HUNTON
ANDREWS KURTH

Welfare Plan Check-Up: Assessing Your Welfare Plan's Compliance

Presentation for:
Employee Benefits Academy
March 23, 2023

Presentation by:
Michelle Lewis, Counsel, Hunton Andrews Kurth
Jordan Latham, Associate, Hunton Andrews Kurth
Ali Qamar, Associate, Hunton Andrews Kurth

Housekeeping: Questions

HUNTON ANDREWS KURTH

- Questions during this presentation
  - We encourage questions (even though your audio lines are muted)
  - To submit a question, simply type the question in the blank field on the right-hand side of the menu bar and press return
  - If time permits, your questions will be answered at the end of this presentation. And if there is insufficient time, the speaker will respond to you via e-mail after this presentation

Housekeeping: Recording, CE Credits and Disclaimer

HUNTON ANDREWS KURTH

- Recording
  - This presentation is being recorded for internal purposes only
- Continuing education credits
  - A purpose of the webinar series is to provide FREE CE credits
  - To that end, each presentation is intended to provide 1 credit hour in the following areas:
    - CLE: 1 credit hour (CA, FL, GA, NC, NY, TX and VA)
    - CPE: 1 credit hour (Texas)
    - HRCI: This activity has been approved for 1 (HR (General)) recertification credit hours toward California, GPHR, PHRi, SPHRI, PHR, and SPHR recertification through the HR Certification Institute
    - SHRM: This program is valid for 1 PDC for the SHRM-CPSM or SHRM-SCPSM
  - If you have any questions relating to CE credits, please contact Anna Carpenter at acarpenter2@huntonak.com.
- Disclaimer
  - This presentation is intended for informational and educational purposes only, and cannot be relied upon as legal advice
  - Any assumptions used in this presentation are for illustrative purposes only
  - No attorney-client relationship is created due to your attending this presentation or due to your receipt of program materials

Michelle Lewis

HUNTON ANDREWS KURTH

Counsel
Email: mlewis@HuntonAK.com
Phone: 202-955-1859

2200 Pennsylvania Avenue NW
Washington, DC 20037

Michelle concentrates her practice in the areas of health and welfare plans, qualified retirement plans, and executive deferred compensation plans.

She delivers insightful and practical advice to clients in addressing a broad spectrum of employee benefit issues, including drafting plan documents, preparing IRS submissions, resolving ERISA and Internal Revenue Code compliance issues, advising on benefit claims and appeals, addressing various litigation issues, and negotiating employee benefit vendor contracts and HIPAA business associate agreements.

Jordan Latham

HUNTON
ANDREWS KURTH

Associate
Email: jlatham@HuntonAK.com
Phone: 713-220-3707

600 Travis Street, Suite 4200
Houston, TX 77002

Jordan focuses her practice on executive compensation and employee benefit arrangements, including their related tax and corporate governance aspects.

Jordan advises clients across various industries on ERISA, HIPAA, Internal Revenue Code (Code), and Affordable Care Act (ACA) compliance requirements governing employee benefits and compensation arrangements. She also assists clients engaged in corporate transactions with understanding and quantifying potential tax and financial exposures related to executive compensation issues under Code sections 280G and 409A and employee benefit plan compliance.

Ali Qamar

HUNTON
ANDREWS KURTH

Associate
Email: aqamar@HuntonAK.com
Phone: 214-979-2928

1445 Ross Avenue, Suite 3700
Dallas, TX 75202

Ali concentrates his practice in the areas of health and welfare plans, qualified retirement plans, and executive compensation.

He advises clients on a range of compensation and benefits matters, along with related issues of tax, accounting, securities, and corporate governance.

