



# BENEFIT *Advisor*

## In This Issue

*In this final issue of the McGraw Wentworth Benefit Advisor for 2009, we review the important developments that affected employee benefit programs this year. We also review the year-end housekeeping issues organizations should revisit annually.*

*We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth web site at [www.mcgrawwentworth.com](http://www.mcgrawwentworth.com).*

## “2009 Year-End Review”

Unfortunately, the economy continued a year long struggle in 2009. Most organizations in our area have been challenged by our weak economy.

Even though Congress has worked diligently on health care reform, no bill has passed both houses and the provisions of proposed bills change almost daily. With all the emphasis on health care reform, you would think the government would not have the time to pass additional rules on employer benefit plans. However, quite a few rules affecting employee benefit plans were passed or clarified this year.

Below is a summary of the key 2009 changes:

- Final FMLA regulations became effective at the beginning of 2009. In addition, toward the end of 2009 Congress made changes to the FMLA and clarified FMLA rights for members of the armed forces.
- Michelle’s Law took effect, extending health care coverage to dependent students too ill to continue in school full-time.

- The Genetic Information Non-Discrimination Act or GINA took effect in 2009. Several aspects of GINA were clarified throughout the year.
- Mental Health Parity provisions will affect most organizations in late 2009 or early 2010.



- HIPAA Special Enrollment rights were amended in an effort to provide universal health care coverage to children.

- HITECH, a piece of legislation included in ARRA (American Reinvestment and Recovery Act of 2009) significantly changed HIPAA’s Privacy and Security Rules.
- ARRA also included provisions changing several aspects of COBRA coverage and also changing employer notice requirements.
- Most employers must file Form 5500 electronically beginning this year.

Employers should review our annual summary to ensure they are complying with these new rules. Although certain rules have not taken effect yet, employers need to understand them in order to plan for next year.

## Final FMLA Regulations with Service Member Changes

New Family Medical Leave Act (FMLA) regulations took effect on January 16, 2009. Employers were not given much lead-time between the date of their release and the date they became effective. The new regulations did clarify some complicated issues. Check our January 2009 *Benefit Advisor* for a comprehensive discussion of these regulations at [http://mcgrawhrentworth.com/Benefit\\_Advisor/2009/BA\\_Issue\\_1.pdf](http://mcgrawhrentworth.com/Benefit_Advisor/2009/BA_Issue_1.pdf).

These new final regulations include the following key points:

- They clarify responsibilities in joint employer situations; for example, when a temporary employment agency places a worker with another employer to perform duties on behalf of that employer.
- They clarify the first criterion an employee must meet to be eligible for FMLA: namely, the employee must have worked for the employer for at least 12 months. The 12 months need not be consecutive, and employers are not required to count time worked before a seven year break in service. A call to active duty in the



armed forces cannot be counted as a break in service.

- They define family members such as a spouse, a parent, a son or daughter and next of kin. The FMLA does allow employers to request reasonable proof a family relationship exists.
- Unfortunately they do not provide any additional details clarifying the definition of a serious health condition. Employers routinely struggle with this issue when they

administer the FMLA. In fact, the new regulations only slightly modify the definition. The regulations do include new model forms employers can require

employees to complete to confirm they need the leave for a serious health condition.

- They confirm employers only need to allow 12 weeks of leave for the birth of a child if the same organization employs both the father and the mother. The rules include many more details for employees requesting leaves to adopt or take in a child in foster care. Finally, employers need not offer intermittent leave after a child is born or adopted, but they certainly can allow it if they choose.

- They give more details on the expanded FMLA rights for covered service members called to active duty. The final regulations also provide more details on the extended leave to care for a seriously ill or injured active duty member of the armed services.
- They again require employers to specify how they calculate the leave year. The leave year is any 12-month period in which the 12 weeks of FMLA may be taken. If the employer specifies the calendar year or a fixed 12-month period, in some cases, FMLA leave time may be stacked.
- They do not clarify the rules for managing intermittent leaves.
- They discuss the FMLA and other types of leaves in practical terms. The employer can require employees to take accrued paid leave during an FMLA leave if this requirement applies to all other unpaid leaves. The new regulations also confirm how an FMLA leave and a workers' compensation leave can run concurrently. For example, a workers' compensation carrier can offer light duty, but if the employee still has FMLA leave time available, the employee does not have to return to work until the FMLA leave is exhausted. However, if the employer requires light duty as a condition for continued workers' compensation benefits and the employee does not return to work, the workers' compensation benefits can stop. Job protection must continue for the timeframe the FMLA allows.

