives federal premium assistance.
  - If employer provides, no minimum essential coverage + at least one employee receiving premium assistance = $2,000 annual fee for each full-time employee employed (minus first 30 employees).
  - If employer provides minimum essential coverage + at least one full-time employee receiving premium assistance = the lesser of $3,000 for each employee receiving premium assistance OR $2,000 per employee for each full-time employee employed (minus first 30 employees).
- May have to offer voucher to employees below certain income level to buy coverage through the Exchange.

Health Care Reform: *Revenue Raisers*

- 40% excise tax on high cost health plans ("Cadillac Tax").
- Employee salary reduction contributions to FSAs limited to $2,500, indexed to CPI-U.
- Increase additional tax on distributions from HSAs that are not used for qualifying medical expenses from 10% to 20% of the distribution, effective in 2011.
- Repeal deduction for the subsidy for employers who maintain prescription drug plans for Medicare Part D eligible retirees.
- W-2 Reporting of value of employer-provided benefits.

Mental Health Parity and Addiction Equity Act ("MHPAEA")

- New parity requirements apply to mental health and substance use disorder benefits
  - Financial requirements may be no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan
  - Treatment limits may not be more restrictive than the predominant treatment limits applied to substantially all medical and surgical benefits covered by the plan
  - Out-of-network mandate
  - Parity not expressly required for medical management
- New Disclosure Requirement – Plans must now disclose medical necessity criteria to participants and providers
- Effective January 1, 2010 for calendar year plans.

MHPAEA: The Interim Final Rule

- Interim final rule issued by IRS, CMS and DOL on February 2, 2010 – 4 months after the Act's effective date for calendar year plans.
- The agencies have requested comments by May 3, 2010.
- The rule is applicable for the first plan year beginning on or after July 1, 2010.
- There is a limited **non-enforcement period** until the applicability date for a plan, provided the plan has taken good faith steps to comply with the Act.

MHPAEA: Plan Exclusions of Conditions or Disorders

- Plans are not required to offer mental health or substance use benefits at all.
  - Except for state mandates that may apply to insured plans.
- Plans may permanently exclude all benefits for a specific condition or disorder without violating the parity rules.
- Covering mental health benefits will not require plans to cover substance use disorder benefits.
- But – if a condition is covered, it must be offered in parity with medical/surgical benefits.
- If mental health or substance abuse benefits are provided in any classification (e.g., prescription drugs), benefits must be provided in ALL classifications (e.g., in-patient, out-of-network, etc.)

MHPAEA: Plan Definitions of Conditions & Disorders

- Mental health and substance use disorder benefits are defined by the plan, but must be categorized consistent with generally recognized independent standards of current medical practice (e.g., DSM, International Classification of Diseases, or a state guideline).
  - For example, autism is defined by the DSM as a mental health benefit, so cannot be defined by a Plan as a medical benefit in order to apply cost containment limits.

MHPAEA: Plan Exclusions of Treatments and Treatment Settings

- Definitions of inpatient, outpatient and emergency care are subject to plan design (and may be subject to state law mandates for insured plans).
  - The definitions must be applied uniformly for medical/surgical benefits and mental health/substance abuse benefits.
- Plans CAN exclude certain treatments and treatment settings under the interim final rule.
  - For example, a plan could exclude family counseling or nonresidential treatment facilities that are treatments or treatment settings often prescribed for conditions that are otherwise covered under a plan.
- But, the agencies have requested comments on scope of services and continuum of care issues and have said they will address this in the final rule.

MHPAEA: Parity Requirements – What are Treatment Limitations?

- Parity requirements apply to quantitative and nonquantitative treatment limitations
  - **Quantitative treatment limitations** are expressed numerically
    - For example, annual limits of 50 outpatient visits. Other examples are episodic or lifetime day or visit limits.
    - Quantitative treatment limits cannot accumulate separately (e.g., cannot have an annual limit of 50 visits on outpatient mental health and a separate annual limit of 50 visits for outpatient medical/surgical).

MHPAEA: Parity Requirements – What are Treatment Limitations?

