


BURNHAM BENEFITS
INSURANCE SERVICES

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Health and Welfare Plans: 2009 - 2010 Legislative Summary

A number of legislative changes affecting health and welfare plans require implementation in 2009 or 2010. This Legislative Summary provides an overview of major developments. Employers should review their benefit programs and documents to determine whether they are compliant with the new laws and make changes as necessary.

Children's Health Insurance Program—CHIP Annual Notice Requirement

Employers that maintain group health plans in states that provide premium assistance for the purchase of group health plan coverage under a Medicaid or Children's Health Insurance Program ("CHIP") now have a new notice obligation. The vast majority of states provide this premium assistance, including California, so most employers are impacted.

As a California employer, you must provide a notice to your employees informing them of possible premium assistance opportunities in the states in which they reside ("CHIP Notice"). The initial CHIP Notices must be provided by calendar year plans by January 1, 2011 (for others, the deadline is the later of (1) the first day of the first plan year that begins on or after February 4, 2010; or (2) May 1, 2010). Following the initial notice the CHIP Notices must be provided annually before the start of each plan year.

Medicare Reporting Rules

The Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA") added new mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plans as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation. The purpose of the new reporting rules is to enable Medicare to correctly pay for the health insurance benefits of Medicare beneficiaries by determining whether Medicare or other insurance is required to pay first.

In general, employers will not have any reporting obligations if they have an insurer or third-party administrator to assume the role of responsible reporting entity ("RRE"). Employers with self-insured benefit programs will have to register as an RRE and will remain responsible for reporting. Reporting for group health plans is scheduled to begin **October 1, 2009**. Reporting for self-insured liability arrangements such as workers' compensation is scheduled to begin **July 1, 2010**.

New HIPAA HITECH Rules

Effective February 17, 2010, and as a result of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), business associates are directly subject to certain provisions of the Health Insurance Portability and Accountability Act ("HIPAA") privacy and security regulations.

The American Recovery and Reinvestment Act of 2009 made a number of significant changes to the Privacy and Security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under the new rules, Covered Entities now have an affirmative obligation to notify individuals if their "unsecured PHI" is breached. Business Associates must notify the applicable Covered Entity of a breach involving that Covered Entity's unsecured PHI.

Unsecured PHI is PHI that is not secured through the use of a technology or methodology specified by the Department of Health and Human Services. HHS has specified that encryption and destruction are the two

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methods available for securing PHI. The breach notification rules were effective **September 23, 2009.**

HIPAA has been expanded to impose additional obligations on Business Associates that require revisions to any Business Associate Agreements. Business Associates are now directly subject to many provisions of the Privacy and Security Rules, rather than being governed merely by agreements with Covered Entities. Other changes include changes to the "minimum necessary" standard, restrictions on disclosures, expanded individual rights, and increased penalties for violations.

COBRA Subsidy Extension

ARRA initially provided a 65 percent COBRA premium subsidy for individuals losing health coverage due to involuntary termination of employment between September 1, 2008, and December 31, 2009. The subsidy is generally provided by the employer sponsoring the plan, which is reimbursed through payroll tax offsets. In December 2009, Congress approved an extension of the subsidy to individuals who lose health coverage because of involuntary terminations that occur through February 28, 2010, and to extend the premium subsidy period to 15 months.

Notice of the extension must be provided to eligible individuals. The Department of Labor has issued model notices. Employees who are now eligible for the extended subsidy but who let their COBRA coverage lapse because they thought the subsidy was ending must be allowed to re-enroll in COBRA by paying the subsidized portion of the premium. Employees who paid the full amount of the premium must be reimbursed the excess amount or given a credit for future months.

Excise Tax Reporting Requirements

Group health plans are responsible for compliance with a number of federal laws, such as COBRA, HIPAA Portability, GINA, MHPAEA, Michelle's Law and the Newborns' and Mothers' Health Protection Act ("NMHPA"). If a group health plan does not comply with these requirements, the employer maintaining the plan is subject to an excise tax. Employers are also subject to an excise tax if they do not satisfy comparable contribution rules for health savings accounts ("HSAs"). The Internal Revenue Service (IRS) has issued final regulations on reporting and paying the applicable excise tax, which are effective **January 1, 2010**.

Excise taxes must be reported on IRS Form 8928, "Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code." The due date for the filing and payment of the tax varies depending on the rules violated and the responsible entity. The excise tax may be waived if the failure is not discovered when exercising reasonable diligence, or is due to reasonable cause and is timely corrected. A failure is corrected if it is retroactively undone to the extent possible and the affected beneficiary is placed in a financial position as good as he or she would have been in if the failure had not occurred.

GINA—Genetic Information Non-Discrimination

The Genetic Information Nondiscrimination Act of 2008 ("GINA") provides that group health plans and insurance issuers may not:

- adjust group premium or contribution amounts on the basis of genetic information;
- request or require individuals (or their family members) to undergo a genetic test (with limited exceptions such as for determinations regarding payment based on medical appropriateness); and
- request, require or purchase genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.

Further, GINA amends the definition of protected health information ("PHI") under the HIPAA Privacy Rule to include genetic information.