## NOTABLE THOUGHTS

**YOU CAN EASILY JUDGE THE CHARACTER OF A MAN BY HOW HE TREATS THOSE WHO CAN DO NOTHING FOR HIM.**

**JAMES D. MILES**

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- They do clarify an important issue for employers in these difficult times. Employers do not need to offer greater protections to employees on an FMLA leave than they offer employees actively at work. For example, if your organization intends to lay off a group of employees and one of the employees is on an FMLA leave, you can lay off the employee on the leave. However, your organization must show that the employee would have been laid off regardless of the leave.
- They fine tuned FMLA notice requirements quite a bit and offer new model notices.



The new FMLA regulations clarified quite a few issues that employers need to understand. If your organization did not make these changes at the beginning of the year, you should add an FMLA review to your 2010 work plan.

At the end of 2009, President Obama signed into law the National Defense Authorization Act for Fiscal Year 2010. This defense-related legislation made a couple of changes to the FMLA's qualifying exigency leave and covered service member leave. These changes are explained in our ninth *Special Alert of 2009* at [http://mcgrawhrentworth.com/Special\\_Alert/2009/Special\\_Alert\\_Issue\\_9.pdf](http://mcgrawhrentworth.com/Special_Alert/2009/Special_Alert_Issue_9.pdf).

The basic changes are as follows:

- An employee qualifies for a leave when the employee's son, daughter, or parent is on "covered active duty" in the Armed Forces or has been told of an impending call or order to duty.

*Covered active duty* is a new term. For members of the Armed Forces, it means duty outside the United States. For members

of the Reserves, it means a call or order to active duty outside the United States as specified by federal law.

- The covered service member's leave rights have been expanded. The changes allow leaves for the following:
  - Medical treatment, recuperation or therapy for serious injury or illness incurred in the line of duty or aggravated during active duty.
  - An illness or injury that may not appear immediately after active duty. Some illnesses or injuries may not be evident for some time. To qualify, the treatment, recuperation or therapy must begin within the five years of active duty in the Armed Services and be related to that service time.

Employers may need to amend their FMLA policies to reflect these changes.

## Michelle's Law

Michelle's Law becomes effective on the first day of the first plan year following October 8, 2009. The law affects a dependent child's health plan eligibility for calendar year health plans as of January 1, 2010. It applies to students covered by a group health plan and enrolled in a post-secondary educational institution the day before the first day of a medically necessary leave of absence.

The law does not apply if the plan did not cover the dependent the day before the medically necessary leave of absence. It also does not require the health plan to cover a dependent child not previously covered.

Under Michelle's Law group health plans must continue to cover dependent students for ***one year following the first day of a medically necessary leave of absence from school or until the date the student's coverage would otherwise have ended.*** This extended leave applies ***only if*** the student will lose coverage under the health plan because he or she is too ill to attend classes on a full time basis.

Unfortunately, the law does not clearly define a medically necessary leave of absence. As a result, employers will be challenged to administer this coverage extension effectively. The law merely requires that the leave:

1. Begin when the student is diagnosed with a serious illness or injury.
2. Is medically necessary.
3. Causes the student to lose full-time status under the group health plan terms.

The law does allow the health plan or health insurer to ask the treating physician to verify in writing that the leave is indeed medically necessary. It does not specify, however, the type of information the health plan may request or the actions a health plan can take if the physician does not verify the leave is necessary.

When a group health plan or group insurance issuer notifies employees that they need to certify a covered dependent is a full-time student, the plan must also notify the employee that the health plan will continue to cover the student for one year of a medically necessary leave of absence from school.

Health plans commonly request proof the dependent is a full-time student at least once a year; some plans request proof each semester. Employers must include information on Michelle's Law in any notice regarding this requirement. Employers and health plans will also need to provide this leave information in any documents dealing with health plan eligibility, including an open enrollment newsletter, new hire communications, any eligibility documents posted on the intranet and even in the Summary Plan Description.

If you haven't considered this issue yet, ask your health plan vendor to help you modify your plan documents to comply with Michelle's Law.

### Genetic Information Non-Discrimination Act or GINA

GINA will also affect many employers and health plans this year or early next year. GINA is complicated even with various pieces of guidance issued throughout the year. For more detailed informa-

## NOTABLE THOUGHTS

**ONE OF THE TRUE TESTS OF LEADERSHIP IS THE ABILITY TO RECOGNIZE A PROBLEM BEFORE IT BECOMES AN EMERGENCY.**

**ARNOLD GLASOW**

tion on GINA, please read our October 2008 and July 2009 *Benefit Advisors* at [http://mcgrawworth.com/resources/benefits\\_advisor.html](http://mcgrawworth.com/resources/benefits_advisor.html). In addition, check our *Special Alert* from November of 2009 discussing GINA's effect on wellness plans at [http://mcgrawworth.com/Special\\_Alert/2009/Special\\_Alert\\_Issue\\_8.pdf](http://mcgrawworth.com/Special_Alert/2009/Special_Alert_Issue_8.pdf).

