April 29, 2010

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2011 Health and Welfare Planning

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2011 Health and Welfare Planning

- Overview
  - Health Care Reform
  - Mental Health Parity and Addiction Equity Act
  - CHIPRA Update
  - GINA Update
  - COBRA Subsidy Update

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Health Care Reform

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Health Care Reform

- Health Care Reform
  - Patient Protection and Affordable Care Act (PPACA), H.R. 3590
    - Signed into law on March 23, 2010
  - Amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), H.R. 4872
    - Signed into law on March 30, 2010

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- PPACA Provisions Impacting Group Health Plans
  - Health Plan Mandates
  - Revenue Raising Provisions
  - Reporting Provisions
  - Employer and Individual Mandates
  - Miscellaneous

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What Employer Health Plans Are Impacted?

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What Employer Plans Are Impacted?

- PPACA impacts most employer-sponsored insured and self-insured group health plans
  - Examples: Major medical plans, EAPs and HRAs
- Limited exemptions
  - Plans providing HIPAA-excepted benefits
  - Grandfathered plans

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What Employer Plans Are Impacted?

- Limited Exemption for HIPAA-Excepted Benefits
  - PPACA amends the PHSA to impose certain health plan coverage standards
  - PHSA amendments are incorporated into Part 7 of ERISA
  - ERISA Part 7 contains an existing exemption for certain health plans, including:
    - Stand alone retiree medical plans
    - Limited-scope dental and vision plans
    - Most health FSAs
    - On-site medical clinics

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What Employer Plans Are Impacted?

- Limited Grandfathered Plan Exemption
  - PPACA (as passed on 3/23/10)
    - Grandfathered plans were exempt from the PHSA amendments (*e.g.*, the health plan mandates)
  - HCERA
    - Amended PPACA to make grandfathered plans subject to some of the PHSA amendments
    - Other provisions of PPACA apply

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What Employer Plans Are Impacted?

- Grandfathered Plan Exemption
  - What is a grandfathered plan?
    - Any group health plan in effect on the date of enactment
    - New employees and dependents may join a grandfathered plan without losing the exemption
    - Impact of other plan changes (*e.g.*, addition or modification of a benefit; plan merger; consolidation of plans for ERISA purposes)
  - Application to collectively bargained plans

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2010 PPACA Group Health Plan Provisions

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2010 PPACA Provisions

- Retiree Reinsurance Program
  - HHS program reimburses 80% (minus negotiated cost concessions) for early retiree health claims between $15,000 and $90,000, indexed for inflation
  - Plans must cover early retirees – not actively employed, age 55 or older, not eligible for Medicare

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2010 PPACA Provisions

- Retiree Reinsurance Program
  - Proceeds must be used to lower health costs for enrollees (e.g., premiums, copayments, deductibles, etc.)
  - Program runs from 6/23/2010 until 1/1/2014 or earlier if appropriated funds are expended ($5 billion appropriated under PPACA)
  - Applications available no later than 6/23/2010 and are expected to resemble Retiree Drug Subsidy applications

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2010 PPACA Provisions

- Retiree Reinsurance Program
  - Self-funded and insured health plans are eligible
  - Plans must implement cost-saving programs and procedures for participants with chronic and high cost conditions
  - Participating plans may be audited for compliance
  - White House Fact Sheet: http://www.whitehouse.gov/sites/default/files/rss_viewer/reinsurance_early_retirees_fact_sheet.pdf

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CLASS Act

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CLASS Act

- CLASS Act
  - Voluntary assisted living/long-term care governmental insurance program
  - Benefits paid to participants who are unable to perform normal activities of daily living (*e.g.*, eating, bathing, dressing) or require substantial supervision to protect them from threats to their health or safety due to cognitive impairment for periods of at least 90 days

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CLASS Act

- CLASS Act
  - Voluntary employer involvement in
    - Auto enrollment of employees (similar to 401(k) plan auto enrollment)
    - Withholding employee premiums
  - HHS required to make the CLASS Program actuarially sound
  - Effective January 1, 2011

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2011 PPACA Provisions

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2011 PPACA Provisions

- 2011 PPACA Provisions
  - – Group health plan mandates
    - Provisions affecting all employer-sponsored group health plans *(i.e.,* grandfathered and non-grandfathered plans)
    - Provisions affecting only non-grandfathered plans
  - – Reporting provisions
  - – Revenue raising provisions

