

Legislative Brief

Health and Welfare Plans: 2010-2011 Compliance Update

The last year has brought many big changes for health and welfare plans. This Fickewirth and Associates Legislative Brief summarizes major developments that have an impact on plan sponsors in 2010 and 2011. Please read below for more information and contact your F&A representative with any questions.

HEALTH CARE REFORM

By far the biggest development of the year was the passage of the health care reform law, the Patient Protection and Affordable Care Act (PPACA). PPACA was signed into law on March 23, 2010, and includes several provisions effective in 2010 and 2011. For some of these rules, the specific effective date will depend on the plan year. Also, applicability may depend on whether the plan is a grandfathered health plan or not.

The significant items affecting employer-sponsored health plans in 2010 and 2011 are:

- **Small Business Tax Credit:** Qualified small employers can receive a credit for contributions to purchase health insurance for employees beginning with the 2010 tax year.
- **Extension of Dependent Coverage:** Effective for plan years beginning on or after September 23, 2010, group health plans that offer dependent coverage must provide coverage for adult dependent children up to age 26. Effective March 30, 2010, employer-provided health insurance coverage for these adult children is tax-free to employees.
- **Elimination of Lifetime and Annual Limits:** Effective for plan years beginning on or after September 23, 2010, group and individual plans may not establish lifetime limits on the dollar value of essential benefits. Group health plans may also not establish unreasonable annual limits.
- **Elimination of Pre-Existing Condition Exclusions:** Effective for plan years beginning on or after September 23, 2010, pre-existing condition exclusions may not be applied to enrollees under age 19.
- **Limits on Rescissions:** Effective for plan years beginning on or after September 23, 2010, coverage may not be rescinded (retroactively cancelled), except in the case of fraud or intentional misrepresentation of material fact. Policyholders must be notified prior to cancellation.
- **Coverage of Preventive Health Services:** Effective for plan years beginning on or after September 23, 2010, non-grandfathered health plans must provide coverage for certain preventive health services without imposing cost-sharing requirements.
- **Patient Protections:** Effective for plan years beginning on or after September 23, 2010, the health care reform law puts the following rules in place for non-grandfathered plans:
 - Plans that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children).
 - Plans that provide emergency services may not require preauthorization for receipt of emergency services and cannot impose higher cost-sharing requirements on out-of-network emergency services.
- Plans that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.



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- **Nondiscrimination Rules for Fully-Insured Plans:** Effective for plan years beginning on or after September 23, 2010, non-grandfathered, fully-insured plans may not discriminate in favor of highly compensated individuals as to eligibility or benefits.
- **New Appeals Process:** Effective for plan years beginning on or after September 23, 2010, non-grandfathered plans must implement an effective appeals process and must follow minimum requirements for external claims review.
- **Early Retiree Reinsurance Program:** From 2010 until January 1, 2014, employers that provide health coverage to early retirees may be eligible to participate in a federally funded program providing reimbursement to plan sponsors for certain high-cost claims.
- **Simple Cafeteria Plan:** Eligible small employers can adopt a Simple Cafeteria Plan beginning 2011. If the employer meets certain requirements related to eligibility and contributions, it will be treated as meeting the cafeteria plan nondiscrimination requirements.
- **Limits on OTC Reimbursements:** Beginning in 2011, expenses for over-the-counter medicine or drugs may not be reimbursed by employer plans (such as FSAs and HRAs) without a prescription (except insulin).
- **Increased HSA Penalty Tax:** The penalty tax on HSA withdrawals prior to age 65 that are not used for qualified medical expenses will be increased from 10 to 20 percent in 2011.
- **W-2 Reporting:** Employers will be required to disclose the value of the health coverage provided by the employer to each employee on the employee's annual Form W-2. Note that this requirement is effective, but optional, for the 2011 tax year and will be mandatory beginning with the 2012 tax year.

COBRA PREMIUM SUBSIDY

The American Recovery and Reinvestment Act of 2009 (ARRA) provided a temporary subsidy for the cost of COBRA coverage for certain individuals who were involuntarily terminated from employment. Initially available to individuals whose employment was involuntarily terminated on or before December 31, 2009, the COBRA premium subsidy was extended several times. The final extension prolonged the eligibility period through **May 31, 2010**.

