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Recent Legislation and Regulations Require Changes to Health and Welfare Benefit Plans

July 2009

print

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Congress and federal regulatory agencies have been busy enacting legislation and proffering guidance which implements many new requirements for group health and welfare benefit plans. Many of the changes will require thoughtful action on the part of administrators and sponsors of group health and welfare benefit plans. This brief outline of current health and welfare compliance developments is not intended to be exhaustive, but rather serves to illustrate the depth and breadth of changes facing plan sponsors now and in the coming months.

Final Rules for Cafeteria Plans

*****The previously anticipated January 1, 2009 effective date is expected to be delayed pending review by the Obama Administration*****

While it was expected that the proposed regulations would be finalized in 2008, Department of Labor officials have recently informally indicated that the regulations will be finalized this year with a January 1, 2010, effective date. Once finalized, the regulations are expected to consolidate previously proposed regulations and guidance, and while the Department of Labor has indicated that the proposed regulations may be relied upon now, there are a number of provisions (most notably Section 1.125-7, Non-Discrimination Testing) which require

clarification before implementation by plan sponsors. The net effect of this delay provides plan sponsors with an opportunity to revise plan documents, summary plan descriptions and other benefit communications in advance of the expected effective date.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Effective for plan years beginning on or after October 3, 2009 (January 1, 2010 for calendar year plans)

This Act requires private group health benefit plans that provide mental health and/or substance use disorder benefits through a group health benefit plan that also offers medical and surgical benefits do so on an equivalent basis. The Act imposes several plan design requirements on group health benefit plans that offer mental health and/or substance use disorder benefits including equity in cost sharing, treatment limitations, and coverage decision requirements. The Act builds on the current mental health parity law that requires parity for annual and lifetime limits on coverage. The Act also contains an exception for small group health benefits plans and for increased costs, however, these exceptions are specific and narrow. Because the MHPAEA does not *require* employers to provide either mental health or substance use disorder benefits, plan sponsors will be faced with the decision of whether to continue to offer one or both of these types of benefits beyond the MHPAEA's effective date. A summary of the MHPAEA and a subsequent clarification of the effective date for collectively bargained plans is available in Littler's ASAP articles *Equal Mental Health and Substance Use Benefits Realized* (Oct. 2008) and *Wellstone Act's Effective Date For New Mental Health And Substance Use Disorder Parity Rules Clarified* (Jan. 2009).

Michelle's Law

Effective for plan years beginning on or after November 8, 2009 (January 1, 2010 for calendar year plans)

Michelle's Law extends eligibility for group health benefit plan coverage to certain dependent children over the age of 18 who are enrolled in an institution of higher education. Specifically, the Law extends eligibility to those who would otherwise lose coverage when a medically necessary leave of absence causes the child to fall below full-time student status. The extension of eligibility is intended to protect group health benefit coverage of a sick or injured dependent child for up to one year. Michelle's Law will require a careful review of plan design provisions within written plan documents including insurance contracts in order to ensure compliance with the law. Further information about Michelle's Law can be found in Littler's ASAP article, *Michelle's Law Extends Group Health Benefit Plan Eligibility for Dependent Students on a Medically Necessary Leave of Absence* (Oct. 2008).

Genetic Information Nondiscrimination Act

Effective for plan years beginning on or after May 21, 2009 for the health insurance

provisions under Title I and November 21, 2009 for the employment nondiscrimination provisions under Title II (or January 1, 2010 for calendar year plans)

The Genetic Information Nondiscrimination Act of 2008 (GINA) amends ERISA to restrict the collection and use of genetic information in connection with group health benefits. Group health plans and insurers are now, generally, prohibited from imposing a preexisting condition limitation on the basis of genetic information where a genetically pre-disposed disease or disorder has not yet manifested itself. Further, discrimination in eligibility, premiums or coverage under a plan based on genetic information is also prohibited. GINA also generally prohibits plans from requesting or requiring individuals or their family members to undergo a genetic test and from requesting, requiring or purchasing genetic information for underwriting purposes or prior to an individual's enrollment. Genetic information now expressly falls within HIPAA's definition of "protected health information" and must be treated as such when in the plan's or issuer's possession. Further guidance is expected in advance of the effective date, so employers should be prepared to act quickly in order to comply with GINA. More information about GINA can be found in Littler's ASAP articles, *Genetic Antidiscrimination Law Creates New Compliance Challenges for Employers* (May 2008) and *Proposed Regulations Under Federal GINA Suggest Employer Action Now*, (Mar. 2009).

Health Flexible Spending Account Distributions for Reservists

Applicable now to plans that have been amended for the HEART Act.

Under the Heroes Earning Assistance and Relief Tax Act ("HEART Act"), a health flexible spending account (FSA) may permit unused FSA contributions for qualified reservists to be distributed thereby enabling reservists to avoid the "use it or lose it" rule under Internal Revenue Code section 125. A qualified reservist distribution in the FSA context is one that is made: (1) to a participant/reservist who is called to active duty for a period of at least 180 days (or for an indefinite period); and (2) during the period beginning with the call to active duty and ending on the last day of the coverage period for the FSA that includes the date of the call to active duty. Distributions must meet several requirements in order to be considered "qualified". Plan sponsors will need to amend plan documents, summary plan descriptions and other related employee benefit communications to reflect the changes necessary for qualified reservist distributions. For additional analysis of the HEART Act, see Littler's ASAP article, *Heart Act Affords Greater Protections to Those Serving in Active Military Duty* (Sept. 2008).

