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# EMPLOYEE BENEFITS BRIEFING

**December 2009**

# LEGISLATIVE UPDATE

## A Look Back at Legislative Changes in 2009

*by Jennifer Lunski, Esq.*

At Woodruff-Sawyer, we offer a monthly update on legislative changes that impact employee benefit plans. Employers should review the update to ensure their plans and policies are revised and in compliance with the new legislation and regulations. As the year draws to a close, we would like to provide you with a summary of the employee benefits legislative changes that took place in 2009 and newly passed/pending legislation.

### RECENTLY PASSED/PENDING FEDERAL LEGISLATION

### PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2009

On Monday morning, December 21st, through a series of deals with various senators, the Patient Protection and Affordable Care Act of 2009, or H.R. 3590, passed its first Senate vote with the requisite filibuster-proof 60 votes. Notably, all Republican senators stood unified in voting against this historic legislation.

The Congressional Budget Office and Joint Committee of Taxation also released their revised cost estimate for the legislation, stating that the cost to the federal government over the next 10 years would be $871 billion.

If the Senate passes the bill as expected — after two more procedural votes this week and a final vote set for 7:00 p.m. Christmas Eve — House and Senate negotiators will begin the process of melding the two different bills, which have substantial differences. Woodruff-Sawyer has previously summarized the House bill in our November Legislative Update. However, the chance of major changes from the Senate version is unlikely given the past week's struggle for Democrats to reach an agreement that achieved 60 votes. Democrats are optimistic they can reach a final compromise, but that is by no means guaranteed.

Some of the key provisions of the Senate legislation include the following:

- No public option. Instead, a program requiring the federal Office of Personnel Management to oversee private individual and small-group plans that would be offered in state-based exchanges for the individual and small-group (fewer than 101 employees) markets
- Major insurance market reforms, notably guaranteed issue, elimination of pre-existing conditions restrictions, and community rating for premiums
- An individual mandate requirement. Individuals who do not purchase coverage will pay a penalty

- Employer mandates would impose tax penalties on any employer with 50 or more employees that does not provide the minimum level of coverage. Tax penalties on employers who do provide the minimum level of coverage if employees who are eligible to receive federal health care subsidies enroll in a health exchange plan
- A minimum loss ratio requirement that applies to all fully-insured plans, including grandfathered plans, as of January 1, 2011. Cost of items such as wellness programs is not included in the calculation
- Starting in 2011, there will be a Health Care Flexible Spending Account contribution limit of $2,500 annually (adjusted for inflation)
- Strict modified community premium rating requirements including age bands of 3:1 (i.e. the rates for the oldest person in the pool would be no more than three times higher than for the youngest person). It would apply to all fully-insured plans, regardless of their size
- An expansion of the federal Medicaid program to individuals up to 133% of the Federal Poverty Level (FPL)
- Starting in 2014, a voucher provision that permits employees to get a voucher (equal to the amount the employer would have paid) in lieu of coverage through a group plan if the employee's premium contribution under the plan exceeds 8% of employee's income and the employee makes no more than 400% of the federal poverty wage. The voucher must be used to purchase coverage through the exchange, but any excess (which would be the only taxable benefit) goes to the employee
- Starting in 2013, a .9% surtax on any household with income of more than $200,000 for individuals and $250,000 for those filing joint returns
- Starting in 2013, carriers and other benefits providers (ie: self-funded employers) would be required to pay a "Cadillac plan" tax on any plan benefits valued in excess of $8,500 for individuals and $23,000 for families. Employees who work for companies that primarily employ those in "high risk" occupations, including police, firefighters, coal miners and longshoremen would qualify for higher bases
- Starting in 2011, the bill would impose a direct excise tax on health insurers. The excise tax would not be imposed on self-insured plans. Certain non-profit insurers and mutual companies would be exempt
- No tax on cosmetic surgery, but a 10% sales-type tax on indoor tanning services.
- Clarification on allowable newly implemented wellness and disease management programs, along with a fund to give small business employees access to such programs
- Bars health insurers from deducting executive compensation in excess of $500,000 as expenses
- New annual Form 5500 filing requirements, especially for self-funded plans
- New W-2 reporting obligations
- $2 fee per covered beneficiary of fully-insured and self-funded plans to fund research initiatives
- Penalties for employment waiting periods in excess of 60 days
- The COBRA extension provision in the House bill (affording an extended participation period that would be in effect until COBRA participants are eligible for employer-provided coverage or Health Insurance Exchange provided options become available) is not included in the Senate bill

We are advising clients not to make any immediate changes based on the proposed legislation. We will inform you immediately when a final bill has passed that could impact your employee benefit plans.

