Laws Contained in Part 7 of ERISA

- Health Insurance Portability and Accountability Act (HIPAA Title I)
- Mental Health Parity Act (MHPA)
- Women’s Health and Cancer Rights Act (WHCRA)
- Newborns’ and Mothers’ Health Protection Act (Newborns’ Act)

(Continued on next slide)
Laws Contained in Part 7 of ERISA

- Genetic Information Nondiscrimination Act of 2008 (GINA)
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Michelle’s Law of 2008
- Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA)
- Patient Protection and Affordable Care Act of 2010 (Affordable Care Act)
EBSA Website

http://www.dol.gov/ebsa/

- Compliance Assistance for Health Plans:
  http://www.dol.gov/ebsa/compliance_assistance.html

- Affordable Care Act:
  http://www.dol.gov/ebsa/healthreform/

- Mental Health Parity:
  http://www.dol.gov/ebsa/mentalhealthparity/

- Subscribe for Updates
Development of the Regulations

- Tri-agency process
  - Department of Labor, EBSA
  - Department of Health and Human Services, CMS
  - Department of the Treasury, Internal Revenue Service
Arrangements Subject to Part 7

- **Group Health Plan**
  Definition: An employee welfare benefit plan that provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise

- **Health Insurance Issuer**
  Definition: An insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance

- **Self-insured v. Fully-insured**
  Collection of premiums or contributions
  Assumption of risk for claims
Arrangements *Not* Subject to Part 7

- **Very Small Group Health Plans**

- **Church Plans**
  However, generally subject to parallel provisions in the Internal Revenue Code

- **Governmental Plans**
  However, state and local governmental plans may be subject to parallel provisions in the Public Health Service Act

- **Excepted Benefits**
Arrangements *Not* Subject to Part 7

- **Excepted Benefits:**
  - Benefits excepted in all circumstances (generally not health coverage);
  - offered separately (insurance policy, certificate, or contract) or are not an integral part of the plan; **
  - not coordinated with benefits under another group health plan;
  - offered under a separate policy, certificate, or contract of insurance and supplemental to Medicare, Armed Forces health coverage or similar supplemental coverage provided to coverage under a group health plan.
Arrangements *Not* Subject to Part 7

- **Excepted Benefits:**
  - **Final Regulations** – published on October 1, 2014
    - Limited-scope Dental and Vision
    - Employee Assistance Programs (EAPs)
  - Applicable for plan years beginning on or after January 1, 2015

- **Final Regulations** – published on March 18, 2015
  - Limited wraparound coverage

- Pilot program with a sunset date
Arrangements *Not* Subject to Part 7

- **Excepted Benefits: Limited-scope Dental and Vision**

  Not an integral part of the plan if:

  - Participants may decline coverage; or
  
  - Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.
Arrangements *Not* Subject to Part 7

- **Excepted Benefits: EAPs**
  - EAP does not provide significant benefits in the nature of medical care (amount, scope, and duration of covered services).
  
  - The benefits under the EAP are not coordinated with benefits under another group health plan.
  
  - No employee premiums or contributions are required as a condition of participation in the EAP.
  
  - No cost sharing under the EAP.
Market Reforms

- Market reform guidance is being issued in stages. So far, guidance has included:
  - ACA Section 1251 (grandfathered health plans)
  - PHSA Section 2704 (prohibition of preexisting condition exclusions)
  - PHSA Section 2705 (wellness programs)
  - PHSA Section 2708 (90-day waiting period limitation)
  - PHSA Section 2711 (prohibition on lifetime or annual limits)
  - PHSA Section 2712 (prohibition on rescissions)
  - PHSA Section 2713 (coverage of preventive health services)
  - PHSA Section 2714 (extension of dependent coverage)
  - PHSA Section 2715 (summary of benefits and coverage and uniform glossary)
  - PHSA Section 2719 (internal claims and appeals and external review)
  - PHSA Section 2719A (patient protections provisions)
Preexisting Condition Exclusions

General rule:
- Prohibits both the exclusion of coverage or benefits due to a preexisting condition.

Applicability
- Generally effective for plan years beginning on or after January 1, 2014, however for enrollees who are under 19 years of age, this provision became effective for plan years beginning on or after September 23, 2010.

