

# PPACA and Beyond: What's an Employer to Do?

John Hickman, Esq  
[john.hickman@alston.com](mailto:john.hickman@alston.com)

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# Topics Addressed

- Health Care Reform: Will it leave you PPACA-in it in?
- The Road Once Taken: ARRA All Over Again
  - HIPAA HITECH
- Required Health Plan Changes for 2009-2010
  - Mental Health Parity
  - Genetic Nondiscrimination (GINA)
- Other Developments

# Status

- T'was the night before Christmas and all through the House, not a Senator was sleeping . . .
  - **U.S. Senate passed the Patient Protection and Affordable Care Act (H.R. 3590)**
    - **Merged elements of the Senate Finance Committee and the Senate Health, Education, Labor and Pensions Committee bills.**
  - **U.S. House of Representatives passed its own health care reform bill, the Affordable Health Care for America Act (H.R. 3962), on November 7, 2009**
  - All eyes turned to Conference Committee proceedings . . . or not . . . Instead we had the Massachusetts revolution ?

# The Affordable Care Act

- On March 23, 2010, President Obama signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA)
  - This is the version of PPACA passed by the Senate on December 24, 2009 and passed by the House on March 21, 2010
- The House Reconciliation Bill, H.R. 4872, which was approved by Senate and House March 25<sup>th</sup>, made additional changes as noted herein. It was signed by the President on March 30, 2010.

# Consumer Directed Scorecard

- Short-term – HSAs and FSAs survived very significant threats . . .  
But there are some casualties
  - OTC Medicines and Drugs no longer allowed without an Rx
  - Restrictive grandfather rules may crimp new CDHC (HRAs and HSAs)
  - FSAs will be subject to \$2500 salary reduction cap in 2013
  - Employer attention/resources drained by PPACA Compliance burdens
- Longer-term --
  - Potential application of Cadillac tax in 2018 and beyond could “suck the wind” out of majority of pre-tax benefits
    - FSAs, HRAs, HSAs, pre-tax supplemental coverages
    - Vision, dental are exempt

# The New Health Care Coverage Landscape —General Overview

- Health Care Reforms
  - 2 waves of reforms for Group Health Plans
- Health Care Exchange
- Individual Mandate
- Employer “pay or play” mandate
- Tax Provisions

# Health Insurance Reforms

- Reforms are added to the HIPAA portability subparts of ERISA and the IRC
- 2 waves of reforms
  - Immediate—generally effective first plan year on or after September 23, 2010
  - Other—effective for plan years beginning on or after January 1, 2014
- Liability for failing to comply w/reforms is same as violating HIPAA portability under ERISA/Code
  - Specific performance under ERISA
  - \$100/day penalty under IRC
  - Mandatory Self-Reporting and excise tax for violations (Form 8928)
- The reforms do not appear to apply to:
  - Excepted Benefits (such as dental, vision, Health FSA)
  - Stand alone retiree plans likely exempt as well

# Grandfathered Plans

- Interim Final Regulations issued 6/14
- A plan is a grandfathered plan with respect to individuals who were enrolled on March 23, 2010. The plan does not stop being a grandfathered plan because individuals enrolled on that date cease to be covered, provided that the plan has continuously covered someone since March 23, 2010.
  - Family members may be added
  - “New employees” (newly eligible and newly hired) may be added
  - Two anti abuse rules
    - Merger and acquisition
    - Employer initiated transfer to another option/plan
- Regulations apply separately to each benefit package option offered under a plan

# Grandfathered Plans

- Impermissible changes?
  - Change in insurance carriers (except as provided for plans subject to a CBA—see CBA slide)
    - Change in administrators does NOT impact grandfather plan status
  - Elimination of benefits to treat or diagnose a condition
  - ANY increase in percentage cost sharing (e.g. coinsurance)
  - Certain increases in fixed amount cost sharing
    - [Other than co-payments] medical inflation (from March 23, 2010) reflected as a percentage, plus 15 percentage points
    - [Copayments] greater of (a) medical inflation (from March 23, 2010), reflected as a percentage, plus 15 percentage points and (b) \$5 increased by medical inflation
  - Change in contribution structure
    - A decrease in the employer contribution rate of more than 5 percentage points below the rate on March 23, 2010 for any tier of coverage for similarly situated individuals
  - Certain changes in lifetime/annual limits