Recently published GINA regulations clarify that GINA's prohibition on collecting genetic information prior to or in connection with enrollment, or for underwriting purposes, will affect the use of Health Risk Assessments ("HRAs"). HRAs are tools commonly used by wellness and disease management programs. Pursuant to the regulations, group health plans may not:

- provide a reward or incentive for completing an HRA that requests genetic information, such as family medical history; or
- request genetic information as part of an HRA that must be completed before enrollment in the plan or eligibility for additional benefits under the plan, such as a disease management program.

GINA's rules applicable to group health plans and health insurance issuers are effective for plan years beginning after **May 21, 2009** (**January 1, 2010, for calendar year plans**).

Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") imposes additional requirements on group health plans that offer

mental health and substance abuse disorder benefits. Under current law, plans may not impose lower annual and lifetime limits on mental health coverage than those imposed on medical and surgical benefits. The MHPAEA expands the parity requirements to prohibit plans from doing the following:

- imposing higher copayments, deductibles or out-of-pocket limits on mental health and substance abuse treatment benefits than on medical and surgical benefits;
- placing more restrictive limits on the number of covered office visits, days of inpatient coverage or the duration or scope of treatments available for mental health and substance abuse treatment benefits than those available for other types of medical treatment; and
- excluding out-of-network treatment for mental health and substance abuse treatment benefits if out-of-network benefits are providing for medical and surgical benefits.

The MHPAEA does not apply to employers with 50 or fewer employees during the prior plan year. There is also a limited exception for employers for whom compliance would cause a demonstrated financial hardship. The MHPAEA is effective for plan years beginning after **October 3, 2009** (**January 1, 2010, for calendar year plans**).

The Departments of Health and Human Services, Labor and the Treasury ("Departments") issued interim final rules to implement the MHPAEA. The rules are effective on April 5, 2010, and generally apply to group health plans and group health insurance issuers for plan years beginning **on or after July 1, 2010**. The Departments have stated that for purposes of enforcement, they will take into account good-faith efforts to comply with a reasonable interpretation of the statutory MHPAEA requirements with respect to a violation that occurs before the applicability date of the regulations.

Employers that provide mental health or substance abuse benefits must review their benefit plans to ensure they are compliant with the MHPAEA and its regulations. Plans will need to evaluate whether any substantive changes must be made to their plan designs, such as to the deductible. Plans will also need to review the administration of benefits in order to ensure that administrative procedures are in compliance by the regulatory deadline.

Michelle's Law

Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status.

Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. Further, if any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

The law requires group health plans to provide notice of the requirements of Michelle's Law, in language understandable to the typical plan participant, along with any notice regarding a requirement for certifying student status for plan coverage.

Michelle's Law is effective for plan years beginning on or after **October 9, 2009.**

Calendar year plans must comply beginning **January 1, 2010**.

FMLA Amendment - Benefits for Military Employees and Families

The Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART Act") was enacted on June 17, 2008. The HEART Act provided a special rule allowing "qualified reservist distributions" ("QRDs") of unused amounts in a health FSA to reservists called to active duty. Under the existing rules for health FSAs, distributions could only be made to reimburse substantiated medical expenses, and any funds left unspent at the end of the plan year would be lost. This special rule allows reservists to make a distribution before leaving for active duty so as not to lose those savings.

Permitting QRDs is optional for employers. Employers that want to allow QRDs from their health FSAs must amend their plans. Prospective amendments may be made at any time. A transition rule allows plans to be amended effective retroactively to provide for QRDs prior to January 1, 2010. If the amendment is adopted by **December 31, 2009**, it can apply retroactively to an employee who was called to active duty after June 17, 2008. However, the employee must request the distribution by the last day of the plan year in which

the call to active duty occurred.

In addition, amendments to the Family and Medical Leave Act ("FMLA") that were adopted and effective on **October 28, 2009** expand leave benefits for military families. Eligible military family members may take up to 12 weeks of "qualifying exigency leave" for purposes of things like preparing for a short-notice deployment, arranging for child care, making financial or legal arrangements, and resting and recuperating. Pursuant to the FMLA amendments, this leave is available to eligible families of any member of the Armed Forces who is on "covered active duty" in a foreign country, not just those in the Reserves or National Guard. The FMLA amendments also expand the 26-week military caregiver leave to the families of veterans with serious injuries or illnesses as well as active members.

Employers subject to the FMLA should review their policies and procedures regarding military leave to ensure that they are in compliance with the new requirements as soon as possible, and make revisions as necessary. Employers should also communicate the changes to their employees and expect that more employees will be entitled to leave. The Department of Labor is expected to issue an updated FMLA notice to include the changes.

Cafeteria Plan Regulations

The Internal Revenue Service issued proposed regulations regarding cafeteria plans in August 2007. These regulations provide guidance regarding written plan document requirements, reimbursable expenses, nondiscrimination testing and timing of reimbursements. Although the regulations are not final, employers may rely on them in their good faith compliance efforts. Final regulations have been expected for some time, but have not yet been released. No guidance has been provided on when regulations will be finalized. In anticipation of final regulations, employers may want to review their current plan documents and compare them with the proposed regulations.

Please contact your Burnham Benefits representative with any questions.

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