



# New Federal Legislation Affecting Health Plans

New COBRA Subsidy

New Special Enrollment Rights

New Privacy and Security Requirements in the HITECH Act

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## What are the COBRA Provisions in the American Recovery and Reinvestment Act of 2009 (ARRA)?

- In general, the new law provides a 65% COBRA subsidy (called premium assistance) to employees who are involuntarily terminated between September 1, 2008 and December 31, 2009 (and covered family members).
- For those who qualify, the employer accepts 35% of the COBRA premium as full payment. The plan can then obtain reimbursement from the federal government for the remaining 65%, whether the plan is insured or self-funded.
- There may be additional changes to COBRA – possibly extension of this subsidy beyond 2009 or special rights for COBRA qualified beneficiaries 55 and older. Whether these temporary COBRA provisions are extended, replaced by more fundamental federal health care reform or simply expire, we don't know.

# What Types of Health Plans are Eligible for Premium Assistance?



<b>Health Benefits Eligible for Premium Assistance</b>	<b>Health Benefits Not Eligible for Premium Assistance</b>
<p>Medical plans (including high deductible health plan)</p> <p>Dental plans</p> <p>Vision plans</p> <p>Health Reimbursement Arrangements (HRAs)</p> <p>Any other group health plan subject to COBRA (other than health flexible spending account plans)</p>	<p>Health care flexible spending account plans (Health FSAs)</p> <p>Non-ERISA health savings accounts (HSAs)</p>

## What Types of Employers Must Offer Premium Assistance?

- Employers subject to COBRA.
- Public employers subject to the PHSA.
- The federal government.
- Employers not subject to COBRA but offering insured health coverage subject to state “Mini-COBRA laws” -- e.g. insured plan for 10 employee employer (special rules apply).
- Employers participating in multiemployer plans (special rules apply).

## Which COBRA Qualified Beneficiaries are Eligible for Premium Assistance?

- Eligible for COBRA between September 1, 2008 and December 31, 2009,
- Elect COBRA,
- Qualifying event is the employee's involuntary termination of employment that is not a termination for gross misconduct, and
- Employee's loss of employment occurs between September 1, 2008 and December 31, 2009.

## Notes on Eligibility Issues

- **Must be a COBRA qualified beneficiary (presumably excludes domestic partners who are not Code Section 152 dependents).**
- With the exception (perhaps) of newborns and newly adopted children, have to have been a qualified beneficiary at time of qualifying event.
  - Example: Jack, an AEI, elects COBRA in September, 2009. He marries in October and adds his spouse to his COBRA coverage through his special enrollment rights. We do not think she is eligible for premium assistance.

# What is an Involuntary Termination of Employment?

- **Currently no guidance.**
- If for gross misconduct, not eligible, even though involuntary.
- Performance based termination would be eligible (absent gross misconduct).
- Terminations resulting from position eliminations, straights RIFs would be involuntary.
- Reduction in hours without employment termination not eligible.
- But lots of gray areas: Window programs? Layoffs of union workers with rights of recall? Early retirements? Resignation after drastic salary decreases?
- Some possible models:
  - Internal Revenue Code Section 409A's definition of involuntary separation from service. (If so would it include good reason and window programs?)
  - State definitions of involuntary termination for purposes of unemployment compensation.
- IRS has promised guidance.

## What Happens if an Individual Requests Premium Assistance and the Plan Denies the Request?

- Expedited DOL review available “in such form and manner as shall be provided...”
- Decision made within 15 business days after receipt of application for review.
- Review shall be de novo and final.
- Reviewing court shall grant deference to DOL determination.
- ERISA remedies available to participants in plans subject to COBRA.

# What is the Amount of Premium Assistance?

- Premium assistance is 65% of what the plan would otherwise be requiring the qualified beneficiary to pay for the COBRA continuation coverage. **In other words, the plan can only charge the AEI 35% of whatever the plan normally charges for this COBRA coverage, not what the plan could charge.**
- Examples:
  - Plan charges maximum amount permitted by COBRA (100% cost of coverage plus 2% administrative fee). Premium assistance rate for qualified beneficiary is 35% of the 102% rate.
  - Plan charges less than maximum amount permitted by COBRA (e.g. plan provides coverage at “employee rates” for some limited time after termination). Premium assistance rate for qualified beneficiary is 35% of the employee rate.

# Special Issues: Severance Plans

- If employer currently subsidizes health coverage during severance period and if permissible under terms of plan, employers may want to terminate continued provision of subsidized coverage during severance while premium assistance is available and required.
- Potential issues:
  - Is plan clear that subsidized severance period is COBRA coverage?
  - Can plan be amended to change health subsidy?
  - Will changing health subsidy raise issues about viability of release?
  - Does amending plan raise any 409A issues?
  - Is affected employee likely to be “high income individual”?

