

Special points of interest:

- Medicare Part D Disclosure to CMS
- Final FMLA Regulations for Service Members
- ARRA
- CHIPRA
- New York State Surcharge
- Form 5500
- Mental Health Parity & Addiction Equity Act
- Michelle's Law
- Privacy Practices Reminder
- Medicare Secondary Payer Mandatory Reporting
- Genetic Information Non-Discrimination Act (GINA)

Quarterly Newsletter

Centers for Medicare and Medicaid Services (CMS) Medicare Part D Disclosure Requirements Have Been Updated

Under Medicare Part D regulations, most Group Health Plans offering prescription drug coverage to Part D eligible individuals must disclose their Creditable Coverage status to CMS on an annual basis. CMS requires electronic filing of the disclosure form.

For purposes of determining whether prescription drug coverage is creditable or non-creditable, CMS has revised their disclosure form. A copy of the revised form and answers to frequently asked questions can be found at: https://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp

Final FMLA Regulations Add Two New Types of Leave for Relatives of Service Members

The DOL has finalized its FMLA regulations. The final regulations, which were effective January 16, 2009, provide extensive guidance about the impact of two new types of leave that covered employers are required to provide for eligible relatives of service members. The regulations clarify that eligible employees (e.g., family members of National Guard and Reserve personnel on active duty), may take up to 12 work weeks of leave during any 12-month period for a "qualifying exigency," defined to include short-notice deployment; military events and related activities; child-care and school activities; financial and legal arrangements; counseling; rest and recuperation; post-deployment activities; and other activities agreed upon by the employee and employer. Under the second type of leave (service member care leave), an eligible employee who is the spouse, son, daughter, parent, or next of kin (i.e., nearest blood relative) of a covered service member is entitled to take up to 26 workweeks of leave during a 12-month period to care for the service member. The regulations also define key terms, such as "next of kin of a covered service member" and "serious injury or illness," to help in administering the service member leaves.

The final regulations consolidate the employer notice requirements into a "one-stop" section to clear up conflicting provisions and time periods. They are also intended to clarify and strengthen the employer notice requirements to better inform employees about their FMLA rights and obligations. The employee notice obligations modify a provision that had been interpreted to allow some employees to notify their employers of their need for leave up to two full business days after an absence, even if they could provide notice sooner. Under the final regulations, employees must generally comply with the employer's usual and customary notice requirements for such leave, barring any unusual circumstances.

The regulations include new and updated forms, such as Certifications of Health Care Provider for Employees' and Family Member's Serious Health Condition, and Certifications of Qualifying Exigency and for Serious Injury or Illness of Covered Service member for Military Family Leave.

The final regulations include few changes to the provisions regarding group health plan benefits.

For more information please go to: <http://www.dol.gov/esa/whd/fmla>

American Recovery and Reinvestment Act of 2009 (ARRA)

In a previous Client Alert BAS advised you of the American Recovery and Reinvestment Act of 2009 otherwise known as the economic stimulus package. This new law created detailed new rights to COBRA premium assistance for employees (and their families) who are involuntarily terminated between September 1, 2008 and December 31, 2009.

Additional information regarding ARRA can be found at: <http://www.dol.gov/ebsa/COBRA.html>

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

In a previous Client Alert BAS advised you of the Children's Health Insurance Program Reauthorization Act of 2009, which extends and expands the state Children's Health Insurance Program (CHIP). Among other

things, the new law allows states to subsidize premiums for employer-provided group health coverage for eligible children and families. It also amends the Code, ERISA, and the PHSA to provide additional special enrollment rights, as well as new notice and disclosure obligations for employers that maintain Group Health Plans.

Group Health Plans must permit employees and dependents who are eligible but not enrolled for coverage to enroll in two additional circumstances: (1) the employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the plan within 60 days after the termination, or (2) the employee or dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the plan within 60 days after eligibility is determined. These new special enrollment rights were effective April 1, 2009.

Employers that maintain Group Health Plans in states that provide Medicaid or CHIP assistance in the form of premium assistance subsidies are required to provide written notices to their employees, informing them of the potential opportunities for premium assistance in the states in which they reside to help pay for health coverage for employees or dependents. The new law directs the U.S. Department of Health and Human Services (HHS) and the Department of Labor (DOL) to develop national and state-specific model notices by February 4, 2010 to enable employers to comply with the notice requirement. Employers may provide these notices along with other plan materials notifying the employee of health plan eligibility, with open enrollment materials, or when furnishing the SPD. The notice requirement is effective for plan years beginning after the date on which model notices are first issued.

For more information please go to: <http://www.cms.hhs.gov/CHIPRA>

New York State Health Care Surcharge Increases

The New York state fiscal budget for 2009-2010 has raised existing surcharges on health care services performed on or after April 1, 2009 through December 31, 2011.

The Health Care Reform Act (HCRA), which was originally enacted in 1996, implemented a patient services tax designated for an indigent care pool and a graduate medical education tax designated for a professional education pool. All non-governmental payers, including HMO's, Blue Cross and Blue Shield plans, and self-funded health care plans are subject to these surcharges.

