



EMPLOYEE BENEFITS NEWSLETTER ~ JANUARY 2010

Health Care Progress Report: Fights over Transparency, Tax Measures



The White House may be trying to put a positive spin on the status of the health care bill in Congress, but the fact is, significant differences remain between the House and Senate bills. Democrats from both the House and the Senate aired some of their grievances this past week about the parts of the legislation they don't like, so now they will be hard-pressed to resolve those issues in order to move the legislation before President Obama's still unscheduled State of the Union speech.

Congress has reached the fourth step of the health care legislative process. But Democrats are skipping the formal process (known as the conference committee) of merging the House and Senate bills in favor of working out the differences behind closed doors.

Obama will meet with union leaders to discuss their concerns with one of the Senate health care bill's primary funding mechanisms—a tax on high-end insurance policies. Labor unions have blasted the provision, arguing it would compel insurers to either pass on the cost of the tax to consumers, or to cut benefits in order to avoid the tax.

The unions are rallying their members to call their representatives this week to express their opposition to the excise tax as well as other Senate provisions. However, they're also acknowledging the provision is likely to remain in the final bill:

“When you have a president who says he wants to incorporate it and a Senate that says it wants to incorporate it and some in the House who say they want to incorporate it,” Andy Stern, president of the Service Employees International Union, told The Hill newspaper, “it’s hard to look that in the face and say we can just win this outright.”

Along with the unions, House Democrats have also expressed concern about the excise tax. Mr. Obama reportedly said last week that he supports the policy, even though he promised as a presidential candidate to avoid taxing the middle class or imposing taxes on health benefits.

The president has also been in hot water with some this year for breaking his promise of keeping the health care debate transparent - even Sen. Claire McCaskill (D-Mo.), one of the president's most vocal supporters, is saying Democrats should broadcast health care discussions.

Now, opponents of the excise tax are raising even more transparency complaints with the administration. The liberal blog network Daily Kos reported last week that MIT economist Jonathan Gruber, one of the leading proponents of the excise tax, had a contract worth more than \$300,000 with the Health and Human Services Department to evaluate the president's health care reform plans. Gruber failed on numerous occasions to disclose the contract, and the White

House has referred to Guber as an “objective” health care analyst.

The failure to disclose this relationship prompted the New York Times to issue a correction for an op-ed it published from Gruber on the subject of taxing health benefits. The Times wrote, “Had editors been aware of Professor Gruber’s government ties, the Op-Ed page would have insisted on disclosure or not published the article.

Meanwhile, the Democrats continue to negotiate over other provisions that could change the cost of the health care bill by billions of dollars, such as Sen. Ben Nelson’s deal to cover the cost of Medicaid expansion in Nebraska with federal funds. In the wake of complaints from everyone from Calif. Gov. Arnold Schwarzenegger to Sen. Blanche Lincoln (D-Ark.), Nelson says he is trying to extend the deal to all 50 states in spite of the enormous cost it would place on the federal government.

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Voluntary Benefits' Widening Options

U.S. employers are increasingly offering voluntary benefit options as the way to meet the needs of a diverse workforce, according to Top Trends in Voluntary Benefits, a report on a survey conducted last August and September by the not-for-profit International Foundation of Employee Benefit Plans (IFEFP).

Ninety-one percent of the 833 U.S. employers surveyed were corporations. The survey defined voluntary benefits as supplementary benefits made available by an employer, often at a group rate or premium discount to employees.

Eight-four percent of the respondents surveyed were said they offer voluntary benefits, and 5 percent plan to offer them. The most commonly offered options include:

- ◇ **Term life insurance, 73 percent**
- ◇ **Vision insurance, 53 percent**
- ◇ **Long term care insurance, 51 percent.**
- ◇ **Long term disability insurance, 50 percent**
- ◇ **Accident insurance, 49 percent**
- ◇ **Dental insurance, 48 percent**

Smaller but still significant percentages of employers offer newer niche voluntary products such as automobile insurance, 32 percent; homeowners; or renters' insurance, 29 percent; debt counseling and financial planning, 22 percent; identity theft coverage, 22 percent; college savings plans, 21 percent; and pet insurance, 19 percent.

Seventy-eight percent of employers said they believe that offering voluntary benefits results in only slight or moderate increases in administrative costs.

"The survey shows voluntary benefits are a significant part of plan sponsors' strategic benefits approach, and they are poised to increase in prevalence in the coming years. These benefits improve employee satisfaction, with minimal administrative costs for employers," says Sally Natchek, senior director of research at IFEFP.

"Long term care is one of the fastest growing voluntary benefits," Natchek points out. "Aging Baby Boomers, who have perhaps experienced the overwhelming costs of custodial care with a parent, are expected to drive the future trend in purchasing long-term care insurance."

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Maximum HSA Contribution to Rise in 2010

The maximum contributions that can be made to health savings accounts in 2010 will increase as will the minimum deductible imposed by health insurance plans linked to HSAs and the maximum out-of-pocket expenses that employees can be required to pay, the Internal Revenue said. The maximum contribution that can be made to an HSA in 2010 for employees with single coverage will be \$3050, up from \$3000 in 2009. The maximum HSA contribution for those with family coverage will rise to \$6150, up from \$5950.