## When is Premium Assistance Available?

- Available for “period of coverage” beginning on or after February 17, 2009.
- Generally March 1.
- If AEI overpays for COBRA in March or April, plan can reimburse excess within 60 days of payment or credit to future payments if it is reasonable to believe credit will be used within 180 days of overpayment.

# When Does Premium Assistance End?

- Premium assistance ends on the earliest of the following events:
  - 9 months after commencement of premium assistance.
  - The date following the expiration of maximum COBRA coverage.
  - The date COBRA is lost for some other reason (e.g. non-payment of reduced premium).
  - The first date that the individual is **eligible for** other employer group health coverage or Medicare. Note that eligibility for coverage, not coverage, is what is required. Also, coverage consisting only of dental, vision, counseling, health FSA, on-site medical facilities providing only first-aid services, prevention and wellness care, or similar care, do not prevent premium assistance eligibility.

## How Does the Employer Know if the Individual is Eligible for Other Coverage?

- AEI required to notify plan of eligibility for other coverage.
- failure to provide timely notice results in 110% penalty imposed on the AEI for premium reduction provided “after termination of eligibility” (subject to reasonable cause exception).

## Special Issues with Eligibility for Other Coverage

- Per informal IRS statements, if an AEI has eligibility for other disqualifying health coverage and then loses the disqualifying eligibility, s/he could receive premium assistance beginning after eligibility for other coverage is lost (if otherwise eligible).
  - Example (BASED ON INFORMAL STATEMENTS OF IRS): John was terminated on June 30, 2009, lost health coverage and became eligible for COBRA on July 1, 2009. John was eligible for his wife Mary's coverage in July and August, 2009. John (and Mary) lose this coverage on August 31, 2009. If John is otherwise eligible for COBRA from his employer (e.g. timely election etc.), then he would be eligible for 9 months of premium assistance beginning September 1, 2009.

## Are There Income Restrictions on Eligibility for Premium Assistance?

- Premium assistance recaptured for “high-income individuals” (HIIs).
  - Defined as those with between \$125,000 and \$145,000 in modified adjusted gross income in year when receiving premium assistance if filing singly (\$250,000 and \$290,000 if filing jointly).
  - Subsidy phases out for HIIs.
  - HIIs can waive subsidy by notifying employer. Waiver is irrevocable.
  - In absence of a waiver, plan continues to provide premium assistance.
  - If HII does not file waiver, repays subsidy in part or whole with tax return.

## Does the Employer Have to Provide New Notices Relating to Premium Assistance?

- Yes. Area of greatest confusion.
- Failure to update and distribute notices as required potentially subjects employers to daily COBRA penalties (DOL \$100 per day and IRS \$110 per day).

# Supplement All COBRA Election Notices with:

- Availability of premium assistance.
- Forms to establish eligibility for premium assistance.
- Name, address and telephone number necessary to contact plan administrator and any other entity in connection with premium assistance.
- Description of extended election period for individuals who had no COBRA election in place on February 17, 2009 but who would be an AEI if such election were in effect.
- Description of obligation to notify plan of eligibility for other disqualifying employer health coverage or Medicare.
- Description of rights to reduced premiums and any conditions on entitlement to reduced premiums.
- If offered, description of option to enroll indifferent coverage (see Slide xx).
- It appears this supplement to the election notice must be sent to all qualified beneficiaries experiencing qualifying events after September 1, 2008, regardless of the nature of the qualifying event. Section 3001(a)(7)(A).

# Notice of Extended Election Periods

- **Special extended 60 day election period required for those who are eligible for premium assistance, except that as of February 17 they (i) have not elected COBRA but are still in their election period, (ii) elected COBRA but never paid or stopped paying, or (iii) did not elect COBRA and the COBRA election period has expired., as of February 17, who did not elect COBRA and whose election period expired, or who elected and dropped COBRA?**
- 60 day election period runs from later of February 17 or provision of new supplemental notice.
- Deadline to provide extended election notice is April 18, 2009.
- Some confusion about who should be sent the extended election notice. We recommend that it be sent to all employees (and qualified beneficiary dependents) terminated on or after September 1, 2008, regardless of reason for termination.
- Some commentators are advising sending extended election notices to ALL qualified beneficiaries regardless of nature of qualifying event. May be easier to decide when model notices are issued.

# Will There be DOL Model Notices?

- Yes. Models to be issued on or before March 19, 2009.