Because of the statutory sunset, eligibility for the COBRA premium subsidy essentially expired after May 31, 2010. However, individuals who qualified for the subsidy on or before May 31, 2010 are still eligible to pay reduced premiums for 15 months, as long as they are not eligible for another group health plan or Medicare.

Although employers no longer had to provide the premium subsidy to individuals who terminated employment after May 31, 2010 (or provide ARRA-compliant COBRA notices), they will still have to administer COBRA coverage in accordance with the subsidy requirements for those individuals who are still eligible for the reduced payments.

CHIPRA NOTICE REQUIREMENTS

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was signed into law in 2009. CHIPRA imposed a new notice obligation on employers that maintain group health plans in states that provide premium assistance subsidies for Medicaid or CHIP plans. These employers must notify their employees of potential opportunities for premium assistance. Employers that fail to issue these notices are subject to penalties of up to \$100 per day per employee.

The DOL issued a model notice for employers in early 2010. Employers must send the notice annually, free of charge, starting with the **first plan year after February 4, 2010 (January 1, 2011 for calendar-year plans)**. Plans with plan years beginning between Feb. 4, 2010 and April 30, 2010 had until May 1, 2010 to provide the notice.



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The notice may be provided with open enrollment materials or the summary plan description, but must appear "separately and in a manner which ensures that an employee who may be eligible for premium assistance could reasonably be expected to appreciate its significance."

GENETIC INFORMATION NONDISCRIMINATION – RULES FOR EMPLOYERS

On November 9, 2010, the Equal Employment Opportunity Commission (EEOC) issued regulations implementing Title II of the Genetic Information Nondiscrimination Act of 2008 (GINA). Title II is designed to protect individuals from employment discrimination based on their genetic information. The regulations are effective **January 10, 2011**.

Under Title II and the regulations, employers may not discriminate against an individual on the basis of the individual's genetic information for hiring, discharge, compensation or the terms, conditions or privileges of employment. The regulations clarify definitions related to the use of genetic information and contain rules on when employers can acquire genetic information.

The regulations state that an employer will not violate GINA if it obtains genetic information through provision of a voluntary wellness program, as long as the individual is not required to provide genetic information to participate or receive a reward. They also require employers to post notice of employees' rights regarding genetic information.

GENETIC INFORMATION NONDISCRIMINATION – RULES FOR HEALTH PLANS

Title I of GINA contains rules for group health plans and insurance issuers. It was effective for plan years beginning after **May 21, 2009 (January 1, 2010, for calendar year plans)**. Title I provides that group health plans and insurance issuers may not:

- Adjust group premium or contribution amounts on the basis of genetic information;
- Request or require individuals (or their family members) to undergo a genetic test (with limited exceptions such as for determinations regarding payment based on medical appropriateness); and
- Request, require or purchase genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.

Interim final regulations, which provide guidance on how GINA affects wellness and disease management programs, were issued on October 7, 2009. The regulations apply to plan years beginning **on or after December 7, 2009, (January 1, 2010 for calendar year plans)**.

The regulations clarify that GINA's prohibition on collecting genetic information prior to or in connection with enrollment, or for underwriting purposes, will affect the use of Health Risk Assessments (HRAs). HRAs are tools commonly used by wellness and disease management programs. Pursuant to the regulations, group health plans may not:

- Provide a reward or incentive to an individual for completing an HRA that requests genetic information, such as family medical history; or
- Request genetic information as part of an HRA that must be completed before enrollment in the plan or eligibility for additional benefits under the plan, such as a disease management program.

MENTAL HEALTH PARITY

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) imposes requirements on group health plans that offer mental health and substance abuse disorder benefits. The MHPAEA, which applies to employers with more than 50 employees, was effective for plan years beginning after October 2, 2009. It expanded the existing parity requirements to prohibit plans from doing the following:



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- Imposing higher copayments, deductibles or out-of-pocket limits on mental health and substance abuse treatment benefits than on medical and surgical benefits;
- Placing more restrictive limits on the number of covered office visits, days of inpatient coverage or the duration or scope of treatments available for mental health and substance abuse treatment benefits than those available for other types of medical treatment; and
- Excluding out-of-network treatment for mental health and substance abuse treatment benefits if out-of-network benefits are provided for medical and surgical benefits.

