Wells Fargo Insurance Services

February 2010

Legislative update

February topics

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Regulations on Mental Health Parity and Addiction Equity Act of 2008

Background

The Mental Health Parity and Addiction Equity Act of 2008 ("the Act") is effective for plan years beginning on or after October 3, 2009, with a delayed effective date for collectively bargained plans. The Act does not require group health plans to provide mental health or substance abuse disorder benefits. However, for plans sponsored by employers with 50 or more employees that provide mental health or substance use disorder benefits, the Act requires parity with medical and surgical benefits in the following key areas.

- Financial requirements (including deductibles, co-payments, coinsurance, and out-of-pocket expenses) that apply to mental health or substance abuse disorder benefits cannot be more restrictive than the "predominant" (defined below) financial requirements that apply to "substantially all" (defined below) medical and surgical benefits under the plan. In addition, separate cost-sharing requirements cannot apply only to mental health or substance abuse disorder benefits.
- Treatment limitations (including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment) that apply to mental health or substance abuse disorder benefits cannot be more restrictive than the "predominant" treatment limitations that apply to "substantially all" medical and surgical benefits under the plan. In addition, separate treatment limitations cannot apply only to mental health or substance abuse disorder benefits.
- Plans that cover medical and surgical benefits by out-of-network providers must also cover mental health or substance abuse disorder benefits by out-of-network providers in a manner that is consistent with the other requirements of the Act.

Joint interim final regulations

On January 29, 2010, the U.S. Department of Labor, the Department of Health and Human Services, and the Internal Revenue Service issued interim final regulations regarding the Act. The regulations are effective for plan years beginning on or after July 1, 2010; for example, calendar year plans are required to comply with the regulations beginning January 1, 2011. For group health plans maintained under a collective bargaining agreement ratified on or before October 3, 2008, the regulations do not apply to the plan for plan years beginning before the date that the collective bargaining agreement expires (determined without regard to extensions agreed to after October 3, 2008) or July 1, 2010, whichever is later.

Aggregate lifetime or annual limits

The general parity requirement with respect to aggregate lifetime or annual limits is explained in the regulations by separating plans into three groups:

- Plans with no limits or limits on less than one-third of medical and surgical benefits;
- Plans that have limits on at least two-thirds of medical and surgical benefits; and
- Plans that fall outside of these two groups.

In determining whether the portion of medical and surgical benefits, subject to an aggregate lifetime or annual dollar limit, represents one-third or two-thirds of all medical and surgical benefits, the regulations look to the dollar amount of all plan payments for medical and surgical benefits expected to be paid under the plan for the plan year.

If a plan does not include an aggregate lifetime or annual limit on any medical and surgical benefits, or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical and surgical benefits, it may not impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits.

If a plan includes an aggregate lifetime or annual limit on at least two-thirds of all medical and surgical benefits, it must either apply the aggregate lifetime or annual limit both to the medical and surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical and surgical benefits and mental health or substance use disorder benefits, or include an aggregate lifetime or annual limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit on medical and surgical benefits.

For plans that do not fit within the first two groups, the plan must either impose no aggregate lifetime or annual limits, or an aggregate or lifetime limit that is no less than the average limit for medical and surgical benefits calculated using the weighted average of the aggregate lifetime or annual limits applicable to medical and surgical benefits.

Financial requirements and treatment limitations

The regulations establish six classifications of benefits where parity, with respect to financial requirements and treatment limitations, must be provided:

1. Inpatient in-network
2. Inpatient out-of-network
3. Outpatient in-network
4. Outpatient out-of-network

5. Emergency care
6. Prescription drugs

The regulations confirm that the financial requirements apply to deductibles, co-payments, coinsurance, and out-of-pocket maximums, and distinguish between quantitative and non-quantitative treatment limitations. Quantitative treatment limitations include annual, episodic, and lifetime day and visit limits. Non-quantitative treatment limitations include medical management standards; formulary design for prescription drugs; standards for provider participation (including reimbursement rates); plan methods for determining usual, customary, and reasonable charges; refusal to pay for higher cost therapies until lower cost methods are shown to be ineffective; and exclusions for failure to complete a course of treatment.

The determination of the portion of medical and surgical benefits in a classification of benefits, subject to a financial requirement or quantitative treatment limitation, is based on the dollar amount of all plan payments for medical and surgical benefits in the classification expected to be paid under the plan for the plan year.

The regulations explain that the "level of a type of financial requirement or treatment limitation" refers to the magnitude of the type of financial requirement or treatment limitation. For example, different levels of coinsurance include 20 percent and 30 percent, different levels of a co-payment include $15 and $20, different levels of a deductible include $250 and $500, and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode. Coverage unit refers to the way in which individuals are grouped by the plan for purposes of determining benefits, premiums, or contributions (for example, self-only, employee-plus-one, or family).

