

EMPLOYEE BENEFITS LAW ALERT

March 26, 2009

**COMPLIANCE DATES APPROACHING ON THREE MORE LAWS AFFECTING
GROUP HEALTH PLANS**

Compliance Dates of 2009 and 2010

*Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act
Genetic Information Non-Discrimination Act
Michelle's Law*

Aside from the new HIPAA obligations arising under the American Recovery and Reinvestment Act (See [HIPAA Changes Affecting Group Health Plans And Business Associates Made By The American Recovery And Reinvestment Act of 2009](#)) and obligations arising under the Children's Health Insurance Program Reauthorization Act of 2009 (See [April 1, 2009 Starts New Compliance Obligations For Group Health Plans Under The Children's Health Insurance Program Reauthorization Act Of 2009](#)) three other laws affecting group health plans, enacted earlier, also have compliance dates beginning in 2009 and 2010. The laws are the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, the Genetic Information Non-Discrimination Act and Michelle's Law. Following is a summary of the key provisions of these laws.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("MHPAEA") amends the existing federal Mental Health Parity Act. Under the existing Mental Health Parity Act, health plans that offer mental health benefits are prohibited from setting lower annual and lifetime limits for mental health benefits than for medical and surgical benefits. This continues under MHPAEA and is expanded to include substance abuse benefits.

Existing law permits plans to limit the number of treatments or impose different cost sharing requirements for mental health benefits. Now under MHPAEA, in addition to the prohibitions on lower annual and lifetime limits, group health plans (or health insurance coverage offered in connection with such plans) are prohibited from imposing financial requirements and treatment limitations for mental health and substance abuse benefits that are more restrictive than those applied to medical and surgical benefits. In general, MHPAEA applies to group health plans maintained by an employer having more than 50 employees during the prior calendar year. Note that the law does not require plans to offer mental health and substance use benefits (although insured plans may be required to do so by state insurance law mandates). But, plans that do offer mental health and substance abuse benefits must comply with MHPAEA. Following is a summary of MHPAEA's key provisions.

- **Financial Restrictions.** Financial requirements (deductibles, co-payments, coinsurance, and out-of-pocket expenses) for mental health or substance use disorder benefits may be no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan. Plans may not impose cost-sharing requirements that apply only to mental health or substance abuse disorder benefits.

- **Treatment Restrictions.** Treatment limits (limits on frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment) applicable to mental health or substance use disorder benefits may be no more restrictive than the predominant treatment limitations applicable to substantially all medical and surgical benefits covered by the plan. Plans may not impose treatment limitations that apply only to mental health or substance abuse disorder benefits.
- **Out-of Network Benefits.** Plans that offer out-of-network coverage for medical and surgical benefits will also be required to offer coverage for mental health and substance use disorder benefits on an out-of-network basis.
- **Increased Cost Exemption.** A group health plan may qualify for an exemption on a year by year basis if compliance with MHPAEA results in an increase for a plan year of the total cost of coverage with respect to all benefits under the plan by two percent (2%) or more in the first year that MHPAEA applies to the plan (or by one percent (1%) or more in subsequent plan years). The exemption applies for the following year. MHPAEA requires plans to comply with the law for at least six months of the plan year involved before the exemption is available. The exemption requires determination and written certification by a qualified actuary of the cost increases and notification to governmental agencies, participants and beneficiaries of the plan's election to use the exemption.
- **Required Disclosures.**
 - Plan administrators (or health insurance issuers) must provide the criteria used for medical necessity determinations with respect to mental health or substance use disorder benefits to any current or potential participant, beneficiary, or contracting provider upon request in accordance with regulations to be issued.
 - The reasons for denial of payment for mental health and substance abuse benefits must be provided by the plan administrator (or health insurance issuer) to participants or beneficiaries upon request in accordance with regulations to be issued.