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2011 PPACA Provisions - All Health Plans

- Adult Dependent Coverage
  - Health plans that provide dependent coverage must cover adult dependent children until age 26
    - Includes married dependents
    - Excludes grandchildren
    - Coverage is non-taxable
  - Effective January 1, 2011, for calendar year plans
  - Prior to 2014, grandfathered health plans do not have to cover an adult dependent that is eligible for other employer-sponsored health coverage

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2011 PPACA Provisions - All Health Plans

- Adult Dependent Coverage
  - Who is a dependent?
    - Not defined but guidance to be issued
  - Implementation Issues
    - Extension of adult dependent children coverage before the effective date
    - Extension of eligibility to exempt plans (*e.g.*, dental, vision, life, etc.)
    - Contribution / charges for dependent coverage

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2011 PPACA Provisions - All Health Plans

- Annual Limits
  - Annual limits on the dollar value of "essential benefits" are prohibited unless specifically authorized by HHS
    - Effective January 1, 2011, for calendar year plans
    - HHS to issue guidance regarding permitted annual limits
    - In 2014, annual limits on the dollar value of essential benefits are prohibited altogether
  - What is still allowed?

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2011 PPACA Provisions - All Health Plans

- Annual Limits
  - What are Essential Benefits?
    - PPACA directs HHS to issue guidance
    - Must include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services, including oral and vision care

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2011 PPACA Provisions - All Health Plans

- Lifetime Limits
  - Lifetime limits on the dollar value of "essential benefits" are prohibited
    - Effective January 1, 2011, for calendar year plans
  - Lifetime limits can be imposed on non-essential benefits

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2011 PPACA Provisions - All Health Plans

- Pre-Existing Condition Exclusions
  - Health Plans may not impose a pre-existing condition exclusion for enrollees under age 19
    - Effective January 1, 2011, for calendar year plans
    - In 2014, expands to include all enrollees

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2011 PPACA Provisions - All Health Plans

- Coverage Rescission
  - No rescission of coverage once an enrollee is covered except for fraud or intentional misrepresentation of material fact
  - No cancellation of coverage except for nonpayment of premiums and plan termination
  - Application to self-insured health plans
  - Effective January 1, 2011, for calendar plan years

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2011 PPACA Provisions - All Health Plans

- New Form W-2 Reporting Requirement
  - Employers must calculate and report the aggregate cost of all employer-provided health coverage on each employee’s Form W-2
    - Must include all “applicable employer-sponsored coverage”
  - How is the “aggregate cost” determined?
    - Apply rules similar to the COBRA premium rules
  - Effective for the 2011 tax year (January 2012 W-2s)

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2011 PPACA Provisions - All Health Plans

- Over-the-Counter (OTC) Drugs
  - HRAs, FSAs and HSAs may not reimburse OTC drug expenses on a non-taxable basis
    - Exception for prescribed OTC drugs
  - Effective Dates
    - HRAs and FSAs – effective for expenses incurred with respect to taxable years beginning 1/1/2011
    - HSAs – effective for amounts paid with respect to taxable years beginning 1/1/2011

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2011 PPACA Provisions - All Health Plans

- Over-the-Counter (OTC) Drugs
  - Implementation Issues
    - Plans which operate on a non-calendar plan year
    - Reimbursement of OTC drugs without a prescription during the 2 ½ month grace period
    - Impact on debit cards

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2012 PPACA Provisions

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2012 PPACA Provisions - All Health Plans

- Uniform Explanation of Coverage
  - Summary of plan benefits and coverage must be given to enrollees, participants and beneficiaries before enrollment and reenrollment in the health plan
  - Summary must satisfy certain standards relating to appearance and content
    - HHS (working with the NAIC) must issue guidance regarding the standards prior to 3/23/2011

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2012 PPACA Provisions - All Health Plans

- Uniform Explanation of Coverage
  - Must provide 60 days advance notice of any material change in coverage not described in the last summary distributed to participants (*i.e.*, material mid-year changes)
  - Penalty of $1,000 per participant for each willful violation

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2012 PPACA Provisions - All Health Plans