GINA is divided into two titles. Title I covers health plans and genetic information. Title II covers employment practices and genetic information.

Title I states:

- **Insurance carriers and employers cannot increase group premiums because of genetic information.** Since the Health Insurance Portability and Accountability Act also prohibits discrimination based on genetic information, most employers and health insurance carriers have already removed discriminatory provisions from their contracts.
- **Insurance carriers and employers cannot use genetic information to determine eligibility or set premiums in the individual and Medigap Markets.** This provision will affect wellness plans if the health risk assessment includes family health

history questions and the employer offers premium incentives or benefits incentives to complete the health risk assessment.

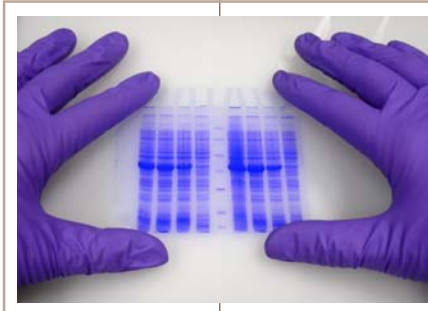
- **Group health plans, individual insurance carriers and Medigap markets may use genetic data only under specific conditions.**

In general, they cannot request or require genetic testing. The health plan may, however, request genetic test results to

determine whether the test is a covered service. In this case, the plan can request only the minimum amount of information necessary to

make a determination. The law does include exceptions to this provision for research studies.

- **The Health Insurance Privacy and Accountability Act rules apply to GINA.** GINA does not override HIPAA rules for using and disclosing information. Group health plans can still use health information for the reasons HIPAA specifies, including plan administrative functions.



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Title II of GINA prohibits employers from using or deliberately acquiring genetic information as a condition of employment, requires employers to keep genetic information confidential and strictly limits certain entities from disclosing genetic information on employees as well as applicants.

GINA establishes a wide range of prohibited discriminatory practices in the work place. Employers cannot discriminate based on genetic conditions in:

- Hiring, promotion, and demotion
- Seniority
- Discipline and termination
- Compensation and the conditions and privileges of employment

Employers cannot segregate or classify employees because of genetic information, such as a family history of serious heart conditions. Let's say an employee with a family history of heart conditions has a stressful job and the employer is concerned that the stress may seriously affect the employee's health. The employer cannot reassign the employee to a less stressful position without risking being charged with genetic discrimination.

Employers cannot ask other entities to discriminate; for example, they cannot require an employment agency to ask applicants for genetic information then tell that agency not to forward any candidates with family histories of specific conditions. In these cases, both the em-

ployers and the employment agencies would be violating the GINA employment terms.

GINA does allow employers access to genetic information, but only in the following six instances:

1. Inadvertently Requesting or Requiring Genetic Information
2. Health or Genetic Services
3. Family Medical Leave Act
4. Commercially and Publicly Available Information
5. Genetic Monitoring
6. DNA Testing for Law Enforcement or Human Remains Identification Purposes

GINA also includes confidentiality provisions if employers ever have a reason to maintain genetic information. GINA requires employers to treat this information confidentially just as they treat other medical information they must use or maintain. As a rule, GINA prohibits employers from disclosing genetic information. They can reveal this information only in the following situations:

- Employees request their own genetic information.
- An occupational health researcher requests the information if the research complies with federal or state law.
- A court requests the information; the information released must be tailored to the court order. The employer must also notify the employee the information is being released because of a court order.

- Government officials request relevant information to determine compliance with a statute.
- Employers need to disclose the information to comply with FMLA or any similar state leave law.
- Federal, state or local public health officials need the information to deal with a contagious disease that presents an imminent hazard.

GINA's employer restrictions are more complex than its group health plan restrictions.

### Mental Health Parity

The Wellstone Act was passed in October 2008 and is just now affecting many group health plans. This act requires mental health plan coverage to be truly equivalent to other medical and surgical expense coverage.

Many organizations are confused about the effective date for the Wellstone Act. The effective date can vary depending on your situation:

- Mental health parity rules affect health plans as of the first day of the first ERISA plan year after October 3, 2009. Be careful, sometimes your ERISA plan year is not the same as your health insurance policy renewal year. Some organizations are not subject to ERISA. If that is the case, your organization should use your policy renewal date.



• If your plan is subject to a collective bargaining agreement, that agreement may determine the effective date for the mental health parity rules. The effective date for the new Mental Health Parity rules for group health plans under collective bargaining agreements ratified before October 3, 2008 is explained below. The changes to Mental Health Parity rules do not apply to **plan years beginning before the later of:**



- A. The date on which the **longest running collective bargaining agreement** relating to the plan ends (regardless of any extensions); ***or***
- B. January 1, 2010.

