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Welfare Plan Changes for 2010

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Agenda



- ▶ HIPAA Privacy/Security
- ▶ CHIPRA
- ▶ Michelle's Law
- ▶ GINA
- ▶ Mental Health Parity
- ▶ Medicare Secondary Payer Reporting

HIPAA Privacy/Security Changes - Overview

- ▶ HITECH – Health Information Technology for Economic and Clinical Health Act
- ▶ Enacted as part of economic stimulus bill on February 17, 2009
- ▶ Federal funding for health information technology initiatives to improve administrative efficiencies

HIPAA Privacy/Security - Summary of HITECH Changes

- ▶ Notification of breach
- ▶ Increased civil monetary penalties and enforcement
- ▶ Direct application of security rule to business associates

HIPAA - Notification of Breach

- ▶ New requirement (in addition to the existing obligation to mitigate damage from breach)
- ▶ Similar to state data breach notification laws
- ▶ Applies to “unsecured” PHI that is “accessed, acquired, or disclosed” by or to an unauthorized person as a result of a “breach”
- ▶ Must notify “affected individuals” and the Department of HHS in the event of breach

HIPAA - Notification of Breach



- ▶ Notice must include:
 - A brief description of the breach, including the date of breach and discovery
 - A description of the types of unsecured PHI disclosed or misappropriated during the breach
 - The steps individuals should take to protect themselves from potential harm
 - A description of the covered entity's actions to investigate the breach and mitigate harm now and in the future
 - Contact procedures (including a toll-free telephone number) for affected individuals to find additional information

HIPAA - Notification of Breach

- ▶ Notice must be provided “without unreasonable delay” and in no event later than 60 days after discovery of breach
- ▶ Notice must be provided to each individual, in writing, by first-class mail
- ▶ If more than 500 affected individuals in same state or geographic area, must also provide notice to prominent media outlets
- ▶ If 10 or more affected individuals cannot be located, must post notice in major print media or on home page of Company website

HIPAA - Civil Monetary Penalties

- ▶ Penalty for violations due to reasonable cause has increased from \$100 per violation to \$1,000 per violation
- ▶ Violations due to willful neglect are subject to penalty of \$10,000 per violation (if corrected) and \$50,000 per violation (if not corrected)
- ▶ Willful neglect to be defined by regulation within 18 months

HIPAA - Enforcement

- ▶ Secretary of HHS required to conduct full investigation if preliminary investigation of complaint indicates possible willful neglect
- ▶ State attorneys general can sue on behalf of individuals (injunction or damages of up to \$25,000)
- ▶ Future regulations (within 36 months) will allow aggrieved individuals to share in penalties

HIPAA - Business Associates - Current Law

- ▶ Liability of Business Associates (B/As) prior to HITECH –
 - No direct application of HIPAA privacy or security rules – so no civil or criminal penalties could be assessed on B/As
 - Potential liability to covered entity (if B/A agreement included indemnification) but generally covered entity's only recourse is right to terminate agreement upon B/A's breach and failure to cure

HIPAA - Business Associates – New Law

- ▶ Business Associates under HITECH:
 - Now directly subject to many of the HIPAA Security Rules in the same manner as covered entities
 - Now subject to civil and criminal penalties for violating those Security Rules in the same manner as covered entities
 - Now subject to civil and criminal penalties for failure to adhere to the Privacy provisions in the Business Associate agreement

HIPAA - Business Associates – New Law

- ▶ This means B/As must now:
 - Appoint a Security official
 - Train workforce in the Security Rule
 - Perform a risk assessment re: E-PHI
 - Develop specific policies and procedures, and implement administrative, physical and technical safeguards, re: E-PHI
 - Notify covered entity of security breach
 - Submit to periodic audits by HHS

HIPAA - Business Associates – New Law

- ▶ Business Associates must now “monitor” the covered entity, and if covered entity is violating the privacy or security rules, the B/A must:
 - Ask covered entity to stop violation; and
 - Terminate agreement if violations are not stopped; or
 - Report violations to HHS if termination of the agreement is not feasible

HIPAA Privacy/Security – Effective Dates

- ▶ Increase in civil penalties - effective immediately
- ▶ Notification of breach provisions effective 30 days after final regulations issued (regulations due by August 16, 2009)
- ▶ General effective date for most other provisions (including business associate requirements) is February 17, 2010

History of CHIP

- ▶ Created in 1997, as State Children's Health Insurance Program (or "SCHIP")
- ▶ Designed to provide health coverage for children in families above Medicaid level, but too poor to purchase private health coverage (up to 200% of poverty level)
- ▶ Funded by state and federal governments
- ▶ States determine eligibility, benefits, etc.