For Plan Participants who live in New York State and Plan Participants who incur charges in New York State, a 9.63% surcharge is imposed on every payment made for inpatient and outpatient hospital services, diagnostic and treatment centers, and clinical laboratories. Self-funded plans may make the surcharge payments either directly to the state pool or to the provider. However, payments made directly to the provider require an additional 28.27% surcharge.

Payers must file monthly forms reporting patient services payments, the payer's surcharge obligations for the month, and the payer's total liability for covered lives. Failure to file the required monthly reports within 60 days of the due date may result in a civil penalty. Third party administrators and payers are required to file the reports electronically at <http://www.hcrapools.org>.

An explanation of the surcharges and copies of required forms may be obtained at <http://www.health.state.ny.us/nysdoh/hcra/hcrahome.htm>

If you have elected to have BAS file the NYHCRA surcharge on your behalf, the filings are current with the increased surcharge.

Form 5500 for 2008 Plan Year

The DOL, IRS, and Pension Benefit Guaranty Corporation have released advance, informational copies of the Form 5500, Schedules, and Instructions to be used by employee benefits plans reporting on 2008 plan years (generally, those are plan years beginning in 2008 for which annual reports are due in 2009). The majority of the changes identified in the 2008 Instructions relates to new actuarial schedules and to multiemployer pension plans and do not affect 401(k) plans or ERISA welfare plans.

The mandatory electronic filing rules apply to plan years beginning in 2009 (for which annual reports generally are due in 2010). However, for 2009 short plan year filers with due dates before January 1, 2010, the new EFAST2 system may not be available when they are required to file. According to the Instructions, the special extension for short plan year filings is being granted to encourage short plan year filers to wait to file their 2009 Form 5500s electronically under the new EFAST2 system. The DOL news release cautions that these forms are for informational purposes only and may not be filed; filers should monitor the EFAST website at <http://www.efast.dol.gov> for information on approved software vendors for completing the 2008 forms and on the availability of the official government-printed forms.

Short plan year filers whose due date to submit their 2009 filing is before January 1, 2010, will be given an automatic extension to electronically file their Form 5500s within 90 days after the 2009 filing system is available on the DOL website. Filers that choose not to take advantage of the extension will need to submit their filings to EFAST by the applicable short plan year deadline using 2008 forms.

For a copy of Form 5500 (Annual Return/Report of Employee Benefit Plan) (2008)]: <http://www.dol.gov/ebsa/5500main.html#2008>

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act Of 2008

The mental health parity requirements for Group Health Plans have been expanded as part of the emergency economic stabilization legislation that was signed by President Bush on October 3, 2008. The legislation, The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, amends the mental health parity provisions in ERISA, the PHSA, and the Code, eliminating the sunset provision under which existing requirements would have expired on December 31, 2008, and adding new requirements regarding mental health and substance abuse disorder benefits. These new requirements apply for plan years beginning after October 3, 2009, and for calendar year plans beginning January 1, 2010.

The existing mental health parity provisions-which require parity between medical/surgical benefits and mental health benefits in the application of annual and aggregate lifetime limits-have been expanded to apply to substance abuse disorder benefits.

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. For this purpose, the term "financial requirements" includes deductibles, co-payments, co-insurance, and out-of-pocket expenses. Furthermore, plans may not have separate cost-sharing arrangements that apply only to mental health or substance abuse disorder benefits.

Likewise, the treatment limitations that apply to mental health or substance abuse disorder benefits may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits covered under the plan, and plans may not have separate treatment limitations that apply only to mental health or substance abuse disorder benefits. For this purpose, the term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

The criteria for medical necessity determinations for mental health or substance abuse disorder benefits must be made available to current or potential participants, beneficiaries, or contracting providers upon request in accordance with regulations. The reasons for any denial of mental health or substance abuse disorder benefits must also be made available to the participant or beneficiary on request or as otherwise required in accordance with regulations.

If a plan provides both medical/surgical benefits and mental health or substance abuse disorder benefits and offers coverage for out-of-network medical or surgical benefits, then coverage must also be provided for out-of-network mental health or substance abuse disorder benefits "in a manner that is consistent with" the parity requirements.

The parity requirements continue to include an exemption for certain small employers. The definition of "small employer" has been modified slightly and now includes employers that employed an average of at least 2 employees (or 1 employee in the case of an employer residing in a state that permits small groups to include a single individual) but no more than 50 employees during the preceding calendar year (determined on a controlled group basis).

The existing increased cost exemption has been replaced with a more detailed cost exemption that is available only if the plan has complied with the parity requirements for the first six months of the plan year involved. A plan will qualify for the exemption if the increased cost of applying the parity requirements to mental health and substance abuse disorder benefits exceeds: (1) 2% of the actual total plan costs in the first plan year in which the parity requirements are applied; and (2) 1% in each of the subsequent plan years.

