

## Special points of interest:

- Mental Health Parity & Addiction Equity Act
- Michelle's Law
- Medicare Secondary Payer Mandatory Reporting
- Genetic Information Non-Discrimination Act (GINA)
- Form 5500
- New Leave Rights
- HSA/HDHP Contribution Limits for 2010
- COBRA Enrollments Double Since Subsidy
- Preparing for Changes in Mandates & Plan Requirements
- Holiday Observance

## Quarterly Newsletter

**JUST A REMINDER*****The Mental Health Parity and Addiction Equity Act of 2008***

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 became effective for Plan Years beginning after October 3, 2009, and for Calendar Year Plans beginning January 1, 2010. Briefly, Plans that offer both medical/surgical benefits and mental health or substance abuse disorder benefits must ensure that the financial requirements that apply to mental health or substance abuse disorder benefits are no more restrictive than the most common or frequent financial requirements that apply to substantially all medical and surgical benefits covered under the Plan. (More information can be found in the first quarter 2009 BAS newsletter)

***Michelle's Law***

Michelle's Law became effective for Plan Years beginning on or after October 9, 2009 and for Calendar Year Plans beginning January 1, 2010. Briefly the law is intended to allow 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 extension of coverage applies to a dependent child's leave of absence from, or any other change in enrollment at, a postsecondary educational institution (including colleges and universities) on account of a serious illness or injury from which the child is suffering while covered under a health Plan that would otherwise cause the child to lose dependent status for purposes of coverage. (More information can be found in the first quarter 2009 BAS newsletter)

***Medicare Secondary Payer Mandatory Reporting***

Beginning January 1, 2009, insurers or third-party administrators (TPA's) for group health Plans, and Plan administrators or fiduciaries of self-insured and self-administered group health Plans were required to report information gathered from Plan sponsors and Plan participants to CMS in order to identify situations where the Plans are (or have been) primary to Medicare. The information needs to be submitted on a quarterly basis and there are several different due dates for implementation of the

reporting process.

BAS will be reporting the necessary information on behalf of its Clients. Key to this data sharing will be the inclusion of all dependent social security numbers.

***The Genetic Information Nondiscrimination Act of 2008 (GINA)***

The group health Plan provisions of GINA were effective for Plans with Plan Years beginning after May 21, 2009 and for Calendar Year Plans, January 1, 2010. GINA prohibits group health Plans, issuers of individual health care policies and employers from discriminating on the basis of genetic information.

The Health Insurance Portability and Accountability Act (HIPAA) already prohibits group health Plans from discriminating against individuals and family members on the basis of genetic information. Consequently, most group Plans are already complying with the requirements of the Genetic Information Nondiscrimination Act (GINA). However, the GINA, unlike HIPAA, does not allow an opt-out by non-federal governmental Plans. (More information can be found in the first quarter 2009 newsletter)

**LEGISLATIVE/COMPLIANCE ISSUES*****HSA Contribution Limits and HDHP Minimum Deductibles/Out-of-Pocket Maximums for 2010***

The IRS has released the 2010 cost-of-living adjustments for HSA contribution limits and for HDHP deductibles and out-of-pocket maximums.

**HSA Contribution Limits.** The 2010 annual HSA contribution limit for individuals with employee only HDHP coverage is \$3,050 (up \$50 from 2009) and for individuals with family HDHP coverage it is \$6,150 (up \$200 from 2009).

**HDHP Minimum Required Deductibles.** The 2010 minimum annual deductible for employee only HDHP coverage is \$1,200 (up \$50 from 2009) and for family HDHP coverage it is \$2,400 (up \$100 from 2009).

**HDHP Out-of-Pocket Maximum.** The 2010 maximum limit on out-of-pocket expenses (including items such as deductibles, co-payments, and co-insurance, but not premiums) for employee only HDHP coverage is \$5,950 (up

\$150 from 2009) and for family HDHP coverage it is \$11,900 (up \$300 from 2009).

The annual catch-up contribution limit (for HSA-eligible individuals who are age 55 or older), set by statute, remains at \$1,000 for 2010.