## EXTENSION OF COBRA PROVISIONS IN THE AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA)

On Saturday, December 19, 2009, the President signed the Department of Defense Appropriations Act of 2010 (the "Act"), which includes an extension of the COBRA subsidy that was originally introduced under the American Recovery and Reinvestment Act of 2009 ("ARRA").

Major changes to the ARRA subsidy include:

- The total allowable time an individual can receive the COBRA subsidy has been increased by six months (from nine to fifteen months).
- The subsidy extends the eligibility period by including individuals who are involuntarily terminated between January 1, 2010 and February 28, 2010.
- The changes in eligibility and coverage will require new COBRA subsidy notices (i) describing the 15 month maximum period for the COBRA premium subsidy and (ii) informing individuals who lost coverage due to nonpayment or who overpaid for coverage of the changes providing for continued subsidized coverage. Notices must be sent to all subsidy-eligible individuals who are covered under COBRA — or are involuntarily terminated — on or after November 1, 2009. The deadline for the notice is 60 days after the Act's enactment date (i.e. February 17, 2010).
- An individual whose original subsidy period has expired (i.e., on November 30, 2009) and has not paid their unsubsidized COBRA premium for their next COBRA period (i.e. December 2009) must be permitted to pay for this period of coverage retroactively. This retroactive grace period is 60 days after the date that the Act was enacted (i.e., February 17, 2010) or, if later, 30 days after the date that a subsidy extension notice is provided. Conversely, eligible individuals whose COBRA premium subsidy expired under the original subsidy period and have paid the full COBRA rate for the next coverage period are now entitled to a credit for the individual's subsequent coverage period to account for the overpayment.

For a copy of HR 3326 (Sec. 1010, starting on page 153), please visit:
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3326eah.txt.pdf
If you have any questions on the ARRA COBRA subsidy, please contact your Woodruff-Sawyer account representative.

## SUMMARY OF PAST LEGISLATION IN 2009

## CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

On Wednesday, February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3). This law requires employers who sponsor health plans to amend their plans. Plan amendments require provisions that allow for the enrollment of eligible individuals, with a government subsidy; notification to employees; and requirements for specified information to state officials.

**Special Enrollment Rights**

Employers are required to allow special enrollment rights allowing enrollment in an employer plan if employees or dependents become, or are eligible, under a State Children's Health Insurance Program (SCHIP) or Medicaid. Special enrollment rights must occur in either of the following scenarios: 1. Within 60 days of the individual or dependent losing eligibility for Medicaid or SCHIP; or 2. Within 60 days of becoming eligible for premium assistance under Medicaid or SCHIP even if the employee previously refused employer coverage or the timing is not within the open enrollment period.

**Employee Notices**

Employers must provide employees notice that includes information about available state assistance. Within one year (February 4, 2010) from the date of enactment the government will provide model notices, including both national and state-specific notices. Notices are required to be distributed by employers to employees upon eligibility for an employer plan, when Summary Plan Descriptions are distributed and during open enrollment.

The law specifies that under ERISA, employers that fail to give individual notices will be penalized $100 a day for each individual violation.

The general effective date of the new law is April 1, 2009. Employer notice provision requirements become effective the plan year beginning after the date the new model notices are issued. State disclosure requirements will become effective after the Department of Labor (DOL) and Health and Human Services (HHS) issue guidance based on their joint working group.

## ARRA INCREASE IN TRANSIT PASS LIMITS

ARRA also changed the monthly reimbursement limits for transit passes under §132(f) of the Tax Code. Before ARRA, the monthly limits were $120 for transit passes and vanpooling combined, $230 for parking and $20 for bicycles. Starting in March 2009 and continuing through December 2010, the limit for transit passes equals the parking limit ($230).