What We'll Cover

HUNTON ANDREWS KURTH

- Our primary focus today will be on ERISA compliance
- Most of the topics we'll cover are those that have come up for clients in the context of a DOL audit, including:
  - Plan documentation requirements
  - Reporting requirements
  - Health care reform compliance
  - Transparency requirements
  - Mental health parity compliance
  - COVID-19 relief
  - HIPAA compliance
  - Wellness program considerations
  - Other required notices

Plan Documentation Requirements

HUNTON ANDREWS KURTH

- Plan document
  - Wrap Plan Document
- Summary Plan Description (SPD)
- Summary of Material Modifications (SMM)
- Summary of Benefits & Coverage (SBC)

Plan Documentation Requirements – The Plan Document

HUNTON ANDREWS KURTH

- **Written document**: ERISA requires that a plan document "be established and maintained pursuant to a written instrument"
- Plan documents should also contain the following content:
  - Plan name, plan number (three-digit number that is assigned to the plan by the plan administrator or plan sponsor), and plan year (cannot exceed 12 months)
  - Eligibility rules for when a participant is eligible to participate in the plan
  - Fiduciary name, contact information and responsibilities of the fiduciaries
  - Description of funding (i.e., self-insured or insured) and how payments are to be made
  - Claims procedures
  - Amendment procedures
  - Any termination policies/rights to terminate the plan and distribution of assets upon plan termination
  - Information regarding COBRA, HIPAA and other federal mandates

Plan Documentation Requirements – Wrap Document

HUNTON ANDREWS KURTH

- Welfare plans will often offer multiple benefits (i.e., medical, dental, life insurance, FSA, disability, vision). Plan sponsors/administrators can use a “wrap document” as a way to bundle these multiple benefits into one single ERISA plan
- A wrap document essentially “wraps around” all ERISA health and welfare benefits and includes required disclosures that are not typically found in other documents
- Benefits of a wrap plan include:
  - Minimize the risk of lawsuits and financial penalties and keeps the plan compliant
  - Helps save time and money. By consolidating all health and welfare plans under the same wrap document, there’s no need to update or amend multiple documents for legislative or plan sponsor changes
  - Simplifies the Form 5500 filing process. Instead of filing a separate Form 5500 for each ERISA health and welfare plan, a wrap document enables the plan sponsor to file a single Form 5500 for all benefits covered under the wrap document

Plan Documentation Requirements – Wrap Plan

HUNTON ANDREWS KURTH

Wrap Plan + SPD

- Together this would satisfy the plan document requirement as well as the SPD requirement

Wrap Plan + Third Party Agreements/Insurance Policies

- Plans often use third-party carriers and/or insurance carriers to provide welfare benefits – using a wrap plan to "wrap" around these third-party documents and insurance contracts will satisfy the ERISA plan document

Plan Documentation Requirements – Plan Document Delivery

HUNTON ANDREWS KURTH

- The plan document is not typically delivered to plan participants
- Must be provided to a participant or beneficiary upon request within 30 days to avoid $110/day penalty

Plan Documentation Requirements – Summary Plan Description

HUNTON ANDREWS KURTH

- The SPD is often described as the "employee facing version of a plan document"
- It should be written in a matter that is to be understood by the average plan participant

Plan Documentation Requirements – SPD Content Requirements

- Identifying information about the plan, the plan sponsor/administrator, and any fiduciaries
  - name of the plan
  - the plan number for ERISA Form 5500 purposes
  - name and address of the plan sponsor / employer
  - plan sponsor's EIN
  - plan administrator's name, address, phone number
  - designation of any named fiduciaries, if other than the plan administrator, e.g., claim fiduciary
  - type of plan or brief description of benefits, e.g., life, medical, dental, disability
  - the date of the end of the plan year for maintaining the plan's fiscal records (which may be different from the insurance policy year)
  - the type of plan administration, e.g., administered by contract, insurer, or sponsor
  - agent for service of process and address for service of process

Plan Documentation Requirements – SPD Content Requirements

- The requirements for eligibility in the plan
- Description of benefits
- Plan benefits and exclusions, including cost sharing provisions, limits on non-essential benefits, condition or limits on emergency care, preauthorization requirements, provisions related to the use of in-network provider, and much more
- Subrogation/right of reimbursement
- Description of the circumstances which may result in disqualification, ineligibility, or denial or loss of benefits
- Plan amendment/termination provisions relating to the right of the plan sponsor to amend or terminate at any time
- Source of contributions (employee v. employer)
- Funding medium – a description of whether benefits are insured or self-funded
- Claim procedures
- The SPD must clearly explain the participant's enforcement rights under ERISA
    - Model language is provided under Labor Regulation section 2520.102-3
- Various other legal notices that we will cover in more detail later in this presentation

Plan Documentation Requirements – SPD Updates and Delivery

HUNTON ANDREWS KURTH

SPD Updates

- SPD must be updated every 5th year, unless there have been no amendments made during that 5-year period that would affect the SPD. Every 10th year, the SPD must be updated regardless of whether any amendments have been made or not.

