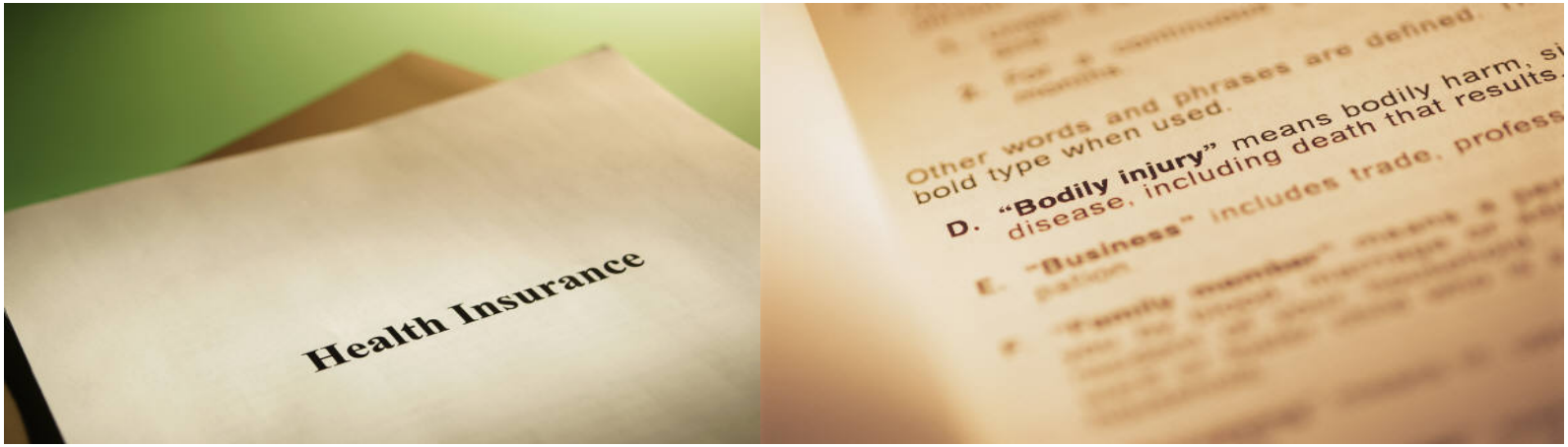

Plan Document Changes for Latest Regulatory Developments

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About Cynthia Marcotte Stamer

Cynthia Marcotte Stamer is nationally known for her more than 20 years of work, publications and presentations on employee benefit, health care and human resources matters.

Chair of the ABA RPTE Employee Benefit & Other Compensation Committee, a Council Member of the ABA Joint Committee on Employee Benefits, Past Chair of the ABA Health Law Section Managed Care & Insurance Section and Board Certified in Labor and Employment Law, Ms. Stamer is known and valued for her ability to draw upon her expansive knowledge of the complex tapestry of federal and state judicial precedent and statutory, regulatory, contracting, other laws and industry operations to help payers, plan sponsors and other employee benefit and insurance industry clients manage risk and achieve objectives.

Chair of the Curran Tomko and Tarski LLP Labor, Employment & Employee Benefit Employment Practice, Ms. Stamer continuously advises and represents health and other employee benefit plans, their fiduciaries, insurers, sponsors, administrators and other vendors about the design, documentation, administration and defense of employee benefit and insurance programs, ethics, compliance and management processes and tools for administering these and other processes, and ERISA and other employee benefit, insurance, tax, licensing, privacy and data security, human resources, contracting, technology, risk management and other legal compliance and operational concerns. She designs and writes insured and self-insured health, 24-hour and other occupational injury benefit and risk management, disability management, corporate health and wellness, disease management, utilization, audit, patient empowerment, deferred compensation and pension and other employee benefit, insurance and retirement programs. Her work includes leading edge development and use of 24-hour coverage and other occupational injury, ex-pat and other medical tourism products, min-med and other limited benefit plans, fraternal benefit and association plans, hi-deductible health plans and deductible reimbursement programs.

