

ERISA: Title I, Part 7

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. *****

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)

(Continued on next slide)

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)

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: EAPs

- EAP does not provide significant benefits in the nature of medical care (amount, scope, and duration of covered services).
- The benefits under the EAP are not coordinated with benefits under another group health plan.
- No employee premiums or contributions are required as a condition of participation in the EAP.
- No cost sharing under the EAP.

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)

Grandfathered Health Plans

- ◆ Generally, grandfathered health plans are plans that were in existence, and in which an individual was enrolled, on March 23, 2010.
- ◆ Grandfathered health plans must comply with many, but not all, of the ACA market reform provisions under ERISA.

Grandfathered Health Plans

Six changes that will relinquish a plan's grandfather status:

- 1) Elimination of all or substantially all benefits to diagnose or treat a particular condition;
- 2) Any increase in percentage cost-sharing after March 23, 2010;
- 3) An increase in fixed-amount cost-sharing (other than copayments) of more than 15% plus medical inflation;
- 4) For copayments, an increase that exceeds the greater of: 15% plus medical inflation or \$5 plus medical inflation;

Grandfathered Health Plans

- 5) Decrease in employer or employee organization contribution rate based on cost of coverage towards the cost of any tier of coverage for any class of SSI by more than 5 percentage points below the rate for the coverage period that includes 3/23/2010;
- 6) Change in annual limits

Note: There are also disclosure and maintenance of records requirements as well.

Internal Claims and Appeals and External Review

- ◆ 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.
 1. Adverse benefit determinations (ABD). An ABD eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

Internal Claims and Appeals

2. Notice of urgent care determinations. Must notify a claimant of an initial ABD on an urgent care claim as soon as possible, but generally not later than 72 hours after the receipt of the claim.
3. Full and Fair Review. Must provide claimants (free of charge) with any new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with a claim as, well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.
4. Avoiding conflicts of interest. All claims and appeals must be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

Internal Claims and Appeals

5. Notices – Form and Manner. Must be provided in a culturally and linguistically appropriate manner.
- Applicable non-English language. With respect to an address to which a notice is sent, if 10% or more of the population residing in the county is literate only in the same non-English language.
 - See CLAS data at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CLAS-County-Data_Jan-2016-update-FINAL.pdf
 - If threshold is met, plans and issuers are required to provide, in any applicable non-English language:
 - Oral language services.
 - Assistance with filing claims and appeals.
 - In English versions of notices, a prominently displayed statement indicating how to access the language services provided.

Internal Claims and Appeals

6. Notices - Content. Notices must provide broader content and specificity.

- Provide sufficient information to identify the claim involved (Date of service, health care provider and claim amount)
- Notice to participants of their right to diagnosis and treatment code information upon request
- A description of the reasons for denial and of the standard that was used in denying the claim.
- A description of available internal appeals and external review processes, including how to initiate an appeal.
- The availability and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- Model notices available at: <http://www.dol.gov/ebsa/healthreform>

Internal Claims and Appeals

7. Deemed exhaustion. If a plan or issuer fails to adhere to all the requirements of the internal claims and appeals process, the claimant will be deemed to have exhausted internal appeals, and will be able to initiate an external review and pursue any available remedies.

Exception if violation of procedural rules was:

- De minimis;
- Non-prejudicial;
- Attributable to good cause or matters beyond the plan/issuer control;
- In the context of an ongoing good faith exchange of information;
- AND
- Not reflective of a pattern or practice of non-compliance.

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



Prohibition on Preexisting Condition Exclusions

Prohibition on Preexisting Condition Exclusions

- ◆ Generally, a preexisting condition exclusion is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day.

Prohibition on Preexisting Condition Exclusions

General rule:

- ◆ Prohibits both the exclusion of coverage or benefits due to a preexisting condition.
- ◆ Beware of hidden preexisting condition exclusions

Example:

Plan covers dental treatment for injuries in connection with an accident only if the accident occurred while individual covered under the plan.



90-day Waiting Period Limitation

90-day Waiting Period Limitation

- ◆ Prohibits the application of any waiting period that exceeds 90 days
- ◆ A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective.
- ◆ Eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days.
- ◆ Variable hour employees: may use measurement period consistent with Code section 4980H.

90-day Waiting Period Limitation

- ◆ Other conditions for eligibility permissible unless condition is designed to avoid compliance.
- ◆ Cumulative hours-of-service requirements: permissible as long as they do not exceed 1,200 hours.
 - Waiting period must begin once satisfied.
 - One-time eligibility requirement
- ◆ Reasonable and bona fide employment-based orientation periods – maximum length of one month
- ◆ Conforming changes to existing regulations



Prohibition on Lifetime or Annual Dollar Limits

Prohibition on Lifetime or Annual Dollar Limits

- ◆ A group health plan or issuer may not:
 - establish any lifetime limits on the dollar value of essential health benefits
 - establish an annual limit on the dollar value of essential health benefits
 - For plan years prior to January 1, 2014, it was permissible for a plan to establish certain restricted annual limits on the dollar value of essential health benefits which were incrementally phased out by January 1, 2014

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).