Delivery Timing

- New plans: within 120 days of plan establishment
- New participants: within 90 days of when they are first covered
- Ongoing participants: if material changes were made to the plan, then 210 days after the last day of the 5th plan year if the SPD was updated; 210 days after the last day of the 10th plan year no material changes during the 10-year period

Plan Documentation Requirements – Summary of Material Modifications

HUNTON ANDREWS KURTH

- Whenever a "material modification" has been made to the plan a "Summary of Material Modifications" must be provided to plan participants (in the same manner as a SPD). It should be written in a matter that is to be understood by the average plan participant
- Common material modifications include:
  - changes to deductibles and eligibility
  - elimination of benefits payable under the plan;
  - reduction of benefits payable under the plan;
  - reduction in a service covered by an HMO;
  - new conditions or requirements that are imposed for obtaining covered services or benefits.

Plan Documentation Requirements – SMM

HUNTON ANDREWS KURTH

- If the “material modifications” have been incorporated into a SPD, then a SMM is not necessary
- Must be delivered within 210 days after the end of the plan year, or within 60 days after a “material reduction” in benefits
- Subject to the $110/day penalties for failure to provide within 30 days after a participant or beneficiary has requested it

Plan Documentation Requirements – Summary of Benefits and Coverage (SBC)

HUNTON ANDREWS KURTH

- The Affordable Care Act (“ACA”) requires that group health plans provide plan participants with a SBC as a means for them to compare available health insurance coverage options
- The SBC has stringent content requirements – to aid with this the DOL website provides templates and detailed instructions on how to meet these requirements
- Often, the TPA/insurance will prepare the SBC, while the Plan administrator has the duty to distribute
- Failure to furnish an SBC can lead up penalties of up to $1,362 per failure in 2023 (indexed yearly for inflation)

Plan Documentation Requirements – Summary of Benefits and Coverage (SBC)

HUNTON ANDREWS KURTH

- Must be furnished under 4 scenarios:
  - Open enrollment (renewal of coverage)
    - For plans with automatic renewal, generally 30 days prior to the new plan year
  - Initial enrollment (for new participants)
  - HIPAA special enrollment events (within 90 days)
  - Upon request (within 7 business days)

Reporting Requirements – Form 5500

HUNTON ANDREWS KURTH

- Under ERISA, a Form 5500 is required for any welfare benefit plan that:
  - Has 100 or more participant as of the beginning of the plan year
  - Is funded through a trust, regardless of participant count
- An individual is considered a “welfare benefit plan participant” for the Form 5500 purpose if the individual is:
  - A current employee who is covered by the welfare plan
  - A former employee who is covered by the welfare plan (i.e., COBRA participants, retirees, etc.)
  - A former employee who is eligible to elect coverage under COBRA but has not yet elected coverage
  - Spouses and dependents are not counted
- A Form 5500 is required for each welfare benefit plan – this is where a wrap plan document is helpful

Reporting Requirements – Form 5500

HUNTON ANDREWS KURTH

- A Form 5500 must be filed every year
- Failure to do so could result in the following penalties
  - $2,233 per day (indexed for inflation, with no limit)
  - IRS penalties of $25 per day (limited to $15,000 per return)
- Summary Annual Report (SAR)
  - If a Plan files a Form 5500, plan administrators must also provide a SAR to any plan participants and beneficiaries receiving plan benefits
  - The SAR must contain basic financial information about the plan and the right to request additional information (e.g., the plan's assets and liabilities, income, expenses, etc.)
  - Must be provided within nine months of the close of the plan year; or two months after the extension period if an extension is granted for the Form 5500 filing

Health Care Reform Compliance

- Health care reform, in the form of the Patient Protection and Affordable Care Act (ACA), brought many changes for employers and their health plans
- ACA compliance continues to be an area of focus in DOL investigations
- Due to time constraints, we are not covering the various reporting and employer shared responsibility requirements under the ACA, which are IRS requirements.

