Health and Welfare Plans

- **Mental Health Parity and Addiction Equity Act of 2008:** This law, which applies to employers with more than 50 employees, extends the mental health parity laws to substance-use disorders in two ways. First, benefits for mental health and substance-use disorders must be in parity with medical/surgical benefits with respect to both the application of aggregate lifetime and annual dollar limits. Second, plans may not have different financial requirements (e.g. deductibles, copayments or coinsurance), treatment limitations (e.g. number of covered visits and days of inpatient coverage), or out-of-network coverage limitations for mental health and substance use disorder benefits than for medical/surgical benefits.

    - **Action Item:** Plans that provide mental health and/or substance abuse coverage must be in compliance by the first plan year beginning after October 2, 2009 (January 1, 2010, for calendar year plans), including a required amendment for self-insured and/or wrap plans.

- **Genetic Information Nondiscrimination Act of 2008 (GINA):** Title I of GINA, which is effective the first plan year after May 21, 2009 (January 1, 2010, for calendar year plans), prohibits certain uses and disclosures of genetic information, including for underwriting purposes, and prohibits discrimination based on genetic information by group health plans. Title II of GINA, which is effective starting November 21, 2009, prohibits discrimination based on genetic information in the employment context generally. Click here for a discussion of Title II. GINA defines genetic information to include family medical history and genetic tests, counseling and education. An important implication of Title I of GINA is that it prohibits employers and insurers from requesting, requiring or purchasing genetic information in many circumstances. Consequently, employers generally are prohibited from asking questions about family history on mandatory or voluntary pre-enrollment health risk assessments.

    - **Action Item:** Plan sponsors must review their health risk assessments and evaluate whether their HIPAA privacy notices, procedures, business associate agreements and group health plan documents should be amended to reflect GINA.

- **EEOC Opinion on Wellness Programs and Health Risk Assessments:** The Equal Employment Opportunity Commission (EEOC) issued a non-binding opinion letter this year stating that requiring health risk assessments as a condition of participation in the employer's group health plan violates the ADA.

    - **Action Item:** The opinion set forth by the EEOC should be considered by plan sponsors requiring, or considering requiring, a pre-enrollment health risk assessment as a condition to participation in a group health plan.

- **Michelle's Law:** Seriously ill college students, who would otherwise lose dependent coverage under a group health plan, may continue coverage for up to one year while on medically necessary leaves of absence.

    - **Action Item:** Self-insured plans must be amended to comply with Michelle's Law before the first plan year beginning after October 8, 2009 (by December 31, 2009, for calendar year plans).

- **HIPAA:** The Health Information Technology for Economic and Clinical Health Act (HITECH) makes significant changes to the privacy and security requirements of HIPAA. HITECH is generally effective February 17, 2010, but many provisions have earlier effective dates that require careful review. First, HITECH directly subjects business associates to HIPAA's privacy and security rules, which will require business associate agreements to be updated to comply with the changes. Second, effective 30 days after regulations are issued, both business associates and covered entities have new obligations regarding security breach notification. Third, in certain circumstances, a covered entity must agree to a request to restrict disclosures to a health plan for payment or health care operations. Fourth, HITECH imposes new restrictions on disclosures prohibiting the sale of protected health information (PHI) and imposing marketing restrictions regarding PHI. Fifth, several changes in enforcement have taken place, including a substantial increase of civil penalties, state attorneys general now having enforcement power, and

regulations requiring the sharing of civil penalties with individuals.

  - **Action Item:** HITECH is generally effective February 17, 2010, but because many changes are dependent upon regulations being issued, document compliance with the HIPAA changes may need to wait until after regulations are issued. For group health plans, HIPAA privacy policies and business associate agreements should be amended now.

- **Children's Health Insurance Program Reauthorization Act (CHIPRA):** CHIPRA required group health plans to be amended by April 1, 2009, to allow for a new enrollment opportunity for employees and their dependent children who either lose coverage under Medicaid or a state child health assistance program, or who become eligible for premium payment assistance under such a program. CHIPRA also requires group health plans to provide employees with certain information regarding Medicaid and state health assistance programs, and to cooperate with government requests for certain plan information. These provisions, however, are not effective until the first plan year following the year in which the DOL has issued model notices, which may be as late as April 1, 2010 (January 1, 2011, for calendar year plans).

  - **Action Item:** Self-insured group health plans and/or wrap plans must be amended for CHIPRA and group health plans must be reviewed for CHIPRA compliance.

- **Family and Medical Leave Act (FMLA):** Effective January 16, 2009, new FMLA regulations require certain leave rights relating to eligible family members of military service members. Other changes affect continuing treatment for serious health conditions, certification of fitness for duty, reporting absences, employer's ability to contact an employee's health care provider, waiver of FMLA rights and FMLA form documents issued by the Department of Labor.

  - **Action Item:** If a detailed explanation of FMLA rights is included in a plan, the plan may need to be amended to comply.

- **Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART):** Under the HEART Act, a plan may provide military service reservists the option to cash out their health flexible spending account (FSA) balances when called to active duty. The IRS has issued guidance that gives the administrator flexibility in deciding how much of the participant’s balance will be available, up to the entire benefit election for the year, less reimbursements.

  - **Action Item:** Plans must be amended prior to making “Qualified Reservist Distributions” to service members. Transitional guidance provides that plan sponsors may amend their plans retroactive to June 18, 2008, so long as the amendment is adopted by December 31, 2009.

- **Medicare Secondary Payer:** Beginning in April 2009, Centers for Medicare & Medicaid Services (CMS) began requiring group health plans to share certain data with CMS on an ongoing basis. The reporting burden generally falls on insurance companies and third-party administrators (TPA), but plan administrators and fiduciaries of self-insured plans that do not use a TPA must self-report. Most of the reporting deadlines have expired, but an important deadline remains: reporting entities must file, no later than the first filing of 2011, information on spouses and other family members of active participants whose initial date of coverage was prior to January 1, 2009.

  - **Action Item:** Coordinate with your TPA to confirm that the TPA will make this filing.

- **Wrap Plans:** Not all welfare plans are written to comply with the above new rules. One way to ensure documentary compliance is to use a “wrap plan”, which bundles your ERISA welfare plans under one basic document. This basic document, combined with the insurance booklets and other related documents, form the legal plan document. By including language that complies with these governing laws in your basic wrap plan document, you ensure documentary compliance for each individual welfare plan. A wrap plan also permits you to file a single 5500 for all of the plans that are included in the wrap, rather than a separate

5500 for each. The wrap plan can include: health, dental, vision, cafeteria, dependent care, disability and life (among others).