## ARRA HIPAA CHANGES

ARRA created new Private Health Information breach notification requirements, expanded Business Associate responsibilities, and expanded individual rights.

**Increased Enforcement and Penalties**

A tiered schedule of civil penalties applies to violations of HIPAA, as displayed on the chart below.

A percentage of penalties collected can be paid to the individual who is harmed. Additionally, a State Attorney General may now bring a civil action on behalf of state residents who have been impacted adversely by a HIPAA violation. Attorney's fees and the costs of the action can be awarded to the State if the court rules that a HIPAA violation exists.

| Violation Type | Amount of Penalty |
|---|---|
| Unknowing violations (where the person could not have known that the violations would take place under reasonable circumstances) | $100 per violation with a maximum of $25,000 per calendar year for multiple violations per plan |
| Violations made with reasonable cause (no willful neglect involved) | $1,000 per violation with a maximum per plan of $100,000 per calendar year for multiple violations |
| Violations done with willful neglect where the violator took corrective measures | $10,000 per violation with a maximum per plan of $250,000 per calendar year for multiple violations |
| Violations done with willful neglect where no corrective measures were taken | $50,000 per violation with a maximum per plan of $1,500,000 |

**New Breach Notification Requirements**

Under ARRA, effective September 15, 2009, covered entities, group health plans and business associates must notify individuals if private health information is used or disclosed in an unsecured manner. The individual needs to be notified within 60 calendar days of the discovery of the breach. Delivery methods approved under ARRA include first-class mail, website posting or media announcement or email. For breaches that affect more than 500 individuals, a notice must also be provided to media outlets and HHS.

## HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH (HITECH)

On April 17, 2009, the Department of Health and Human Services (HHS) released guidance regarding how covered entities and business associates should secure individuals' protected health information as required under HIPAA. The new regulations are part of the Health Information Technology for Economic and Clinical Health (HITECH) provisions of ARRA. You can access the guidance at http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/federalregisterbreachrfi.pdf

Group health plans and sponsors have typically relied on business associates to protect private health information. Under HIPAA, vendors that have access to private health information enter into business associate agreements with health plans and sponsors to ensure that any information will be protected. ARRA will require that business associate agreements be amended to ensure that they comply with the new privacy and security laws effective February 17, 2010. The business associates will be subject to the substantive provisions of the HIPAA security rules in the same manner and to the same extent as covered entities. In addition, business associates will be subject to civil and criminal penalties for violations of the rules. Moreover, HHS will be conducting periodic compliance audits of business associates and covered entities.

## MENTAL HEALTH PARITY ACT APPLIES GENERALLY TO PLAN YEARS FOLLOWING OCTOBER 2009.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Act") was signed into law by President Bush on October 3, 2008 as part of the $700-billion bailout legislation for Wall Street. This Act applies to all group health plans with 51 or more employees, and will cover an estimated 82 million individuals in self-insured employer health plans that are not governed by state mental health parity laws and another estimated 31 million individuals in plans that are subject to state regulation. The Act generally takes effect for plan years beginning after October 3, 2009. Key provisions of the Act can be found in our November Legislative Update.

A health plan can be exempted from the Act if it can prove that parity is raising its total plan costs by more than 2% in the first year after enactment of the parity law and 1% thereafter, but plans must first implement parity for at least six months.

## GENETIC INFORMATION AND NONDISCRIMINATION ACT AND THE AMERICANS WITH DISABILITIES ACT

Our October 2009 legislative update reviewed the interim regulations ("Regulations") on the Genetic Information and Nondiscrimination Act (GINA), which are effective on December 7, 2009. As a result of GINA, many employers will be required to modify their health risk assessments (HRAs).

We have also discovered that, absent some official guidance from the Equal Employment Opportunity Commission (EEOC), certain programs associated with wellness could violate the Americans with Disabilities Act (ADA) as they would effectively penalize employees who do not participate in incentives and discounts.