Health Care Reform Compliance

HUNTON ANDREWS KURTH

- Dependent Coverage to Age 26
  - Your plan should cover dependents up to age 26, if dependent coverage is otherwise offered
  - The age 26 mandate does not require plans to offer dependent coverage for children, but most do to avoid penalties under ACA's employer shared responsibility provisions
    - The ACA doesn’t require small group health plans to offer dependent coverage although most do

Health Care Reform Compliance

HUNTON ANDREWS KURTH

- Lifetime and Annual Limits
  - Effective for the first plan year beginning on or after September 23, 2010, non-grandfathered group health plans must have **eliminated lifetime limits** on essential health benefits
  - Effective for plan years beginning on or after January 1, 2014, annual dollar limits on essential health benefits were prohibited as well
  - Essential health benefits include:
    - Ambulatory care services
    - Emergency services
    - Hospitalization
    - Lab services
    - Pregnancy, maternity and newborn care
    - Mental health disorder/substance use services
    - Rehabilitative and habilitative services and devices
    - Preventive and wellness services and chronic disease management
    - Pediatric services, including oral and vision care
    - Prescription drugs

Health Care Reform Compliance

HUNTON
ANDREWS KURTH

- Pre-Existing Condition Exclusions
  - Group health plans must not have eliminated **pre-existing condition exclusions**
- No Excessive Waiting Periods
  - Group health plans and insurers are prohibited from applying a waiting period that exceeds 90 days

Health Care Reform Compliance

HUNTON ANDREWS KURTH

- Rescissions
  - Group health plans are prohibited from rescinding coverage for individuals who are covered under the plan—except in cases where the individual has engaged in fraud or made an intentional misrepresentation of material fact
    - Plan language must specify rescission provisions
    - Written notice of any rescission must be provided at least 30 days in advance

Health Care Reform Compliance

HUNTON ANDREWS KURTH

- Preventive Services
  - Non-grandfathered group health plan must cover recommended **preventive services** without cost-sharing requirements
  - Non-grandfathered plans must cover specific **preventive services for women** without cost-sharing requirements
    - These services include well-woman visits, mammograms, STD screening and contraceptives

Health Care Reform Compliance

HUNTON ANDREWS KURTH

- Claims and Appeals Procedures
  - Health care reform established new claims and appeals requirements for non-grandfathered plans
  - Expanded definition of adverse benefit determination to include:
    - determinations of whether a participant or beneficiary is entitled to a reasonable alternative standard under a wellness program
    - any rescission of coverage, whether or not there is an adverse effect on any particular benefit at the time that coverage is rescinded
  - More stringent procedures to provide full and fair review and to avoid conflicts of interest

Health Care Reform Compliance

- Claims and Appeals Procedures
  - Requirement to provide an appropriate external review process by an external review organization
  - Include additional information in notices to claimants, such as information identifying the claim, reasons for the denial, the description of the appeals process and information regarding available consumer assistance
  - Provide notices in a culturally and linguistically appropriate manner
  - In an audit, the DOL will likely request copies of claim and appeal denial letters to ensure they satisfy the claims regulation requirements

Health Care Reform Compliance

HUNTON ANDREWS KURTH

- Marketplace/Exchange Notice Requirements
  - Employers covered by the Fair Labor Standards Act (FLSA) are required to provide a notice to employees about the health insurance marketplace of the state(s) in which they operate
  - Employers are not required to provide a separate notice to dependents or other individuals who are or may become eligible
  - New hires must receive the notice within 14 days of the employee's start date
  - May be distributed electronically or by hard copy
  - Model can be found at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/coverage-options-notice

Health Care Reform Compliance

- Patient Protections
  - Effective for plan years beginning on or after September 23, 2010, non-grandfathered group health plans were required to include certain patient protections, such as:
    - If the plan requires participants to choose a primary care provider, allow participant to choose any available participating primary care provider or pediatrician
    - Permit participants to obtain OB/GYN care without a pre-authorization or referral
    - Eliminate pre-authorization requirement for emergency services
    - Eliminate increased coinsurance or copayment requirements for out-of-network emergency services

Expanded Patient Protections under the CAA

HUNTON ANDREWS KURTH

- For plan years beginning on or after January 1, 2022, the Consolidated Appropriations Act (CAA) added significant new patient protection provisions and more broadly imposed the original ACA patient protection provisions
- Primary Care Provider Designation
  - The primary care provider designation patient protection provisions apply to both ACA non-grandfathered and grandfathered plans.