- Plan Fees
  - Temporary fee imposed on insured and self-insured plans based on the average number of lives covered during the plan or policy year
    - Fee is $2 ($1 for fiscal years ending in 2013)
    - Not applicable to HIPAA-excepted benefit plans
  - Effective for plan years ending after 9/30/2012
  - Scheduled to expire for plan years ending after 9/30/2019

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2013 PPACA Provisions

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2013 PPACA – All Health Plans

- Health FSA Limits - 2013
  - Cap on Health FSA *employee* contributions
    - $2,500 (as adjusted for inflation)

- Elimination of Retiree Drug Subsidy Deduction
  - Effective 2013, employers will not be entitled to a tax deduction for Medicare Part D retiree drug subsidy payments
  - Special application of accounting rules

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2013 PPACA – All Health Plans

- Notice Regarding the Exchange
  - Existing employees of all employers (not just large employers) must be notified by March 1, 2013, and new hires must be notified upon hire of:
    - The right to purchase coverage under an Exchange
    - The employee may be eligible for a premium tax credit, if the plan's share of total costs is less than 60%
    - The potential loss of the employer contribution if coverage is purchased through the Exchange (unless they are eligible for a free choice voucher)

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2014 PPACA Provisions

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2014 PPACA - All Health Plans

- Automatic Enrollment
  - Employers with more than 200 full-time employees must automatically enroll new employees in medical coverage
  - Must provide notice and an opt out procedure
  - IRS could establish an earlier effective date

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2014 PPACA – All Health Plans

- Expanded Reporting Requirements
  - To the IRS and, in summary fashion, to each full-time employee
  - Large employers (and any employer that offers minimum essential coverage and pays a portion of the cost where the required employee contribution exceeds 8% of wages) must report:
    - Whether they offer minimum essential coverage; the lowest cost premium option in each enrollment category; waiting periods; the employer's share of the total allowed costs of benefits; and the number, name, address and TIN of each full-time employee enrolled and the months during which the employee (and dependents) were covered

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2014 PPACA – All Health Plans

- Design Mandates
  - No annual limits can be imposed on "essential health benefits"
  - No pre-existing condition exclusions can be applied (not just to those under age 19)
  - Dependent children can remain covered until age 26, regardless of whether they are eligible for other employer coverage
  - No waiting periods in excess of 90 days

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PPACA Changes
for Non-Grandfathered Plans Only

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PPACA – Non-Grandfathered Plans Only

- Grandfathered plans are exempt from many requirements that will apply to new plans or plans that lose their grandfathered status
- Changes Only for Non-Grandfathered Plans for plan years beginning on or after September 23, 2010
  - No cost-sharing permitted for preventive care measures, including visits, immunizations and screenings
    - This means no deductibles, copays, coinsurance
  - Fully-insured plans cannot discriminate in favor of HCEs
    - This extends the rule that currently applies to self-insured plans to fully-insured plans
    - This affects the use of executive-only fully insured plans or insurance policies to sidestep nondiscrimination rules imposed on self-funded plans

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PPACA – Non-Grandfathered Plans Only

- Changes Only for Non-Grandfathered Plans for plan years beginning on or after September 23, 2010
  - New rules for appeals process
    - Must notify participants where to get help with appeals process
    - Notice of the process must be in “culturally and linguistically appropriate manner”
    - Participants may review their file, present evidence and testimony, and receive continued coverage during the appeals process
    - In addition to an internal review process, plans must provide both an external review process that complies with applicable State external review processes, or for self-insured plans, that meets the minimum standards established by the Secretary

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PPACA – Non-Grandfathered Plans Only

- Changes Only for Non-Grandfathered Plans, for plan years on or after September 23, 2010
  - New patient protections include:
    - Allow designation of any participating primary physician available to take new patients, if the plan requires a designation
    - For children, allow designation of a pediatrician as the PCP, if the plan requires a designation
    - Access to emergency services without prior authorization and treat as in-network, ER surcharges questionable
    - Access to an OB/GYN, without prior authorization

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PPACA – Non-Grandfathered Plans Only

- Changes Only for Non-Grandfathered Plans, for plan years on or after September 23, 2010
  - Reporting Requirements
    - Must report to HHS, state insurance commissioners and make available to the public the information intended to improve health outcomes

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PPACA – Non-Grandfathered Plans Only