# Grandfathered Plan

- Transition Rules:
  - Changes made as a result of the following situations will not result in the loss of grandfathered plan status and are considered part of the plan terms on March 23, 2010, even though they are not effective until after March 23, 2010:
    - Changes made pursuant to a legally binding contract in effect on March 23, 2010
    - Changes pursuant to a filing with a State insurance department before March 23, 2010, or
    - Changes pursuant to written plan amendments adopted before March 23, 2010

# Grandfathered Plans

- Grace Period: Changes made after March 23, 2010 and before the date the regulations are publicly available that would otherwise affect grandfather status may be revoked or modified in order to preserve the grandfather.
  - Must be effective as of the first day of the first plan year beginning on or after September 23, 2010. This transition rule applies to changes that are effective before the date the regulations are publicly available, or changes that are effective on or after such date pursuant to a legally binding contract, a State insurance filing, or a written plan amendment in effect on such date

# Grandfathered Plans

- There is no delayed effective date for collectively bargained plans, whether fully insured or self insured.
- Fully insured plans subject to a CBA are subject to special rules:
  - Change in insurance carrier prior to termination of last CBA does not cause loss of grandfather plan status
  - Other changes made prior to the termination of the last CBA—including those that otherwise cause a loss of grandfather plan status—do not cause a loss of grandfather status
- Whether the grandfather applies after the expiration of the CBA is measured by comparing the benefits in effect at that time to the benefits in effect on March 23, 2010.

# Grandfathered Plans

- *Good Faith Compliance:* Before the date the regulations are publicly available, a reasonable good faith interpretation of the statute that results in plan and policy terms that “only modestly” exceed the parameters for changes that result in loss of grandfathered status set forth in the regulations will be taken into account for enforcement purposes.

# Implementation Issues related to GF Status

- The “bucket list”: Determine whether any of six “prohibited buckets” have been changed
- What about . . .
  - Change from fully insured to self-funded
  - Changes to network or formulary
  - What is a separate coverage option
  - Dropping one of many coverage options
  - Implementing new coverage categories (spouse, children)
  - Moving retirees into free-standing plan

# Grandfathered Plans

- Disclosure requirements
  - Claim of grandfathered status must be communicated to participants and beneficiaries in plan materials.
- Substantiation
  - A plan or insurance carrier must maintain records documenting the following:
    - the terms of the plan or health insurance coverage in effect on March 23, 2010; and
    - any documents necessary to support its status as a grandfathered plan (for example, a copy of a legally binding contract in effect on March 23, 2010).
  - These documents must be made available for examination by participants, beneficiaries and federal agency officials

# Effective in 2010

- Small employer tax credit
  - A new tax credit for eligible small employers equal to a portion of the employer's cost to provide health insurance
  - Employers with no more than 25 “full-time equivalent” employees and annual average wages of no more than \$50,000 are eligible
- Auto-enrollment for employers with more than 200 employees
  - Provision has no separate effective date, so general rule that effective date is date of enactment appears to control
  - But compliance is effectively delayed until regulations are issued

# Effective in 2010 (90 days after 3/23/10)

- State high risk pool for individuals with pre-existing conditions but without creditable coverage for 6 mos.
  - Insurer or employer found to have encouraged individuals to disenroll and join high risk pool must reimburse expenses
- Retiree reinsurance for coverage provided to “early” retirees (age 55-65)
  - Only 5 billion made available
  - Established within 90 days of March 23, 2010; ends January 1, 2014
  - Reimbursement for 80% of eligible claims in between 15k and 90k.
  - Reimbursements must be used to lower costs of the plan
  - Employers must apply (copy of application available online)
  - Agreements required with insurers (and likely TPAs)