- **Nonquantitative treatment limitations** are limitations that affect the scope or duration of benefits under the plan that is not expressed numerically.
  - **New Parity Rule:** Any **processes, strategies, evidentiary standards** or other factors used in applying the nonquantative treatment limitation to mental health/substance abuse benefits must be **comparable to and applied no more stringently** than the processes, strategies, evidentiary standards or other factors used in applying the limitation with respect to medical/surgical benefits in the same "**classification**".
    - This rule applies to the terms of the plan as written and in operation.
  - Variation is allowed only to the extent that recognized clinically appropriate standards of care may permit a difference.

MHPAEA: Parity Requirements – What are Treatment Limitations?

- **Nonquantitative treatment limitations parity rule** applies to –
  - Medical management
  - Prescription drug formulary design
  - Standards for determining provider admission to a network, including reimbursement rates
  - Determinations of usual and customary charges
  - Fail-first or step-therapy protocols
  - Conditioning benefits on completion of a course of treatment
- The agencies intend to add to this list
- An EAP cannot be the gatekeeper for mental health if no similar arrangement for medical/surgical

MHPAEA: Parity Requirements – What are Financial Requirements?

- Financial requirements include deductibles, copayment, coinsurance and out-of-pocket maximums
  - Separately accumulating deductibles or out-of-pocket maximums is now prohibited
  - A plan may not (without passing the parity tests) treat all mental health/substance use disorder providers as specialists and automatically apply a higher copayment than for primary care physicians for medical/surgical.

MHPAEA: Determining Parity – Classifications and Coverage Units

- Parity must be determined **classification-by-classification**
  - Specific classifications required by the rule are:
    - Inpatient, in-network
    - Inpatient, out-of-network
    - Outpatient, in-network
    - Outpatient, out-of-network
    - Emergency care
    - Prescription drug
  - No other classifications are permitted
- Parity must be determined for each **coverage unit** (e.g., employee only, employee + one, family, etc.)

MHPAEA: Determining Parity – The "Substantially All" Test

- A "**type**" of financial requirement (e.g., all copays) or quantitative treatment limitation applies to **substantially all** medical/surgical benefits within a classification if it applies to **at least 2/3** of all the benefits (based on projected plan cost) in that classification.
  - Any **reasonable method** may be used to determine the dollar amount expected to be paid under the plan – including national data or data across an insurer's book of business.
  - Benefits at a zero level (e.g., $0 copay for well baby visits or $0 coinsurance for preventive care) are counted in the denominator (i.e., not subject to the financial requirement)

MHPAEA: Determining Parity – The "Predominant" Test

- If the "**Substantially All**" Test is met for a type of requirement or limitation, then the plan must pass the "**Predominant**" Test for the specific "**level**" of requirement or limitation to be applied to mental health/substance abuse.
  - For a level of financial requirement or treatment limitation to be predominant, it must apply to **at least 50%** of all medical/surgical benefits within the classification.
  - If there is no single level that applies to 50%, there are complex aggregation rules.

MHPAEA: New Single Group Health Plan Rule

- The parity rules apply separately with respect to each combination of medical/surgical and mental health/substance abuse coverage that any participant can **simultaneously receive** from an employer.
  - As a result, mental health/substance abuse **carve-outs** with limits are prohibited.
- All such combinations constitute a "**single group health plan**" for parity purposes.
  - For example, if an employer offers three packages plus one mental health plan, parity requirements (including nonquantitative treatment limitations) must be met with regard to each package when combined with the mental health plan.
  - If an **EAP** is overlaid on top of a plan with full parity, it will not be subject to the parity requirements.
    - Not clear how this will apply to **account based plans**.

MHPAEA: Exemptions

- Small Employer Exemption
  - Parity rules apply to employers who employed an average of more than 50 employees on business days during the preceding calendar year.
    - Agencies intend to issue guidance clarifying how to count employees

MHPAEA: Exemptions

- Cost Exemption
  - If parity requirements cause a health plan's total costs to increase by 2% in the first plan year and 1% in subsequent plan years, plans can apply for relief from parity requirements for one plan year (but will have to comply the following year)
    - Plans must comply with parity for at least 6 months before claiming the cost exemption for the following year

MHPAEA: New Disclosure Requirements

- Upon request by a current or potential participant, beneficiary or contracting provider, the plan administrator or health insurance issuer must provide the criteria for **medical necessity determinations** made under the plan with respect to mental health or substance abuse benefits.