- Changes Only for Non-Grandfathered Plans, effective January 1, 2014
  - Must cover routine costs related to clinical trials for individuals with cancer or other life-threatening disease or condition
    - This excludes the investigational service itself or those clearly inconsistent with established standards of care
    - Cannot discriminate against such individuals
  - No cost-sharing provision in excess of the limits under Code Section 223(c)(2)(A)(ii) (the HDHP out of pocket maximum, which is currently $5,950 for individuals and $11,900 for families)
    - Cost-sharing includes deductibles, copays, co-insurance
  - No discrimination based on health status
  - Rewards under a wellness program are increased to 30% of the cost of coverage (currently limited to 20%)

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Employer and Individual Mandates

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PPACA Employer Mandate

- Employer Mandate
  - Large employers must provide “minimum essential coverage” to full-time employees or pay a monthly penalty if a full-time employee is eligible for and obtains subsidized coverage through the Exchange
  - Effective January 1, 2014

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PPACA Employer Mandate

- Employer Mandate
  - Large employer = average of 50 or more full-time employees during the prior year
    - Determined on a controlled group basis
    - Must include full-time equivalents
  - Full-time employee = one who works on average 30 hours or more per week

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PPACA Employer Mandate

- Employer Mandate
  - Minimum Essential Coverage
    - Coverage under an eligible employer-sponsored group health plan
    - Employer must pay at least 60% of the allowed health plan costs
    - Employee may not be required to pay more than 9.5% of the employee’s household income

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PPACA Employer Mandate

- Employer Mandate
  - Penalty for Offering No Coverage
    - $2,000 per full-time employee (excluding first 30 employees) if one full-time employee receives subsidized coverage through the Exchange
    - FTEs not included in calculating the penalty

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PPACA Employer Mandate

- Employer Mandate
  - Penalty for “Under Subsidizing” Health Coverage
    - $3,000 per full-time employee who receives subsidized coverage through the Exchange (excluding employees who received a Free Choice Voucher)
    - Not greater than the penalty that applies for not offering any coverage

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Free Choice Vouchers

- Free Choice Vouchers
  - All employers who offer subsidized health plan coverage must provide a voucher to employees who opt out of the plan if:
    - The employee’s household income does not exceed 400% of the FPL for a family of the size involved, and
    - The employee’s share of the cost of coverage would be between 8% and 9.8% of household income
  - The voucher may be used to purchase coverage through the Exchange

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PPACA Individual Mandate

- Individual Mandate
  - Individuals must maintain Minimum Essential Coverage or pay a penalty
  - Exceptions
    - Cost of coverage exceeds 8% of the individual's household income
    - Short gaps (less than 3 months) in coverage
    - Not required to file a Federal tax return
  - Effective January 1, 2014

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PPACA Individual Mandate

- Individual Mandate
  - Individuals may be eligible for subsidized coverage through the Exchange if:
    - The individual's household income ranges from 100% to 400% of the Federal poverty line
    - No subsidy if the employer provides Minimum Essential Coverage (*i.e.*, employer covers 60% of allowed plan costs and individual is not required to pay more than 9.5% of household income for coverage)
  - Certain reporting requirements apply

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"Cadillac Plan Tax"

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Cadillac Plan Tax

- Cadillac Plan Tax
  - Employers and insurers must pay a 40% tax on "excess health coverage"
    - Excess Health Coverage = Total cost of coverage exceeding $10,200 for self-only coverage and $27,500 for all other coverage
    - Certain high risk professions have a higher threshold
    - Amount is adjusted for inflation
    - Does not apply to coverage under stand alone dental and vision plans (unclear if exemption only applies to insured plans)
  - Effective January 1, 2018

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Health Care Reform Wrap-Up and Concluding Comments

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Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Wellstone Act)

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Wellstone Act

- Overview
  - Significantly broader than the Mental Health Parity Act of 1996
  - Also applies to substance abuse benefits
  - Strives to provide actual parity with medical and surgical benefits
  - Interim final regulations were issued February 2, 2010
  - Plans redesigned in 2010 to comply with the Wellstone Act need to be reviewed for compliance with the regulations that are more expansive than the statute

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- Effective Date
  - The Wellstone Act generally became effective January 1, 2010, for calendar year plans
  - These regulations apply for plan years beginning on and after July 1, 2010, which means January 1, 2011, for calendar year plans (special rules apply to plans maintained pursuant to a collective bargaining agreement)
  - Government agencies will take into account good faith efforts to comply with a reasonable interpretation of the Wellstone Act prior to the effective date of the regulations, but this does not prevent participants from bringing claims