# Prohibition on Lifetime and Annual Limits

## PHSA 2711(NGF)

- Interim final regulations
  - Essential benefits defined by statute -- no further clarification yet
  - Minimum allowable annual restrictions
    - \$750k PY before 9/23/2011
    - \$1.25M PY before 9/23/2012
    - \$2M PY before 9/23/2014
- Implementation Issues related to Scope of prohibition
  - Financial limits only (possible DHHS view may be broader)
  - Prohibition on aggregate benefits or specific benefits too
  - What benefits are “essential”
    - Chiro
    - Fertility treatment
    - Transplants
  - Scope of special enrollment rights for newly eligibles
  - Impact on HRAs
- **Required actions:**
  - Eliminate all lifetime dollar maximums that apply generally to all benefits.
  - Ensure that annual dollar maximums are within the phase-out allowance.

# Prohibition on Rescissions

## PHSA 2712 (NGF)

- No rescission of coverage is permitted except in cases of fraud or intentional misrepresentation
  - Interim final regulations define rescission as any retroactive termination of coverage
  - Permissible rescission (e.g., for fraud, intentional misrepresentation) requires at least 30 days notice.
  - Termination for nonpayment of premiums not a rescission
- Implementation issues
  - How to handle ineligible participant/dependent terminations
  - How to handle administrative errors

# Prohibition on Rescissions

## PHSA 2712 (NGF)

- **Required action:**

- Absent fraud or intentional misrepresentation, remove all rescissions, including those for:
  - Discovery of an ineligible dependent or former spouse upon a dependent audit.
  - Mistaken enrollment (e.g., enrolled employee's regularly scheduled work hours fall below plan eligibility level).
  - Failure to notify plan of a COBRA qualifying event (e.g., divorce, dependent aging out) (FYI: some authorities differ on intersection of rescission rules and COBRA rules; future guidance is expected).
  - Any eligibility failure based on retroactive eligibility determinations (e.g., union employees covered if they worked at least one hour during the month, but eligibility determination is not made until the close of the month).
- If rescission due to fraud or intentional misrepresentation is enforced, provide 30 days advanced notice to affected individuals.
- Adhere to claims procedures, as rescission is an adverse benefit determination (including the requirement to continue with concurrent care).

# Age 26 Coverage Mandate

## PHSA 2714 (NGF)

- (NGF) Plans that cover dependent children must provide for coverage of a dependent “child” *to age 26*
  - There is no requirement to cover children of covered dependent children (i.e., grandchildren)
  - Applies to “married” children
  - Consider impact on disabled coverage extensions and Michelle’s Law
  - Agencies appear to define “child” as set forth in plan
  - For grandfathered plans only, no requirement to cover if eligible for other coverage as employee (until 1/1/2014)
  - Tax exclusion under 105(b) (and 501(c)(9) and 401(h)) expanded to include a “child” (as defined by IRC 152(f)(1) *through age 26*.
    - Potential immediate impact for FSAs/HRAs that define eligibility based on 105(b)

# Age 26 Coverage Mandate

## PHSA 2714 (NGF)

- Implementation Issues: Age 26 Mandate
  - What is scope of coverage mandate
    - Application to plans that cover grandchildren and/or unrelated children “residing” with employee
      - Require guardianship and/or “parent/child” relationship
      - Further agency guidance?
  - Communication and special enrollments
  - Difficulty in policing “other employment coverage” exception for certain GF plans

# Age 26 Coverage Mandate

## PHSA 2714 (NGF)

- **Required action:**
  - Raise limiting age for children to 26.
  - Check plan definition for “dependent” to ensure it is not tied to a section of the code that may violate the rules (e.g., 152).
  - Remove all eligibility limitations for any child under age 26 except to define the relationship between the child and participant, including references to such child as a “tax dependent”, or to such child’s marital, student, employment, or residency status.
  - Check all plan/SPD provisions that may be affected (e.g., dependent eligibility is often repeated in sections regarding termination of coverage and COBRA).

