

## CHANGE HAS COME TO GROUP HEALTH & WELFARE PLANS

2009 promises to be a year of change on many levels across the nation, including group health and welfare plans. The following summary highlights some of the key federal law changes that you will see over the next twelve months, including an overview of legislation recently passed by the House that may significantly impact COBRA. We have also included a timeline for your reference.

As many of the items have already been addressed in earlier communication pieces, we have included links to those original documents for your reference.

### **BICYCLE BENEFIT**

**Effective January 1, 2009**, employers may provide eligible employees up to a \$20 per month tax-free reimbursement for certain qualified bicycle commuting expenses incurred during the calendar year (January – December).<sup>1</sup> Eligible expenses include bicycle purchase, improvements, repairs and storage.

The \$20 reimbursement is available in any month of the calendar year where the employee is an eligible individual. An employee is eligible if he or she:

- Regularly uses the bicycle for a substantial portion of travel between his/her residence and place of employment, and
- Is not participating in another Section 132(f) qualified transportation benefit program (e.g. parking or transit).

Reimbursements must be made during the calendar year or within 3 months following the calendar year.

The bicycle commuter benefit program is a reimbursement arrangement provided by the employer. Unlike other qualified transportation fringe benefits, the employee may not make a pre-tax salary reduction election to pay for bicycle expenses.

*For more information, see our article in the Winter 2008 Benefits Insider:*

[http://www.kpcom.com/newsletters/documents/Benefits\\_Insider\\_Winter\\_2008.pdf](http://www.kpcom.com/newsletters/documents/Benefits_Insider_Winter_2008.pdf)

### **NEW DEFINITION OF QUALIFYING CHILD**

The definition of a qualifying child under Internal Revenue Code (Code) Section 152(c) has been amended to add two additional requirements:

- The child must be younger than the taxpayer, and
- The child may not be married filing a joint tax return with a spouse.

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<sup>1</sup> Unlike other qualified transportation benefit programs under Code Section 132(f), the \$20 benefit is fixed with no annual adjustment.

Also, a new Code Section 152(c)(4) has been added providing that a non-parent may claim a child as a qualifying child when (1) the child's parents do not claim the child as their qualifying child and (2) the non-parent has a higher adjusted gross income than any parent.

**This definition took effect for taxable years beginning January 1, 2009.**

*For more information, see our article in the Winter 2008 Benefits Insider:*

[http://www.kpcom.com/newsletters/documents/Benefits\\_Insider\\_Winter\\_2008.pdf](http://www.kpcom.com/newsletters/documents/Benefits_Insider_Winter_2008.pdf)

### **CAFETERIA PLAN REGULATIONS**

The proposed cafeteria plan regulations issued in 2007 became **effective January 1, 2009**. Informal comments from the IRS indicated an extension may be forthcoming, but at the time of publication no extension has been provided. At this point, employers should be operating in good faith compliance with the proposed regulations.

*For more information, see our Technical Bulletin:*

<http://www.kpcom.com/newsletters/documents/NewCafeteriaPlanRegulations8.21.07.pdf>

### **QUALIFIED RESERVIST DISTRIBUTIONS**

Employers have the option of providing Qualified Reservist Distributions (QRDs) from a health flexible spending account (FSA). QRDs are an exception to the general rule that a health FSA may never be "cashed-out". Employees eligible for a QRD are members of a reserve component<sup>2</sup> ordered or called to active duty for a period of 180 days or more (or an indefinite period) who request distribution made on or after the call/order and before the last day of the plan year, or grace period if applicable.

The provision is optional and employers will need to amend their plan documents. QRDs became available on and after June 18, 2008. Plans providing QRDs must be amended retroactively back to the date of the first QRD issued by the plan no later than December 31, 2009. After December 31, 2009, plans adding a QRD may only do so prospectively.