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

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

“Substantially All” and “Predominant”

Substantially all: does a type of financial requirement or treatment limitation imposed on MH/SUD benefits in a classification apply to at least two-thirds of med/surg benefits in that classification?

- ◆ Example: Outpatient, in-network benefits
 - \$1 million med/surg benefits expected to be paid ; \$700,000 expected to be subject to copayments.
 - Copayments apply to substantially all med/surg in this classification

Mental Health Parity

Substantially All and Predominant

If a plan can apply a type of financial requirement or quantitative treatment limitation to MH/SUD in a classification, what level can be applied?

Predominant: what level applies to more than one-half of substantially all med/surg benefits in that classification?

- ◆ Same Example: Outpatient, in-network benefits
 - \$1 million expected to be paid; \$700,000 subject to copayments.
 - \$15 copayment applies to 25% of substantially all and \$30 copayment applies to 75% of substantially all.
 - \$30 copayment is predominant level of copayment.

Mental Health Parity

What can be applied to MH/SUD?

\$30 is the predominant copayment applied to outpatient, in-network med/surg benefits.

- Plan cannot impose a copayment in this classification that is more restrictive than \$30 copayment.

Mental Health Parity

Cumulative Financial Requirements and Quantitative Treatment Limitations

- ◆ Statute: Ensure that there are no separate financial requirements or treatment limitations that are applicable only to MH/SUD benefits.
- ◆ Regulation: No separate cumulative financial requirements or quantitative treatment limitations.
- ◆ NOTE: Does not apply to lifetime and annual dollar limits.

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

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

- ◆ *Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*
 - Purpose: to identify provisions that require further inquiry beyond the plan/policy terms to determine compliance
 - Provides examples of plan provisions that should trigger analysis including:
 - Preauthorization & pre-service notification requirements
 - Fail-first protocols
 - Probability of improvement
 - Written treatment plan required

Mental Health Parity

◆ Enforcement

- MHPAEA Enforcement Fact Sheets issued January 2016, January 2017, April 2018, and September 5, 2019.
- EBSA relies on its investigators to review plans for MHPAEA compliance.
- Benefits Advisors pursue voluntary compliance from plans on behalf of participants and beneficiaries.
- EBSA works with service providers to obtain voluntary global corrections when a violation relates to a prototype document or systemic operation.

COVID-19 and EBSA

- ◆ On March 13, 2020, a National Emergency was declared beginning March 1, 2020 on a nationwide basis due to the COVID-19 outbreak.
- ◆ To help employee benefit plan participants and beneficiaries, plan sponsors, and employers impacted by the COVID-19 outbreak, EBSA has issued several guidance documents.

FFCRA and CARES Act

- ◆ **Families First Coronavirus Response Act (FFCRA): Enacted on March 18, 2020.**
 - **Sec. 6001. Coverage of testing for COVID-19.**
 - **Generally requires group health plans and health insurance issuers to cover diagnostic testing for COVID-19 without cost-sharing requirements (such as deductibles, copays, or coinsurance) or medical management requirements (such as prior authorization).**

FFCRA and CARES Act

- ◆ **Coronavirus Aid, Relief, and Economic Security (CARES) Act:**
Enacted on March 27, 2020.
 - **Sec. 3201. Coverage of diagnostic testing for COVID-19.**
 - **Amended the FFCRA to require a broader range of diagnostic items and services that plans must cover without cost sharing.**
 - **Sec. 3202. Pricing of diagnostic testing.**
 - **Plans and issuers must reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website.**

Overview of EBSA Resources

- ◆ EBSA has a dedicated resource page in response to COVID-19 at:
<https://www.dol.gov/agencies/ebsa/coronavirus>.
- ◆ FAQs on the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act Implementation
 - Part 42 (April 11)
 - Part 43 (June 23)
- ◆ COVID-19 FAQs for Participants and Beneficiaries (April 28)
- ◆ EBSA Disaster Relief Notice 2020-01 (April 28)
- ◆ Joint DOL/IRS Treasury Final Rule – Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak (May 4)
- ◆ New COBRA Notices and FAQs (May 1)
- ◆ Interim Final Rule on Rapid Coverage of Preventive Services for Coronavirus and Price Transparency for COVID-19 Diagnostic Tests (October 28)
- ◆ Webinars for Workers and Families every week.

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>

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

QUESTIONS?

