



BURNING BENEFITS NEWS

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EXTENDED COBRA SUBSIDY MEANS NEW COMPLIANCE OBLIGATIONS FOR GROUP HEALTH PLAN SPONSORS

President Obama signed into law on December 19 an extension and expansion of a COBRA premium subsidy law that was originally set to expire on December 31. Originally passed as part of the American Recovery and Reinvestment Act of 2009, the COBRA premium subsidy provides for assistance-eligible individuals to pay only 35 percent of their COBRA premiums, with the remaining 65 percent to be reimbursed to the plan sponsor through a tax credit. So what's new under the extending legislation? Group medical plan sponsors should be aware of four critical components of the extending legislation:

1. **Extended Eligibility Period.** The subsidy relates to assistance-eligible individuals who experience an involuntary termination of employment September 1, 2008, through February 28, 2010 (previously December 31, 2009).
2. **Extended Subsidy Period.** The length of the subsidy period has been extended by 6 months (from 9 to 15 months of subsidized COBRA coverage).
3. **Retroactive Election Period.** Individuals who dropped COBRA coverage after reaching the end of the subsidy period (before the legislation extended it to 15 months) will have an extension of their grace period to pay the reduced premium. To continue the subsidized COBRA coverage without a gap in coverage, they must pay the 35 percent of premium costs for any past due periods by (i) February 17, 2010, or, if later, (ii) 30 days after notice of the extension is provided by their plan administrator.

If an individual already paid the full premium, the excess must be credited against additional months of coverage or refunded.

4. **Sponsor Notice Requirement.** By February 17, 2010, plan sponsors must give notice regarding the extension to any individuals who were eligible for the subsidized coverage on or after October 31, 2009. Going forward, the plan sponsor must provide the revised subsidy information within the statutory time period for providing other COBRA information.

ARE YOU AND YOUR BUSINESS ASSOCIATES READY FOR THE NEW HIPAA BREACH NOTIFICATION RULES?

Earlier this year, the Department of Health and Human Services ("HHS") released final (interim) regulations covering the new breach notification rules under the Health Insurance and Accountability Act ("HIPAA") Privacy and Security Rules. The Federal Trade Commission ("FTC") issued similar regulations for certain entities not covered by HIPAA. The new breach notification rules were enacted by the Health Information Technology for Economic and Clinical Health Act ("HITECH") section of the American Recovery and Reinvestment Act ("ARRA"). *We plan on testing you on these acronyms.*

Background

The HITECH provisions include the direct regulation of business associates, breach notification requirements, additional individual privacy rights and strengthened enforcement with increased penalties. This article focuses on the breach notification rules.

Effective Date of Breach Notification Rules

The new breach notification rules are effective September 23, 2009 (September 24, 2009, for FTC-covered entities). However, HHS (and FTC) will not begin imposing sanctions under the rule until February 22, 2010.

Notice Requirements

Covered entities (i.e., health care providers, health plans and other entities covered by HIPAA) must notify affected individuals of a breach of unsecured PHI. Breach generally means the unauthorized acquisition, access, use, or disclosure of unsecured PHI which compromises the security or privacy of the information. Subject to certain exceptions, notice is required when there is a significant risk of financial, reputational or other harm to the individual as determined by the covered entity or business associate through a formal risk assessment.

If more than 500 individuals are affected, HHS must be notified. If more than 500 residents of a state are affected, the media must be notified as well. Business associates (e.g., third-party administrators, consultants and other vendors) must notify covered entities of breaches by the business associate.

Timing of Notice

Affected individuals must be notified without unreasonable delay and no later than 60 days after the breach is discovered by a covered entity or business associate.

Contents of Notice

The notice should include the following information written in plain language:

- Brief description of what happened, including date of breach and date of discovery
- Types of PHI involved (e.g., full name or Social Security number)
- Any steps the individuals should take to protect themselves from potential harm
- Brief description of what the covered entity is doing to investigate the breach, to mitigate harm to the individuals and to protect against further breaches
- Contact information for affected individuals to ask questions, including a toll-free number, e-mail address, web site or postal address.

Penalties

Penalties range based on the conduct involved from \$100 per violation (\$25,000 maximum per year) to the maximum penalty of \$50,000 per violation (\$1.5 million maximum per year).

Required Actions

- Establish notice procedures and update privacy procedure
- Maintain breach logs
- Train employees
- Revise business associates agreements

If you need help updating your business associates agreements or otherwise complying with HITECH, please give us a call.

MOST GROUP HEALTH PLANS AND MANY CAFETERIA PLANS REQUIRE PLAN AMENDMENTS FOR MICHELLE'S LAW

In our year-end 2008 newsletter, we told you about Michelle's Law. The deadline for complying with Michelle's Law was October 9, 2009 (**January 1, 2010** for calendar-year plans). Michelle's Law prohibits group health plans from discontinuing coverage of college students who are covered based on their enrollment in post-secondary education (e.g., on parent's coverage) and who take a medically necessary leave of absence. Coverage must continue until the earlier of (1) one year from the date of the academic absence, or (2) the date on which coverage would otherwise terminate under the plan's terms (for example, at a particular age). Such students must be entitled to the same benefits during the medically necessary leave of absence, as would apply if they had not taken a leave and had continued to be a college student. Any requests for certification of a dependent's student status must contain an explanation of a dependent child's rights under Michelle's Law.