Your Woodruff-Sawyer representatives will inform you if and when the EEOC issues guidance on the issue of whether or not certain wellness designs could violate the ADA. In the interim, we are advising clients who need to modify their HRA to: 1. Remove all questions that ask for genetic information which includes family medical history; and 2. Identify and remove open-ended questions. The Regulations make clear that open-ended questions are problematic since they may elicit responses that include genetic information.

## STATE UPDATES

### NEW YORK BENEFIT PLANS INCLUDE SAME-SEX REQUIREMENTS

New York benefit plans that are fully insured and offer spousal coverage must recognize legally performed same-sex marriages, due to a Circular Letter issued by the New York Insurance Department (the "Department") on November 21, 2008. The Circular Letter states that "where an employer offers group health insurance to employees and their spouses, the same-sex spouse of a New York employee who enters into a marriage legally performed outside New York is entitled to health insurance coverage to the same extent as any opposite-sex spouse." The Circular Letter also declares that an insurer's failure to comply with this requirement may be considered to be an unfair act or practice and/or unfair discrimination under New York's Insurance Law.

In addition, the Circular Letter states the Department's position that an employer's failure to treat same-sex spouses the same as opposite-sex spouses may violate New York's Executive Law, which targets unlawful discrimination. All insurance plans governed by New York insurance law will need to comply with the Circular Letter.

### NEW YORK EXTENDS DEPENDENT COVERAGE THROUGH AGE 29

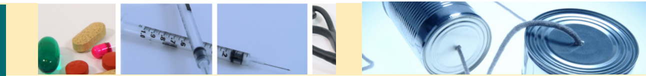
On July 29, 2009, New York enacted a law that requires insurers to offer coverage to unmarried dependents of subscribers through age 29 who live in New York and are not eligible for group coverage or Medicare. This law is effective on September 1, 2009. It only applies to New York sitused contracts and policies of insurance that are issued, renewed, modified, altered or amended on or after such date.

Under the law, each group plan must allow dependents who have lost coverage due to the previous age restrictions an election period of 60 days from the qualifying event as well as 12 months from the effective date of this statute to elect coverage under their parents' policy(ies). Insurance carriers are also required to establish a "distinct premium" for this group of individuals and employers are not required to pay anything towards the cost. The law also requires insurers to offer employers an option to purchase coverage that includes young adults as dependents in family policies through age 29.

For more information on this law, including the text of the bill, please visit: http://www.ins.state.ny.us/health/S6030_Age29.htm

### SAN FRANCISCO HEALTH CARE ORDINANCE SUPREME COURT UPDATE

On March 9, 2009, the United States Court of Appeals for the Ninth Circuit denied the Golden Gate Restaurant Association's request for a rehearing en banc. Therefore, the Health Care Security Ordinance remains in effect. On October 5, 2009, The Supreme Court asked for the Solicitor General's opinion, and a decision about accepting the petition to review the case will be made after they receive this opinion.



## IOWA AND VERMONT LEGALIZE SAME-GENDER MARRIAGES

On April 3, 2009, the State of Iowa legalized same-gender marriages. In addition, on April 7, 2009 Vermont legalized same-gender marriage.

## OREGON BILL CALLING FOR TAX INCREASES ON MEMBERS PASSED

On August 4, 2009, Oregon Governor Ted Kulongoski signed HB 2116 into law. This law extends health coverage to uninsured children in Oregon. HB 2116 created, among other things, a tax on medical insurance premiums as partial funding for increased access to health care.

Effective October 1, 2009, health carriers must remit one percent of the "gross premium amount" paid by their insured members to the State of Oregon. The tax is in effect through 2013. Funds generated by the premium tax will help expand health care access for the uninsured, including the expansion of the Oregon Health Plan to 35,000 uninsured, low-income adult Oregonians, as well as 80,000 uninsured Oregon children through a new program called "Health Care for All Oregon Children."

The premium tax applies to insured products from October 1, 2009 through September 30, 2013 (as we understand the law, self-funded employers are not affected by this change).

*The information provided in this Legislative Update should not be construed as legal advice or legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only and you are urged to consult an attorney concerning your own situation and any specific legal questions you may have.*

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***About Jennifer***

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