Expanded Patient Protections under the CAA

HUNTON ANDREWS KURTH

- Surprise Billing Protections
  - The emergency services patient protection provision no longer applies in its original form and is significantly broadened to prevent surprise billing generally, including the following scenarios:
    - OON emergency care
    - Ancillary services (e.g., anesthesia) provided by OON providers at in-network facilities
    - OON care provided at in-network facilities without the patient's advance informed consent
    - Air ambulances

Expanded Patient Protections under the CAA

HUNTON ANDREWS KURTH

- Surprise Billing Protections
  - If care is provided by an OON provider, the participant can only be required to pay the *in-network* cost sharing amount
  - Amount paid must count towards deductible and out of pocket maximum in the same manner as if made for an in-network provider
  - Providers prohibited from balance billing plan participants for any remaining amounts
  - External review process expanded to cover adverse determinations involving surprise billing protections

Expanded Patient Protections under the CAA

HUNTON ANDREWS KURTH

- Independent Dispute Resolution
  - The CAA adds an independent dispute resolution process that permits the plan to engage in a 30-day negotiation process with the out-of-network provider
  - Some uncertainty on IDR rules
    - ➢ Regulations issued in July and October 2021
    - ➢ In February 2022, a federal district court struck down portions of the new IDR provisions (other provisions remain in place)
    - ➢ The DOL then issued a memo stating that it would withdraw guidance based on the invalidated portions of the rules, but that other portions of the No Surprises Act remain in effect

Expanded Patient Protections under the CAA

HUNTON ANDREWS KURTH

- Continuity of Care
  - Effective for plan years beginning on or after January 1, 2022, group health plans must provide 90 days of continued care if in-network providers (without cause) leave the plan's network
  - Applies to both ACA non-grandfathered and grandfathered plans

Other CAA Transparency Requirements

- Prohibition on Gag Clauses effective December 27, 2020
  - The first annual attestation provision due December 31, 2023
  - Submitted online at: https://hios.cms.gov/HIOS-GCPCA-UI
- Mental Health Parity Comparative Analysis
  - Effective February 10, 2021
- Updated Medical ID Cards with Cost-Sharing Information
  - January 1, 2022; good faith, reasonable interpretation until the Departments issue regulations
- Machine-Readable In-Network Rates and Out-of-Network Allowed Amounts with Detailed Pricing Information
  - First due July 1, 2022

Other CAA Transparency Requirements

HUNTON ANDREWS KURTH

- Annual Reporting on Pharmacy and Drug Costs
  - First Due December 27, 2022 (grace period to January 31, 2023); due annually by June 1 going forward
- Price Comparison Tool for First 500 Shoppable Items/Services
  - First plan year on or after January 1, 2023
- Price Comparison Tool for Remaining Shoppable Items/Services
  - First plan year on or after January 1, 2024

Mental Health Parity Compliance

HUNTON ANDREWS KURTH

- If a group health plan that provides medical/surgical benefits also provides either mental health or substance use disorder benefits, the plan may be subject to the "mental health parity" requirements as set forth by the Mental Health Parity Act (MHPA) and the Mental Health Parity and Addiction Equity Act (MHPAEA)
- Group health plans that are subject to these requirements will be subject to three different mandates:
  - ***Annual or Lifetime Limits.*** Annual or lifetime dollar limits for medical/surgical benefits must generally have the same (or higher) dollar limits compared to MH/SUD benefits
  - ***Parity as to Financial Requirements and Quantitative Treatment Limitations.*** Must provide parity between medical/surgical benefits and MH/SUD benefits as to financial requirements (i.e., deductibles, copayments, coinsurance, and OOP maximums) and quantitative treatment limitations (i.e., number of treatments, visits, or days of coverage)
  - ***Parity as to Nonquantitative Treatment Limitations.*** Must comply with other parity-related requirements for NQTLs (such as medical management standards)