For further information please go to [http://www.irs.gov/irb/2009-22\\_IRB/ar09.html](http://www.irs.gov/irb/2009-22_IRB/ar09.html)

### **IRS Posts Reminder that COBRA Subsidy Recipients Must Notify Plan of Other Coverage or Face Penalty**

The IRS has posted on its website a reminder that COBRA subsidy recipients who later become eligible for other group health Plan coverage or Medicare should notify their Plan in writing that they are no longer eligible for the subsidy, in order to avoid a penalty. The IRS webpage explains that if an individual continues to receive the subsidy after he or she is eligible for certain other coverage, such as group health coverage from a new job or Medicare, the individual may be subject to a penalty of 110% of the subsidy provided after he or she became eligible for the other coverage.

For further information please go to <http://www.irs.gov/businesses/small/article/0,,id=212421,00.html>

### **Form 5500 Filing Under EFAST2**

The Department of Labor (DOL) has begun compiling its list of companies that have developed "approved software" for use in preparing and submitting Form 5500 for the 2009 Plan Year under the new all-electronic EFAST2 system. DOL final regulations issued in 2007 require that all Form 5500s be filed electronically for Plan Years beginning on or after January 1, 2009. Because Form 5500 is generally due by the end of the seventh month following the end of the Plan Year, the vast majority of Plan filers will have until at least July 2010 to make the changes necessary to allow electronic filing. Filers can prepare and submit Form 5500s using the DOL's free ("no-frills") filing system (called "IFILE"), but the vast majority of filers are expected to use EFAST2-approved commercial software.

To help with this transition, the DOL presented two webcasts in 2009, Form 5500 using EFAST2, both of which are available on the EFAST website. <http://www.efast.dol.gov/software.html>

### **New Law Expands FMLA Leave Rights for Employees Who Are Relatives of Veterans and Members of the Armed Forces**

National Defense Authorization Act for Fiscal Year 2010, Pub. L. No. 111-84 Effective October 28, 2009

The President has signed defense-related legislation that includes amendments to the FMLA's provisions regarding qualifying exigency leave and covered servicemember leave for employees who are relatives of servicemembers. Here are highlights of the changes that are likely to affect private-sector employers and employees:

**Qualifying Exigency Leave.** An employee's entitlement to qualifying exigency leave has been changed to reflect that the employee's spouse, son, daughter, or parent must be on "covered active duty" (a new term) in the Armed Forces (or have been notified of an impending call or order to such duty). For members of a regular component of the Armed Forces, covered active duty means duty during deployment to a foreign country; for members of a reserve component, it means duty during deployment to a foreign country under a call or order to active duty pursuant to specified provisions

of federal law.

**Covered Servicemember Leave.** An employee's entitlement to leave to care for a covered servicemember with a serious injury or illness has been expanded to apply when the employee is the spouse, son, daughter, parent, or next of kin of a veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness and who was a member of the Armed Forces (including the National Guard or Reserves) at any time during the five-year period preceding the date of the treatment, recuperation, or therapy. In addition, the definition of serious injury or illness has been expanded to include injuries or illnesses that existed before a servicemember's active duty began and were aggravated by service in the line of duty on active duty in the Armed Forces. For veterans, a serious illness or injury is a "qualifying injury or illness" (as defined by the DOL) that was incurred in the line of duty on active duty in the Armed Forces (or that existed before the beginning of active duty and was aggravated by service in the line of duty on active duty) and that manifested itself before or after the servicemember became a veteran.

No changes have been made to the FMLA's health benefit provisions however, these expanded leave rights for employees who are relatives of servicemembers or veterans may result in more employees taking FMLA leave, which will affect administration of group health Plans.

### **NEED TO DO**

#### ***Women's Health and Cancer Rights Act Annual Notice***

The "Women's Health and Cancer Rights Act", passed in 1998, requires health Plans to provide Plan Participants with a written notice of the mastectomy provisions of the Act. An initial written notice of the coverage under the Act must be provided to Plan Participants upon enrollment annually thereafter. Attached to this Newsletter is a sample notice that can be utilized for the initial, as well as the annual notification. This notification should, as in the case of other required notifications, be issued to Mr. & Mrs. in cases where new Plan Participants are married or active Plan Participants have their spouses covered by the Plan.

#### ***Update PHI Access Form***

Our PHI Access Form was developed for your use in documenting those employees or classes of employees who will be given access to Protected Health Information (PHI).

Attached is a PHI Access Form for your use in providing us with the current names or classes of employees that are allowed to receive PHI from BAS.