Interim final rules implementing the MHPAEA were issued on February 2, 2010. The rules generally apply to group health plans and group health insurance issuers for plan years beginning **on or after July 1, 2010**. The Departments have stated that for purposes of enforcement, they will take into account good-faith efforts to comply with a reasonable interpretation of the statutory MHPAEA requirements with respect to a violation that occurs before the applicability date of the regulations.

FMLA RIGHTS FOR NON-TRADITIONAL FAMILIES

On **June 22, 2010**, the U.S. Department of Labor issued an Interpretation Letter to expand FMLA rights for employees who have a parental relationship with a child, regardless of the legal or biological relationship. Under the new interpretation, these employees will be entitled to FMLA leave to care for a sick child with whom they have a parent-child relationship.

Examples of employees affected by the interpretation include an uncle who is caring for his niece and nephew when their single parent has been called to active military duty, a grandmother who assumes responsibility for her sick grandchild when her own child is debilitated, and an employee who parents a child with his or her same-sex partner. Individuals in these situations will be able to take advantage of the 12 weeks of unpaid leave to care for a sick loved one provided by the FMLA.

HITECH REQUIREMENTS

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) was enacted on February 17, 2009, as part of the American Recovery and Reinvestment Act of 2009 (ARRA). The HITECH Act made a number of significant changes to the Privacy and Security provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Under the HITECH Act, HIPAA was expanded to impose additional obligations on Business Associates that required revisions to Business Associate Agreements. Business Associates are now directly subject to many provisions of the Privacy and Security Rules, rather than being governed merely by agreements with Covered Entities. Other changes include changes to the "minimum necessary" standard, restrictions on disclosures, expanded individual rights, and increased penalties for violations. These changes were generally effective **February 17, 2010**.

Covered Entities also have an affirmative obligation to notify individuals if their "unsecured Protected Health Information" is breached. Business Associates must notify the applicable Covered Entity of a breach involving that Covered Entity's unsecured PHI. Unsecured PHI is PHI that is not secured through the use of encryption or destruction. The breach notification rules were effective September 23, 2009, but Department of Health and Human Services did not begin enforcing the rule until **February 22, 2010**.

SAFE HARBOR FOR SMALL PLAN CONTRIBUTIONS

The DOL issued a safe harbor regarding the timing of employee contributions to small welfare plans, which were effective **January 14, 2010** (these rules also apply to small retirement plans, although the safe harbor deadline is different).

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Under the general DOL rule, employers have a limited amount of time to deposit employee contributions into a retirement or welfare plan before the amounts become “plan assets,” which are subject to a number of requirements. Contributions must be deposited as soon as they can reasonably be segregated from the employer’s general assets, but no later than 90 days after receipt for welfare plans.

The safe harbor rule provides that employers with small health plans will be considered to have made a timely deposit to a welfare plan if employee contributions are deposited within **seven business days** of receipt or withholding. A small health plan is one with fewer than 100 participants at the beginning of the plan year. The safe harbor is optional. If employers choose not to take advantage of it, they must still comply with the general rule.

COORDINATION WITH TRICARE BENEFITS

TRICARE is the health care program that services active duty service members, reservists, retirees and other members of the military. The Department of Defense issued final regulations related to TRICARE-eligible employees, which were effective on **June 18, 2010**. The final rules apply to any state or local government, as well as to any employer that employs at least 20 employees. Violations of the rules can lead to penalties of \$5,000 for each violation.

The regulations prohibit employers from offering TRICARE beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment in, a group health plan that is primary to TRICARE. There are some exceptions to the rule for benefits that are offered to all employees or that are offered without an incentive.

CAFETERIA PLAN REGULATIONS

The Internal Revenue Service issued proposed regulations regarding cafeteria plans in August 2007. These regulations provide guidance regarding written plan document requirements, reimbursable expenses, nondiscrimination testing and timing of reimbursements. Although the regulations are not final, employers may rely on them in their good faith compliance efforts.

Final regulations have been expected for some time, but have not yet been released. No guidance has been provided on when regulations will be finalized. In anticipation of final regulations, employers may want to review their current plan documents and compare them with the proposed regulations.

Please contact your F&A representative with any questions.

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