Overview of CHIPRA Changes

- ▶ **Children's Health Insurance Program Reauthorization Act ("CHIPRA"):**
 - Dropped the "State" from name
 - Allows states to go up to 300% of poverty level
 - States may now provide premium assistance
 - Two new "special enrollment" events
 - New employer notice obligations
 - Duty to respond to state requests for information
 - Many provisions already in effect

CHIPRA - Premium Assistance

- ▶ States may now subsidize the cost of coverage for dependent children under employer group health plans
- ▶ Generally, subsidy may cover only incremental cost of covering children
- ▶ However, employee and spouse may also qualify for premium assistance

CHIPRA - Subsidy Mechanics

- ▶ Subsidy paid to employee or sponsoring employer
- ▶ Employer may opt out of direct payments
- ▶ Child (or parent) may decline to enroll in employer plan
- ▶ Theoretically effective as of 4-1-09

CHIPRA - Special Enrollment Events

- ▶ Group health plan must allow eligible child (and sometimes parent) to enroll in plan upon becoming eligible for CHIP premium assistance (or similar premium assistance under Medicaid)
- ▶ Group health plan must allow eligible child (and sometimes parent) to enroll upon loss of coverage under either CHIP or Medicaid
- ▶ Both events effective as of 4-1-09

CHIPRA - Special Enrollment Issues

- ▶ Health plan must allow at least 60 days to request special enrollment
- ▶ Note: Existing HIPAA special enrollment events apply 30-day deadline
- ▶ Health plan documents must be amended to reflect new enrollment events, as well as 60-day deadline
- ▶ Special enrollment notice should be revised, as well

CHIPRA - Coordination of Benefits

- ▶ CHIP may still pay claims that are not covered under employer plan
- ▶ In that event, employer plan must pay primary to CHIP (similar to current rule for Medicaid)
- ▶ Effective as of 4-1-09
- ▶ May require plan amendment

CHIPRA - Notice to Employees

- ▶ Employer must notify employees of availability of CHIP premium assistance (depending upon state)
- ▶ Notice may be included in
 - SPD
 - Enrollment materials
 - Separate notice of eligibility

CHIPRA - Model Notices

- ▶ DOL and HHS are to issue model notices (including state-specific notices) by February 2010
- ▶ Employers must provide these notices as of first day of plan year after they are issued
- ▶ Penalty for noncompliance = \$100 per participant per violation

CHIPRA - Disclosure to States

- ▶ Employer must respond to request for information from state CHIP agency
- ▶ DOL and HHS are to issue model response form
- ▶ Employers must use that form as of next plan year
- ▶ Penalty for noncompliance = \$100 per participant per violation

Michelle's Law

- ▶ Requires group health plans to extend coverage (for up to one year) when a dependent child loses eligibility as a “student” because of a “medically necessary” leave of absence
- ▶ Named after Michelle Morse, a student at Plymouth State University, who died of colon cancer

Michelle's Law - Definitions

- ▶ Dependent Child – child of a covered employee who is eligible solely because of his/her status as a “student” at a college, university or other post-secondary educational institution
- ▶ Medically Necessary Leave of Absence – leave of absence (or change in status) caused by serious illness or injury, as certified (in writing) by treating physician

Michelle's Law - Requirements

- ▶ Leave of absence/change in status must cause loss of “student” status (and therefore loss of coverage) under group health plan
- ▶ Coverage must continue for up to one year, unless child's coverage ends earlier under another plan provision (such as exceeding plan's eligibility age or parent's termination of employ.)

Michelle's Law - Requirements

- ▶ Coverage must continue as if child were still student (even if new vendor)
- ▶ If plan requires certification of student status, any notice of that requirement must also describe right to continue coverage under new law
- ▶ Law does not dictate who must pay for coverage – (treat like COBRA?)

Michelle's Law – Effective Date

- ▶ Applies to plan years beginning on or after October 9, 2009 (i.e., January 1, 2010 for calendar-year plans)
- ▶ May require update of plan document, Summary Plan Description, enrollment materials and other employee communications
- ▶ Coverage may be taxable if child is not a tax-code dependent (unless employee pays full cost of coverage)

Genetic Information Non-Discrimination Act (GINA)

- ▶ Effective for plan years beginning after May 21, 2009
- ▶ Prohibits group health plan (and health insurers) from restricting enrollment or adjusting premium for the *group* on the basis of genetic information

GINA – Scope of Coverage

- ▶ Applies to insured and self-funded group health plans
- ▶ Includes governmental plans
- ▶ Does not apply to life insurance, disability insurance, or long-term care insurance

GINA – What is “Genetic Information”?