As changes occur in your staffing, we request that you submit a revised PHI Access Form. Please complete the form and return it within the next two weeks to the Compliance Manager at BAS' Homewood office at 17475 Jovanna Drive Suite 1B, Homewood, IL 60430 or email it to [privacyassistance@benadmsys.com](mailto:privacyassistance@benadmsys.com) or fax it to 708-799-2848.

#### ***EEOC Revises its "Equal Employment Opportunity is the Law" Poster to Address ADA Amendments and GINA***

EEOC Poster: "Equal Employment Opportunity is the Law" (Rev. Nov. 2009) Available at: <http://www1.eeoc.gov/employers/poster.cfm>

The EEOC has revised its "Equal Opportunity is the Law" poster, which employers must post to notify employees of current federal employment discrimination laws prohibiting job discrimination based on race, color, sex (including pregnancy), national origin, religion, age, equal pay, disability and genetic information. Among the changes contained in the November 2009 version of the poster are a revised "Disability" section reflecting the Americans with Disabilities Act Amendments Act of 2008 (effective January 1, 2009), and a new "Genetics" section reflecting the employment nondiscrimination requirements of the Genetic Information Nondiscrimination Act of 2008 (GINA) (effective November 21, 2009). The poster applies to most private employers, state and local governments, educational institutions, employment agencies and labor organizations.

There are three ways for employers to comply with the requirement that they post updated information. They can (1) print the new "EEO is the Law" poster supplement and post it alongside the September 2002 or August 2008 version they currently have posted; (2) print and post the November 2009 poster; or (3) order a new poster from the EEOC. Copies of the poster and the poster supplement are currently available in English on the EEOC website. The EEOC expects that the new posters will also be available in Spanish, Chinese and Arabic soon.

## **INDUSTRY TRENDS**

### ***COBRA Enrollments Double Since Subsidy Was Enacted***

A new analysis from Hewitt Associates indicates that COBRA enrollments have doubled since the government enacted a new subsidy to make health insurance more affordable to millions of laid-off Americans.

According to Hewitt, more than 14 million workers are now eligible for the COBRA subsidy under the American Recovery and Reinvestment Act of 2009 (ARRA). Hewitt examined the COBRA enrollment activity for 200 large U.S. companies representing 8 million employees and found that from March 2009 to June 2009, monthly COBRA enrollment rates for Americans eligible for the subsidy averaged 38%, up from 19% for the period from September 2008 through February 2009.

Under the original COBRA legislation, involuntarily terminated workers were required to pay up to 102% of the health care premium to extend coverage. According to Hewitt data, this translates to approximately \$8,800 a year in COBRA health care costs for the average worker. Under ARRA, eligible workers receive a nine-month subsidy that leaves them responsible for paying only 35% of the COBRA premium, or about \$3,000 a year. Hewitt's research shows that on average, active workers with employer-sponsored health coverage pay 22% of the premium cost, or \$1,900 a year.

The COBRA subsidy significantly reduces the cost of health care coverage for workers who were laid off. However, the average American may still find it difficult to pay for this benefit when they have less income coming in, which is perhaps why enrollment numbers didn't jump higher, said Karen Frost, Hewitt's health and welfare outsourcing leader. It's possible these laid off workers are simply seeking coverage with a new employer or through their spouse's employer. Unfortunately, it's also likely that some are just foregoing health insurance altogether.

### **A TIP FROM OUR SUBROGATION DEPARTMENT**

When completing Form 5500 please be careful when filling out Line 9a, "Plan funding arrangement" which offers several options. Self funded benefit Plans are "trusts" which are funded with "general assets of the sponsor". Sometimes a Client will choose the option

"insurance" which would not be correct.

According to the Form 5500 instructions from the IRC, "insurance" means the Plan has an account, contract, or policy with an insurance company, insurance service, or other similar organization (such as Blue Cross, Blue Shield, or a health maintenance organization) during the Plan year. Since this would not be applicable to a self funded Plan this option would not be appropriate.

Marking "insurance" can interfere with the subrogation process and result in a loss of reimbursement dollars. Some states, for example Kansas, Missouri, New York, New Jersey etc., have an anti subrogation provision which prevents subrogation in health insurance policies. ERISA preempts state anti subrogation statutes and allows an ERISA Plan the right to claim reimbursement from the injured party. Attorneys will request a copy of Form 5500 to determine whether a Plan is a self funded ERISA Plan rather than an insured Plan to ascertain whether a reimbursement will need to be made back to the Plan.