- Generally applies to group health plans and group health insurance issuers, including grandfathered group health plans.
Watch out

✓ Beware of hidden preexisting condition exclusions

Example:
Plan covers dental treatment for injuries in connection with an accident only if the accident occurred while individual covered under the plan.
90-day Waiting Period Limitation

General rule:
Prohibits the application of any waiting period that exceeds 90 days

Applicability:
- Applicable for plan years beginning on or after January 1, 2014
- Applies to grandfathered and non-grandfathered group health plans

Final regulations published on February 24, 2014
90-day Waiting Period Limitation

- Other conditions for eligibility permissible unless condition is designed to avoid compliance.

- Cumulative hours-of-service requirements: permissible as long as they do not exceed 1,200 hours.
  - Waiting period must begin once satisfied.
  - One-time eligibility requirement

- Reasonable and bona fide employment-based orientation periods – maximum length of one month

- Conforming changes to existing regulations
Wellness Programs

- Plans may not require an individual to pay higher premium or contribution rates than other similarly situated individuals based on a health factor.

  ✓ Exception: Rewards for adherence to certain wellness programs
Wellness Programs

- Final rules published on June 3, 2013
  - ERISA section 702
  - PHS Act section 2705
- Effective for plan years beginning on or after January 1, 2014
Wellness Programs

- **Participatory wellness programs**: none of the conditions for obtaining a reward is based on an individual satisfying a standard related to a health factor.
  - Must be available to all similarly situated individuals.

- **Health-contingent wellness programs**: requires an individual to satisfy a standard related to a health factor in order to obtain a reward.
  - Activity-only
  - Outcome-based
Wellness Programs

Five requirements for health-contingent wellness programs:

1. Must give individuals eligible for the program the opportunity to qualify for the reward at least once per year;

2. Reward does not exceed 30% of the total cost of coverage (increased to 50% for programs designed to prevent or reduce tobacco use).
Wellness Programs

3. Reasonable design:

- Activity-only: must be reasonably designed to promote health and prevent disease. Determination based on all relevant facts and circumstances.
  - Has a reasonable chance of improving the health of, or preventing disease in, participating individuals;
  - Is not overly burdensome;
  - Is not a subterfuge for discriminating based on a health factor; and
  - Is not highly suspect in the method chose to promote health or prevent disease.

- Outcome-based: additional requirement – reasonable alternative standard must be provided to any individual who does not meet the initial standard based on a measurement, test, or screening.
Wellness Programs

4. Uniform availability and reasonable alternative standards:

- Activity-only: reasonable alternative standard if it is unreasonably difficult due to a medical condition or is medically inadvisable to attempt to satisfy the initial standard.
  - Physician verification if reasonable under the circumstances.

- Outcome-based: reasonable alternative standard for any individual who does not meet the initial standard based on a measurement, test, or screening.
  - No physician verification.
  - Requirements for reasonable alternative standard that is, itself, an activity-only program or an outcome-based program.
Wellness Programs

5. Notice of availability of reasonable alternative standard (and, if applicable, possibility of waiver of original standard):

- Disclosure in all plan materials describing terms of program

- Must include contact information and statement that recommendations of individual’s personal physician will be accommodated.

- For outcome-based wellness programs - must be included in any disclosure that an individual did not satisfy an initial outcome-based standard.

- Sample language
Prohibition on Lifetime or Annual Limits

- A group health plan or issuer may not:
  
  - establish any lifetime limits on the dollar value of essential health benefits for any individual for plan years beginning on or after September 23, 2010.
  
  - establish an annual limit on the dollar value of essential health benefits for any individual for plan years beginning on or after January 1, 2014.
Prohibition on Lifetime or Annual Limits

“Essential health benefits” refers to Section 1302(b) of the Affordable Care Act and applicable regulations (issued by HHS) to the extent such limits are otherwise permitted under applicable Federal and State law.

Statutory categories (1302(b)):

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care
Currently Applicable Regulations and Guidance:

- Final rules: published on June 16, 2015
- Apply for plan years beginning on or after September 1, 2015
- Apply for individual market coverage that begins on or after January 1, 2016
Plans and issuers must use the template as is. There are special instructions to allow flexibility to the extent the plan’s terms cannot reasonably be described in a manner consistent with the template and instructions.

The SBC is limited to 4 double-sided pages, with no smaller than 12 point font.