- Plan administrator or health insurance issuer must also make available upon request or as otherwise required, the reason for any **denial** of reimbursement or payment for services with respect to mental health or substance use disorder benefits.

  - The interim final rule provides that compliance with ERISA's claims procedure rules as to denials constitutes compliance with this rule for both ERISA and non-ERISA plans (e.g., church plans).

MHPAEA: Takeaways – What Should Plans Do Now?

- **Step 1** – Review plan for good faith compliance with the Act until the applicability date for the Plan (e.g., January 1, 2011 for calendar year plan).
- **Step 2** – Analyze Plan design under new parity tests for the upcoming plan year.
  - Document results of "Substantially All" and "Predominant" tests.
  - Document processes and strategies for nonquantitative treatment limitations for mental health/substance use disorder and medical/surgical for comparison purposes.
  - Prepare to make medical necessity and claims denial disclosures

HITECH Act (HIPAA Privacy)

- New HIPAA privacy rules (most effective 2/17/10).
- New security breach notification rule (effective 9/24/09).
- Significantly increased civil penalties.
- Health plans must update business associate agreements (and may need to update privacy notices, too).
- HHS to issue regulations “soon.”

HITECH Act:
Hew HIPAA Penalties

- Prompted by HHS audits or complaints by individuals.
- Civil Penalties:
  - Where not "knowing" – minimum $100 per violation, up to $25,000 per year / maximum $50,000 per violation, up to $50,000 per year.
  - Where due to "reasonable cause" – minimum $1,000 per violation, up to $100,000 per year / maximum $50,000 per violation, up to $1.5 million per year.
  - Where due to "willful neglect" - minimum $10,000 per violation, up to $250,000 per year / maximum $50,000 per violation, up to $1.5 million per year.

HITECH Act:
New HIPAA Penalties

- Criminal Penalties:
  - May be brought against *any individual* who obtains or discloses information from a covered entity without authorization.
  - Penalties for wrongful disclosure:
    - Up to $50,000 fine, 1 year imprisonment.
    - If false pretenses, up to $100,000 fine, 5 years imprisonment.
    - If for commercial gain, personal gain, or malicious harm, up to $250,000, 10 years imprisonment.

HITECH Act:
Security Breach Notification

- If there is a security breach, must notify individuals involved.
- Applies to breaches of "unsecured PHI," which is PHI that is not encrypted or destroyed.
- To trigger notice requirement, disclosure must pose "significant risk of financial, reputational, or other harm to the individual."
- Plan must notify individual within 60 days by first class mail (or email if specified as preference).
- Time starts running when ANYONE in organization knows of breach.

HITECH Act:
Security Breach Notification

- Contents of Notice:
  - Description of what happened, including date of breach and discovery.
  - Types of PHI involved.
  - Steps individuals can take to protect themselves from potential harm.
  - Steps plan is taking to investigate, mitigate losses, and protect against further breaches.
  - Contact information.

HITECH Act:
Security Breach Notification

- If more than 500 individuals in a state affected, must provide notice to prominent media outlets.
- Must keep log of breaches and file with HHS by March 1st of each year.
- Must notify Secretary of HHS immediately of breaches involving 500 or more individuals.
- Secretary will list breaches involving 500 or more individuals on its website.

COBRA Premium Subsidy

- The 2010 Dept. of Defense Appropriations Act ("DOD Act") extended the COBRA subsidy program until 2/28/2010
  - Maximum COBRA subsidy period extended to 15 months
  - Clarified that only the qualifying event must occur prior to 2/28/2010 (loss of coverage may occur later)

COBRA Premium Subsidy

- **Retroactive COBRA Elections.** Group health plans are required to allow those who exhausted the 9 month COBRA subsidy period and dropped COBRA coverage to retroactively elect COBRA coverage for up to an additional 6 months, and receive the subsidy for that time.

- **Rebate for COBRA Premiums.** Group health plans are required to allow those who exhausted the 9 month COBRA subsidy period and continued to maintain COBRA coverage (and paid 102% of the premium) to receive a reimbursement payment or credit for 65% of the COBRA premium payments that were paid for up to 6 months following the 9 month COBRA subsidy period.