Please review your Form 5500's to confirm that your Plan was correctly identified and to ensure that the Plan's reimbursement rights are not thwarted.

## **PREPARING FOR CHANGES IN MANDATES AND PLAN REQUIREMENTS**

Regardless of how provisions are finally structured in the health care reform debate, potential changes in how group health plans are administered will create, and increase administrative duties for Plan Administrators and Claims Administrators.

Examples of additional duties required due to potential legislative mandates include:

- Additional reporting requirements due to basing premium rates and taxes on the employee's income;
- Requirements for collection of certain data and submission of information to a government database;
- Tracking premium differentials based on participation in health status improvement programs; and
- Coordinating specific requirements for Plan enrollment materials in terms of length and content.

BAS is in close contact with its Representatives in Congress and professional associations who are communicating with government regulators who are monitoring the ever changing developments on health care reform. We continue to identify "Leaders in Class" business partners to add additional value to your Benefit Plan and as these changes move from concept to reality, we will provide you with our recommendations on how we can further serve and assist you in filling these needs for your Plan.

## **HOLIDAY OBSERVANCE**

This Holiday Season our offices will be closed on Thursday, December 24, 2009, Friday December 25, 2009 and January 1, 2010.

Our entire organization joins in wishing you a very Joyous Holiday Season.

Best wishes for a Happy, Healthy and Successful New Year!

# PHI ACCESS

## Individuals with Access to Protected Health Information

HIPAA requires that only those employees or classes of employees or other persons under the control of the Plan sponsor, and as described in your Plan document, will be given access to Protected Health Information (PHI)\*. In order to assist us in identifying the appropriate individuals who may be given access to PHI, please consider those persons involved in activities, such as:

- General Plan administration - medical, dental and vision;
- Lawsuits involving your Plan;
- Renewal process;
- Claims appeals;
- Cases handled by Utilization Review;
- Determinations of claims to be paid outside of the Plan; and
- Administration of COBRA, Flex, etc.

For example, if the Board of Directors or Officers of the company may view PHI when dealing with lawsuits, renewals, etc., you may simply state "Board of Directors" or "Officers of the company". Please note that all employees who have access to PHI will be required to undergo training on your Plan's HIPAA Policies & Procedures.

***Group Name:***

Please insert the **Name, Title, Department and Email Address** of the individuals who have access to PHI:

Name	Title	Department	Email Address

**Broker Access**

Name	Email Address

***Contact Name:*** \_\_\_\_\_ ***Phone:*** \_\_\_\_\_

***E-mail:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

***If you need additional space, please attach a separate sheet. Please FAX this Form to 708-799-2848 mail to Benefit Administrative Systems, L.L.C., 17475 Jovanna Drive, Suite 1D, Homewood, IL 60430***

\*Protected Health Information (PHI):

1. Either identifies the person or reasonably can be used to identify the person;
2. Is created or received by the health care provider, health plan, employer, or health care clearinghouse;
3. Is maintained or transmitted by a covered entity orally, in writing, or electronically; and
4. Relates to the past, present, or future physical or mental health/condition of a person or relates to the provision of health care to a person, OR relates to the payment for the provision of health care to a person.

**SAMPLE**

**THIS NOTICE SHOULD BE REPRODUCED  
ON YOUR COMPANY LETTERHEAD**

Date: \_\_\_\_\_

Participant Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

In compliance with the Women's Health and Cancer Rights Act this letter serves as your annual notification regarding benefits for mastectomies and various related services.

As you have been previously notified, your Group Health Plan provides coverage for performance of a mastectomy, the procedures necessary to effect reconstruction of the breast on which a mastectomy was performed, the cost of prostheses (implants, special bras, etc.) as well as physical complications of all stages of mastectomy, including lymphedemas, as maybe recommended by an attending physician of any patient on whom a mastectomy has been performed.

As previously amended, the Plan will provide coverage for any necessary surgery or reconstruction of the breast on which a mastectomy was not performed in order to produce a symmetrical appearance, for any participant or beneficiary of the Plan who receives plan benefits for a mastectomy.

Coverage for such surgery or reconstruction will be subject to the same deductibles and copayments that apply to mastectomies under the Plan's current terms, which are described in your Group Health Plan's Plan Document and Summary Plan Description.