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LEGISLATIVE ACTIONS AFFECTING HEALTH PLANS DURING 2009

This **Insights** summarizes the major features of the **Genetic Information Nondiscrimination Act of 2008, The Heroes Earnings Assistance and Tax Relief Act of 2008, The Mental Health Parity and Addiction Equity Act of 2008 and Michelle's Law** which become effective this year or allow retroactive changes during this calendar year.

The Genetic Information Nondiscrimination Act of 2008 (GINA) was signed into law on May 21, 2008 and prohibits employers, insurers, and health plan sponsors from using genetic information to discriminate against employees and family members with respect to:

- Plan eligibility and contribution requirements (Title I), and
- Employment-related decisions such as hiring, promotions, and firing (Title II).

Title I of **GINA** applies to group health plans sponsored by private employers, unions, and state and local government employers; issuers in the group and individual health insurance markets; and issuers of Medicare supplemental (Medigap) insurance.

Genetic information, broadly defined, includes genetic tests or a request for such services, participation in clinical research as well as an individual or family member being diagnosed with a genetic disorder. While Title I of GINA amends the discrimination provisions of other laws including the Health Insurance Portability and Accountability Act (HIPAA), it does recognize that receipt of genetic information for payment of claims, utilization review, preauthorization of services, etc. is still necessary to properly operate the plan. Information used in this way will not require prior authorization from a plan participant. Violations of Title I

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will result in penalties levied against the plan sponsor of \$100 per day for each affected individual (subject to limitations). Other penalties are applicable for Title II violations.

Title I of GINA becomes effective for plan years beginning after May 21, 2009 (January 1, 2010 for calendar year plans). The Title II employment provisions take effect on November 21, 2009. Employers and plan sponsors should review health plan documents and other employment-related practices and materials to assure compliance.

The Heroes Earnings Assistance and Tax Relief Act of 2008 (HEART) gives employers the *option* of allowing employees called to active duty as a reservist for at least 180 days, the ability to receive all or part of a healthcare flexible spending account (FSA) balance as a Qualified Reservist Distribution (QRD). An employer has some design flexibility and can select one of three options for determining the amount of the QRD. However, QRDs must be distributed within 60 days of the reservist employee's request and generally must be treated as wages subject to employment taxes and included in gross income for the year.

The HEART Act was signed into law on June 17, 2008 and could be applied to distributions beginning on or after June 18, 2008. Employees who reported for active duty before June 18, 2008 may still be eligible for a QRD. IRS Notice 2008-82 gives employers who would like to offer this benefit until December 31, 2009 to retroactively update plan documents, provided that all HEART requirements are met.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was signed into law on October 3, 2008 as part of the Emergency Economic Stabilization Act. This extensive piece of legislation eliminated the sunset provisions of the 1996 Mental Health Parity Act and now requires that, if offered under a group health plan, mental health and substance abuse benefits must be equivalent to the plan's medical and surgical benefits.

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MHPAEA generally applies to self-insured, as well as, fully insured group health plans sponsored by employers and governments. Unless state law applies, small employers (those with less than 50 employees) are exempt from the MHPAEA requirements. Furthermore, the federal legislation does not require that mental health and substance abuse benefits be offered nor does the law require the coverage for specific conditions, however, insured plans must continue to comply with applicable state provisions.

The basic requirements of MHPAEA, which generally become effective for plan years beginning on and after October 3, 2009 (January 1, 2010 for calendar year plans), include the following:

- The plan's financial arrangements, including deductibles, copayments, coinsurance and out-of-pocket expenses must be the same or better than the plan's most common or frequent requirements for medical and surgical benefits. Provisions of the original Act prohibiting a plan from imposing more restrictive annual and lifetime mental health limitations continue to apply and have been extended to cover substance abuse benefits, as well.
- The plan may not impose frequency limits that cap the number of visits or days of coverage for mental health and substance abuse benefits that are more restrictive than the plan's medical and surgical benefits.
- Out-of-network mental health and substance abuse benefits must be made available if the option is extended to medical and surgical benefits.
- The plan must disclose any "medically necessary" determination criteria to current or future participants and contracting providers upon request and provide relevant claim denial information.

