New Healthcare Laws Impact Employee Benefit Plans

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BREAKING NEWS

On February 17, 2009, President Obama signed the "American Recovery and Reinvestment Act," commonly referred to as the stimulus bill. Among its many provisions is one that directly impacts employers and their group health plans. Effective March 1, 2009, an employer with a group health plan must subsidize health plan continuation coverage (either under COBRA or state continuation laws) for any employee involuntarily terminated between September 1, 2008, and December 31, 2009. The employer must pay 65% of the cost and the employee 35%. This special employer subsidy lasts nine months or until the terminated employee is eligible to be covered by another group health plan or Medicare. The employer reimburses itself for this cost by taking a credit against future payroll taxes. The Department of Labor must issue model notices to be sent to affected employees within 30 days of the signing of the law. In addition, guidance is expected to be provided on the meaning of involuntary termination. Employers are urged to seek legal advice as soon as possible on their obligations under this law.

SOME IMPORTANT HEALTH PLAN LAWS PASSED IN 2008

During 2008, several laws were passed that take effect for some employers during 2009. These laws affect the benefits and design of employer-sponsored employee group health plans, which should be of interest to physicians who both sponsor such plans as well as those who treat patients whose care will be paid for by such plans.

1. Wellstone-Dominici Mental Health Parity and Addiction Equity Act

The law with the most impact is the Wellstone-Dominici Mental Health Parity and Addiction Equity Act. This was passed during October of 2008 as part of the negotiations over the financial institution bailout legislation. The Act will apply to healthcare plan years starting on and after October 3, 2009. This means for calendar-year plans that the new provisions take effect January 1, 2010. The law applies only to employers with 50 or more employees.

The law does not mandate that an employer-sponsored group health plan provide mental health or addiction benefits, but it states that if such benefits are provided they must be provided on the same basis as benefits are provided for medical and surgical conditions. This means a group health plan can no longer charge higher co-pays or set limits on the number of covered visits or days of in-patient treatment that differ from those applicable to medical conditions. Along these same lines, if a group health plan does not require that services for physical ailments be rendered by a network provider, it cannot require that mental health services be provided within a network. This is a major change, in that in the past plans often limited mental health services to those provided by a specific network of healthcare providers in order to contain costs.

As was the case with the earlier Mental Health Parity Act, there is an exemption from the Act on account of costs. If an employer can show after a year of mental health coverage in compliance with the new law that costs increase by more than 2% (or by 1% for each year thereafter), then the employer is exempt from the Act for the next plan year only. However, an actuary must be hired to perform this calculation, which might make it of limited use.

2. Michelle's Law

A second law enacted during 2008, which has a more limited scope, is "Michelle's Law," named after a college student who lost her health insurance coverage when she had to drop out of college due to a severe illness.

In the past, a full-time college student could usually be covered under a parent's group health plan as long as the individual retained full student status. However, once that status was lost, such as due to illness requiring dropping out of college, the health plan coverage was lost as well. Under this new law, coverage will be required to

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be continued for a full-time student who drops out of college due to a serious medical condition on the same basis as for individuals who do remain full-time students for a period of 12 months, or less if coverage would have ended anyway. An example of coverage ending anyway would be the attainment of a certain age such as age 23.

The law raises some administrative issues in that it requires that coverage be continued when a leave of absence from college is "medically necessary," and a physician must certify this fact. Still unanswered is how this will work as a student's medical condition changes. Hopefully, regulations will clarify how changes in the seriousness of a medical condition will impact this right of health coverage continuation. Michelle's law has an effective date of plan years beginning on or after October 9, 2009.

3. Genetic Information Nondiscrimination Act

Another law enacted during 2008 was the Genetic Information Nondiscrimination Act. This law applies to both employers for employment purposes and to group health plans. Neither can use genetic information in a discriminatory manner. The law applies to group health plans for plan years beginning after May 21, 2009, meaning January 1, 2010, for calendar-year plans. The law applies to employers for employment purposes as of November 21, 2009.

Group health plans and insurers cannot require that a participant take a genetic test, and enrollment and premium costs under group health plans cannot be affected in any manner by genetic information.

For purposes of group health plans (both self-insured and commercially insured), a genetic test does not include an analysis relating to a manifested disease. Thus for health insurance, information regarding an existing disease can still be required. This same rule does not apply in the employment context. In other words, an employer has no right to require or obtain results from a genetic test for employment purposes even if the results relate to an existing disease. There is a limited exception from this rule in cases where the employer is monitoring the biological effects of toxic substances.

Genetic information is not only the obvious result of a genetic test but also the "manifestation of a disease or disorder" in family members. This would appear to mean that no longer can a plan or insurer ask any questions about the history of disease in a participant's family.