Additionally, the maximum out-of-pocket expense, including deductibles, that employees can be required to pay next year will rise to \$5950 for single coverage, up from \$5800 in 2009, and \$11,900 for family coverage, up from \$11,600.

The minimum deductible of the high-deductible health insurance plan to which HSAs must be linked will increase in 2010 to \$1200 for single coverage and \$2400 for family coverage. The current minimum deductibles are \$1150 for single coverage and \$2300 for family coverage.

Wellness At Work For You

Do Your Health and Wellness Plans Violate GINA?

Many employers with wellness programs that use health risk assessments will have to modify their assessments to avoid running afoul of the Genetic Information Nondiscrimination Act of 2008 (GINA) under final interim regulations.

Overview

Title I of GINA generally prohibits plans and insurers from increasing group premiums and contributions based on genetic information, requesting or requiring genetic testing, and, importantly to employers, collecting "genetic information" either "prior to or in connection with enrollment" or for "underwriting" purposes. The regulations, which implement Title I of GINA, amend the HIPAA nondiscrimination rules found in the ERISA and the Internal Revenue Code, as well as the HIPAA privacy regulations.

The DOL/IRS/HHS regulations are limited to health plans and health insurers; they do not address employment practices covered under Title II of GINA. Wellness programs that are neither ERISA plans nor group health plans under HIPAA (e.g., because they provide only referral services and no medical care) would not be subject to these regulations but would have to comply with Title II of GINA and EEOC regs.

Genetic information is defined to include an individual's genetic tests, requests for and receipt of genetic services, and family medical history. An employee's genetic information includes any manifestation of a disease or disorder in the employee's family members. For this purpose, "family members" include dependents plus all relatives to the fourth degree without regard to whether they are related by blood, marriage or adoption.

Prohibitions on Collecting Genetic Information

GINA prohibits group health plans and insurers from collecting genetic information for underwriting purposes and prior to or in connection with enrollment. Underwriting includes rules for determining eligibility, computing premiums or contributions, and applying existing conditions. As a result, the prohibition on collecting genetic information for underwriting is not limited to insurance rating and pricing activities

but includes changes to deductibles and other cost-sharing plus discounts, rebates, in-kind payments and other (punishment) for completing a health risk assessment or participating in a wellness program. The regs clarify that offering reduced premiums or other rewards for providing genetic information (in this case, the family medical history that often is a routine part of health risk assessments) would be impermissible "underwriting."

Impact on Wellness Programs

The new regulations clarify that wellness programs providing a reward for completing a health risk assessment that collects family medical history generally will violate GINA unless the forms are modified. Even though prior regulations under the HIPAA nondiscrimination rule would have permitted such programs in many cases, particularly where the reward was based on participation in the wellness program rather than its results; under GINA such a program would be an impermissible collection of genetic information for underwriting purposes.

Through a range of examples, though, the new regs do offer employers options for redesigning their wellness plans to avoid violating GINA. For example, a wellness program that does not collect family medical history will be permissible under GINA, even if it includes participation or results-based rewards (although employers will still need to consider whether it satisfies HIPAA's requirements). In addition, collecting family history but not offering any reward would be allowed if the information is not collected prior to or in connection with enrollment in the wellness program. Another option the regs highlight is to request two distinct health risk assessments from employees after (and unrelated to) enrollment in the health plan: one providing a reward for completing a health risk assessment that does not elicit any family medical history or other genetic information, and another purely voluntary and separate health risk assessment that seeks information as to family medical history and genetic testing, to which no reward is tied.

Prohibition in Adjusting Group Rates

While HIPAA's nondiscrimination provisions preclude group health plans from discrimination based on health

factors, GINA expands that prohibition. Under GINA, a group health plan cannot adjust premiums or contributions for similarly situated employees based on genetic information. Previously, plans and insurers could adjust group premiums based on genetic information (or other health factors) if individual premiums were not affected. Under GINA, even if the plan or insurance company has collected genetic information from an employee or other covered dependents lawfully, that information may not be used to set rates.

The new regs clarify that GINA will not prevent a group health plan or insurer from using claims information or health information from individuals other than genetic information when setting premium and contribution rates. In addition, plans may consider the cost of any covered genetic testing and services when determining pricing for plan coverage.

Impact on Employers

Employers that sponsor any group health or wellness plan will want to:

Review their plan documents and administration for compliance with these new rules.

Work with their administrators and insurers to confirm that they have not set rates impermissibly based on genetic information and do not use genetic information for any underwriting purposes including the application of any existing condition exclusion period. Avoid requesting or requiring any genetic testing or genetic information from their employees. Particularly for employers that are offering wellness programs in connection with an upcoming open enrollment session, special attention should be given to any health risk assessments or other enrollment forms that collect genetic information, medical history or any other information that might fall within GINA's scope.