Effective Dates. *For non-collectively bargained plans, the effective date is the plan year beginning after October 3, 2009. For calendar year plans this means January 1, 2010. For non-calendar year plans beginning November 1 or December 1, the effective date is in 2009. For example, November 1, 2009 is the effective date for a plan with a plan year running from November 1- October 31.*

For group health plans maintained pursuant to a collective bargaining agreement, MHPAEA will be effective on the later of: (a) the date on which the last of the collective bargaining agreements relating to the plan terminates (without regard to any extension agreed to after October 3, 2008), or (b) January 1, 2010.

Action Steps.

- Plan Sponsors and Plan Administrators should review all group health plan designs and amend as necessary to comply with MHPAEA prior to the effective date applicable to the plan.

GENETIC INFORMATION NONDISCRIMINATION ACT

In general, the Genetic Information Nondiscrimination Act ("GINA") prohibits discrimination by group health plans, health insurance issuers and employers against an individual based on the individual's genetic information. The term '**genetic information**' includes information about an individual's genetic tests, the genetic tests of family members (including first through fourth-degree relatives), and the manifestation of a disease or disorder in a family member (including any request for or receipt of genetic services or participation by the individual or family member in clinical research that includes genetic services). The public policy behind GINA is to protect the public from concerns about discrimination based on genetic information allowing individuals to take advantage of genetic testing and advances in treatment. Following is a summary of GINA's key provisions.

GINA's Group Health Plan Provisions

GINA applies to all group health plans, there are no exceptions for small plans.

- **Underwriting.** Group health plans and health insurance issuers generally may not request, require, or purchase genetic information for underwriting purposes, and may not collect genetic information about an individual before the individual is enrolled or covered. Underwriting purposes means: (a) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage; (b) the computation of premium or contribution amounts under the plan or coverage; (c) the application of any preexisting condition exclusion under the plan; and (d) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits.
- **Group Health Plan Premiums.** Under existing law (HIPAA non-discrimination rules), group health plans and insurers are prohibited from establishing eligibility rules or imposing higher premiums or contributions on an individual on the basis of his or her health factors (including genetic information). However, the HIPAA nondiscrimination rules do not prohibit plans and insurers from establishing rates for the entire group based on a health factors (including genetic information) of an individual enrolled in the plan. Now, under GINA, group health plans and insurers are prohibited from setting premium and contributions for the employer group on the basis of genetic information of an individual enrolled in the plan. GINA does not prohibit plans and insurers from increasing premiums for the group based on *manifestation* of a disease or disorder in any individual enrolled in a health plan. However, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members to further increase the premium for the employer group. For example, where there are several family members covered by a plan, manifestation of a disease or disorder in one covered family member cannot be used as genetic information about other covered family members to further increase the premium for the group.

- **Genetic Testing.** Group health plans and health insurance issuers offering health insurance coverage in connection with group health plans may not request or require an individual or a family member of such the individual to undergo a genetic test. This rule does not limit the authority of a health care professional to request that an individual undergo a genetic test. And, does not preclude a group health plan or health insurance issuer from obtaining and using the results of a genetic test in making a determination regarding payment (as defined by HIPAA) subject to a minimum necessary standard. There is also an exception for research purposes under certain conditions. **‘Genetic test’** means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. Genetic test does not include an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes, or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.
- **Relationship to HIPAA Regulations.** GINA does not prohibit a covered entity from making any use or disclosure of health information that is authorized for the covered entity under the HIPAA regulations. And, GINA requires the HIPAA Privacy regulations to be amended, *effective May 21, 2009*, to treat genetic information as protected health information, prohibit use of genetic information for underwriting purposes and make the definitions of genetic information and underwriting consistent with GINA.