Mental Health Parity Compliance

HUNTON ANDREWS KURTH

- The CAA imposes a new MHPAEA documentation requirement, requiring group health plans and insurance carriers that offer both medical/surgical benefits and MH/SUD benefits, and that impose NQTLs on MH/SUD benefits, to perform and document a comparative analysis of the design and application of the NQTLs
- This comparative analysis must be available to the Departments (DOL/HHS/IRS) or applicable state authorities upon request no later than February 10, 2021
- First Tri-Agency MHPAEA Report to Congress found "None of the comparative analyses reviewed to date have contained sufficient information upon initial receipt," and "EBSA believes that authority for DOL to assess civil monetary penalties for parity violations" needed

Compliance with Coronavirus-Related Relief

HUNTON ANDREWS KURTH

- The FFCRA requires group health plans to cover certain COVID-19 related diagnostic and preventive services during the national emergency without imposing any cost-sharing requirements, prior authorization, or other medical management requirements
- The requirement to provide coverage for certain COVID-19 diagnostic services applies to all group health plans, including grandfathered plans, except for retiree-only plans and excepted benefit plans
- The CARES Act broadened the diagnostic services for which coverage is required under the FFCRA
  - Requires non-grandfathered group health plans, other than retiree-only plans and plans offering only excepted benefits, to provide coverage for certain COVID-19 preventive services

Compliance with Coronavirus-Related Relief

HUNTON ANDREWS KURTH

- With the end of the public health emergency, these free coverage mandates will no longer apply effective May 11, 2023 (the announced end to the public health emergency)
- Note – the CARES Act requires non-grandfathered health plans to continue offering in-network COVID-19 vaccinations at no cost as part of the ACA's preventive services mandate, which applies indefinitely to in-network immunizations

HIPAA Requirements, Wellness Program Considerations, & Other Required Notices

HUNTON ANDREWS KURTH

- HIPAA Required Notices & Policies
- Wellness Program Considerations
- Other Required Notices

HIPAA Requirements

HUNTON ANDREWS KURTH

- The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires self-insured and fully insured plans having access to an individual protected health information (PHI) to comply with several standards in order to safeguard PHI including:
  - Providing participants with a Notice of Privacy Practices
  - Implementing Privacy and Security Policies and Procedures
  - Establishing Business Associate Agreements when third parties may have access to PHI in the course of providing services to the covered entity

HIPAA Requirements – Notice Privacy Practices

HUNTON ANDREWS KURTH

- The Notice of Privacy Practices (NPP) must describe how the covered entity (i.e., health plan, healthcare provider, healthcare clearinghouse) may and may not use PHI and what the patient's rights and obligations are with respect to PHI
  - Model notices are provided at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/model-notices-privacy-practices/index.html
- Required Contents of the Notice
  - Header
  - Uses and Disclosures
  - Individual Rights
  - Covered Entity Duties
  - Complaints
  - Contact for further information
  - Effective Date

HIPAA Requirements – Notice of Privacy Practices

HUNTON ANDREWS KURTH

- Responsibility for delivery of the notice
  - For self-insured plans, the plan sponsor/administrator must furnish this notice
  - For fully-insured plans:
    - ***When the employer handles PHI***: The insurer or HMO must furnish the notice, or the employer if the plan has access to PHI (other than summary health information and participation and enrollment data).
    - ***When the employer does not handle PHI***: Where the employer sponsor of a fully insured plan does not create or handle PHI, except for summary health information and participation enrollment data, the notice obligation falls on the health insurer or the HMO
- Timing
  - Must be provided to any new enrollees at the time of enrollment or upon request. Thereafter, participants must be "reminded" of the availability of the notice once every three years. If there are material changes to the NPP, within 60 days of a material change.