*For more information, see our Technical Bulletin:*

<http://www.kpcom.com/newsletters/documents/Qualified%20Reservist%20Distributions%20-%20Technical%20Bulletin%20-%20Oct%203%202008.pdf>

### **90% RULE EXTENSION – DEBIT CARDS**

**June 30, 2009** will now be the last day employer-provided health FSA and HRA medical expense reimbursement cards ("debit cards") may be used at stores with the Drug Stores and Pharmacies merchant category code unless (1) the store uses an approved inventory information approval system (IIAS) or (2) on a store-location-by-store-location basis, 90% of the store's gross receipts during the prior taxable year consisted of items that qualify as medical expenses under Code Section 213(d). This is an extension from the original expiration date of December 31, 2008.

*For more information, see our article in the Winter 2008 Benefits Insider:*

[http://www.kpcom.com/newsletters/documents/Benefits\\_Insider\\_Winter\\_2008.pdf](http://www.kpcom.com/newsletters/documents/Benefits_Insider_Winter_2008.pdf)

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<sup>2</sup> As defined by 37 U.S.C 101 to include:

- the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corp Reserve, the Air National Guard, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

## **MANDATORY INSURER REPORTING**

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (the Act) imposes a mandatory reporting obligation on group health plans. The purpose of this new requirement is to better identify and coordinate instances where group health plans are (or should be) paying primary to Medicare. **Provisions of the Act are effective January 1, 2009.** We summarized these requirements in an earlier communication to you. In most instances the reporting obligation will fall on the insurer (in a fully insured arrangement) or the third party administrator (TPA) in a self-insured arrangement where claims are paid and/or adjudicated by the TPA. In the limited situation where an employer self-insures and self-administers a group health plan (e.g. a health reimbursement arrangement administered in-house), the plan sponsor will have the reporting obligation.

*For more information, see our Technical Bulletin:*

<http://www.kpcom.com/newsletters/documents/Mandatory%20Insurer%20Reporting%20for%20Group%20Health%20Plans%20-%20Technical%20Bulletin%20-%20Oct%2024%202008.pdf>

## **REVISED CREDITABLE COVERAGE LETTERS**

The Centers for Medicare and Medicaid Services (CMS) issued revised creditable and noncreditable coverage letters for Medicare Part D. The notices are for use after **January 1, 2009.**

The changes are mainly structural and did not change the substance of the disclosure. In particular, CMS opted to do away with the separate personalized creditable/non-creditable coverage notice. Instead, the revised notices contain a section where an employer may personalize the notice. Upon a participant's request, an employer/plan sponsor may personalize the notice for an employee.

Copies of the revised letters and guidance are available at:

[http://www.cms.hhs.gov/CreditableCoverage/08\\_CCAfterJanuary1.asp#TopOfPage](http://www.cms.hhs.gov/CreditableCoverage/08_CCAfterJanuary1.asp#TopOfPage)

## **FMLA REGULATIONS**

Final FMLA regulations became effective **January 16, 2009.** The new regulations significantly change many aspects of FMLA administration and provide the first guidance on the new military leave provisions (qualifying exigency leave and military caregiver leave). Employers need to be operating in compliance with the final regulations, which also include new notice requirements. Employers should review their current policies, practices and notices for compliance and ensure individuals responsible for FMLA are adequately trained.

*For more information, see our Technical Bulletin:*

<http://www.kpcom.com/newsletters/documents/FMLA%20Final%20Regulations%20-%20Technical%20Bulletin%20-%20Dec%205%202008.pdf>

## **GINA**

The requirements under the Genetic Information Nondiscrimination Act (GINA) affect both group health plans and employment practices.

### *Group Health Plans*

GINA applies to all group health plans and prohibits the plan (and health insurance issuer) from adjusting premium or contribution amounts for the plan based on genetic information.<sup>3</sup>

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<sup>3</sup> GINA prohibits discrimination on the basis of genetic information. Genetic information is defined as information about:

- an individual's genetic tests,

Further, the group health plan (or health insurance issuer) may not request, require or purchase genetic information for underwriting or enrollment purposes. This may create an issue for Health Risk Assessments (HRAs) that are tied to enrollment. If the HRA asks questions related to genetic information (e.g. questions regarding a family member's health history), such questions may violate GINA. HRAs should be reviewed to ensure compliance with these new requirements.