## Should Plans Update Any Other Materials?

- We recommend updating initial COBRA notice and summary plan description.
- Consider use of supplement for initial notice (in case law is temporary).

## How Are Employers Reimbursed for Providing 65% Premium Assistance?

- **Note: This slide assumes a single employer plan subject to COBRA. Different rules apply to multiemployer plans and small insured plans not subject to COBRA but subject to state continuation coverage law.**
- If self-funded plan, employer can claim reimbursement after AEI has paid 35% premium.
- Employer offsets premium assistance against payroll taxes (i.e. federal withholding and FICA).

## What Reporting Requirements Do Employers Have Relating to Premium Assistance?

- Report premium assistance reimbursement claimed on lines 12a and 12b of 2009 IRS Form 941 (copy in materials).
- **Additional reporting may be required by IRS.** ARRA requires plans to maintain records (i) to extent subsidy is claimed, attesting to involuntary nature of terminations, (ii) amount of payroll tax offset and estimates of offsets for subsequent reporting periods, (iii) TINS of all covered employees, amount of subsidy reimbursed and indication of whether subsidy reimbursement is for single or more than single level of coverage.
- Premium assistance not reported as taxable income on AEI's W-2. May be other W-2 reporting required.

## What Happens if an Employer Claims Too Much Reimbursement?

- Any overpayment will be treated as an underpayment of payroll taxes. Presumably means subject to penalties on underpayment of payroll taxes.

# What is the Plan Enrollment Option?

- **THIS IS OPTIONAL.**
- Plan can let AEIs elect different health coverage than coverage in effect immediately before qualifying event if:
  - The employer so elects.
  - The premium is the same or less than the prior coverage.
  - The coverage is also offered to active employees.
  - The different coverage is not only dental, vision, counseling, referral services , on-site clinic with limited services or a health FSA.
  - AEI has **90 days** to elect from notice of the plan enrollment option.

# HIPAA Special Enrollment Changes

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- Enacted prior to Economic Stimulus Bill under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA").
- Medicaid and CHIP basics.
- New special enrollment events relating to Medicaid and CHIP effective April 1, 2009.
- Deadline to request special enrollment.
- Covered group health plans.
- New employer notice to employees of state premium assistance programs.
- New required employer disclosure to states about group health plan coverage.
- Penalties for non-compliance.
- Action items.

# Medicaid and CHIP Basics

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- **Medicaid**

- Centers for Medicare and Medicaid Services (“CMS”) oversees the Medicaid program
- Provides health coverage to low income individuals
- Funded by federal and state general revenues
- 29 million children are enrolled

- **CHIP**

- Formerly called S-CHIP
- CMS oversees CHIP
- Companion program to Medicaid
- Covers mostly just children
- Provides health and now dental coverage
- Generally eligible if ineligible for Medicaid because income is too high but unable to afford private health plan coverage
- Funded by federal and state general revenues
- 7 million children are enrolled

# New Special Enrollment Events Effective April 1, 2009

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- **Loss of coverage due to loss of eligibility for Medicaid or CHIP**
  - Employer group health plan must permit special enrollment if an eligible employee or dependent loses coverage under Medicaid or CHIP due to a loss of eligibility.
  - No special enrollment is required if eligible employee or dependent loses Medicaid or CHIP coverage due to nonpayment.
  - Many group health plans already permit election changes due to loss of eligibility for Medicaid or CHIP because such changes are permitted under Code §125 due to loss of group health plan coverage sponsored by a government.
- **Eligibility for premium assistance under Medicaid or CHIP**
  - Employer group health plan must permit special enrollment of an eligible employee or dependent if such individual becomes eligible for government premium assistance under Medicaid or CHIP.

# Deadline to Request Special Enrollment

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- Current special enrollment rules provide that special enrollees have “at least 30 days” after the event to request special enrollment.
- For the new events relating to Medicaid and CHIP coverage, special enrollees must request enrollment within 60 days after the loss of Medicaid or CHIP coverage or within 60 days of the determination of eligibility for Medicaid or CHIP premium assistance.

