

## *2009 Compliance Update for Health and Welfare Plans*

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This Client Alert provides a broad overview of several recent statutory and regulatory changes that have a significant impact on the operation and administration of employer-provided health and welfare plans that require implementation in 2009 or 2010. Employers should examine their benefit programs closely in light of these changes and take immediate action where necessary to ensure compliance.

### **New Excise Tax Reporting Requirements Take Effect in 2010 for Violations of COBRA, HIPAA, and Other Group Health Plan Mandates**

The Internal Revenue Code has long imposed excise taxes for failing to comply with COBRA, HIPAA, and certain other federal mandates applicable to group health plans. Historically, the IRS has not assessed such taxes as part of an audit and, until now, there has never been a requirement for employers to self-report and pay the excise taxes. Beginning in 2010, however, employers are required to report and pay these excise taxes on IRS Form 8928 ("Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code"). The form must be filed on or before the due date for filing the employer's federal income tax return (determined without extensions). Employers (and insurers and third-party administrators) who are required to pay these taxes but fail to timely do so will be subject to penalties and interest under Code Section 6651, unless the failure is due to reasonable cause and not willful neglect.

The excise taxes are imposed for failing to meet the requirements of COBRA, HIPAA's nondiscrimination and portability requirements, the Genetic Information Nondiscrimination Act ("GINA"), the Mental Health Parity and Addiction Equity Act ("MHPAEA"), the Newborn's and Mother's Health Protection Act (minimum hospital stays for mothers and newborns), and Michelle's Law (coverage of dependent students on medically necessary leaves of absence). The amount of the excise tax is generally \$100 per individual to whom the violation relates per day for each day of noncompliance, subject to certain limits and other special rules. But no excise tax is due where the failure to comply is unknown when exercising reasonable diligence, or where the failure is due to reasonable cause, not willful neglect, and is timely corrected by retroactively undoing the failure to the extent possible and placing the affected individual in a financial position as good as he or she would have been in had the failure not occurred.

Similar reporting requirements apply to excise taxes imposed for failing to satisfy the comparable employer contribution requirements for health savings accounts and Archer medical savings accounts.

## Discrimination Based on Genetic Information

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits group health plans from discriminating against individuals on the basis of genetic information. It is effective for plan years beginning after May 21, 2009 (January 1, 2010 for calendar-year plans). GINA generally:

- prohibits a group health plan from adjusting premium or contribution amounts for a group on the basis of genetic information;
- prohibits plans from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;
- allows a group health plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the plan does not use the information for underwriting purposes and meets certain disclosure requirements;
- prohibits a group health plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment; and

*Health Risk Assessments Significantly Impacted.* Recently published GINA regulations prohibit employers from requesting genetic information (including family medical history) as part of health risk assessments (HRAs) and other wellness programs before enrollment or in exchange for benefits or incentives such as premium reduction or lower deductibles or co-pays. Employers that request genetic information (e.g., family medical history) as part of HRAs and other wellness programs will need to revise those arrangements to comply with GINA.

- amends the definition of protected health information under HIPAA to include genetic information, thereby extending HIPAA's privacy protections to such information.

## Mental Health and Substance Abuse Benefits

Starting in 2010, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") imposes significant new requirements on group health plans that offer mental health and substance abuse benefits. Current law prohibits health plans from imposing lower annual and lifetime limits on mental health coverage than on other types of medical coverage. The MHPAEA further limits other types of financial and non-financial limitations that plans may impose on mental health coverage and substance abuse benefits. Some of the MHPAEA's key provisions are as follows:

- financial limitations—including limitations on deductibles, copayments, coinsurance, and out-of-pocket expenses—imposed on mental health and substance abuse benefits may not be higher than those imposed on other types of medical coverage;
- group health plans may not place limits on the scope or duration of treatment for mental health or substance abuse that are more restrictive than for other types of medical treatment;

- group health plans must provide, upon request, information to plan participants and providers regarding the criteria for determining whether mental health or substance abuse treatment is medically necessary, and the reasons for denial of coverage; and
- coverage of mental health and substance abuse benefits by out-of-network providers must be on par with out-of-network coverage for medical treatment.

The MHPAEA also contains a narrow and limited exemption for employers that demonstrate that compliance is too costly.

### **Health Information Privacy Rules Expanded**

The American Recovery and Reinvestment Act ("ARRA") significantly expanded the health information privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Group health plan sponsors should review their HIPAA compliance efforts and business associate agreements before the new legislation becomes effective on February 17, 2010.

Under the new rules, "covered entities" (such as group health plans) and their "business associates" (generally entities that provide services such as claims processing, data analysis, and billing to covered entities) must notify affected individuals of a breach in the privacy of their protected health information. The new law also enhances the enforcement mechanisms and penalties for failure to comply.

Detailed information about the new requirements can be found in these Paul Hastings Client Alerts: "Obligations Imposed by Stimulus in Cases of Breach Involving Protected Health Information Clarified" (August 2009), available [here](#), and "Stronger Protections for Health Information are Part of the Fiscal Stimulus" (March 2009), available [here](#).

