

ERISA: Title I, Part 7

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U.S. Department of Labor



Employee Benefits Security Administration

Office of Health Plan Standards and Compliance Assistance

***Unless otherwise noted, this draft is current as of February 2020. Although EBSA makes every effort to assist the public, these slides are not intended to be, and should not be construed as, legal advice. They are also not a substitute for any regulations or interpretive guidance issued by EBSA. ***

Agenda

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- ▶ Introduction and Background of Part 7 of ERISA
- ▶ Affordable Care Act (ACA) Market Reforms
- ▶ Mental Health and Substance Use Disorder Parity
 - ▶ General Rules
 - ▶ FAQs and other Resources

Agenda Continued

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- ◆ Part 7 Disclosure Requirements
- ◆ Additional Compliance Tips and Tools
- ◆ COBRA in the American Rescue Plan Act

Introduction and Background of ERISA Part 7

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)

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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)
- ▶ 21st Century Cures Act (Cures Act)

Development of the Regulations

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- ▶ Tri-department process
 - ▶ Department of Labor, EBSA
 - ▶ Department of Health and Human Services, CMS
 - ▶ Department of the Treasury, Internal Revenue Service

Arrangements Subject to Part 7

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- ▶ 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

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- ▶ Very Small Group Health Plans
- ▶ Church Plans
 - However, generally subject to parallel provisions in the Internal Revenue Code
- ▶ Governmental Group Health Plans
 - However, state and local governmental group health plans may be subject to parallel provisions in the Public Health Service Act
- ▶ Excepted Benefits

Affordable Care Act Market Reforms

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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 dollar 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)

Summary of Benefits and Coverage and Uniform Glossary

- ▶ Unless otherwise permitted by the instructions, plans and issuers must not alter the template.
 - ▶ Special Rule for Limitations, Exceptions, and Other Important Information: To the extent that the inclusion of these limitations and exceptions would make compliance with the limit impossible, the plan or issuer should cross reference the pages or identify the sections where they are described in the applicable document.
- ▶ The SBC is limited to 4 double-sided pages, with no smaller than 12 point font.

Summary of Benefits and Coverage and Uniform Glossary

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Coverage Examples

- ▶ The SBC includes coverage examples- a tool to help consumers compare coverage options.
- ▶ Plans and issuers are provided the necessary information 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.

Summary of Benefits and Coverage and Uniform Glossary

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Who provides/receives an SBC:

- ▶ Issuer to Plan (or plan sponsor)
- ▶ Plan/ Issuer to Participants and beneficiaries
 - ▶ Plans/issuers must generally provide SBCs for each benefit package for which the P or B is eligible.

Summary of Benefits and Coverage and Uniform Glossary

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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

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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.

Internal Claims and Appeals and External Review

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- ▶ Plans and issuers must initially incorporate the internal claims and appeals processes set forth in the Department of Labor Claims Procedure Regulation (See 29 CFR 2560.503-1) and update such processes in accordance with standards established by the Secretary of Labor.
- ▶ 7 additional requirements added to Claims Procedure Regulation by these regulations.

External Review

- ▶ Section 2719 of the PHS Act requires plans and issuers to implement an effective external review process that meets minimum standards established by the Secretary.
- ▶ The statute, final regulations and a series of technical releases provide a basis for determining when plans and issuers must comply with the Federal or State External Review Processes as well as guidelines for these processes.
- ▶ Guidance issued has established guidelines for the following External Review Processes:
 - ▶ Federal Processes
 - ▶ Independent Review Organization (IRO) process
 - ▶ HHS-administered process
 - ▶ State Process
 - ▶ NAIC Uniform Model Act parallel or similar processes

Mental Health Parity

- MENTAL HEALTH PARITY ACT OF 1996 (MHPA)
- MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)
- 21ST CENTURY CURES ACT (CURES ACT)
- THE SUPPORT FOR PATIENTS AND COMMUNITIES ACT (SUPPORT ACT)

Mental Health Parity

- ▶ Only applicable to plans offering both:
 - ▶ medical/surgical (med/surg) benefits; and
 - ▶ mental health or substance use disorder (MH/SUD) benefits
- ▶ Anti-abuse provision: look at all possible combinations of med/surg and MH/SUD benefits
- ▶ Does not apply to employers with 50 or fewer employees (but non-grandfathered, small group market coverage must include coverage for MH/SUD benefits for plan years beginning or after January 1, 2014).
- ▶ Increased cost exemption

Mental Health Parity

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

- ▶ General Rule: financial requirements or quantitative treatment limitations applicable to MH/SUD benefits can be no more restrictive than the predominant financial requirements or quantitative treatment limitations applied to substantially all medical and surgical benefits covered by the plan.

Mental Health Parity

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SUMMARY - GENERAL RULE ANALYSIS

1. Within a classification
2. Substantially all med/surg benefits
3. Predominant level applied to substantially all
4. Requirements or limitations that can be applied to MH/SUD benefits

Mental Health Parity

- ▶ General rule is applied within each of six classifications of benefits.
- ▶ Six Classifications:
 - Inpatient, in-network
 - Inpatient, out-of-network
 - Outpatient, in-network*
 - Outpatient, out-of-network*
 - Emergency care
 - Prescription drugs
- ▶ Classifications are mutually exclusive and must be used.
- ▶ If a plan provides benefits for a MH/SUD, the plan must provide MH/SUD benefits in all classifications in which medical/surgical benefits are offered (including out-of-network classifications).