HIPAA Requirements - Privacy and Security Policy

HUNTON ANDREWS KURTH

- HIPAA requires covered entities to establish privacy and security policies that cover the administrative, physical and technical safeguards implemented to protect PHI

Administrative Safeguards

- Security Management Process
- Security Personnel
- Information Access Management

Physical Safeguards

- Facility Access and Control
- Workstation and Device Security

Technical Safeguards

- Access Control
- Audit Controls
- Integrity Controls

HIPAA Requirements - Business Associate Agreements

HUNTON ANDREWS KURTH

- When a covered entity permit contractors subcontractors, or other outside persons or entities ("Business Associates") to access PHI, HIPAA requires that a covered entity obtain satisfactory assurances that the business associate will appropriately safeguard the PHI it receives or creates on behalf of the covered entity
- The assurances must be in writing, whether in the form of a contract or other agreement between the covered entity and the business associate

HIPAA Requirements - Business Associate Agreements

HUNTON ANDREWS KURTH

- Required contents of a Business Associate Agreement:
  - Specify each party's responsibilities when it comes to PHI;
  - Describe permitted and required PHI uses for the business associate; and
  - Include a statement that says the business associate "will not use or further disclose the protected health information other than as permitted or required by the contract or as required by law."

Wellness Program Considerations

HUNTON ANDREWS KURTH

- HIPAA's nondiscrimination rules provide that individuals may not be denied eligibility or continued eligibility to enroll in a group health plan based on any health factors they may have.
  - HIPAA's nondiscrimination rules apply to wellness programs if they are considered group health plans (GHPs)
    - Does the wellness program provide medical care? (e.g., biometric tests for blood pressure, cholesterol, and blood sugar, immunizations, disease management programs)
    - Is participation limited to employees enrolled in the health plan?
    - Are incentives tied to the attainment of a health standard?

Wellness Program Types

- **Participatory Programs** are offered to all similarly situated individuals and do not require an individual to meet a standard related to a health factor to obtain an incentive
  - Examples: Fitness center reimbursements ; Diagnostic testing programs that do not base incentives on results; Smoking cessation reimbursements regardless of whether the employee quits smoking
- **Health-Contingent Programs** require an individual to satisfy a standard related to a health factor or undertake more than a similarly situated individual based on a health factor to obtain an incentive
  - **Activity-based**: require an individual to perform or complete an activity related to a health factor. Examples include walking, dieting, or exercise programs
  - **Outcome-based**: require an individual to attain or maintain a specific health outcome such as quitting smoking or attaining certain biometric test results

Wellness Programs and HIPAA Compliance

HUNTON ANDREWS KURTH

- **Participatory Programs** do not violate the nondiscrimination rules if the program is made available to all similarly situated individuals
  - If factors other than health status (like scheduling limitations) limit the individual's ability to take part in the program, that does not mean the plan has violated the nondiscrimination rules.
- **Health-Contingent Programs**, because they discriminate based on health factors, may be exempt from HIPAA's nondiscrimination rules if the following safeguards exists:
  - Limited incentives
  - Reasonable Design
  - Annual Opportunity
  - Reasonable Alternative Standards (RAS)
  - Disclosure of RAS

Wellness Programs and HIPAA Compliance

HUNTON ANDREWS KURTH

- **Limited Incentive**: Generally, the total incentive must not exceed 30% (or 50% for programs designed to prevent or reduce tobacco use) of the cost of employee-only coverage under the plan.
  - If dependents (such as spouses and/or dependent children) may participate in the wellness program, the incentive must not exceed 50 percent of the cost of the coverage in which an employee and any dependents are enrolled.
- **Reasonable Design**: The program must be reasonably designed to promote health or prevent disease. For this purpose, it must:
  - Have a reasonable chance of improving health or preventing disease;
  - Not be overly burdensome;
  - Not be a subterfuge for discriminating based on a health factor; and
  - Not be highly suspect in method.

Wellness Programs and HIPAA Compliance

HUNTON ANDREWS KURTH

- **Annual Opportunity**: The program must give eligible individuals an opportunity to qualify for the incentive at least once per year.
- **Reasonable Alternative**: Must be made available to individuals for whom it is unreasonably difficult due to a medical condition to satisfy the original standard during that period
- **Disclosure**: The availability of a reasonable alternative standard (or waiver of the original standard) must be disclosed in all plan materials describing the terms of the program.
  - For outcome-based programs, this information must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard
    - Model Disclosure: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-c.pdf

Other Required Notices

HUNTON ANDREWS KURTH

HIPAA Special Enrollment Rights Notice

- Inform employees who previously declined health coverage to enroll for coverage regardless of a plan's open enrollment period upon the occurrence of specific events (i.e., marriage, birth/adoption, loss of other coverage)
- Employers must provide each eligible employee with this notice at or before the time an employee is initially offered enrollment in a group health plan. This notice is typically incorporated into the plan's Summary Plan Description (SPD).
  - Model Notice: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-c.pdf