Each year, a group health plan may elect an MHPAEA *one-year exemption* for the following plan year, if it can demonstrate that the requirements increase plan costs by more than 2% in the first applicable plan year and by more than 1% in each year, thereafter. The

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demonstration requires an actuarial certification including plan experience under MHPAEA for at least six months of the plan year involved. In addition, plan participants, state, federal and regulatory authorities must be notified of the exemption and the plan will be subject to a Department Of Labor or other state agency audit.

Plan sponsors or insurers may be subject to fines of up to \$100 per day per beneficiary for failure to comply with the law. Participants may also file civil suits to receive covered benefits to which they believe they are entitled.

Employers, plan sponsors and insurers should review existing health plans to determine the impact on plan design and costs. Employers might wish to consider an *earlier-than-normal review process* to assess plan design options and to review and revise all relevant documents and communication materials in a timely fashion.

Michelle's Law, signed by President Bush on October 9, 2008, will require group health plans and health insurers to continue coverage to post secondary student dependents under a parent's health plan for up to one year due to a medically necessary leave of absence. Michelle's Law will apply to nearly all forms of health insurance, including coverage under self-funded ERISA plans and fully insured group and individual health insurance as well as non-ERISA plans such as governmental and church plans. The new requirements will apply to medical, dental, and vision coverage. The law does not, however, require a plan to cover dependents, nor does it regulate the definition of a dependent. Plans that do not utilize a full-time student definition for older dependents will not be impacted by Michelle's Law.

Michelle's law will become effective for plan years beginning on and after October 9, 2009 (January 1, 2010 for calendar year plans) and will apply to medically necessary leaves of absence that commence during the plan year. Michelle's Law protects a full-time student dependent from experiencing a loss of coverage as a result of a medically necessary

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withdrawal from school or a reduction in hours to part-time student status. Prior to enactment, the loss of full-time student status would most likely result in a more expensive COBRA qualifying event. Currently, it is unclear how COBRA and Michelle's Law will ultimately interact and further guidance is expected from the IRS.

Group health plans that extend benefits to postsecondary students must continue coverage for up to one year under the following circumstances:

- The plan receives written certification from a treating physician that states the child is suffering from a serious injury or illness and requires a medically necessary leave of absence from his/her studies, and
- The loss of student status would otherwise result in a loss of coverage under the terms of the plan.

Other key features of the law include:

- A notice describing the student's rights under Michelle's Law must be included with the student verification documents,
- The one-year measurement period begins on the first day of the medically necessary leave of absence and may end earlier than one year if coverage under the plan would normally cease due to other reasons,
- The benefits during the medically necessary leave of absence must be the same as if the child had not been forced to suspend student status, and
- A student on a medically necessary leave of absence would continue to be eligible for benefits through the end of the one-year period when a plan sponsor makes changes to the plan (e.g. changes in insurance provider, benefit design, or a change to a self-insured plan) and benefits under the new plan are offered to dependent children.

Employers and plan sponsors should review and update plan documents, notices, certification forms, enrollment materials and other employee communication materials as necessary. In

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In addition, employers may need to treat the value of the continued coverage as imputed income if the dependent does not satisfy the dependent definition under Code Section 152 which basically limits a qualifying dependent (for tax purposes) to a student who has not attained the age of 24 as of the close of such calendar year.

Summary

These legislative initiatives will require employers and plan sponsors to review their existing benefit plans to ensure that they are in compliance. Changes to plan provisions, policies, benefit design, plan documents, and other communication materials may be necessary. Employers and plan sponsors should consult with their benefits advisors.

Contact your Chernoff Diamond representative for more information.

This brief summary is not intended to be a comprehensive legislative analysis. Chernoff Diamond is a benefits advisory firm and does not provide tax or legal advice. Employers should consult with qualified legal and/or tax counsel for guidance in respect of matters of law, tax and related regulation.