While this seems straightforward, it is no wonder that employers are confused. Please consider the following:

1. If your health plan has two or more **collective bargaining agreements**, your plan technically does not need to improve mental health benefits until the longest running **collective bargaining agreement** expires.
2. Please note, the Mental Health Parity rule changes will not apply until the beginning of plan year following the expiration of the longest running agreement. In most collective bargaining agreements, effective dates are not necessarily tied to the plan year, so you are not required to make the benefit changes mid-plan year.

This Act requires most health plans to adjust their mental health and substance abuse coverage as follows:

- The Wellstone Act extends the “equivalent benefit requirement” to both mental health and substance abuse benefits; thus most health plans will have to revise their limits on these benefits. The law defines substance abuse benefits as “benefits with respect to the treatment of substance abuse as defined by the health

plan and in accordance with Federal and State law.”

- Parity provisions apply to all health plan costs the employee must pay, such as copayments, coinsurance, deductibles and any other out-of-pocket expenses. The plan must treat mental health and substance abuse benefits in the same way it treats medical and surgical benefits.
- Some health plans cover mental health and substance abuse services only if the patient uses an in-network provider. If you cover other medically necessary services in- and out-of-network, you will also need to cover mental health and substance abuse services in- and out-of-network in order to comply with the Wellstone Act.
- The plan must indicate the type of mental health and substance abuse services that it will cover.

The Act does not *require* the plan to cover mental health or substance abuse services. However, if the plan does cover these services, it must cover them in substantially the same way it covers all other medically necessary services.

The actual wording of the Wellstone Act is fairly vague. The Department of Health and Human Services is currently drafting new rules to clarify the requirements. Those regulations will likely be released in the first quarter of next year.

Most employers will need to comply with the Mental Health Parity rules. The only two exceptions are:

1. ***Small Employer Exception:*** A company with at least two employees (or at least one in states that permit small groups to include only one person) but not more than 50 employees during the preceding year is exempt.
2. ***Cost Exemption:*** Employers can apply for a one-year cost exemption if their total annual cost to comply with the Wellstone Act significantly increases plan cost. An increase of more than 2% during the first year is considered significant. The cost increase to be considered is the combined cost for medical, surgical, mental health and substance abuse coverage. In subsequent years, employers can apply for the cost increase exemption if they can show at least a 1% increase. The cost exemption is very detailed. For more

information on the cost exemption, please see our February 2009 *Benefit Advisor* at [http://mcgrawhrentworth.com/Benefit\\_Advisor/2009/BA\\_Issue\\_2.pdf](http://mcgrawhrentworth.com/Benefit_Advisor/2009/BA_Issue_2.pdf).

Complying with the mental health parity rules has been a challenge for most employers. Hopefully, the new regulations will clarify many of the gray areas.

### HIPAA Special Enrollment Rights

President Obama signed the Children’s Health Insurance Program Reauthorization Act of 2009 on February 4, 2009. This federally funded health insurance program is administered by each state and covers low-income pregnant women and children. The act also covers children who may not be eligible for Medicaid but come from a low income family that cannot afford employer-sponsored health coverage or do not have coverage available. This act expands CHIP and funds it through 2013.

Although the federal government funds CHIP and provides general guidelines, the states determine benefits and delivery systems. For that reason, these programs vary significantly from state to state. MiChild is Michigan’s CHIP program.

The 2009 Reauthorization Act expanded CHIP’s funding and its provisions. One key improvement is the expanded eligibility:

- CHIP is a need-based program. It originally applied to a pregnant woman or child not eligible for the state Medicaid program but with family income less than 200% of the federal poverty level Congress

sets every year. For 2009, the federal poverty level for a family of four is \$22,000 a year. This new act increases the income level to be eligible for CHIP to 300% of the federal poverty level, which roughly equates to \$66,000 for a family of four.

- Some states cover certain non-pregnant adults. These provisions will be phased out over time and non-pregnant adults will no longer be eligible under CHIP.

CHIP is different in each state. Michigan chose not to adopt the increase to 300% of the Federal Poverty Level. They may adopt it in the future. If your employees have questions, they should contact their state of residence CHIP plan.

CHIP now affects employer group health plans in three major ways:

- Potential Premium Assistance
- Special HIPAA Enrollment Rights
- Communication Requirements at Open Enrollment



### Potential Premium Assistance

Michigan does not offer premium assistance, but some other states do. In those states, it may be less expensive for the state to subsidize the employee under the employer’s group health plan than it would be to cover the employee under CHIP plan. Those states may not only subsidize the employee contribution, they may also, in some rare cases, help with out-of-pocket costs for deductibles, coinsurance and so on.