# Mandatory Coverage of Preventive Care PHSA 2713 (GF)

- First dollar coverage (i.e., no cost-sharing) must be provided for certain evidence-based preventive care (including well-child care) and certain immunizations
  - Regulations allow for network and medical management restrictions
  - Implementation issues
    - Conform wellness/preventive care to list and ensure no cost sharing applies
    - How to communicate list of covered expenses to participants

# Mandatory Coverage of Preventive Care

## PHSA 2713 (GF)

- **Required action:**
  - Ensure that all preventive care requirements listed in the regulation are covered 100% for the January 1, 2011 plan year
  - Have administrator or insurer confirm that all preventive care requirements posted on HHS website are covered. Note that aspirin, folic acid, and iron supplements are covered as preventive care, so review these requirements with your prescription drug plan to determine whether these drugs and supplements will be covered under the prescription drug plan or medical plan.

# New Claim Appeals Process PHSA 2719 (GF)

- Required Changes for ERISA plans
  - Definition of “adverse benefit determination”
    - Now includes rescission determinations
  - Urgent Care Timeframe
    - No more than 24 hours
  - Appeals Procedure
    - Access to documents
  - Conflicts of Interest
  - Denial Notice Content
  - Strict Adherence
  - External review

# New Claim Appeals Process PHSA 2719 (GF)

- Implementation Issues: New Claim Appeals Process
  - Challenges in implementing “external review”
  - Should all plans (e.g., dental, vision) keep same appeal process or differentiate
  - SPD disclosure issues (what and when)

# Network Providers

## PHSA 2719A (GF)

- **Special rules regarding health care providers:**
  - Plan enrollees are allowed to select their primary care provider, or pediatrician, from any available participating providers;
  - Precludes prior authorization or increased cost-sharing for emergency services, whether in-network or out-of-network
    - Interim final regulations require payment at greater of network rate, out of network rate, or Medicare rate; and
  - Precludes plans from requiring authorization or referral by the plan for obstetrical or gynecological care
- **Required action:**
  - If designation of a PCP is required or provided, then incorporate the model language into the SPD.
  - Remove contrary provisions in the plan (e.g., referral requirements for OB/GYN)
  - Interim final regulations impose notice requirements
  - Eliminate all disparate financial requirements/cost-sharing between in-network and out-of-network emergency services.
  - Eliminate all precertification-type requirements from emergency services, including for mental health/substance abuse.
  - Ensure that any administrative requirement for out-of-network emergency services is the same as those for in-network (e.g., post-emergency services “notice” requirement for out-of-network should not be 24 hours if in-network emergency services notice requirement is 48 hours).

# Additional PYA 9/23/2010 Mandates

- (NGF) No pre-existing condition exclusions on enrollees under age 19
  - Could apply to young employees, spouse or dependent children
  - Implementation issues
    - Determine if any pre-ex in plan may apply to children

# Additional PYA 9/23/2010 Mandates

- (NGF) Prepare and distribute a new “Summary of Coverage”
  - Distributed at enrollment, no more than 4 pages, and 12pt font
  - Notice of material changes in Summary required 60 days prior to effective date
  - Agencies will identify additional requirements within 12 months
  - Plans will have an additional 12 months to distribute
- (GF) Fully insured plans sponsored by employers will generally be required to satisfy the same Section 105(h) discrimination requirements that apply to self-funded plans
  - Applicable to premium reimbursement plans (not subject to 105(h)?)
  - Penalty is \$100 per day excise tax (self reported) for affected participant