- ▶ Family medical history
- ▶ Genetic tests, counseling, and education
- ▶ Not gender or age

GINA – Pre-enrollment Restrictions

- ▶ GINA prohibits plans from requesting, requiring, or purchasing genetic information *prior to* enrollment
- ▶ May raise issues with pre-enrollment health risk assessments (HRAs) because many HRAs include questions about family medical history

GINA – Group Premiums

- ▶ Plan cannot use genetic information to adjust group premium or contribution amounts
- ▶ Actual claims experience or manifested disease or disorder can still be used to set premiums

GINA - Exceptions

- ▶ Payment – Can still ask for and use genetic information for claims purposes (i.e. determination of medical necessity)
- ▶ Incidental acquisition
- ▶ Health care professionals
- ▶ Research

GINA - Penalties

- ▶ \$100 per day per person
- ▶ Non-willful violations due to reasonable cause – lesser of \$500,000 or 10% of aggregate penalty paid in preceding calendar year
- ▶ Willful violations – no cap

Mental Health Parity

- ▶ Requires full parity between mental health benefits and medical/surgical benefits
- ▶ Group health plan is *not* required to provide mental health coverage, but to the extent that it does, such coverage must be on the same terms and conditions as other physical conditions

Mental Health Parity - Requirements

- ▶ Affects treatment limits or frequency limits (e.g. outpatient visit limits or hospital stay limits)
- ▶ No different deductibles or coinsurance levels
- ▶ Also applies to substance abuse
- ▶ Must provide out-of-network coverage if provided for medical/surgical benefits

Mental Health Parity - Exemptions

- ▶ Small employers exempt – less than 50 employees
- ▶ Cost exemption – if total plan cost increases by more than 2% in first year, or more than 1% in subsequent years
 - Must be certified by actuary based upon actual claims experience
 - Must notify participants and beneficiaries
 - Only applies for following plan year

Mental Health Parity – Effective Date

- ▶ Effective for plan years beginning on or after October 2, 2009
- ▶ For collectively bargained plans, effective the later of January 1, 2010 or the expiration of the collective bargaining agreement

Medicare Secondary Payer (MSP) Mandatory Reporting

- ▶ Requires group health plans (or their TPA/insurer) to report certain data elements to CMS with respect to “active covered individuals”
- ▶ For purposes of identifying situations where group health plan should pay primary to Medicare
- ▶ Will require electronic submission of data file on a quarterly basis

MSP Reporting

- ▶ Effective January 1, 2009
- ▶ No reporting until July 1, 2009 for plans that do not already have voluntary data share agreement with CMS
- ▶ Registration and testing to begin April 1, 2009
- ▶ Basic and expanded reporting options (with or without prescription drug coverage information)

MSP – Who Must Report?

- ▶ Small employers with less than 20 employees exempt (except for kidney dialysis and kidney transplant)
- ▶ Responsible reporting entities (RREs) are “an entity serving as an insurer or third party administrator for a group health plan...and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary.”

MSP – Active Covered Individuals

- ▶ All individuals age 55 through age 64 who have coverage based on their own or a family member's current employment status (45 and older as of January 1, 2011)
- ▶ All individuals age 65 and older who have coverage based upon their own or a spouse's current employment status
- ▶ All individuals who have been receiving kidney dialysis or who have received a kidney transplant, regardless of their own or a family member's current employment status and regardless of their age
- ▶ All individuals who are under age 55, are known to be entitled to Medicare, and have coverage in the plan based on their own or a family member's current employment status
- ▶ No COBRA or retiree coverage (except for kidney dialysis or kidney transplant)

MSP Reporting - Dependents

- ▶ Transition rule applies to collection of SSNs for dependents
- ▶ RREs must submit the SSNs for all spouses and family members who are Active Covered Individuals and whose initial date of coverage is January 1, 2009, or later, in their initial file submission
- ▶ RREs have until their file submission in the first quarter of 2011 to submit records with the SSNs for spouses and other family members who are Active Covered Individuals and whose initial date of coverage was **prior** to January 1, 2009.

MSP Reporting – Penalties

- ▶ \$1,000 per day per individual for whom information should have been submitted
- ▶ Penalty is in addition to any potential claim under MSP regulations (i.e., that group health plan should have paid primary to Medicare)



Thank you for your participation.

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