The provisions of GINA also amend the HIPAA privacy rule to include genetic information as protected health information. Privacy notices will need to be amended to reflect this inclusion.

**The group health plan provisions of GINA are effective for plan years beginning on or after May 21, 2009 (January 1, 2010 calendar year plans).** Regulations should be issued before the effective date. There are significant penalties associated with noncompliance. Plan sponsors should review their plan documents to ensure compliance.

### *Employment Practices*

Employers are prohibited from discriminating against an employee with respect to compensation, terms, conditions or privileges of employment based on the employee's genetic information. Employers are also prohibited from requesting, requiring or purchasing genetic information about an employee or the employee's family members with limited exceptions.

Any genetic information the employer may have about the employee must be treated as a confidential record in accordance with the Americans with Disabilities Act.

These provisions are effective November 21, 2009. Any violations are treated as unlawful employment practices under Title VII of the Civil Rights Act. Employers will want to review policies and procedures to ensure compliance.

*For more information, see our article in the Summer 2008 Benefits Insider:*  
<http://www.kpcom.com/newsletters/documents/BenefitsInsiderSummer2008.pdf>

### **MENTAL HEALTH PARITY**

The requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Act) are effective **for plan years beginning on or after October 3, 2009 (January 1, 2010 for calendar year plans).**

The provisions of the Act apply to group health plans maintained by an employer with 50 or more employees. The Act does not require that the employer provide mental health or substance abuse benefits, but if the plan provides such benefits, they must be treated in the same manner as any other medical or surgical benefit.

The requirements include:

- Parity in the financial requirements including deductibles, co-payments, coinsurance, and out-of-pocket expenses between mental health/substance abuse benefits and medical/surgical benefits.
- Treatment limitations for mental health/substance abuse benefits must be no more restrictive than limitations imposed on medical and surgical benefits by the plan. Further, the plan may not impose separate treatment limitations that only apply to mental health and substance abuse benefits. This includes limitations on the frequency or number of visits, limits on days of coverage, or other similar limits on the scope and duration of treatment.
- If the plan provides out-of-network coverage for medical/surgical benefits, it must provide for out-of-network mental health and substance abuse benefits.

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- genetic tests of family members of such an individual and
  - the manifestation of a disease or disorder in family members of such individual.

### *Exemption*

A group health plan) may request an exemption from the parity requirements for the following year if the increased cost of compliance with the requirements exceeds:

- 2% of total plan costs in the first year of the parity requirements and
- 1% of total plan costs in each subsequent year.

Any such determination must be made by an actuary after the plan has complied with the parity requirement for the first 6 months of the plan year. When claiming the exemption, the plan must provide proper notification to the Department of Labor and participants and beneficiaries of the exemption.

### *Interaction with State Law*

Many states have insurance laws that already provide the parity described under the Act. State law will continue to apply where it affords greater benefits than required under the Federal Law.

It is important to note that many state mental health requirements may not include parity with respect to chemical dependency. Those plans will need to be reviewed for compliance with the Federal requirement by the effective date.

*For more information, see our article in the Winter 2008 Benefits Insider:*

[http://www.kpcom.com/newsletters/documents/Benefits\\_Insider\\_Winter\\_2008.pdf](http://www.kpcom.com/newsletters/documents/Benefits_Insider_Winter_2008.pdf)

### **MICHELLE'S LAW**

In the event of a medically necessary leave of absence<sup>4</sup> from a postsecondary educational institution (e.g. colleges and universities) due to a serious illness or injury, Michelle's Law requires continuation of health coverage for the student. Coverage must be continued for the student as if he/she were still covered as an active student under the plan for the earlier of: 1) one year after the first day of medically necessary leave, or 2) the date coverage would otherwise terminate under the plan.