# Effective in 2011

- Employers must report aggregate value of employer-sponsored coverage on Form W-2 (first report due in 2012)
  - Includes COBRA rate of all health coverage subject to Cadillac tax
  - Are payroll systems in place to capture amounts
- No reimbursement of OTC medicines or drugs (except insulin) by health FSA, HRA, or HSA without prescription
  - Related to expenses incurred in calendar year 2011; not based on “plan year”

# Effective in 2013

- Health FSA salary reductions limited to \$2,500 each year
  - The cap is indexed to the CPI starting in 2014
- Deduction previously permitted for amounts allocable to the Medicare Part D subsidy for prescription drug plans is eliminated

# Reforms Effective Plan Years On/After 2014

- (NGF) No preexisting condition exclusions or limitations are permitted
- (NGF) Prohibition on excessive waiting periods—i.e. no waiting period in excess of 90 days
- Fair Health Insurance Premiums (applicable only to health insurers)
  - Limitations on premium setting (e.g. limitations on premium setting based on age, tobacco use)
  - Indirect impact on self insured plans?

# Reforms Effective Plan Years On/After 2014

- (GF) No discrimination based on health status is permitted
  - Essentially, the same rules that currently exist under HIPAA
  - The bill raises maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20 to 30 percent of the COBRA cost of coverage
    - Also gives the Secretaries of Labor, HHS, and the Treasury leeway to increase the percentage to 50 percent
- (GF) Cost limitations
  - Out-of-pocket expenses do not exceed the amount applicable to coverage related to health savings accounts (HSAs)
  - Deductibles do not exceed \$2,000 for single coverage and \$4,000 for family coverage (as indexed)
    - Deductible requirement may only apply to fully insured plans in small group market

# Reforms Effective Plan Years On/After 2014

- (GF) Fully insured plans in small group market must provide essential benefits
  - Not applicable to fully insured plans in large group market and self insured plans
  - Self insured plans NOT required to provide essential benefits
- (GF) Group and individual plans are required to cover routine costs of participation in certain clinical trials by qualified individuals
- (GF) No nondiscrimination against providers who act within the scope of their license
  - Not an any willing provider statute

# Individual Responsibility

- Effective January 1, 2014
- Individuals who do not enroll in qualifying coverage, including qualifying employer-sponsored coverage, must pay an excise tax of the greater of
  - \$95 in 2014 \$325 in 2015 and to \$695 in 2016 and thereafter
  - A percentage of income equal to 1.0% in 2014, 2.0% in 2015, and 2.5% in 2016 and thereafter
- Families will pay half the amount for children up to a cap of \$2,250 for the entire family or percentage of household income (if greater)
- After 2016, dollar amounts will increase by the annual cost of living adjustment

# Individual Responsibility

- Individual enrolled in “minimum essential coverage” meets the requirements
- What is “minimum essential coverage”?
  - Gov’t sponsored programs (e.g. Medicare, Medicaid, Tricare)
  - Plans in the individual market
  - “Eligible Employer Sponsored Plan”
    - Group health plan
    - Fully insured plan in large/small group market
  - Grandfathered Plan
- “Excepted Benefits” do not qualify as “minimum essential coverage”

# Health Insurance Exchange

- PPACA provides funds to states to establish a health insurance exchange through which individuals may purchase health insurance beginning in 2014
- Exchange-related provisions in PPACA impact employers in the following ways:
  - Beginning in 2017, states may allow all employers of any size to offer coverage through the exchange
    - Prior to 2017, only small employers - employers with 100 employees or less (except in states that limit small employers to employers with 50 or fewer employees)—may participate
  - Employers who offer coverage through the exchange may permit employees to pay for such coverage with pre-tax dollars through the employer's cafeteria plan

# Vouchers

- Employers that offer coverage and make a contribution must offer “free choice vouchers” to qualified employees for the purchase of qualified health plans through exchanges
  - The free choice voucher must be equal to the contribution that the employer would have made to its own plan
  - Employees qualify if household income does not exceed 400% of the federal poverty level and required contribution under the employer’s plan would be between 8 and 9.8 percent of income
  - Free choice vouchers are excludable from employees’ incomes (to the extent used for health care) and deductible by employer
    - Excess employer contribution must be paid to employee as taxable compensation
  - Voucher recipients eligible for tax credits through exchange