Effective Date for Group Health Plan Provisions. *The group health plan provisions are effective for plan years beginning after May 21, 2009. For calendar year plans , this means January 1, 2010. For non-calendar year plans with plan years beginning June 1- December 1, the effective date occurs in 2009. For example, the effective date will be June 1, 2009 for a plan with a plan year running from June 1- May 31.*

GINA’s Employment Discrimination Provisions

- GINA makes it an unlawful employment practice for an employer (in general an employer with 15 or more employees), employment agency, labor organization, or training program to:
 - fail or refuse to hire, or to discharge, any employee, or otherwise to discriminate against any employee with respect to the compensation, terms, conditions, or privileges of employment of the employee, because of the individual’s genetic information; or limit, segregate, or classify the employees of the employer in any way that would deprive or tend to deprive any employee of employment opportunities or otherwise adversely affect the status of the employee as an employee, because of the employee’s genetic information.
 - request, require, or purchase genetic information with respect to an employee or a family member of the employee. Six (6) limited exceptions apply .
- **Treatment Of Information As Part Of Confidential Medical Record.**—If an employer, employment agency, labor organization, or joint labor-management committee possesses genetic information about an employee or member, the

information is required to be treated as a confidential medical record of the employee or member. The entity holding the information will be considered in compliance if the information is treated as a confidential medical record under the Americans with Disabilities Act.

- **Limitation On Disclosure.** An employer, employment agency, labor organization, or joint labor-management committee may not disclose genetic information concerning an employee or member. Limited exceptions apply.

Proposed Regulations. On March 2, 2009, the EEOC issued proposed regulations for public comment.

Effective Date of Employer Provisions. *The employment provisions of GINA are effective November 21, 2009.*

Action Steps.

- Group Health Plan sponsors and administrators should review plan operations for all group health plans (including with insurers or third party administrators ("TPAs") for self-insured plans) to make sure operations are in compliance prior to the effective date applicable to the plans.
- Group Health Plans should revise HIPAA privacy policies and procedures and notices as necessary to conform with the treatment of genetic information as protected health information and prohibit use and disclosure for underwriting purposes. These changes to HIPAA privacy are effective May 21, 2009.
- Employers should review all employee policies, procedures and practices and amend them as necessary to comply with GINA prior to November 21, 2009.

MICHELLE'S LAW

Michelle's law applies to group health plans covering dependent children on the basis of being enrolled in a postsecondary educational institution. The law was enacted to ensure that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Following is a summary of the key provisions of Michelle's Law.

- **Extended Coverage.** The law requires group health plans to extend the coverage of a dependent child who is on a medically necessary leave of absence if the child is enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the leave of absence. Coverage must be extended until the sooner of: (1) one year from the start of a medically necessary leave of absence, or (2) the date coverage would otherwise terminate under the terms of the plan. A 'medically necessary leave of absence' means a leave of absence from a postsecondary educational institution or any other change in enrollment that—(1) commences while the child is suffering from a serious illness or injury; (2) is medically necessary; and (3) causes the child to lose student status for purposes of coverage under the terms of the plan. The extended coverage must provide the same benefits as if the child was not on a medically necessary leave of absence.

- **Certification by Physician Required.** Written certification must be provided by a treating physician of the child certifying that the child is suffering from a serious illness or injury requiring a medically necessary leave of absence.
- **Notice of Michelle's Law.** A group health plan (and health insurance issuer providing health insurance coverage in connection with the plan) must include with any notice regarding a requirement for certification of student status for coverage, notice of the terms for continued coverage during medically necessary leaves of absence under Michelle's law. The description must be in language understandable to the typical plan participant.

Effective Date. *Michelle's law is effective for plan years beginning on or after October 9, 2009. For calendar year plans this means January 1, 2010. For non-calendar year plans with plan years beginning November 1 or December 1, the law is effective in 2009. For example, the law is effective on November 1, 2009 for a plan with a plan year running from November 1- October 31.*

Action Steps.

- Plan Sponsors and administrators should conform operations (and insure that insurers and TPAs for self-insured plans do so), amend plans and prepare and distribute the notice of Michelle's Law prior to the effective date applicable to the plan.

This Employee Benefits Alert was prepared by [Joni Landy](#) whose practice focuses on health and welfare benefits. If you have questions about any of the matters in this Alert, please contact:

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