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Wellstone Act - Applicability

- Plans Subject to the Wellstone Act
  - Applies to coverage that provides mental health or substance use disorder benefits, even if no medical/surgical benefits are provided, if such coverage is offered in connection with a health plan that otherwise offers medical/surgical benefits
  - The point of this rule is to close a loophole that would have allowed employers to circumvent the rules by establishing separate plans for mental health or substance use benefits

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Wellstone Act - Exemptions

- Limited Exemptions Are Available
  - Employers who employed an average of at least two but no more than 50 employees during the preceding calendar year
  - Plans with fewer than two participants who are current employees
    - This includes stand-alone retiree health plans
  - Plans subject to the increased cost exemption (if the plan complies for one year, the exemption applies to the following year only)

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Wellstone Act – Coverage is Not Required, But…

- Plans Can Define Covered Mental Health Disorders
  - Plans are not required to provide benefits for mental health or substance abuse disorders
  - If such benefits are provided, benefits for ALL such disorders are not required
  - Plans can define what benefits are covered
    - The definition must be consistent with generally recognized independent standards of current medical practice, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM)

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Wellstone Act – Quantitative Limits

- General Rule
  - A group health plan or insurer cannot apply financial requirements or treatment limitations on mental health or substance abuse disorders that are more restrictive than the "predominant" restriction or limitation imposed on substantially all medical/surgical benefits *in the same classification*
    - Financial requirements include deductibles, copays, out-of-pocket limits, annual and lifetime dollar limits
    - Treatment limitations include number and frequency of covered visits/days
    - Predominant means greater than one-half; substantially all means at least two-thirds

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Wellstone Act – Parity Within Classifications

- The classifications are:
  - Inpatient/in-network (IN)
  - Inpatient/out-of-network (OON)
  - Outpatient/IN
  - Outpatient/OON
  - Emergency care
  - Prescription drugs
- Must analyze benefits provided within each classification in which medical/surgical benefits are provided

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Wellstone Act – Exclusions Are Difficult

- Exclusions are difficult as a practical matter
  - If a plan provides a benefit for a disorder, the benefits for that disorder must comply with the Wellstone Act
    - Cannot exclude coverage for anxiety disorders, but cover prescription drugs for that disorder
    - Issue: the plan will not be providing benefits in all the classifications for which medical/surgical benefits are provided (such as out-patient/in-patient expenses)

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Wellstone Act – Nonquantitative Limits

- Rules Also Apply to Non-quantitative Treatment Limits
  - Nonquantitative treatment limits include (but are not limited to):
    - Medical management standards, such as limits based on medical necessity or preauthorization requirements
    - Prescription drug formulary design
    - Determination of UCR amounts
    - Requirements for using lower cost therapies first
    - Conditioning benefits on the completion of a course of treatment

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Wellstone Act – Nonquantitative Limits

- Factors Must Be Comparable
  - The factors used for mental health/substance use benefits must be comparable to (and not applied more stringently than) those applied to medical/surgical benefits, unless recognized clinically appropriate standards of care permit a difference
- Example:
  - Some plans require a participant to exhaust EAP benefits first
  - This design violates the regulations because it imposes a "gatekeeper" requirement that is not imposed on other medical/surgical benefits

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Wellstone Act - Deductibles

- No separate deductibles or out-of-pocket maximums permitted
  - The Wellstone Act could be read to allow a plan to impose a separate deductible or out-of-pocket maximum for mental health/substance abuse benefits
  - The regulations specifically provide that this is not permissible
    - Cannot have a $500 deductible for medical expenses and a separate $500 deductible for mental health/substance abuse; can have a $1,000 combined deductible

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Wellstone Act – Action Items

- SPDs and requirements imposed for benefits must be reviewed again in light of the regulations issued in February
  - Confirm no separate deductibles, OOP, etc.
  - Confirm benefits for mental/substance abuse are not conditioned on satisfying rules that are more stringent than are required for medical/surgical benefits, such as:
    - Requiring use of a gatekeeper first
    - Requiring completion of a program of treatment
    - Use of other medical management tools
  - If the plan attempts to carve out benefits for a condition, confirm that NO benefits are provided (such as prescription drugs or services from an internist for that condition)

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