# Employer Responsibility

- Effective January 1, 2014 - play or pay mandate #1:
  - Employers with 50 or more full-time “applicable” employees are subject to the following penalties related to coverage that they offer or fail to offer to full-time employees:
    - Applicable employers who fail to offer full-time employees health coverage must pay a penalty with respect to each full-time employee in any month in which any full-time employee receives a federal subsidy for the exchange
      - The penalty is determined on a monthly basis and is the product of the total number of full-time employees of the employer (over 30) for that month and 1/12 of \$2000 (up from \$750)
        - » For example, a business with 51 employees that does not offer coverage is subject to tax equal to 21 times the applicable payment amount

# Employer Responsibility

- Effective January 1, 2014 - play or pay mandate #1 (cont'd):
  - Part-time employees are taken into account solely for the purpose of determining if an employer has at least 50 employees
    - The number of full-time employees otherwise determined is increased by dividing the aggregate number of hours of service of employees who are not full-time employees by 120
  - Employers who are “applicable large employers” solely because of seasonal employees who are otherwise full-time employees and that work less than 120 days during the year are NOT considered “applicable large employers”

# Employer Responsibility

- Effective January 1, 2014 - play or pay mandate #2:
  - Even when coverage is extended, applicable employers who offer coverage for any month to a full-time employee who is certified as having enrolled in the exchange and received a tax subsidy is subject to a penalty equal to the product of the total number of such employees who have received a tax subsidy and 1/12 of \$3000 (capped at 1/12 of \$2000 times the total number of full-time employees during such month)
    - Note: employees offered employer coverage are not eligible for a credit unless their required premium exceeds 9.5% of household income or the plan's share of allowed costs is less than 60%.

# Cadillac Plan Tax

- Beginning in 2018, PPACA (as modified by the Reconciliation Bill) imposes a 40 percent excise tax on:
  - “Coverage providers:” for the sum of months in which the aggregate value of employer sponsored health coverage for the employee exceeds:
    - 1/12 of \$10,200 for single coverage and \$27,500 for family coverage
      - The higher family threshold applies to both single and family coverage offered under a multiemployer plan
      - These amounts are to be adjusted automatically if health costs increase by more than anticipated before 2018
      - The thresholds are increased by CPI + 1 in 2019, and by CPI thereafter
      - An employer may make an adjustment to reduce the cost of plans when calculating the tax if the employer’s age and gender demographics are not representative of a national average
      - The PPACA transition rule for high cost states does not apply
    - The annual limit for retirees between ages 55 and 64, individuals engaged in certain high-risk professions (e.g., law enforcement professionals, EMTs, longshoremen, construction workers, and miners), and those employed to install electrical or telecommunication lines is increased to \$11,850 for individual coverage and \$30,950 for family coverage

# Cadillac Plan Tax

- Determined by the employer and assessed against “coverage providers”
- “Coverage providers” are defined to include the following:
  - In the case of fully insured plans, the health insurer
  - In the case of HSA or medical savings account (MSA) contributions, the employer making the contributions
  - In the case of a self-insured plan or flexible spending account (FSA), the person that administers the plan (e.g., the TPA)
- In many cases, employer-sponsored coverage will include both fully insured and self-insured contributions ( also includes HSA contributions)
  - The coverage provider’s applicable share of the tax will bear the same ratio to the total excess benefit as the cost of provider’s coverage to the total value of employer-sponsored coverage