Please contact us if you need help complying with Michelle's Law or with updating your plan documents.

GINA REQUIRES QUICK RESPONSE TIME

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits health insurance and employment discrimination based on genetics.

GINA Prohibits:

- Collecting genetic information either for underwriting purposes or prior to, or in connection with, enrollment (*e.g., requesting family history in exchange for a premium reduction or requesting health risk assessment with family history prior to enrollment*);
- Requesting or requiring genetic tests; and
- Adjusting group insurance premium or contribution rates.

Builds On HIPAA's Protections

GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Requires Quick Response Time!

Compliance required for plan years beginning after May 21, 2009. (**January 1, 2010** for calendar year plans.) Interim final regulations were just issued on October 7, 2009.

Applies to Group Health Plans

GINA applies to all group health plans (insured and self-funded) but has the most impact on those with a health risk assessment, wellness program or disease management program.

Enforcement and Remedies

Remedies include a \$100 penalty per day per impacted individual with a minimum of \$2,500 for minor violations and \$15,000 for significant violations and a maximum penalty of \$500,000 for

unintentional failures. Also available are remedies similar to those under Title VII of the Civil Rights Act of 1991 (e.g., reinstatement, hiring, promotion, back pay, punitive damages).

Required Actions

- Review all group health plans, especially those with a health risk assessment, wellness program or disease management program
- Review enrollment materials, Family and Medical Leave forms and related employment policies and practices
- Confirm health insurance carriers, third party administrators and stop/loss carriers are complying with new rules.

ARE YOU COMPLYING WITH THE RED FLAGS RULE?

You thought you were busy before... The FTC “Red Flags” Rule requires many businesses to develop, implement and administer an Identity Theft Prevention Program designed to detect the warning signs – or “red flags” – of identity theft. The Red Flags Rule goes beyond the HIPAA Privacy and Security rules that require safeguarding protected health information (“PHI”). The Red Flags Rule covers HIPAA PHI, plus additional information (for example, credit card information and background checks on employees).

Quickly Approaching Deadline

The Red Flags Rule has been in effect since January 1, 2008. On November 1, 2009, the Federal Trade Commission began enforcing the rule.

Applies to Many Unsuspecting Businesses

The Red Flags Rule applies to “**Financial Institutions**” and “**Creditors**” with “**Covered Accounts**.”

- The term “**Creditors**” is broadly defined to include businesses that regularly defer payment for goods and services and bill customers later (for example, health care providers, utility companies, finance companies, real estate agencies and law firms).
- “**Covered Accounts**” include (i) consumer accounts primarily for personal, family or household purposes involving multiple payments or transactions (for example, credit cards, auto loans, checking/savings accounts); and (ii) any other account for which there is a reasonably foreseeable risk of identity theft (for example, small business accounts).

Employee Benefit Plans

The overall impact on employee benefit plans isn’t clear at this point. However, the FTC has stated that the rule doesn’t apply to a 401(k) plan just because it offers loans since participants are borrowing from themselves, and it doesn’t apply to health flexible spending accounts (unless debit cards are offered).

Non-compliance Penalty

The FTC can seek both monetary civil penalties (\$3,500 maximum per violation) and injunctive relief for violations of the Red Flags Rule.

Available FTC Materials are located at <http://www.ftc.gov/bcp/edu/microsites/idtheft/>.

- Do-it-yourself Prevention Program form with step by step instructions
- How to Guide for Business
- FAQs

We would be happy to assist you in complying with the Red Flags Rule.

**Inflation Adjusted Limits for
Qualified Plans, Social Security and Health Benefits**

QUALIFIED PLANS	2010	2009
Elective Deferrals 401(k) and 403(b)	\$ 16,500	\$ 16,500
457 Deferral Limit	\$ 16,500	\$ 16,500
Annual Benefit Limit	\$195,000	\$195,000
Annual Contribution Limit	\$ 49,000	\$ 49,000
Annual Compensation Limit	\$245,000	\$245,000
Highly Compensated Threshold	\$110,000 (HCE in 2011)	\$110,000 (HCE in 2010)
Top-Heavy Key Employee Compensation	\$160,000	\$160,000
Catch-Up Contributions 401(k) 403(b) 457 SEP	\$ 5,500	\$ 5,500
SIMPLE Contributions	\$ 11,500	\$ 11,500
SIMPLE Catch-Ups	\$ 2,500	\$ 2,500
SOCIAL SECURITY		
Social Security Wage Base Cap	\$106,800	\$106,800
HEALTH SAVINGS ACCOUNTS Annual Limits		
HDHP Minimum Deductible		
Self Only	\$1,200	\$ 1,150
Family	\$2,400	\$ 2,300
HDHP Maximum Out-of-Pocket		
Self Only	\$5,950	\$ 5,800
Family	\$11,900	\$11,600
HSA Maximum Contribution		
Self Only	\$3,050	\$3,000
Family	\$6,150	\$5,950
Catch-Up Contributions Age 55 by year end	\$1,000	\$1,000

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