Most importantly, the regulations explain what "substantially all" and "predominant" mean for purposes of the Act. A type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical and surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical and surgical benefits in that classification. If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical and surgical benefits in a classification, then that type of financial requirement or quantitative treatment limitation cannot be applied to mental health or substance use disorder benefits in that classification.

If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical and surgical benefits in a classification, the level of the financial requirement or quantitative treatment limitation that is considered to be the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical and surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

With respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical and surgical benefits in a classification, if there is no single level that applies to more than one-half of medical and surgical benefits in the classification, subject to the financial requirement or quantitative treatment limitation, then the plan may combine levels until the combination of levels applies to more than one-half of medical and surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification.

Conclusion

Employers with questions about how the regulations affect their group health plan should contact their Wells Fargo Insurance Services representative for assistance.

Model CHIPRA notice

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows states to decide whether medical assistance will be provided to the poor and the young either directly (through the state Medicaid or children's health insurance program) or through premium assistance for those with access to an employer's medical plan. In states that authorize such a choice, CHIPRA requires that employers notify all employees (not just plan participants) of the potential opportunity to receive premium assistance from their state of residence. The U.S. Department of Labor (DOL) and Department of Health and Human Services have now released a model CHIPRA notice that may be used by employers for this purpose. The model notice is available at: http://www.dol.gov/ebsa/chipmodelnotice.doc.

According to the federal government, all but 10 states have adopted the CHIPRA choice as of January 22, 2010: Connecticut, Delaware, Hawaii, Illinois, Maryland, Michigan, Mississippi, Ohio, South Dakota, and Tennessee.

Employers with employees in any of the other 40 states are required to provide the model CHIPRA notice to employees in those states, beginning with the first plan year after February 4, 2010. For example, an employer with a calendar year plan must provide the model CHIPRA notice to employees by January 1, 2011. The notice may be included with open enrollment materials or sent by first class mail. The notice may also be sent electronically, as long as the DOL's electronic disclosure safe harbor requirements are met.

For additional information on CHIPRA and the notice requirements, please contact your Wells Fargo Insurance Services representative.

New model COBRA notices

The Department of Defense Appropriations Act of 2010 extends the COBRA premium subsidy in two ways – by including involuntary terminations through February 28, 2010, and by expanding the subsidy period from nine months to 15 months. To help facilitate these changes, the DOL has released three model COBRA notices.

The first in the set of model COBRA forms is an updated model general notice, which should be sent to individuals who experience a COBRA qualifying event of any kind after September 1, 2008, and through February 28, 2010. The updated model general notice should be sent within the normal time frames that apply under COBRA. If an out-of-date version of the general notice was sent instead, the updated model general notice should be sent as soon as practicable; otherwise, the 60-day period for electing COBRA coverage may not expire.

The second in the set is an updated alternative notice, which is intended for use by insurance carriers complying with state continuation coverage laws. Only insurance carriers (not employers) are responsible for distributing the updated alternative notice.

The third in the set is a model premium assistance extension notice, which should be sent to individuals in the following groups:

1. Assistance eligible individuals with COBRA coverage as of October 31, 2009;
2. Anyone eligible for COBRA coverage due to termination of employment (voluntary or involuntary) that took place on or after October 31, 2009, and through December 19, 2009; and
3. Assistance eligible individuals who ceased to pay for COBRA coverage after receiving nine months of premium subsidy.

The model extension notice should be sent by February 17, 2010, to individuals in the first two groups identified above. The DOL has advised, however, that the model extension notice does not need to be sent to those who informed the group health plan (on or after October 31, 2009) that they have become eligible for Medicare or other group health plan coverage (which disqualifies them from receiving the subsidy). Also, anyone with COBRA coverage as of October 31, 2009, who stopped paying the reduced COBRA premium amount in November, before expiration of the original nine-month subsidy period, must be sent the model extension notice but would not have the ability to resume COBRA coverage (because they did not exhaust the original nine months of subsidized coverage available to them).

The third group of individuals identified above must receive the model extension notice within 60 days of the first day of their "transition period," which begins immediately at the end of their nine months of COBRA premium subsidy. For example, if an assistance eligible individual began receiving the COBRA premium subsidy on March 1, 2009, and the original nine-month subsidy period expired on November 30, 2009, then the model extension notice must be sent to that individual by January 29, 2010.