Medicare Mandatory Reporting

Effective January 1, 2009

A new reporting requirement for group health benefit plans was established through the Medicare, Medicaid and SCHIP Expansion Act of 2007 (MMSEA). The Act requires third party administrators (TPA) or insurers to gather information necessary to determine the coordination of Medicare benefits with a Medicare eligible individual's group health plan coverage. The purpose is to determine whether the benefits paid for medical services under a

group health plan are primary to Medicare and to recover overpayments where benefits under Medicare are erroneously paid primary to group health coverage. In cases where there is no TPA or insurer, the reporting requirement will fall to the plan sponsor or fiduciary of the group health plan. Reports are to be submitted to the Secretary of Health and Human Services on approved forms and is enforced with steep fines for noncompliance ($1,000 per day for each plan participant whose information should have been submitted, in addition to other applicable penalties under Federal law). The Centers for Medicare Services has devised a user guide on its website that explains the reporting requirement and what compliance steps are necessary. The user guide is updated periodically and can provide useful information with regard to compliance with these reporting requirements. Plan sponsors are urged to consult with counsel for a clear understanding of the reporting requirements and with their TPA or insurer to ensure that the responsible party is prepared to fully comply with the requirements in a timely manner.

Final Family and Medical Leave Act (FMLA) Regulations

Effective January 16, 2009

The final FMLA regulations have been issued and became effective on January 16, 2009. Key changes to FMLA that may affect health and welfare benefit plan documents include eligibility determinations, termination of benefits for non-payment while on leave, benefit reinstatement upon return to work, notice requirements on the part of both the employer and employee and newly expanded leave rights for employees with family members who are called to active duty or who are being treated for wounds received in combat. To the extent that plan documents and employee communications contain provisions related to a plan participant's health and welfare benefits provided while on FMLA leave, documents should be reviewed by counsel as soon as possible to ensure compliance with the final regulations. For additional information on the FMLA amendments see Littler ASAP articles, *Relief in Sight? DOL Issues Final FMLA Regulations* (Nov. 2008) and *Department of Labor Clarifies FMLA Amendments Related to Service Member Care and Other Military-Related Exigencies* (Nov. 2008).

Americans with Disability Act Amendments Act

Effective January 1, 2009

President Bush signed the ADA Amendments Act of 2008 (ADAAA) on September 25, 2008. The Act makes several changes of interest to plan sponsors of group health and welfare plans, including changes to key terms used within the definition of disability under the law and an expansion of the scope of protection of the ADA in reaction to several United States Supreme Court decisions. There are now two newly defined terms within the definition of "disability" under the ADAAA: (1) *major bodily functions* includes, but is not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions; and (2) *major life activities* includes, but is not limited to, such activities as sitting, standing, breathing, speaking, learning, reading, concentrating, thinking, etc. The Act provides that the definition be interpreted as broadly as possible in favor of individuals under the ADA and that mitigating measures (e.g. eyeglasses or

contact lenses) may not be taken into account when assessing whether an individual has a disability that limits major life activities. While the analysis of whether or not a health benefit plan discriminates against individuals with disabilities has not changed, the changes to the key terms argue in favor of a review of group health benefit plan coverage and exclusion provisions to ensure compliance with the new requirements. Further guidance for compliance with the ADAAA is anticipated in 2009 from the EEOC. More information about the ADAAA is available in Littler's ASAP article, *Congress Tells the Courts How to Interpret the ADA* (Sept. 2008).

Newborns' and Mothers' Health Protection Act

Effective January 1, 2009

Final regulations for the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) have been issued effective January 1, 2009. The interim rules have been retained to a large extent with a few notable clarifications. The term *attending provider* has been clarified to specifically exclude "a plan, hospital, managed care organization or other issuer" within its definition. This is relevant as it is now clear that these excluded entities are *not* permitted to render a decision regarding the early discharge of a mother or newborn *before* the end of the applicable minimum stay rules. Notice requirements under the NMHPA for various types of group health plans now clearly permit the electronic distribution of notices so long as the method of distribution complies with the general rules for electronic transmission of plan documents and other materials required by ERISA. Plan sponsors are encouraged to review written plan provisions to determine the need for amendment in order to comply with the final NMHPA rules and other ERISA-related requirements that may be implicated.

