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BENEFIT NEWS BRIEFS

Health & Welfare Plan Reminder
Upcoming Compliance Dates

The whirlwind of legislative activity over the past year has yielded a bumper crop of compliance deadlines for group health plans, including multiemployer group health plans. In particular, let's take look at some the new compliance dates and some recurring one's as well: (1) the *Adoptions Act*; (2) *HIPAA Privacy*; (3) *HIPAA Special Enrollment CHIP*; (4) *Medicare Part D Notice of Creditable/Non-Creditable Coverage*; (5) *Michelle's Law*; (6) *New MHPA*; and (7) *MMSEA reporting*.

Adoptions Act

The Fostering Connections to Success and Increasing Adoptions Act of 2008 ("*Adoptions Act*") was effective January 1, 2009. The law makes changes to the definition of "dependent" under Code Section 152. Plans that offer coverage to what would be non-traditional family members such as a grandchild or foster child would be impacted.

Plans that offer such coverage should amend their definition of dependent to comply with the new requirements by end of 2009. For details on this somewhat technical but important change, see *Research Memo 2009-42*.

HIPAA Privacy and Security

As reported in *Research Memo 2009-47*, the ARRA stimulus bill included changes to the HIPAA Privacy Rules. Most of these changes are effective **February 17, 2010 or later.** However, as discussed in detail in *Research Memo 2009-47*, new reporting requirements will apply around September 2009, if guidance is timely published. Health plans and Business Associates will be required to report a *Breach* of **unsecured** PHI. "Unsecured PHI" means PHI that is not secured through the use of an encryption technology or methodology specified by HHS guidance. Multiemployer health plans should review the suggested "to do" items at the end of *Research Memo 2009-47* and any other industry publications on the subject to prepare for the coming changes.

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HIPAA Special Enrollment Rights

The *Children's Health Insurance Program (CHIP) Reauthorization Act of 2009* amended the Code and *ERISA* to add special enrollment periods to group health plans. Unlike the current 30-day special enrollment available under the *Health Insurance Portability and Accountability Act* (*HIPAA)* amendments to *ERISA, the new enrollment periods last for 60 days* and are **effective April 1, 2009**.

The special enrollment rights apply to a participant or dependent who: (1) suffers a termination of Medicaid or CHIP coverage or (2) becomes eligible for employment assistance under Medicaid or CHIP.

Plans should review their *HIPAA* Creditable Coverage notices to see if any references to special enrollment rights need to be updated; especially the *Notice of Special Enrollment* plans are required to give under *ERISA* regulation Section 2590.701–6 and also review the health plan's language on special enrollment rights, if any. See *Benefit News Briefs 2009-23* for more details

Medicare Part D Creditable / Non-Creditable Coverage Notice

This is a recurring annual notice under the Medicare Part D program that must be issued by group health plans. Under the Medicare Part D regulations, most entities that currently provide prescription drug coverage to Medicare beneficiaries must disclose if the entity's coverage is "creditable prescription drug coverage." This disclosure is required whether the coverage is primary or secondary to Medicare.

The Medicare Part D regulation specifies creditable coverage disclosures must be made to Part D eligible individuals at least annually prior to November 15th of the year. See *Benefit News Briefs 2009-6* for the most recent information on the model notices provided by CMS.

Michelle's Law

Michelle's Law *requires ERISA*-governed group health plans (including *self-funded multiemployer group health plans*) or health insurance issuers to continue coverage to post-secondary (college, etc) students who would otherwise lose dependent coverage under the health plan if they take a "medically necessary" leave of absence due to a serious medical condition or injury.

The law is effective for plan years beginning on or after October 9, 2009, or January 1, 2010 for calendar year plans. Health plans should operate in accordance with the law on the effective date and be amended in a timely manner. Generally, the definition of "dependent" or "eligible person", etc. will need to be amended to set out the new dependent rights. See *Benefit News Briefs 2008-52* for more details.

New MHPA

For shorthand, the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Wellstone/Domenici Act)* is often referred to as the "new" *Mental Health Parity Act" (MHPA).* Prior to being amended by the *Wellstone/Domenici Act,* the *MHPA* provided for parity in the application of

aggregate lifetime and *annual dollar limits* on mental health benefits with the limits on medical/surgical benefits. The *MHPA* did not require parity for substance abuse or chemical dependency benefits. The *Wellstone/Domenici* Act changes this and now **requires parity** for "mental health" benefits and also for "substance use disorder" benefits, *if offered by the plan*.

The new requirements are discussed in detail in *Special Bulletins 2008-50* and *2008-67* and are generally effective for the plan years beginning November 2009 or later. However, the law contains a **special effective date for collectively bargained plans** – plan years beginning after the *later of:*

- the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act [*October 3, 2008*]), or
- January 1, 2010.

Health plans may choose to begin taking steps to be compliant by January 1, 2010 regardless of when their collective bargaining agreements expire; or health plans that have collective bargaining agreements that do not expire until 2011 or 2012 may choose to wait to be compliant.

MMSEA Reporting

The *Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA*) imposed new reporting requirements on group and non-group health plans. The new reporting requirement requires insurers, TPAs/administrators and trustees of group health plans (including multiemployer group health plans) to gather certain information from plan sponsors and plan participants and submit it to the Centers for Medicare and Medicaid Services (CMS). This reporting requirement and subsequent guidance has been reported on most recently in *Benefit News Briefs 2009-40.* Responsible reporting entities that did not have voluntary data sharing agreements in place with CMS begin will begin submitting information between July 1 and October 1, 2009.

Conclusion

Multiemployer health plan trustees and plan professionals have a lot of work to do in light of these upcoming deadlines. The upside is the deadlines provide an added incentive to review plan forms, notices and benefit design to ensure the health plan is administered in an up-to-date manner and compliant with the numerous laws affecting such plans. Let the fun begin!

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As we went to publication, the interim final *HIPAA Privacy* notice rules were posted at *http://www.federalregister.gov/OFRUpload/OFRData/2009-20169_PI.pdf*. We will report on this next week.