# Cadillac Plan Tax

- The coverage subject to the excise tax rule includes:
  - The applicable premium (determined in accordance with COBRA rules) for all accident and health coverage provided by the employer, even if paid for with after-tax dollars by the employee (except vision only insurance, dental insurance, accident and disability insurance, long-term care insurance, and after-tax funded hospital indemnity and/or specified disease coverage)
  - Both non-elective and salary reduction contributions to a health FSA
  - Employer contributions (presumably including salary reductions) to an HSA

# Other New Taxes

- Several new taxes are imposed, including:
  - Indoor tanning procedures effective for services performed on or after July 1, 2010)
  - New sector tax on health insurers (but not self-insured plans or TPAs) beginning in 2014
  - 0.9 percent increase in Medicare taxes for those earning more than \$200,000 for single individuals and \$250,000 for joint filers (effective beginning in 2013)
    - Such individuals would also be subject to a 3.8% tax on their net investment income (to the extent total income exceeds the thresholds)
    - This new tax would be effective starting in 2013
  - CER fee: A fee equal to \$2 (\$1 in 2013) multiplied by average number of covered lives. Applies to both fully insured and self insured plans.

# ARRA's Amendments to HIPAA Privacy & Security Rules

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# Amended HIPAA Privacy and Security Rules

- HIPAA Amendments are in The Health Information Technology for Economic and Clinical Health Act (HITECH) provisions of The American Recovery & Reinvestment Act of 2009 (ARRA).
- Effective Date: February 17, 2010, except as otherwise noted.
- Significant Set of Regulations Clarifying Business Associate Obligations (and timing for new BAAs) Issued in July

# Overview of Amendments to HIPAA Privacy and Security Rules

- Expanded Obligations of Business Associates (BAs)
- Affirmative Notification of Breach Requirements
- Guidance on “Minimum Necessary” Standard
- Prohibition on Sale of PHI
- Restrictions on Marketing
- Limited Application to Personal Health Records (PHR) Vendors
- Increased Enforcement and Penalties, including application to BAs

Mental Health Parity:  
What it Means for Health Plan Design  
and Employers

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# Mental Health Parity

## (If at first you don't succeed, try, try again)

- Original Mental Health Parity Act (1996)
  - Impacted Benefit Maximum -- But Not Deductible or Copayment Requirements
  - N/A to Substance Abuse Treatment
  - Small Employer Exception (50 or Fewer Employees)
- Wellstone Act (effective plan years commencing on or after October 4, 2009, or Jan. 1, 2010 for calendar year plans)
  - True benefit parity requirement (copayments, coinsurance, days of coverage, etc)
  - Applies to substance abuse as well
- Interim Final Regulations issued on February 2, 2010
  - Effective for all plan years beginning on or after July 1, 2010
  - Good faith compliance with statute until applicable effective date

# In a Nutshell . . .

- Substance Abuse Included.
  - Extends the current parity law provisions related to annual and lifetime maximums to include substance abuse benefits.
  - Also extends new provisions of the Wellstone Act to substance abuse benefits.
  - In this regard, it is important to note that substance use disorders are defined as set forth under the terms of the plan.

# In a Nutshell . . .

- Financial Requirements.
  - Requires that financial requirements under the plan with regard to deductibles, co-payments, coinsurance and out-of-pocket expenses for mental health and substance abuse benefits covered under the plan be the same or better than the financial requirements for medical and surgical benefits under the plan.

# In a Nutshell . . .

- Treatment Limitations.
  - Prohibits treatment limitations (e.g., 30-day annual maximum for outpatient mental health treatment) for mental health and substance abuse benefits covered under the plan to the extent that medical and surgical treatments are not also limited.

# In a Nutshell . . .

- Out-of-Network Coverage.
  - Requires that plans providing out-of-network coverage for medical and surgical benefits also provide out-of-network options for mental health and substance abuse benefits covered under the plan.

# In a Nutshell . . .

- Availability of Plan Information.
  - The criteria for determining whether mental health and substance abuse treatment is “medically necessary” (to the extent this is a requirement for coverage under the plan) must be provided to participants and contracting providers upon request.