COBRA Subsidy Provisions of the American Recovery and Reinvestment Act

Effective February 17, 2009

The American Recovery and Reinvestment Act of 2009 (ARRA), the stimulus legislation signed on February 17, 2009, by President Obama, contains sweeping revisions to the group health plan continuation coverage provisions contained in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The ARRA has created a 65% COBRA premium subsidy for eligible former employees (and their covered dependents) who were involuntarily terminated and lost group health benefit coverage between September 1, 2008 and December 31, 2009. The subsidy is effective on and after the date of enactment (February 17 or for "monthly period of coverage" plans, March 1, 2009). The Act requires the employer to "front" the subsidy by collecting only 35% of the applicable COBRA premium from the qualified beneficiary. The employer is then reimbursed, by claiming a credit from the employer's quarterly federal payroll tax deposits, for the 65% COBRA premium subsidy (or with a direct tax credit, if payroll tax deposits are insufficient). The Department of Labor and the Internal Revenue Service have both established websites that provide accessible information about the COBRA subsidy to employers and employees. In addition, the Department of Labor has produced four separate model COBRA notices that communicate the information necessary to

satisfy the COBRA subsidy notice requirements established under ARRA. For more information about the COBRA subsidy see Littler's ASAP *Stimulus Package: An In-Depth Look at the New COBRA Subsidy in the ARRA* (Feb. 2009) and *IRS Clarifies Key Provisions of the New COBRA Subsidy* (Apr. 2009).

Children's Health Insurance Program Reauthorization Act of 2009

Effective April 1, 2009

On February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA reauthorizes and expands the scope of the State Children's Health Insurance Program (now known as CHIP). Of special note are new requirements that directly affect employer-sponsored group health plans: (1) a new Health Insurance Portability and Accountability Act (HIPAA) special enrollment right that takes into account loss of eligibility for coverage or gain or eligibility for premium assistance from a state under a Medicaid or CHIP plan is effective on April 1, 2009; and (2) new notice requirements for employers including a notice of availability of benefits under Medicaid or CHIP and a notice to the state of coverage coordination information. The notice requirement is effective the first day of the plan year following February 4, 2010 (or January 1, 2011 for calendar year plans). Plan sponsors are encouraged to revise plan documents, notices and employee communications with information about the new special enrollment rights under HIPAA. More information about CHIPRA can be found in Littler's ASAP, *Effective Date of New Special Enrollment Period Under CHIPRA Arrives* (Apr. 2009).

Health Insurance Portability and Accountability Act

Generally effective February 17, 2010

The ARRA imposes new HIPAA privacy and security requirements on entities associated with group health plans. Previously, many privacy and security rules established under HIPAA were limited to covered entities, including group health benefit plans. Now, the ARRA has extended HIPAA's privacy and security rules to business associates and other vendors directly and has enhanced HIPAA's civil and criminal penalties, including a provision permitting protected individuals to share in monetary penalties collected by the government, and authorizing state attorney generals to file HIPAA privacy and security enforcement actions in federal courts for breaches occurring in their states. The new law also includes new notice requirements upon discovery of a breach of Protected Health Information (PHI), accountability standards for PHI and enhanced enforcement mechanisms. Before the ARRA's provisions concerning HIPAA become effective in February 2010, employers should revisit their own HIPAA compliance efforts, discuss with their business associates the security measures that have been implemented to reduce the risk of a security breach involving unsecured PHI, and amend their business associate agreements to address the new compliance obligations and risks created by ARRA. For more information about HIPAA amendments under ARRA see Littler's ASAP article *Recent Enforcement Actions and Significant Amendments to HIPAA Privacy Rule*

Compel Employers to Revisit Their Compliance Efforts (Mar. 2009).

Qualified Transportation Fringe Benefit

Effective March 1, 2009

The ARRA also contains an adjustment of the maximum dollar amount permitted for certain commuting expenses under a qualified transportation fringe benefits plan. As of March 1, 2009, the Act increases the pre-tax or subsidized transit pass and vanpool amount for 2009 from the present value of $120 per month to $230 per month. While the cap has risen, it is still limited to the lesser of $230 or the actual qualified expenses incurred. The law does not require that employers make these adjustments nor does it require that any such adjustments be made effective March 1. Existing programs, including withholding authorizations for employees paying for such benefits on a pre-tax basis, should be reviewed to determine whether, if the employer chooses to increase the subsidy level, further authorization must be obtained from participating employees for such adjustments. More information can be found in Littler's ASAP article, *Besides COBRA: What Does the Stimulus Package Have for Employers* (Feb. 2009).

Upcoming Regulation Action

The Department of Labor (DOL) and the Internal Revenue Service (IRS) has released the semi-annual regulatory agendas. Among those anticipated actions are:

- Final DOL regulations for the MHPAEA
- Additional guidance in the form of final DOL regulations for HIPAA in light of CHIPRA
- Proposed DOL regulations for the electronic communication with welfare benefit plans
- Final DOL and IRS regulations for GINA
- Proposed IRS regulations for the calculation of COBRA premiums
- Final IRS regulations for HIPAA portability regulations
- Final IRS regulations for cafeteria plans

Take Action Now

The majority of the legislative and regulatory developments summarized above will require changes in both the administration and documentation of a group health benefit plan. With respect to documentation, plan documents, including the written plan document, the summary plan description and related employee communications, including enrollment materials and forms, will require updating in anticipation of the effective date or, where already effective, no later than the end of the plan year with in which the group health plan was subject to the new law.

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