The model extension notice informs individuals in this third group that they can resume COBRA coverage by making a retroactive premium payment at the subsidized rate (35 percent of the regular COBRA premium) by no later than February 17, 2010, or (if later) 30 days from the date they receive the extension notice. For example, if an individual in this group receives the model extension notice on February 1, 2010, he or she has until March 2, 2010 (i.e., the later of February 17 or 30 days after February 1) to pay all retroactive premiums for COBRA coverage at the subsidized rate.

None of the new model COBRA notices discusses the issue of individuals who continued their COBRA coverage after the original nine-month subsidy period expired by paying the full unsubsidized premium amount. The DOL has advised that individuals who paid the full premium amount in December 2009 should contact their plan administrator to discuss receiving a refund or a credit against future COBRA premium payments. Employers can add this language to the model extension notice as well, and calculate the credit or refund amount in advance.

The new model COBRA forms can be found on the DOL Web site at http://www.dol.gov/ebsa/COBRAmodelnotice.html.

HITECH becomes effective

The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) requires notification of certain individuals and groups whenever a breach occurs in the privacy of unsecured protected health information (PHI). Employers should take the following steps to ensure compliance with these breach notification rules, which become effective in February 2010.

- Update your business associate agreements to include the new HITECH provisions (for group health plans that are self-insured).
- Implement a breach notification procedure as part of your group health plan's policies and procedures for complying with HIPAA privacy and security.
- Train your staff on the new breach notification procedures, to ensure their compliance with the new rules.

Employers should seek the advice of legal counsel in working through these compliance issues.

Reminder for small group health plans to furnish HIPAA privacy notice

Under the Health Insurance Portability and Accountability Act (HIPAA), group health plans are required to notify plan participants at least once every three years of their right to receive a copy of the HIPAA privacy notice. This obligation may also be satisfied by furnishing participants with a copy of the privacy notice itself.

On April 14, 2010, small group health plans (defined as plans with less than $5 million in annual gross receipts or claims paid) will reach the sixth anniversary of the initial distribution of the privacy notice. As a result, small group health plans are required to distribute the notice no later than April 14, 2010, or send a reminder informing plan participants of their right to receive a copy of the notice (unless the privacy notice has been re-issued in the interim).

Responsibility for distributing the privacy notice is often delegated to the insurance carrier or third party administrator (for insured or self-insured group health plans, respectively). Employers with small group plans should confirm at this time whether the carrier or third party administrator has already complied with the notification obligation.

The privacy notice or reminder can be distributed by mail to plan participants at their home. If a reminder is used, it may be included in a plan newsletter or other publication. E-mail distribution is not sufficient for this purpose, unless the employer has written consent from each participant agreeing to receive electronic communications.

Form 5500 electronic filing update

EFAST2, which is the DOL's electronic system for filing Form 5500, is now operational on the DOL Web site.

Effective January 1, 2010, all Form 5500 annual returns and reports of employee benefit plans (regardless of the plan year) must be filed electronically using EFAST2. Paper filing is no longer accepted by the DOL, except that 2008 Form 5500 filings (including delinquent and amended filings) can still be filed using paper forms – or by using the original EFAST system – as long as the filing takes place by October 15, 2010.

With EFAST2, each employer must designate one or more employees (not third parties) to electronically sign Form 5500 on behalf of the plan administrator. These employees should be officers or key employees of the employer with authority over the employer's employee benefit plan. Before they can electronically sign any Form 5500, they will need to be "credentialed" with the DOL by having them access the EFAST2 Web site and register with the DOL.

California increases State Disability Insurance maximum benefit

For 2010, the California Employment Development Department announced that the maximum weekly State Disability Insurance (SDI) benefit will increase from $959.00 to $987.00. Additionally, the maximum annual employee SDI contribution will increase from $997.36 to $1,026.48, and the SDI wage ceiling will increase from $90,669 to $93,316.

Hawaii increases Temporary Disability Insurance maximum benefit

For 2010, the Hawaii Department of Labor and Industrial Relations announced that the maximum weekly Temporary Disability Insurance (TDI) benefit will increase from $510.00 to $523.00. Additionally, the maximum weekly employee TDI contribution has increased from $4.39 to $4.51 and the TDI weekly wage ceiling has increased from $877.69 to $901.70.

Question of the month

Question
How long are we required to keep summary plan descriptions?

Answer
Federal Employee Retirement Income Security Act (ERISA) law requires plan administrators to retain certain records for inspection by the DOL for six years. These records include:

- Documents and reports of matters subject to ERISA reporting and disclosure requirements (including summary plan descriptions, summaries of material modification, Forms 5500, and summary annual reports); and
- Supporting documents with enough detail to allow verification or clarification of information filed with the DOL or the Internal Revenue Service (such as vouchers, worksheets, receipts).

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