The template may be produced in color or grayscale.
Summary of Benefits and Coverage and Uniform Glossary

- Under the final regulations the SBC will contain all statutorily required content elements as well as three additional elements:

  - An internet address for obtaining a list of network providers;
  - An internet address for information about the prescription drug coverage under the plan or coverage;
  - An internet address where an individual can review and obtain the Uniform Glossary, as well as a contact phone number to obtain a paper copy of the uniform glossary, and disclosure that paper copies are available.
Summary of Benefits and Coverage and Uniform Glossary

Coverage Examples

- The SBC includes coverage examples - a new tool to help consumers compare coverage options.
- The two required coverage examples are having a baby and managing type 2 diabetes.
- The illustrative benefits scenario is a hypothetical situation using a sample treatment plan for a specified condition during a specific timeframe, and is based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse (NGC), Agency for Healthcare Research and Quality (AHRQ).
Summary of Benefits and Coverage and Uniform Glossary

Coverage Examples (continued)

- Plans and issuers will be provided the necessary information, such as medical coding and allowed amounts, to be able to simulate how claims would be processed under the scenario, which will generate an estimate of cost sharing the consumer might expect to pay for the scenario under the coverage.
  - HHS makes the information necessary for plans and issuers to simulate these claims available at http://cciio.cms.gov.
The Uniform Glossary includes all statutorily required terms, as well as additional terms recommended by the NAIC.

Plans and issuers must make the Uniform Glossary available upon request within seven business days.

The SBC must include an internet address where the Uniform Glossary can be obtained.
Summary of Benefits and Coverage and Uniform Glossary

- Who provides/receives an SBC:
  - Issuer to Plan (or plan sponsor)
  - Plan/ Issuer to Participants and beneficiaries

- In general, plans/issuers must provide SBC to Ps and Bs with respect to each benefit package for which the P or B is eligible.

* If either the issuer or the plan provides the SBC to Ps and Bs, the requirement to provide will be satisfied for both entities
Summary of Benefits and Coverage and Uniform Glossary

When an SBC must be provided

- **Upon application**
  - To Plans – As soon as practicable but no later than 7 business days after a request for application
  - To Ps and Bs – With written application materials, or if no written materials are given no later than the first date the P can enroll

- **First day of coverage** (if there are any changes)
  - Must be provided no later than first day of coverage
Summary of Benefits and Coverage and Uniform Glossary

When an SBC must be provided

- Renewal
  - If written application is required for renewal, must be provided no later than the date application materials are distributed
  - If renewal is automatic - No later than 30 days prior to the first day of the new plan or policy year
    - If renewal or reissuance has not occurred before this date, no later than 7 business days after the issuance of the new policy, certificate or contract of insurance
Summary of Benefits and Coverage and Uniform Glossary

When an SBC must be provided

- Upon request
  - As soon as practicable but no later than 7 business days following receipt of a request for an SBC or summary information about the health coverage

- Special enrollment
  - Must be provided to special enrollees no later than the timeframe required to provide an SPD, which is 90 days from enrollment
Summary of Benefits and Coverage and Uniform Glossary

Special Rules to Prevent Unnecessary Duplication

- Requirement to provide SBC is satisfied if another party provides it
- Providing SBC to last known address
- Upon renewal, only provide SBC for benefit package in which individual is enrolled
Summary of Benefits and Coverage and Uniform Glossary

Integration of the SBC with other documents

- Group health plans are permitted to integrate the SBC with other summary materials, including the SPD, as long as the SBC is intact and prominently displayed at the beginning of the materials and all timing requirements are met.
The Departments generally allow electronic delivery of the SBC and Uniform Glossary in accordance with the regulations.

The SBC and Uniform Glossary must be provided in a culturally and linguistically appropriate manner.

- These rules are located in the regulations on Internal Claims and Appeals; External Review PHSA Section 2719
Notice of Modification

- Only if plan or issuer makes any material modification in any terms that affect the content of the SBC other than in connection with a renewal or reissuance of coverage.
- Notice must be provided to enrollees not later than 60 days prior to the date the modification will be effective.

Note: This notice is in advance of timing for SMM notice in other ERISA rules.
Resources

Subscribe to the DOL website for updates!
http://www.dol.gov/ebsa/healthreform/

Other Good Affordable Care Act Resources:

IRS website
www.irs.gov

HHS website
www.healthcare.gov
Contact Information

- EBSA website: www.dol.gov/ebsa
- EBSA web inquiries: www.askebsa.dol.gov
- EBSA (questions and publications): 866-444-EBSA (3272)
- OHPSCA (Problematic Part 7 questions): 202-693-8335
QUESTIONS?