ERISA: Title I, Part 7

U.S. Department of Labor

Employee Benefits Security Administration
Office of Health Plan Standards and Compliance Assistance

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Agenda

- Introduction and Background of Part 7 of ERISA
- Affordable Care Act (ACA) Market Reforms
- Part 7 Disclosure Requirements
- Additional Compliance Tips and Tools

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

- 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

- **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

- **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**

Arrangements *Not* Subject to Part 7

- **Excepted Benefits:**
  - Benefits excepted in all circumstances (generally not health coverage);
  - Limited Excepted Benefits. Benefits offered separately (insurance policy, certificate, or contract) or are not an integral part of the plan;
  - Non-coordinated Benefits. Not coordinated with benefits under another group health plan;
  - Supplemental Excepted Benefits. Offered under a separate policy, certificate, or contract of insurance and supplemental to Medicare, Armed Forces health coverage or similar supplemental coverage provided to coverage under a group health plan.

Arrangements *Not* Subject to Part 7

- **Excepted Benefits: Limited-scope Dental and Vision**

  Not an integral part of the plan if:

  - Participants may decline coverage; or
  - Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

Affordable Care Act Market Reforms

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)

Wellness Programs

- Under the HIPAA nondiscrimination requirements plans may not require an individual to pay higher premium or contribution rates than other similarly situated individuals based on a health factor.
  - Exception: Rewards for adherence to certain wellness programs

- In June 2013, final wellness program regulations were issued under ERISA section 702 and PHSA section 2705.

Wellness Programs

- Participatory wellness programs: none of the conditions for obtaining a reward are based on an individual satisfying a standard related to a health factor.
  - Must be available to all similarly situated individuals.
- Health-contingent wellness programs: requires an individual to satisfy a standard related to a health factor in order to obtain a reward.
  - Activity-only
  - Outcome-based

Wellness Programs

Five requirements for health-contingent wellness programs:

1. Must give individuals eligible for the program the opportunity to qualify for the reward at least once per year;

2. Reward does not exceed 30% of the total cost of coverage (increased to 50% for programs designed to prevent or reduce tobacco use).

Wellness Programs

3. Reasonable design:

- Activity-only: must be reasonably designed to promote health and prevent disease. Determination based on all relevant facts and circumstances.
  - Has a reasonable chance of improving the health of, or preventing disease in, participating individuals;
  - Is not overly burdensome;
  - Is not a subterfuge for discriminating based on a health factor; and
  - Is not highly suspect in the method chose to promote health or prevent disease.
- Outcome-based: additional requirement – reasonable alternative standard must be provided to any individual who does not meet the initial standard based on a measurement, test, or screening.

Wellness Programs

4. Uniform availability and reasonable alternative standards:

- Activity-only: reasonable alternative standard if it is unreasonably difficult due to a medical condition or is medically inadvisable to attempt to satisfy the initial standard.
  - Physician verification if reasonable under the circumstances.
- Outcome-based: reasonable alternative standard for any individual who does not meet the initial standard based on a measurement, test, or screening.
  - No physician verification.
  - Requirements for reasonable alternative standard that is, itself, an activity-only program or an outcome-based program.

Wellness Programs

5. Notice of availability of reasonable alternative standard (and, if applicable, possibility of waiver of original standard):

   - Disclosure in all plan materials describing terms of program
   - Must include contact information and statement that recommendations of individual's personal physician will be accommodated.
   - For outcome-based wellness programs - must be included in any disclosure that an individual did not satisfy an initial outcome-based standard.
   - Sample language

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

- The Uniform Glossary includes all statutorily required terms, as well as additional terms recommended by the NAIC.
- Plans and issuers must make the Uniform Glossary available upon request within seven business days.
- The SBC must include an internet address where the Uniform Glossary can be obtained.

Summary of Benefits and Coverage and Uniform Glossary

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

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

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.

Summary of Benefits and Coverage and Uniform Glossary

Electronic Delivery

- The Departments generally allow electronic delivery of the SBC and Uniform Glossary in accordance with the regulations.

Culturally and Linguistically Appropriate Manner

- The SBC and Uniform Glossary must be provided in a culturally and linguistically appropriate manner.
  - These rules are located in the regulations on Internal Claims and Appeals; External Review PHSA Section 2719.

Transparency

- Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First
  - Issued on June 24, 2019.
- **Transparency in Coverage NPRM**
  - Published in the Federal Register on November 27, 2019.
  - Comment period closed on January 29, 2020.

Transparency NPRM Key Components

- Internet-based self-service tool (and paper), providing searchable price information and cost-sharing estimates.
  - Makes information available for participants, beneficiaries, or enrollees (or their authorized representatives) to estimate and understand out-of-pocket expenses and effectively shop for items and services.
- Two machine-readable electronic files, providing public disclosure of in-network provider negotiated rates and historical out-of-network allowed amounts.
  - Provides access to health insurance coverage information for public to understand health care pricing and potentially dampen the rise in health care spending.

Additional Compliance Tips and Tools

Additional Compliance Tips and Tools

- 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

- Where to look to ensure compliance? The Summary Plan Description is a good place to start but be sure to check:
  - Other plan documents
  - Wellness program materials
  - Certificates or evidence of coverage (COC/EOC)
  - SBC, SMM, CBAs, service provider contracts
  - Form 5500 and financial statements
  - Claims processing policies and procedures
  - Audit reports

Additional Compliance Tips and Tools

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

Resources

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

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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

QUESTIONS?