Interested in learning what a Wellness Program can do for your Company? Call our Certified Wellness Manager at:

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Fast Turnaround Needed on COBRA Subsidy Extension Notices

The U.S. Department of Labor (DOL) and plan administrators alike are racing to prepare the COBRA subsidy extension notices required by the U.S. Department of Defense Appropriations Act of 2010, signed into law on December 19, 2009.

The DOL already has sent to the Office of Management and Budget (OMB) for approval a draft updated model alternative notice, a model premium assistance extension notice and an updated model general notice.

In its Dec. 24, 2009, information collection request (ICR) to the OMB under emergency review procedures, published in the *Federal Register* on Dec. 31, 2009, the DOL noted that assistance eligible individuals (AEIs) now can be eligible for the subsidy if they incur an involuntary termination of employment triggering a COBRA election opportunity by Feb. 28, 2010. Before the extension, AEIs had to experience an involuntary termination of employment by Dec. 31, 2009, to be eligible for the original COBRA subsidy under the America Recovery and Reinvestment Act (ARRA) of 2009, which the U.S. Dept. Of Defense Appropriations Act of 2010 amended.

The length of the premium assistance period also is extended by the Defense authorization law from 9 to 15 months, the DOL noted in its ICR.

But Rachel Cutler Shim, an attorney with Reed Smith in Philadelphia, told SHRM Online on Jan. 7, 2010 that she would not recommend sending COBRA subsidy extension notices yet, but would wait until the DOL issues a final version of the notices. Shim expected the DOL would issue final updated notices soon, and said employers that tweaked and sent out their notices before the final versions would just have to go back and send the DOL's updated notices again if they didn't wait. However, Shim said if the DOL doesn't issue final notices until late January, she would recommend employers send out their own notices.

Employers right now might let plan participants know that they are aware of the extensions and will be sending an additional notice in the future, Shim added. She cautioned though that "an employer that uses electronic communications with its employees to satisfy the notice and document distribution Requirements of ERISA will be required to provide more paper communications because COBRA participants generally cannot receive electronic communications unless they consent in writing."

Identify Notice Recipients

For now, Shim said that employer with health benefits plans should:

Identify any COBRA participants who were eligible for the ARRA subsidy whose eligibility ended and who dropped COBRA coverage once the COBRA subsidy ended, and provide these individuals with the required notice. The notice should indicate that the COBRA subsidy has been extended to 15 months and that these individuals are eligible to re-enroll in subsidized COBRA coverage by paying 35% of the premium by Feb. 17, 2010, or, if later, 30 days after the notice has been provided.

Identify any COBRA participants who were eligible for the subsidy whose eligibility ended and who elected to pay the full COBRA premium. The employer then will have to decide whether to refund the excess premium or offset future premiums by the overpaid amounts. The employer also will have to provide these individuals with a notice regarding the extension of the COBRA subsidy.

Update the COBRA notice to include information about the extension and provide the notice to AEIs on or after Oct. 31, 2009.

Some employers may decide it makes the most sense to send the COBRA subsidy extension notice to all COBRA participants, she said. Employers also should update plan documents and summary plan descriptions to describe the extension of the subsidy.

Shim noted that there was "some confusion regarding whether an individual who terminated employment in December, but had active coverage through the end of the month and did not begin COBRA coverage until January 1 was eligible for the subsidy." she said that the DOL originally indicated that such an individual would not be an AEI. However, the COBRA extension provisions clarify that AEI status is based on the date of termination and not the date that COBRA begins. Consequently, people who end employment in February 2010, but who don't begin receiving COBRA coverage until March 2, 2010, will be eligible for the subsidy. "My guess is that HR departments will have misunderstandings regarding who they must notify about the extension and how to administer coverage for reinstated participants," Shim remarked.



Transition Period Challenges

According to Paul Hamburger, an attorney with Proskauer Rose in Washington, D.C. noted that there will be some strange results with the subsidy extension, he predicted. Suppose, for example, someone's original 9 month ARRA subsidy ended on Nov. 20, 2009, and that person elected nothing during December open enrollment because COBRA was too expensive without the subsidy, which the person erroneously guessed that Congress would not extend. After the COBRA subsidy extension, that person might still elect into an employer's preferred provider organization (PPO) even after open enrollment has ended, Hamburger said.

But suppose someone during open enrollment decided to drop down to a cheaper health maintenance organization (HMO) from the PPO because they couldn't afford the PPO without the subsidy. The U.S. Dept. of Defense Appropriations Act of 2010 does not require the employer to let that person switch back to the HMO if the open enrollment period has ended, he said. But he added that the DOL has said that employers may let the person back in to elect what they had before the 9 months of the original subsidy ended.

Another Subsidy Extension?

Shim also recommended that any HR department plan and budget now for the possibility that the COBRA subsidy might not go away on Feb. 28, 2010. "There is already a proposal in the Jobs for Main Street Act to extend the subsidy until June of 2010," she said.

In addition, she cautioned that "the IRS has started to audit employers that have claimed the subsidy so HR departments should be keeping good records of the identity of all individuals included on the Form 941 (which is used to request the subsidy), each individual's COBRA subsidy request, and a copy of proof that the employee paid 35 percent of the COBRA premium.