Initial COBRA Notice

- Employers with 20 or more employees who are subject to COBRA and who sponsor group health plans must provide an initial COBRA notice to new participants and their covered dependents within 90 days after commencement of coverage under the plan. This notice is required to be distributed to both employees as well as dependents who enroll in COBRA-eligible plan.
- This notice is typically included in the SPD
  - Model Notice: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/cobra/model-general-notice.docx

Newborns' and Mothers' Health Protection Act (NMHPA)

- Informs plan participants of the protections provided to mothers and their newborn children with respect to the length of hospital stays after childbirth
- This notice must be included in the SPD which is provided annually
  - Model Notice: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-c.pdf

Other Required Notices

HUNTON ANDREWS KURTH

Women's Health and Cancer Rights Act (WHCRA)

- Informs employees of coverage for reconstructive surgery and other items and procedures related to a mastectomy
- This notice must be provided when an employee enrolls in coverage and annually
  - Model Notice: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-c.pdf

Medicare Part D Notice of Creditable or Non Creditable Coverage

- Inform employees whether prescription drug coverage is at least as rich as Medicare Part D to avoid penalties
- This notice must be provided no later than October 15th each year
  - Model Notices: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters

Children's Health Insurance Program (CHIP) Notice

- Inform employees they may be eligible for premium assistance through CHIP or Medicaid state programs
- This notice must be provided annually and is typically included with other required annual notices
  - Model Notice: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.doc

Other Required Notices

HUNTON ANDREWS KURTH

Notice of Patient Protections

- Employers sponsoring a health plan with options that require designation of a primary care provider (e.g., HMOs) must provide the notice (there is no requirement to distribute the notice annually)
- Required to be included whenever an SPD or other similar description of benefits is provided
  - Model Notice: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/patient-protection-model-notice.doc

Surprise Billing Notice

- Notice required to inform employees concerning the No Surprise Act's (NSA) protections against surprise billing. The Notice must include:
  - a summary of the consumer protections afforded by the NSA;
  - a summary of any applicable state balance billing law; and
  - appropriate contact information for state and federal agencies that an individual may contact if the individual believes the facility or provider has violated a requirement specified in the notice
- Notice must be posted in a publicly accessible location, posted on a public website, and included on each explanation of benefits
  - Model Notice: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf

Best Practices

HUNTON ANDREWS KURTH

- Get to know your plan
  - Do you have the appropriate plan documentation?
  - Does the content of those documents align with ERISA, ACA, HIPAA, mental health parity and other legal requirements?
- Have a process in place to review your plan for compliance regularly
  - Refer to the DOL’s self-compliance tool for guidance
- Review how, when and to whom your required notices, SPDs, SMMs, SBCs, etc. are being distributed
- Monitor your vendors
- Have a procedure in place for maintaining and storing plan documentation, vendor contracts, etc.

Upcoming Webinars

HUNTON ANDREWS KURTH

Executive Compensation Academy

- Title: Current 280G Mitigation Techniques
- When: April 13, 2023
- Time: 10:00 am – 11:00 am CT

  11:00 am – 12:00 pm ET

Employee Benefits Academy

- Title: A Return to "Normal" – Preparing Your Benefit Plan for the End of the COVID-19 Emergencies
- When: May 25, 2023
- Time: 10:00 am – 11:00 am CT

  11:00 am – 12:00 pm ET

© 2022 Hunton Andrews Kurth LLP. Attorney advertising materials. These materials have been prepared for informational purposes only and are not legal advice. This presentation may not be reproduced without prior written consent from Hunton Andrews Kurth LLP. Hunton Andrews Kurth, the Hunton Andrews Kurth logo, HuntonAK and the HuntonAK logo are service marks of Hunton Andrews Kurth LLP. Contact: Walfrido J. Martinez, Managing Partner, Hunton Andrews Kurth LLP, 2200 Pennsylvania Avenue, NW, Washington, DC, 202.955.1500. Receipt of these materials does not constitute an attorney-client relationship. Prior results do not guarantee a similar outcome.