### **COBRA Subsidy**

In addition to expanding the health privacy rules, the ARRA created a taxpayer-funded COBRA subsidy for qualified beneficiaries who lose health plan coverage due to involuntary termination of employment (other than termination for gross misconduct) from September 1, 2008 through December 31, 2009 and who elect COBRA continuation coverage. Thus, employers should be mindful that the COBRA subsidy will continue to apply to employees who are involuntarily terminated through the end of this year. More information about the subsidy and its related requirements can be found in the Paul Hastings February 2009 Client Alert entitled "New COBRA Subsidy Requires Prompt Action by Employers and Plan Administrators" (available [here](#)).

### **Health Care for College Students on Medical Leave**

Effective January 1, 2010, "Michelle's Law" will prohibit group health plans and health insurers from terminating coverage of dependent students who are on a medically necessary leave of absence from post-secondary education. Many group health plans condition coverage for a dependent child over age 18 on enrollment as a full-time student in a post-secondary educational institution. The new law will require group health plans and health insurers to maintain existing coverage for up to one year for a seriously ill or injured child who takes a medical leave of absence from school. The law also requires group health plans to describe the right to continued coverage in any plan notices regarding certification of student status for plan coverage. Employers should update their plan documents,

summary plan descriptions, and enrollment materials to ensure that they accurately provide for such coverage.

### **Employees on Military Leave**

The Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act) provides employees on military leave with expanded rights and protections under employer-sponsored pension and welfare plans. Under the HEART Act, for any plan year beginning after June 17, 2008, an employer may allow a participant in a health flexible spending arrangement who is called to active military duty for more than 179 days to receive a distribution of his or her unused account balance. This provides an exception to the so-called “use it or lose it” rule, which generally states that the portion of a participant’s account that is not used for medical expenses incurred during a plan year (or during a grace period immediately thereafter) is forfeited.

### **Special Enrollment Rights under Medicaid and SCHIP Programs**

Effective April 1, 2009, federal legislation expanded the State Children’s Health Insurance Program (“SCHIP”) to require new health plan enrollment rights for employees and their dependents. The new special enrollment rights apply when employees or their dependents become eligible for a premium subsidy for coverage under an employer’s group health plan through Medicaid or SCHIP, or when employees or their dependents lose Medicaid or SCHIP coverage. Employees must request coverage under their employer’s health plan within 60 days of becoming eligible for the premium subsidy or losing Medicaid or SCHIP coverage. Employers should update their plan documents, summary plan descriptions, and enrollment materials to address this requirement. In addition, employers will eventually have to provide notice to employees about the premium assistance opportunities available under Medicaid and SCHIP after the Department of Health & Human Services issues a model notice.

### **Minimum Length of Hospital Stay for Mothers and Newborns**

The IRS, HHS, and DOL recently issued final regulations that clarify certain requirements under the Newborns’ and Mothers’ Health Protection Act of 1996 (“NMHPA”). The NMHPA generally requires group health plans and health insurance issuers that cover childbirth to cover a hospital length of stay of at least 48 hours following birth of a child (96 hours in the case of a caesarean section). The final regulations state that a group health plan’s summary plan description must include a description of this requirement, explain that the plan cannot require a provider to obtain authorization from the plan or insurance issuer for prescribing such a stay, and provide that federal law allows an attending provider to discharge the mother or newborn earlier after consulting with the mother. The regulations also clarify the definition of attending provider, provide rules for determining when a hospital stay begins, explain the preauthorization requirements, and describe other provisions of the law.

### **New Medicare Reporting Requirements**

This year, new mandatory Medicare reporting requirements take effect for group health plans as well as liability insurance, including self-insurance, no-fault insurance, and workers’ compensation arrangements. The purpose of these new reporting requirements is to enable the Centers for Medicare & Medicaid Services (“CMS”), the federal agency responsible for administering Medicare, to ensure that it has the necessary information to determine whether those covered by Medicare are also covered by other insurance that, by law, must be primary to Medicare.

For employer-sponsored group health plans, the insurer or third-party administrator (“TPA”) will generally have the obligation to report rather than the employer; however, the insurer or TPA may contractually impose obligations on the employer to furnish it with certain information to assist the insurer or TPA in satisfying its reporting obligations. However, the employer will have a reporting obligation for self-insured liability arrangements such as workers’ compensation. In that case, the employer will have to register with and report to CMS. The employer may use an agent to submit the required data but the employer remains responsible for compliance.

Reporting for group health plans is scheduled to begin October 1, 2009. For self-insured liability arrangements such as workers’ compensation, employers should have registered electronically by September 30, 2009, and reporting is scheduled to begin July 1, 2010.

**Cafeteria Plans**

We anticipate additional changes to the rules concerning flexible spending arrangements and cafeteria plans when the IRS issues final cafeteria plan regulations. The proposed regulations issued in August 2007 would amend the current rules affecting plan documentation, reimbursable expenses, plan discrimination testing, reimbursement of premiums on a pre-tax basis, and various other requirements. Employers will be required to comply with any changes that are incorporated in the final regulations in order for the benefits and coverage provided under cafeteria plans to continue to be excludable from income.



*If you have any questions concerning these developing issues, please do not hesitate to contact any of the following members of the Paul Hastings ERISA and Global Benefits practice:*

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