There will be more guidance to come-the legislation directs DOL,

HHS, and the Treasury Department to issue regulations within a year of the law's enactment to carry out its provisions, although the effective date of the new requirements is not contingent upon such regulations being issued.

On December 23, 2008, a technical correction was made which clarifies that the mental health parity requirements will not apply to Group Health Plans maintained pursuant to a collective bargaining agreement until the later of (a) the date on which the last of the collective bargaining agreements relating to the plan terminates (without regard to any extension agreed to after October 3, 2008), or (b) January 1, 2010.

Michelle's Law

On October 9, 2008, President Bush signed Michelle's Law, which 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 measure was inspired by, and named after, a college student in New Hampshire who was diagnosed with cancer but continued her studies on a full-time basis in order to avoid losing health coverage under her parents' plan. This law is effective for plan years beginning on or after October 9, 2009 and for calendar year plans beginning January 1, 2010.

The legislation applies to health plans governed by ERISA, the Code, and the PHSA.

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.

Coverage continues until the earlier of: (1) one year from the start of the medically necessary leave of absence, or (2) the date on which such coverage would otherwise terminate under the terms of the health plan.

The child must be enrolled as a dependent under a health plan and qualify for coverage on the basis of being a student at a postsecondary educational institution, immediately before the medically necessary leave of absence involved.

Written certification must be provided by a treating physician of the dependent child certifying that such individual is suffering from a serious illness or injury that would require a medically necessary leave of absence.

Notice of Privacy Practices Reminder

The HIPAA privacy rule requires health plans to remind individuals - at least once every three years - that a Notice of Privacy Practices is available. In a FAQ, HHS reminds health plans of this requirement and provides some guidance about how to comply. The FAQ points out that the reminder to individuals can be provided in one of three ways: by sending a copy of the Notice of Privacy Practices, by mailing a reminder that the notice is available and information on how to obtain a copy, or by including that same information in a plan-produced newsletter or other publication.

Like the original Notice of Privacy Practices, a single reminder to the named insured or covered employee is effective for all covered dependents under a health plan.

Large Group Health Plans first were required to distribute the HIPAA privacy notice by April 14, 2003, the first three year notice on April 14, 2006 and now again three years later by April 14, 2009.

Small Group Health Plans first were required to distribute the HIPAA privacy notice by April 14, 2004, the first three year notice on April 14, 2007 and the next one won't be due till April 14, 2010.

For a copy of the FAQ: <http://www.hhs.gov/ocr/privacy/hipaa/faq/notice/1065.html>

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 are 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.

A group health plan's Responsible Reporting Entities (RRE) must provide certain information to CMS for all individuals covered in the plan who (a) effective January 1, 2009 through December 31, 2010, are ages 55 through age 64 with coverage based on their own or a family member's current employment status (effective January 1, 2011, age 55 will be reduced to age 45); (b) are age 65 and older with coverage based on their own or a spouse's current employment status; (c) have been receiving kidney dialysis or have received a kidney transplant, regardless of their own or a family member's current employment status; or (d) are under age 55 (effective January 1, 2011, age 55 will be reduced to age 45), are known to be entitled to Medicare, and have coverage in the plan based on their own or a family member's current employment status. Because CMS must match its data to Medicare's to determine who is a Medicare beneficiary, RREs must also send either a Medicare Health Insurance Claim Number (HICN) or the individual's Social Security Number (SSN) to CMS.

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.

BAS will be sending a report to all of our clients indicating those individuals for whom we do not have a social security number.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (Public law No. 110-233) prohibits Group Health Plans, issuers of individual health care policies and employers from discriminating on the basis of genetic information. The group health plan provisions of the Act take effect for plan years beginning after May 21, 2009 and for calendar year plans, January 1, 2010.

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.

The legislation amends ERISA, the IRS Code and the PHSA (Public Health Service Act) to prevent Group Health Plans and health insurers from adjusting contribution amounts or premiums on the basis of genetic information.

Group Health Plans and health insurers may not request or require an individual or a family member of such individual to undergo a genetic test. However, plans and insurers are permitted to obtain and use the results of a genetic test when making payment determinations (HIPAA privacy minimum necessary rules apply).

Group Health Plans and health insurance issuers may not request, require or purchase genetic information for underwriting purposes.

The EEOC has now issued proposed regulations focusing solely on GINA's employment nondiscrimination requirements.

The employment nondiscrimination requirements prohibit use of genetic information in employment decision making, restrict deliberate acquisition of genetic information, require that genetic information be maintained as a confidential medical record, and place strict limits on the disclosure of genetic information.

Employers are prohibited from discriminating against an individual on the basis of genetic information in regard to hiring, discharge, compensation, terms, conditions, or privileges of employment. Employers are also barred from actions that may limit, segregate, or classify individuals because of genetic information in a way that might deprive them of employment opportunities.

The EEOC is required to issue final regulations by May 21, 2009. The effective date of the employment nondiscrimination requirements is November 21, 2009.

BAS will be reviewing your Plans in relation to the new laws and will determine how Plan Documents need to be amended to bring your Plan into compliance.