The new act also requires employers to allow employees that qualify for CHIP to disenroll from the group health plan mid-year.

### Special HIPAA Enrollment Rights

The Children’s Health Insurance Program Reauthorization Act of 2009 amends HIPAA, PHSA (Public Health Service Act) and the tax code to create two new special enrollment rights:

1. Plans must allow eligible employees and eligible dependents to enroll in the plan if they are no longer eligible for Medicaid or CHIP.
2. Plans must also allow eligible employees and eligible dependents to enroll in the plan if they become eligible for premium assistance under CHIP. This event is a little tricky. The thought is that if a child is not enrolled in the group health plan, but is approved

for premium assistance under CHIP, the group health plan needs to allow the child to enroll in the plan in order to receive the

premium assistance.

The new law specifies that employees have **60 days** to notify the plan of their eligibility for the CHIP program or premium assistance.

Health plans must recognize these new special enrollment rights as of April 1, 2009.

### **Communication Requirements at Open Enrollment**

Under the new act employers must inform employees about CHIP and the premium assistance provisions. The section explaining this requirement is a little confusing. It appears that employers will need to notify employees of coverage available through CHIP every year:

- The Department of Health and Human Services was to release model notices within a year of Congress passing this Act. It has not as yet issued any model notices.
- The regulations do not include specific notice content or delivery requirements.
- Employers will have time to comply with this notice requirement, though. They must deliver the notice before the first day of the first plan year following the release of the model notice.

The communication section also implies employers will need to include basic information on CHIP in the health plan's SPD and also in other plan communication materials such as open enrollment or new hire newsletters.

Hopefully, the Department of Health and Human Services will clarify notification requirements when model notices are released.

If you would like more information on the Children's Health Insurance Program Reauthorization Act of 2009, please read our third *Special Alert* for 2009 at [http://mcgrawwentworth.com/Special\\_Alert/2009/Special\\_Alert\\_Issue\\_3.pdf](http://mcgrawwentworth.com/Special_Alert/2009/Special_Alert_Issue_3.pdf).

### **HITECH Changes to HIPAA's Privacy and Security Rules**

The American Recovery and Reinvestment Act of 2009 (ARRA) included the Health Information Technology for Economic and Clinical Health Act (HITECH Act) which made several changes to HIPAA's Privacy and Security Rules.

The HITECH Act significantly changed

how breaches and misuses of protected health information and electronic protected health information will be handled. The act strictly regulates the actions a covered entity or a

business associate must take if there is a breach of unsecured protected health information.

If the covered entity has reason to believe a breach of unsecured health information has occurred, the covered entity must notify the person affected within 60 days unless doing so would impede a criminal investigation or harm national security. Business associates must notify the covered entity if a breach occurs.

Not only do the covered entities need to notify the person affected, they also need to notify the Secretary of the Department of Health and Human Services (DHHS). The good news is that if the breach affects fewer

than 500 people, the covered entity can keep a log of breach incidents and notify the Secretary of the DHHS once a year. If the breach affects more than 500 people, the covered entity must notify the Secretary of DHHS and the potentially local media immediately. Local media only needs to be notified if the 500 people affected are in the same state or jurisdiction. The DHHS will then post a list of the covered entities involved in these breaches.

The DHHS recently issued more specific guidelines on handling these breaches. For more details on the breach requirements, please read our October 2009 *Benefit Advisor* at [http://mcgrawwentworth.com/Benefit\\_Advisor/2009/BA\\_Issue\\_10.pdf](http://mcgrawwentworth.com/Benefit_Advisor/2009/BA_Issue_10.pdf).

HITECH expanded HIPAA's individual rights in a number of ways, including:

- Employees can ask to receive their protected health information electronically if possible.
- The employee's right to request restrictions on the use of protected health information has been expanded. Covered entities cannot disclose this information to health plans when the employee has fully paid for the services out-of-pocket and does not intend to ask the health plan to pay for those services.
- The HITECH Act expands the situations when a covered entity must report disclosures of protected health information. Initially, covered entities only had to report certain disclosures every six years.



The HITECH Act expands the situations when a covered entity must report disclosures. The covered entity must now report any disclosures of PHI for treatment, payment and health care operations during the previous three years but only if the disclosures were made through an electronic health record. Covered entities will have more time to comply with this requirement because the government needs to issue more specifics on the information employers must include in these reports. The deadlines for these rules vary as follows:

- For electronic health records dated before January 1, 2009, covered entities must report breaches on or after January 1, 2014.
- For electronic health records dated after January 1, 2009, covered entities must report breaches on or after January 2011.