The plan must receive a written certification from the dependent child's physician that the child is suffering a serious illness or injury and the leave of absence is medically necessary.

Employers with health plans subject to this requirement will need to include language describing the continuation provisions afforded by Michelle's Law in any communication materials regarding certification of student status.

Michelle's Law generally applies to self-insured and fully insured group health plans and the individual health insurance market. It will impact those plans with a student status eligibility requirement for a dependent to continue coverage past a specified age. Many plans and some states have loosened the traditional student status requirements and have expanded eligibility provisions to cover dependent children up to a specified age (e.g. 25) without regard to student status. In such cases, Michelle's Law would likely not apply as the child would not lose coverage as a result of losing full-time student status.

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

*For more information, see our article in the Winter 2008 Benefits Insider:*

[http://www.kpcom.com/newsletters/documents/Benefits\\_Insider\\_Winter\\_2008.pdf](http://www.kpcom.com/newsletters/documents/Benefits_Insider_Winter_2008.pdf)

### **FORM 5500 ELECTRONIC DELIVERY AND OTHER CHANGES**

The long-promised electronic filing requirement for Form 5500 and associated schedules and attachments is soon to become reality. **All plan years beginning on or after January 1, 2009 will be required to file electronically** unless another extension is granted. Plan filings for short

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<sup>4</sup> For purposes of this summary, the term *Medically Necessary Leave of Absence* also includes any other enrollment status change that would affect the student's eligibility for health coverage.

plan years that are due prior to January 1, 2010 (when EFAST2, the new electronic filing system, is set to go live) will be granted an optional automatic filing extension. Plans taking advantage of this extension will need to complete their electronic plan filing within 90 days after the electronic filing system is available. Plans may still file prior to this extension deadline by using 2008 forms. More information is available at <http://www.efast.dol.gov/>.

### **PROPOSED LEGISLATION – COBRA EXTENSION**

The House recently passed legislation as a part of the economic stimulus package that may significantly impact COBRA and employers sponsoring health plans subject to COBRA. The bill is H.R. 598 – Title III, the Health Insurance Assistance for the Unemployed Act of 2009 (the Act). A copy is available at <http://waysandmeans.house.gov/media/pdf/110/sbill.pdf>.

This bill proposes two significant changes to COBRA: 1) providing a premium subsidy for certain COBRA qualified beneficiaries and 2) extending COBRA benefits for older workers and long-term employees to Medicare eligibility.

#### *Premium Assistance for COBRA Benefits*

The proposed legislation seeks to reduce the burden associated with the cost of COBRA coverage for “assistance eligible individuals” by treating, for a limited period of time, a COBRA payment as “paid in full” if the individual pays **35%** of the premium.

#### Assistance Eligible Individual

An *assistance eligible individual* is any qualified beneficiary who elects COBRA and satisfies the following two requirements:

- The qualifying event with respect to the covered employee is the involuntary termination of the employee’s employment (other than for gross misconduct), and
- The qualifying event must have occurred between September 1, 2008 and December 31, 2009 and the qualified beneficiary is otherwise eligible for COBRA during that period of coverage and elects coverage.

The assistance eligible individual would include any qualified beneficiary associated with the relevant covered employee (e.g. a dependent of the employee who is covered on the day before the qualifying event). That qualified beneficiary (whether the employee or other dependent) may independently elect COBRA and independently receive a subsidy.

#### Duration

The subsidy would be available for a period up to 12 months from the date the subsidy first applies. Eligibility for the subsidy will terminate prior to the 12-month period (1) at the expiration of the maximum COBRA period, or (2) the date the assistance eligible individual becomes eligible for Medicare or health coverage under another group health plan.

The qualified beneficiary has the obligation to notify the plan in writing should they become eligible for coverage under Medicare or another group health plan. A significant penalty would be imposed on the individual for not notifying the plan of other coverage.