COBRA Premium Subsidy

- **General Notice -** Updated General Notice issued by DOL. Required for anyone experiencing a qualifying event between 9/1/2008 and 2/28/2010 (who has not already been provided a Notice).
  - Employees terminated in December 2009 should receive new Notice and 60 day period to elect COBRA.

COBRA Premium Subsidy

- **Premium Assistance Extension Notice –** New Notice issued by DOL.
  - Must be provided to those who have already been provided COBRA election notice without information regarding the extension of the COBRA subsidy.
  - Individuals who were eligible for the subsidy as of October 31, 2009 (unless in transition period) and those terminating employment on or after October 31, 2009 must be given this Notice by 2/17/2010 (unless provided new General Notice).
  - Individuals in a transition period must be given this Notice within 60 days of first day of transition period (transition period begins after expiration of 9 month subsidy period).

COBRA Premium Subsidy

- **Updated Alternative Notice –** Issued by DOL for qualified beneficiaries under state continuation coverage.

Temporary Extension Act of 2010

- COBRA Eligibility Period extended through March 31, 2010
- "Improvements" include the following:
  - Loss of coverage due to reduction in hours followed by involuntary termination on or after 3/2/10 results in eligibility for subsidy (COBRA measured from date of reduction of hours).
  - New notice obligation by group health plan administrators (or other entities) for the above group
  - New election period for the above group, which only applies to individuals who did not elect COBRA coverage at time of reduction in hours or who elected and then discontinued COBRA coverage.

Temporary Extension Act of 2010

- "Deemed" involuntary termination if reasonable interpretation and attestation.
- Beneficial safe harbor for employers
- Helps minimize risk of payroll tax
- New enforcement provisions
  - Civil penalty of $110 per day if COBRA subsidy is not provided within 10 days of a determination by DOL or HHS that it should be.
  - Express right of action by secretary or “affected individual” to enforce subsidy determination or for “other appropriate relief”

Other Extension Proposals

- House –Passed Jobs for Main Street Act, H.R. 2847
  - Would extend eligibility period for subsidy through June 30, 2010
- HIRE Act
  - Proposed in Senate Finance Committee; provisions dropped from Jobs bill passed by Senate in February
  - COBRA Eligibility Period would be extended through May 31, 2010
- Second Senate Jobs Act considered this week
  - Would extend subsidy eligibility through end of 2010

Outlook

- The passage of the Temporary Extension Act extends subsidy eligibility through March 31.
- This gives Congress another month to consider further extensions, without causing the administrative challenges that occurred with the late passage of the DOD Act extension

MSP Reporting

- Applies with respect to Medicare beneficiaries who have group health plan coverage (insured or self-funded)
- Also applies with respect to Medicare beneficiaries who receive settlements, judgments, awards, or other payment from liability insurance (including self-insurance), no-fault insurance, and workers' compensation
- Plans (or their insurers/TPAs) must report to CMS with regard to Medicare beneficiaries. This process allows CMS to monitor compliance with existing Medicare Secondary Payer rules.

Genetic Information Nondiscrimination Act ("GINA")

- Effective January 1, 2010 for calendar year plans.
- Plan cannot request or require genetic information prior to or in connection with enrollment.
- Plan cannot request or require genetic information for underwriting purposes (which includes rules for eligibility or computation of premium).
- New regulations issued October 7, 2009 - impacts health risk assessments for 2010.
- Additional regulations expected.

Children's Health Insurance Plan Reauthorization Act ("CHIPRA")

- Plan's HIPAA special enrollment provisions must be amended to allow enrollment when:
  - Eligible for premium subsidy; or
  - Lose coverage under Medicaid or CHIP.
- Effective April 1, 2009.
- New notice requirements starting January 1, 2011 (DOL has issued model).

Michelle's Law

- Group health plan must provide coverage for dependent who does not meet “full time” student status due to medically necessary leave of absence.
- Whether leave of absence is “medically necessary” to be determined by dependent’s treating physician (not plan definition).
- Applies January 1, 2010 for calendar year plans.

New Excise Tax Regulation

- Excise taxes must be self-reported effective January 10, 2010 for violations of the following rules:
  - COBRA
  - HIPAA portability
  - HIPAA nondiscrimination
  - GINA
  - Mental Health and Substance Abuse Parity
  - Newborns' and Mothers' Health Protection Act
  - Michelle's Law
  - HSA and MSA comparability rules

Questions

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