HITECH also affects the Security Rule. The Department of Health and Human Services will issue annual guidelines discussing the most appropriate technical safeguards covered entities can use to protect health information electronically. This annual guidance will prompt covered entities to review security annually and update their systems when necessary.

The HITECH Act also significantly changed business associates' responsibilities. Under the HITECH Act, the HIPAA Privacy and Security Rules will apply directly to business associates. This change may not significantly affect covered entities themselves. However, they will need to update their business asso-

TYPE OF VIOLATION	POTENTIAL PENALTY
If offenders did not know and could not have reasonably known that they violated the law, ARRA waives the fine if the violation is corrected within 30 days.	\$100 for each violation capped at \$25,000 for all violations of an identical requirement within the calendar year.
If the violation was reasonable and not deliberate, the fine is higher. ARRA waives the fine if the violation is corrected within 30 days.	\$1,000 for each violation capped at \$100,000 for all violations of an identical requirement within the calendar year.
If the violation was deliberate, but corrected, the fine increases.	\$10,000 for each violation capped at \$250,000 for all violations of an identical requirement within the calendar year.
If the violation was deliberate, and not corrected, the fine is even higher.	\$50,000 for each violation capped at \$1,500,000 for all violations of an identical requirement within the calendar year.

ciate agreements to reflect the business associates' additional responsibilities.

The HITECH Act significantly increases the penalties for violating these rules. The changes include four new tiers of civil fines.

- Initially, these fines were \$100 for each violation capped at \$25,000 for violations of the same requirement within a calendar year. The act increased the fines significantly and the penalties listed in the table at the top of this page are effective immediately.
- Under the new act the Office of Civil Rights can investigate potential HIPAA violations, refer cases to the Justice Department for criminal investigation and assess fines if the Justice Department does not prosecute.

- HITECH requires formal investigations and fines for deliberate violations. The Secretary of the Department of Health and Human Services must issue regulations within 18 months after the bill passes to explain the investigation process.

- The act authorizes any state attorney general to sue anyone violating HIPAA rules in federal district courts. Previously, these law suits were not permitted. However, only the state attorney general can sue, and the act limits damages to \$100 for each violation capped at \$25,000.
- Finally the Government Accounting Office must develop a process for allowing harmed individuals to receive a share of the fines. The



Secretary of Health and Human Services has three years to pass legislation based on the recommendations.

Most employers took steps to comply with HIPAA. Your organization will now need to revisit these steps to make sure they are adequate and make changes to meet the new breach requirements.

### ARRA Changes to COBRA Coverage

The American Recovery and Reinvestment Act of 2009 also contained the "Health Insurance Assistance for the Unemployed Act of 2009." This law gives additional federal financial assistance to COBRA-qualified beneficiaries who lost group health plan coverage due to the involuntary termination of their employment.

COBRA-qualified, assistance-eligible individuals can now pay 35% of the COBRA premium rather than the full amount. The 35% premium payment applies only to assistance-eligible individuals and their covered spouses or dependent children who are also qualified beneficiaries. Employers obtain the remaining 65% through tax credits.

To be considered assistance-eligible, a person must:

- Be a qualified beneficiary who became eligible for COBRA between September 1, 2008, and December 31, 2009.
- Have actually elected COBRA continuation coverage.

The government offers premium assistance for nine months. However, premium assistance may end earlier on one of the following dates:

- The first date an individual becomes **eligible** under any other group health plan (unless the coverage is strictly dental, vision, counseling or referral services, or is solely a health reimbursement arrangement or health flexible spending account, or the coverage is through an on-site medical clinic designed to provide first aid or wellness services).
- The date an individual becomes eligible for Medicare.
- The date the maximum continuation coverage period under COBRA expires.

The act also required employers to inform involuntarily terminated employees that government assistance is available and offer them a second chance to elect COBRA.

Most employers have already notified their involuntarily terminated employees about the ARRA assistance. Although the assistance will not apply for eligible qualifying events as of January 1, 2010, Congress is considering three proposals to date to expand the ARRA assistance. Some bills expand the nine month assistance period, others expand the eligibility for events occurring on or after January 1, 2010 and one even increases the amount of the assistance.

It is likely Congress will extend the ARRA assistance. McGraw Wentworth will keep you posted on any extensions.

### Electronic Form 5500 Requirements

The government has not yet delayed the move to mandatory electronic Form 5500 filing. The effective date for mandatory electronic filing currently affects plans beginning on or after January 1, 2009. The Form 5500 must be filed within 210 days following the close of the plan year. For calendar year plans, the Form 5500 filed in July 2010 will now be the first one that must be filed electronically.