This law will have an impact on employer wellness programs as well. If a wellness program provides genetic services, it must be structured so that only the employee or a board-certified genetic counselor providing the services can receive genetic information that would be identified as relating to a particular individual. The employer can only receive such information on an aggregate basis.

It should be noted that Congress did make it clear that nothing in this legislation would prevent a healthcare provider from requesting that a patient take a genetic test if such a test is part of regular healthcare practices. In addition, Congress said a health plan or insurer can require a minimal amount of information about a genetic test in order to pay a claim. This becomes important when a test is run more frequently than it would be under general medical standards. The example in the legislative history concerns a colonoscopy run annually. Because a healthcare plan may normally cover such a test only every 10 years for screening purposes, the plan can require enough genetic test information to justify running the test more frequently.

CONTINUING LITIGATION ON EXPENSES INCURRED UNDER A 401(K) PLAN

As readers are aware from previous columns, there is increasing litigation over the investment fees paid by plan participants under those ERISA-defined contribution plans in which fees are deducted from a participant's account. There is less controversy when all fees are paid by the plan sponsor.

In the case of *Braden v. Wal-Mart Stores Inc*, decided October 28, 2008, a plan participant brought a lawsuit on the grounds that Wal-Mart selected investments, primarily mutual funds, that charged excessively high fees. The 10 mutual funds in question were indeed actively managed and had higher fees than passively managed funds.

The court dismissed the lawsuit saying there was no evidence that Wal-Mart failed to investigate thoroughly the fees involved. The key to this favorable result for the employer was that looking at fees in itself is not sufficient to show a fiduciary breach but rather one must look to the entire thought process to see if it meets fiduciary standards. As the court said:

> *As fiduciaries, Wal-Mart and the RPC were expected to "defray reasonable expenses of administering the plan . . . ," 29 U.S.C. § 1104(a)(1), by establishing a prudent process to select the Plan's investment options and evaluate the merits of those investments. Here, Plaintiff makes no factual allegations regarding the fiduciaries' conduct. Instead, Plaintiff states the expense ratios and fees were unreasonable and that alternatives were available. None of these allegations show Wal-Mart and the RPC did not investigate all decisions that would affect the Plan. Plaintiff makes conclusory allegations that fiduciaries did not analyze options or use a proper process to investigate the merits and structure of the Plan without any factual support. Wal-Mart and the RPC could have chosen funds with higher fees for any number of reasons, including potential for higher return, lower financial risk, more services offered, or greater management flexibility. Plaintiff's dissatisfaction with fees or earnings does nothing to establish a colorable claim that*

Wal-Mart and the RPC did not properly investigate available options before making a decision.

This case serves as a reminder that plan sponsors must document decision-making with regard to investments offered under retirement plans. As this case shows, a sponsor will most likely not be successfully sued just because there may be a lower cost investment available as long as it can be shown the decision that was made involved a thorough investigation and that multiple factors came into play in making the decision.

NEW RULES UNDER THE FAMILY AND MEDICAL LEAVE ACT

For those medical practices of 50 or more employees, it is important to note that a whole new set of regulations have been issued under the Family and Medical Leave Act (FMLA), originally enacted in 1993. The new regulations took effect in January 16, 2009.

Major changes have been made to an employer's obligation to notify employees of their rights and obligations under FMLA. New model notices have been issued, which means physicians will be receiving a new version of the certification of healthcare provider for an employee's serious health condition. A new form has been designed to handle the situation in which an employee asks for a leave to care for a family member with a serious health condition.

The new regulations permit an employer to follow-up with the healthcare provider for purposes of clarification and authentication although such follow-up must occur through a healthcare provider, human resources professional, leave administrator, or management official. The employee's direct supervisor cannot request this information.

Finally, recently enacted changes to the FMLA statute that provide new rights to employees and family members serving in the military are incorporated in the regulations as well.

NEW WARNING FROM IRS ON BUSINESS START-UP AND RETIREMENT PLAN ASSETS

The IRS has issued a ruling warning against the following scenario. A new corporation is established with a new retirement plan. The owner of the new corporation rolls over proceeds from a prior employer's retirement plan to the new plan. Then an exchange occurs between the rolled-over assets and corporate stock. As a result, the owner has instant business capital without paying any taxes. The IRS will be examining such transactions very carefully because taxes are being circumvented under this process. ■

The above discussion is intended to briefly summarize certain recent legal developments in employee benefits, but is not intended to be legal advice and must not be relied upon as such. All readers are urged to raise any concerns they may have based on matters discussed in this column with experienced benefits legal counsel.