# Covered Group Health Plans

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- No change to existing rules regarding plans subject to special enrollment
- Most common covered group health plans
  - Major medical plans
  - HRAs
- Most common excepted benefits
  - Most health FSAs
  - Most limited scope dental and vision plans

# New Employer Notice to Employees of State Assistance Programs

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- Each employer “that maintains a group health plan in a state that provides medical assistance under Medicaid or CHIP” must provide “each employee” written notice of state Medicaid and CHIP premium assistance programs
- Notices to employees must inform them of premium assistance available in the state in which they reside
- Not clear what it means to maintain a group health plan in a state
- HHS and DOL will issue model state specific and national notices by February 4, 2010
- Employers must distribute the notices beginning the first plan year after the model notices are issued (beginning January 1, 2011 for calendar year plans)
- Employers may provide the notice with the group health plan SPD, with open enrollment information or with any separate plan eligibility rules

# Required Plan Administrator Disclosure to States

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- Upon the request of a state, employers will also be required to disclose to the state information about group health plan benefits available to employees or dependents who have Medicaid or CHIP coverage.
- HHS regulations to be issued regarding information the states will seek.
- States will use this information to determine whether they will provide premium assistance to the employee or dependent to maintain employer coverage (instead of providing coverage through Medicare or CHIP).
- A model coverage coordination disclosure form will be created by HHS and DOL.
- States may begin to use the form the first plan year after it is issued. For calendar year plans, we may see this form used as early as January 1, 2010 or as late as January 1, 2011, depending on when the model form is issued.

# Penalties for Noncompliance

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- \$100 per day for failure to comply with the employee notice requirement
- \$100 per day for failure to disclose required information to a state
- Each violation with respect to any single participant or beneficiary will be treated as a separate violation
- **[Add existing penalties?]**

# Action Items

- Prepare a summary of material modifications (SMM) or restate the summary plan description (SPD) to include the new special enrollment events.
- Begin offering special enrollment as a result of the new events effective April 1, 2009.
- Update special enrollment rights notice that is provided prior to or at the time of enrollment.
- Decide whether to retain the 30 or 31-day deadline that most group health plans have for existing special enrollment events or whether to make the deadline uniform (60 days) for all special enrollment events.
- Wait to comply with the employee notice rules until the model notices are issued by HHS and the DOL.
- Wait to comply with the state disclosure rules until HHS and the DOL have developed the model disclosure form.
- Decide whether to opt out of direct payment from Medicaid or CHIP and instead have employees pay all required employee contributions and then the employee can seek reimbursement from Medicaid or CHIP.
- Wait and see if guidance is issued on the requirement for states to establish a process to permit a parent-employee of child receiving premium assistance to disenroll the child from employer coverage and enroll the child in CHIP coverage as of the first of the month in which the child is eligible for the subsidy (not consistent with Code §125 for pre-tax coverage).

- HIPAA with teeth
- Notification: Security breaches involving 500 or more individuals must be reporting to major news media
- Extends HIPAA to business associates
- Allows regulators to decide what data may be transferred between covered entities and business associates
- Imposes penalties up to \$50,000 per violation, with no maximum cap under certain circumstances
- Authorizes state attorneys general to enforce
- Shares penalties with harmed individuals

# Notification Requirements

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- Applies when unsecured protected health information is “accessed, acquired, or disclosed.”
- Timing – ASAP but not less than 60 days from discovery of the breach or the date breach reasonably should have been discovered.
- Less than 500: notice to individual and HHS (annual requirement)
- Where 10 or more individuals cannot be located: home page of covered entity or major print media
- Where breach affects 500 or more: prominent media outlet serving state and immediately to HHS
- Breach by personal health records vendors reported to individuals and FTC
- Regulations within 180 days; notice provisions apply 30 days later

# HIPAA Extended to Business Associates

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- Business Associates may include employers, third party administrators, wellness and disease management, utilization and subrogation vendors, among others.
- HITECH Act contains contract mandates that require all Business Associate agreements to be rewritten
- Business Associates subject to same civil and criminal penalties applicable to Covered Entities

- Secretary of HHS shall issue guidance on “minimum necessary” disclosures from covered entities to business associates.
- Secretary shall take into consideration information necessary to improve patient outcomes and to detect, prevent, and manage chronic disease.
- Lessons from GINA

- Violations where individual did not know and would not have known through exercise of reasonable discretion:

At Least:                      \$100 per violation, not more than  
\$25,000

Not More Than:            \$50,000 per violation, not more than  
\$1,500,000

- Penalties may be waived or mitigated if violation is corrected with 30 days of date it is discovered (or reasonably should have been discovered)

- Violation due to reasonable cause and not willful neglect:
  - At Least: \$1,000 per violation, not more than \$100,000
  - Not More Than: \$50,000 per violation, not more than \$1,500,000
- Penalties may be waived or mitigated if violation is corrected with 30 days of date it is discovered (or reasonably should have been discovered)

- Violation due to Willful Neglect, but timely corrected:

At Least: \$10,000 per violation, not more than \$250,000

Not More Than: \$50,000 per violation, not more than \$1,500,000

- Violation due to Willful Neglect, and not timely corrected:

At Least: \$50,000 per violation with no cap

# Penalties:

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- “Willful Neglect”
  - To be defined by regulation within 18 months
  - To be enforced within 24 months
  - Mandatory penalties upon showing of Willful Neglect

- HHS is required by law to formally investigate complaints if preliminary investigation of complaint suggests Willful Neglect
- Regulations issued within 36 months will permit harmed individuals to share penalties
- State Attorneys General may enforce through injunction and damages, up to \$100 per violation (not exceeding \$25,000)

# HIPAA Privacy & Security

## ("To do" list for Group Health Plans)

- Wait for HHS guidance (expected by 1/1/2010 and to be updated annually) on the most effective and appropriate technical safeguards for protecting ePHI and consider implementing
- Wait for HHS guidance possibly coming by mid-April 2009 on the technologies or methodologies that make PHI secure and consider implementing
- Comply with new notification rules for breach of unsecured PHI effective 30 days after regulations are issued relating to the technologies or methodologies that make PHI secure (regulations due by 8/16/09 so notification requirements will apply no later than 9/15/09)
- Comply with new HITECH minimum necessary requirements effective 2/17/2010 (further HHS guidance expected by 8/17/2010)
- Effective 2/17/2010, agree to individual requests for restrictions on disclosure of PHI to the plan for purposes of payment or health care operations if the PHI relates to an item or service for which the individual paid in full out-of-pocket
- Comply with new marketing restrictions effective 2/17/2010
- Abide by new rules restricting the sale of PHI beginning no later than 2/17/2011, depending on when regulations are issued

# HIPAA Privacy & Security

## ("To do" list for Group Health Plans)

- Wait and see if the new requirement to log disclosures of PHI made for treatment, payment and health care operations through an electronic health record effective 1/1/2011 or 1/1/2014 (depending on when the records were acquired) applies and be prepared to provide an accounting of such disclosures if applicable
- If the plan uses electronic health records, individuals must be permitted to receive access to PHI in an electronic format and to direct it to be sent to another person or entity, presumably effective 2/17/2010
- Amend business associate agreements by as early as 9/15/09 (since that is the latest date the new breach notification rules will apply)
- Update HIPAA privacy policies & procedures
- Update HIPAA security policies & procedures
- Update HIPAA privacy notice
- Update HIPAA authorization if PHI will be sold for certain purposes
- Conduct privacy and security workforce training

# HIPAA Privacy & Security

## ("To do" list for Business Associates)

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- Recognize that you are now directly subject to some of the HIPAA privacy requirements and all of the HIPAA security requirements
- Comply with the privacy standards that will directly apply effective 2/17/2010
  - Amend business associate agreements with group health plans to include additional required provisions
  - Cure your breaches of business associate agreements
  - Enter into business associate agreements with privacy safeguards by 2/17/2010 with any organization that provides data transmission services to you
  - Comply with new HITECH minimum necessary requirements effective 2/17/2010 (further HHS guidance expected by 8/17/2010)
  - Effective 2/17/2010, comply with changes to request for restriction rules
  - Comply with new marketing restrictions effective 2/17/2010
  - Seek authorization prior to selling PHI for certain purposes (beginning no later than 2/17/2010, depending on when regulations are issued)

# HIPAA Privacy & Security

## ("To do" list for Business Associates)

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- Wait and see if the new requirement to log disclosures of PHI made for treatment, payment and health care operations through an electronic health record effective 1/1/2011 or 1/1/2014 (depending on when the records were acquired) applies and be prepared to provide an accounting of such disclosures if applicable
- Permit access to PHI in electronic format if you hold electronic health records, presumably effective 2/17/2010
- Comply with the security standards that will directly apply effective 2/17/2010**
  - Implement all HIPAA security administrative, technical and physical safeguards by 2/17/2010
  - Wait for HHS guidance (expected by 1/1/2010 and to be updated annually) regarding the most effective and appropriate technical safeguards and consider implementing
  - Wait for HHS guidance possibly coming by mid-April 2009 on the technologies or methodologies that make PHI secure and consider implementing
  - Comply with new notification rules for breach of unsecured PHI effective 30 days after regulations are issued relating to the technologies or methodologies that make PHI secure (regulations due by 8/16/09 so notification requirements will apply no later than 9/15/09)

# HIPAA Privacy & Security ("To do" list for Business Associates)

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- Appoint a security official
- Conduct a security risk analysis
- Develop and maintain written security policies & procedures
- Amend business associate agreements to include new security rules (as early as 9/15/2009 since that is the latest date the new breach notification rules will apply)
- Enter into business associate agreement with security safeguards by 2/17/2010 with any organization that provides data transmission services to you
- Conduct privacy and security workforce training