The government hopes mandatory electronic filing will save money and time. The goal is to allow plans two options when they submit Form 5500 electronically:

1. Employers may file electronically using a system called EFAST. Employers can choose from a number of EFAST software programs available. The DOL currently has a request for proposal out to update the EFAST software. The software may change, but employers will still have the option to use an approved software vendor to file the Form 5500 electronically.
2. Employers may submit Form 5500 information through the Internet. The government has developed the IFILE system that should be available in January 2010.



The government has posted a number of Frequently Asked Questions on the electronic filing process. The FAQs can be found at <http://www.dol.gov/ebsa/faqs/faq-EFAST2.html>.

**Annual Reminders and Updates**

**2010 Medicare Information**

The Department of Health and Human Services released the Medicare information for 2010 (see table at bottom of page).

Part B premiums are higher for Medicare beneficiaries in a higher income range. The income range and the premiums are adjusted annually. At the end of September 2009, the House of Representatives passed a bill that would freeze the Part B income-based premiums at 2009 levels. The Senate has not taken action on this bill. If the bill is not passed, the income adjusted premiums for 2010 will be as shown in the table at the top of page.

The indexed parameters for Medicare Part D for 2010 are found in the table on page 12.

Medicare Part D may also affect employers sponsoring retiree drug plans. Employers offering retiree prescription drug benefits as good as or better than Medicare benefits

INDIVIDUAL RETURN	JOINT RETURN	2010 PART B MONTHLY PREMIUM
\$85,001-\$107,000	\$170,001-\$214,000	\$154.70
\$107,001-\$160,000	\$214,001-\$320,000	\$221.00
\$160,001-\$214,000	\$320,001-\$428,000	\$287.30
>\$214,000	>\$428,000	\$353.60

can apply for a government-paid subsidy based on a percentage of claims paid. The subsidy equals roughly 28% of prescription claims for Medicare Part D covered medications that fall between the cost threshold and cost limit. The cost threshold and cost limit are also indexed and the 2010 amounts are as follows:

	2010
Cost Threshold	\$305
Cost Limit	\$6,200

For certain employers, the retiree drug subsidy is tax-free. Several of the health care reform bills currently being debated would remove the tax-favored status of the drug subsidy. This may change in the future depending on what type of health reform is passed.

**Medicare Part D Notice Requirements**

Employers need to issue two Medicare Part D notices annually.

The first notice concerns creditable coverage and must be sent to Medicare eligible employees. As a rule, these employees must enroll in Medicare Part D before the deadline in order to avoid a late enrollment penalty. However, if your health care plan is creditable and the Medicare beneficiary maintains creditable coverage, the late enrollment penalty will not apply. More details on the wording of the latest model notice can be found in our first *Special Alert* in 2009 at [http://mcgrawwentworth.com/Special\\_Alert/2009/Special\\_Alert\\_Issue\\_1.pdf](http://mcgrawwentworth.com/Special_Alert/2009/Special_Alert_Issue_1.pdf).

More details on the delivery requirements for the Medicare notices can be found at [http://www.mcgrawwentworth.com/Special\\_Alert/2007/Special\\_Alert\\_Issue\\_4.pdf](http://www.mcgrawwentworth.com/Special_Alert/2007/Special_Alert_Issue_4.pdf).

The second notice must be filed directly with CMS. It states your plan's creditable coverage status. It must be sent electronically within 60 days of the beginning of the plan year. Completing the online notice does not take much time; the toughest part is remembering to actually complete it. You can complete the online filing at [https://www.cms.hhs.gov/CreditableCoverage/45\\_CCDisclosureForm.asp](https://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp).

**Medicare Information**

Medicare Part A Deductible (per benefit period)	\$1,100.00
Hospital <b>Per Day</b> Copay (per benefit period)	
60 to 90 day stays	\$275.00
90+ day stays	\$550.00
Skilled Nursing Facility <b>Per Day</b> Copay (after 20 days)	\$137.50
Medicare Part B Monthly Premiums	\$110.50
Medicare Part B Annual Deductible	\$155.00

**Group Term Life Insurance:  
Section 79**

Each year employers need to review the group term life coverage they offer to determine whether employees need to pay taxes on it. Employers have to impute income for the value of the life insurance plan in only a few instances:

- If the employer-paid life insurance exceeds \$50,000.
- If the life plan favors key employees.
- If the employee-paid optional life plan rate table straddles Table I rates.
- If the employer allows voluntary term life coverage to be paid with pre-tax dollars.

The most recent *Benefit Advisor*, available on our website, explains when and how to calculate imputed income.

**W-2 Forms for Short Term Disability Benefits**

At year-end, organizations need to report disability benefits or earnings they paid to disabled employees during the year. Although in many cases, disability carriers pay the benefits, employers need to make sure these benefits are included on the employee's W-2.