# Genetic Information Nondiscrimination Act (GINA)

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# How does GINA impact health plans generally?

- Effective first plan year after May 21, 2009.
  - GINA amends the HIPAA nondiscrimination rules to restrict the access and use of genetic information by group health plans and group health insurers, including non-federal governmental plans.
  - GINA also imposes similar restrictions on insurers in the individual market and issuers of Medigap policies with corresponding amendments to the PHSA and the Social Security Act.
- Interim final regulations issued October 7, 2009 interpret reach of GINA's requirements for group health plans

# What is "Genetic Information"?

- "Genetic information" with respect to any individual means information about:
  - an individual's "genetic tests";
  - the "genetic tests" of "family members" of such individual;
  - the manifestation of a disease or disorder in the individual's family members.

# What is Genetic Information

- Genetic test means "an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes."
- The interim final regulations include examples of certain tests that currently are regarded as genetic or non-genetic tests.
  - For example, a test to determine whether an individual has a genetic variant associated with hereditary non-polyposis colorectal cancer is a genetic test.
  - However, an HIV test, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test.

# What is Genetic Information

- The term "family members" means the individual's dependents under the group health plan, as well as any first-, second-, third- or fourth-degree relative of the dependent or the individual.
  - **In determining who is a first-, second-, third-, or fourth-degree relative of an individual, the interim final regulations treat relatives by affinity (such as by marriage or adoption) the same as relatives by consanguinity (relatives who share a common biological ancestor, or blood relatives).**
  - **In addition, relatives who are not full-blood relatives (such as half siblings) are treated the same as full blood relatives.**

# What are the group health plan limitations under GINA?

- Generally, GINA imposes the following limitations on *all* group health plans and group health insurers based on genetic information:
  - *No premium/contribution adjustment*
  - *No requesting genetic tests*
  - *No underwriting based on genetic information*
  - *No collection of genetic information before enrollment*

# What are the group health plan limitations under GINA?

- *Adjusting premiums/contributions*: Plans and insurers may not adjust the premium or contribution amounts for the group on the basis of genetic information. However, the premium or contribution amount for a group may take into consideration the manifestation of a disease of an individual who is enrolled in the plan so long as this information is not used as genetic information about other group members (*e.g.*, a covered dependent) and to further increase the premium for the employer.
  - **Prior law allowed plans and issuers to adjust premium or contribution amounts for the group health plan (but not within the group) based on genetic information.**

# What are the group health plan limitations under GINA?

- *Requesting Genetic Tests:* Plans and insurers may not request or require an individual or a family member to undergo a genetic test. However, a plan may obtain and use the results of a genetic test as necessary to fulfill its payment obligations under the plan so long as it only requests the minimum amount of information necessary to make payment.

# What are the group health plan limitations under GINA?

- *Requesting Genetic Information for Underwriting:* Plans or insurers may not request, require, or purchase genetic information for "underwriting purposes." For purposes of GINA, "underwriting purposes" means
  - Rules for, or determination of, eligibility for benefits under the plan or coverage;
  - The computation of premium or contribution amounts under the plan or coverage;
  - The application of any pre-existing conditions exclusion under the plan or coverage;
  - Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

# More on Underwriting Prohibition

- **The interim final regulations clarify that underwriting purposes” include changing deductibles or other cost-sharing mechanisms, or providing discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program.**
  - See discussion of Examples 1-2 and 5.
- **Medical appropriateness determinations that require genetic information are not underwriting but information that can be collected is limited to that necessary to make appropriateness determination.**
  - See discussion of Example 4 and 6 below.

# What are the group health plan limitations under GINA?

- *Obtaining genetic information prior to enrollment:* Plans or insurers may not request, require, or purchase an individual's genetic information prior to such individual's enrollment in the plan.
  - See Example 3.

# Other Developments

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- Red Flags Rule Delayed Again
- DOL issues revised Fee Disclosure Regulations
  - Impact for welfare plans