Mental Health Parity

Nonquantitative Treatment Limitations (NQTLs)

- ▶ Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness
- ▶ Formulary design
- ▶ Network tier design
- ▶ Standards for provider admission to participate in a network, including provider reimbursement rates
- ▶ Plan methods for determining UCR
- ▶ Fail-first policies or step therapy protocols
- ▶ Exclusions based on failure to complete a course of treatment
- ▶ Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits

Mental Health Parity

Nonquantitative Treatment Limitations (NQTLs)

- ▶ Processes, strategies, evidentiary standards, or other factors used in applying nonquantitative treatment limitations to MH/SUD benefits must be comparable to, and applied no more stringently than, those used with respect to med/surg benefits.

Mental Health Parity

2018 MHPAEA Self-Compliance Tool

- ▶ Issued April 23, 2018
- ▶ Designed to help evaluate a group health plan or health insurance issuer's compliance with MHPAEA
- ▶ Updated with additional NQTL and disclosure guidance
- ▶ Medication Assisted Treatment (MAT) benefits for opioid use disorders.

Mental Health Parity

- ▶ Recent MHPAEA FAQs
 - ACA FAQs Set 34
 - ACA FAQs Set 38
 - Proposed and Final ACA FAQs Set 39
 - designed to provide additional guidance on disclosure and NQTLs

Additional Compliance Tips and Tools

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- ▶ Use EBSA's Part 7 Compliance Tool to help evaluate compliance.
 - ▶ Summarizes regulations and other guidance used by the Department to implement applicable provisions of Part 7.
 - ▶ Provides detailed examples and tips for to help plan sponsors review for compliance.

Additional Compliance Tips and Tools

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- ▶ Work to ensure the plan is in compliance both as documented and in operation.
- ▶ If you have questions or concerns, contact EBSA.

Resources

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Subscribe to the DOL, EBSA website for updates:

<https://www.dol.gov/agencies/ebsa>

Other Helpful Affordable Care Act Resources:

IRS website:

<https://www.irs.gov/affordable-care-act>

HHS website:

www.healthcare.gov

Resources (continued)

Compliance Assistance for Health Plans:

<https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans>

Affordable Care Act:

<https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers>

Mental Health and Substance Use Disorder Parity:

<https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>

Subscribe for Updates!!!

Contact Information

- ▶ EBSA website:
<https://www.dol.gov/agencies/ebsa>
- ▶ EBSA web inquiries:
<https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>
- ▶ EBSA (questions and publications):
866-444-EBSA (3272)
- ▶ OHPSCA (Problematic Part 7 questions):
202-693-8335



COBRA

IN THE AMERICAN RESCUE PLAN ACT



U.S. DEPARTMENT OF LABOR
EMPLOYEE BENEFITS SECURITY ADMINISTRATION

Overview

QBs who are Assistance Eligible Individuals (AEIs) pay 0% of their premiums for COBRA coverage during the assistance period

Coverage periods beginning on or after April 1, 2021, through September 30, 2021

Premiums reimbursed to employer, plan, or insurer via payroll tax credit

Includes second election period (called an "extended election period")



Assistance Eligible Individual

Generally, an individual:

Who is a qualified beneficiary as the result of an involuntary termination of employment (not for gross misconduct) or a reduction in hours;

Who is eligible for COBRA continuation coverage at any time during the assistance period; and

Who elects coverage



Premium Subsidy Duration

Premium subsidy generally available first coverage period –

Beginning on or after April 1, 2021

Ending earliest of:

September 30, 2021;

End of QB's maximum COBRA continuation period; or

First date eligible for another GHP or Medicare (QB required to notify plan of eligibility for other GHP or Medicare)



Extended Election Period

For AEIs who became eligible to elect COBRA before April 1, 2021.

Provides second election period for certain individuals who do not have a COBRA election in effect, but would be an AEI if such election were in effect.

Includes individuals who didn't elect when first offered and those who elected COBRA coverage and discontinued it before April 1, 2021.

Extended Election Period (cont'd)

Plan must provide AEI with a notice about the extended election period.

AEI can elect up to 60 days after the notice is provided.

COBRA coverage begins the first period of coverage beginning on or after April 1, 2021

Under the extended election, coverage is not retroactive to periods before enactment

Coverage is the same maximum duration the QB would have had if elected when first offered/had not been discontinued.



Notices

General Notice

Notice of Extended Election Period (includes notice of plan enrollment option if permitted)

Notice of Expiration of Period of Premium Assistance



Model Notices

Department of Labor directed to create model notices for plans to use

Available on EBSA's COBRA Premium Subsidy webpage at <https://www.dol.gov/COBRA-subsidy>



Tax Mechanics

Tax treatment for individuals – excluded from gross income

Tax treatment for employer, plan, or issuer – tax credit



Resources

For more information on the COBRA Premium Subsidy,

visit <https://www.dol.gov/COBRA-subsidy> or

Call 866-444-3272 to speak to a benefits advisor

QUESTIONS?

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