Medicare Part D Standard Plan	2010
<b>Annual Deductible</b> (amount the beneficiary pays before benefits are payable)	\$305
<b>Initial Coverage Limit</b> (once the beneficiary meets the deductible, the plan pays 75% and the beneficiary pays 25% until the total prescription expense - paid by plan and beneficiary - reaches the initial coverage limit)	\$2,780
<b>True Out-of-Pocket Maximum</b> (once the beneficiary has paid the true out-of-pocket cost, Medicare catastrophic coverage will pay most of the prescription drug cost). The standard plan pays no part of expenses after the initial coverage limit until the true out-of-pocket maximum is reached.	\$4,500
<b>Total Covered Part D Expenses before Catastrophic Coverage</b> (if the beneficiary has no coverage other than the Medicare Part D plan)	\$6,356.25
<b>Catastrophic Coverage</b> (Medicare pays most of the prescription drug expense once the catastrophic coverage level is reached.) The Medicare beneficiary pays the greater of 5% of drug cost or a \$2.50 generic or \$6.20 brand name copay.	

The income from these benefits is generally reported in one of two ways:

- Disability carriers or third party administrators may issue W-2s directly to participants who received benefits during the year.
- Carriers or administrators may send you a quarterly or annual report with the information you must include on each employee's W-2.

Your short term disability insurer or administrator may issue W-2s for your employees. If the insurer issues the W-2 separately, it is wise to let employees who had claims in 2009 know that they will receive a separate W-2 from the disability vendor. More often disability vendors inform employers of the amount paid in disability benefits and then employers add the benefit income to the employee's W-2.

If your organization self-funds short term disability benefits, you will need to include those benefits in the employee's 2009 W-2. If you use a payroll service to issue W-2s, your payroll vendor must include the additional compensation on the employee's W-2.

Indexed Health Saving Account Limits	2008	2009	2010
<b>HDHP Minimum Deductible</b>			
Self Only Coverage	\$1,100	\$1,150	\$1,200
Family Coverage	\$2,200	\$2,300	\$2,400
<b>HDHP Maximum Out-of-Pocket</b>			
Self Only Coverage	\$5,600	\$5,800	\$5,950
Family Coverage	\$11,200	\$11,600	\$11,900
<b>HSA Statutory Contribution Maximum</b>			
Self Only Coverage	\$2,900	\$3,000	\$3,050
Family Coverage	\$5,800	\$5,950	\$6,150
<b>Catch-Up Contribution (age 55 and older)</b>	\$900	\$1,000	\$1,000

**2010 Indexed HSA Limits**

Each year the IRS releases indexed limits for health savings accounts (HSAs) and high deductible health plans (HDHPs). The limits for the last three years are shown in the table at the bottom of page 12.

**2010 Indexed Plan Limits**

The table to the right summarizes the 2009 and 2010 indexed plan limits.

**Conclusion**

Year-end is always a busy time. Because of reduced staff this year, however, many organizations have been busy all year. With so many issues arising at year-end, it makes sense to create a work plan to handle critical issues so that no tasks are forgotten. If an issue is not urgent but still needs to be considered, place it on the action plan for next year.

Good luck in handling the year-end compliance issues that affect your organization's benefit plans. The McGraw Wentworth team wishes you and your family a happy, healthy and stable 2010! **MW**

Indexed Plan Limits		
Plan Limits	2009	2010
<b>Section 401(k) or SAR-SEP</b>	\$16,500	\$16,500
<b>Section 402(g) maximum pre-tax contribution by employees for elective deferrals</b>	\$16,500	\$16,500
<b>Age 50+ Catch-Up Deferral Limit</b>	\$5,500	\$5,500
<b>Section 403(b) Plan</b>	\$16,500	\$16,500
<b>Section 408(p)(2)(A) SIMPLE Plan Contributions</b>	\$11,500	\$11,500
<b>Section 457(b)(2) Limit</b>	\$16,500	\$16,500
<b>Key Employee Determination - Officers' Earnings Threshold</b>	\$160,000	\$160,000
<b>Section 415 Limit for:</b>		
Defined Contribution Plans (calendar year)	\$49,000	\$49,000
Defined Benefit Plans	\$195,000	\$195,000
<b>Highly Compensated Employees</b>		
Section 414(g)	\$110,000	\$110,000
<b>Includible Compensation - Section 401(a)(17)</b>	\$245,000	\$245,000
<b>FICA Taxable Wage Base:</b>		
Social Security (Tax Rates 6.2%)	\$106,800	\$106,800
Medicare (Tax Rate 1.45%)	No limit	No limit

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