#### Special Election Opportunity

The Act as written provides a 60 day election period for a qualified beneficiary who is eligible for a reduced premium and has not elected COBRA coverage on the date of enactment. The employer/plan administrator would be responsible for notifying eligible individuals of this special election opportunity. The employee would have 60 days from the date of the notification to elect and receive both COBRA coverage and the subsidy. The coverage would begin with the date of enactment and would not include the period of time before that date. However, the duration of COBRA would be counted from the original qualifying event.

#### Reimbursement of Group Health Plans

Employers will be eligible to receive a reimbursement of the premium amount that is not paid by an assistance eligible individual on account of the premium reduction. The reimbursement may be obtained by treating the reimbursable amount as a credit against the employer’s liability for

federal payroll taxes. Should the amount exceed the tax liability, the employer may request reimbursement from the IRS.

#### Notice Requirements

The election notice would be amended to include language regarding the qualified beneficiary's eligibility for and conditions on the premium subsidy. Under the Act, the DOL is tasked with providing model language for these additional notification requirements.

#### *Extension of COBRA Benefits for Older or Long-Term Employees*

The Act further proposes an extension of the duration of COBRA in the event of a termination of employment (other than for gross misconduct) or a reduction in hours for employees who either (1) are age 55 or older, or (2) have 10 or more years of service with the employer at the time of the qualifying event. These individuals would continue their COBRA coverage **until the earlier of enrollment in Medicare or termination of all health plans sponsored by the employer offering COBRA coverage** (as opposed to the traditional 18-month continuation period).

#### *Senate Bill and Next Step for Legislation*

The Senate version of this bill is in committee. It appears the proposed COBRA changes under the Senate version are not as dramatic as the House bill. The Senate bill includes a similar 35%, but limits the duration to 9 months. More significantly, the Senate bill does not include the extension of COBRA coverage for older individuals and those long-term employees. Once the Senate passes its version of the bill, both the House and Senate will work together between their two versions to develop the final product.

We will keep you informed as this legislation progresses.

#### **CONCLUSION**

2008 was a busy year, and 2009 promises to provide more of the same. As always, we will work hard to keep you informed of your compliance obligations in this ever changing environment. Attached is a timeline to help you keep track of the upcoming effective dates.

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## **COMPLIANCE TIMELINE**

### JANUARY 1, 2009

- Bicycle benefit may be offered to employees.
- Changes to the definition of qualified child for purposes of Internal Revenue Code 152. Plans should be reviewed to ensure compliance with this definition.
- Proposed cafeteria plan regulations are in effect (extension may be forthcoming).
- Mandatory Insurer Reporting
- New Creditable Coverage Notices
- Starting January 1, 2009, plan years with a Form 5500 reporting requirement will be subject to the electronic delivery requirements as well as other changes.

### JANUARY 16, 2009

- New FMLA regulations are in effect. Employers should review current policies, procedures and notices to ensure compliance with the new requirements.

### MAY 23, 2009

- GINA takes effect for group health plans with plan years beginning on and after this date. Plans should be reviewed and amended for compliance.

### JUNE 30, 2009

- Last day debit cards may be used at a pharmacy or drug store without an IIAS system or 90% gross receipts in qualified medical expenses.

### OCTOBER 3, 2009

- New Federal Mental Health and Substance Abuse Parity requirements are effective for group health plan years beginning on and after this date. Plans should be reviewed and amended for compliance.

### OCTOBER 9, 2009

- Michelle's Law requirements are effective for group health plan years beginning on and after this date. Plans should be reviewed and amended for compliance.

### DECEMBER 31, 2009

- Last day to retroactively amend plan documents to account for a qualified reservist distributions made between June 18, 2008 and December 31, 2009

### JANUARY 1, 2010

- Calendar year plans will need to be in compliance with GINA, Mental Health Parity and Substance Abuse Act and Michelle's Law.



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