Ms. Stamer also designs and advises clients about fiduciary process and risk management, claims and appeals administration. She counsels and defends clients about regulatory compliance; defends clients in ERISA, contract, and other disputes by private plaintiffs, as well as litigation, audits, licensing board and other enforcement actions by state insurance departments, the Department of Labor, the Internal Revenue Service, the Office of Civil Rights, the Centers for Medicare & Medicaid Services, the Department of Justice, State Attorneys General and other federal and state regulators. She also has extensive experience counseling third party administrators, insurers, self-insured employee benefit plans and their sponsors, medical bill audit, utilization management, cafeteria plan administrators and sponsors, reinsurers, fiduciary liability and other E&0 carriers, consulting firms, brokers, and others about product design and defense; licensure; contract review, drafting, interpretation and enforcement; corporate and broker ethics, regulatory compliance and risk management programs; managed care contracting and compliance; electronic and paper claims and appeals administration under ERISA, clean claims and prompt pay, workers' compensation, and other laws; coordination of benefits with Medicare, Medicaid, CHIP, TRICARE, and other third party liability sources; subrogation and assignment; federal and state health care, insurance, tax, labor, licensing and other matters. The author of "Claim's Processing Under the New World Order" "The Health Care Eligibility Toolkit," and "A Plan Sponsor's HIPAA Privacy & Compliance Toolkit," and many other implementation processes and aids, she regularly advises, develops processes and procedures, and conducts training for insurers, plan fiduciaries and administrators, third party administrators and other service providers, employers, their professional associations and others.

A popular lecturer and widely published author of thousands of publications on health, disability, and other employee benefits, insurance, health care and human resources matters. Ms. Stamer publishes the HR & Benefits Update. Her insights on health care, health insurance, human resources and related matters appear in the Atlantic Information Service, Bureau of National Affairs, World At Work, The Wall Street Journal, Business Insurance, the Dallas Morning News, Managed Healthcare, Health Leaders, and a many other national and local publications. To register to receive the HR & Benefit Update, arrange for training or for additional information about Ms. Stamer, her experience, involvements.

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Curran Tomko Tarski LLP

Curran Tomko Tarski LLP

Sobering Reality

The average employer-sponsored premium for a family of four costs close to $13,000 a year …

Sobering Reality

… The cost of coverage increasingly pales in comparison to the liability …

IRS COBRA Answers

- Temporary Provisions

- Law Effective 2/17/2009 – 12/31/2009

Newborns' and Mothers' Health Protection Act of 1996

- Final Regulations Took Effect 12/22/2008
- Group health plans and group health insurance issuers required to comply for plan years beginning on or after January 1, 2009.

Newborns' and Mothers' Health Protection Act of 1996

Hospital Length Of Stay

Group health plan that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than:

- 48 hours following a vaginal delivery or
- 96 hours following a delivery by cesarean section

Newborns' and Mothers' Health Protection Act of 1996

When Stay Begins

- Delivery in a hospital - at the time of delivery (or in the case of multiple births, at the time of the last delivery)
- Delivery outside a hospital.- when the mother or newborn is admitted as a hospital inpatient in connection with childbirth
- Determination whether an admission is in connection with childbirth is a medical decision to be made by the attending provider

Newborns' and Mothers' Health Protection Act of 1996

Authorization Requirement Prohibited

Plan requirement that physician or other health care provider obtain authorization for prescribing the hospital length of stay for protected period of stay prohibited except as permitted by Regulations

Newborns' and Mothers' Health Protection Act of 1996

Exceptions To Prohibition of Authorization Requirement

- Discharge of mother - Attending provider in consultation with the mother makes decision to discharge mother earlier than the period specified, not apply to period after discharge
- Discharge of newborn - If attending provider in consultation with mother or newborn's authorized representative makes a decision to discharge a newborn child earlier than the period specified, not apply to any period after the discharge.

Newborns' and Mothers' Health Protection Act of 1996

Attending Provider Defined

- "Individual who is licensed under applicable state law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child"
- A plan, hospital, managed care organization or other issuer is not an attending provider

Newborns' and Mothers' Health Protection Act of 1996

Other Penalties Prohibited

A group health plan may not

- **Deny mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the requirements under Act**
- **Provide payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under Act**

Newborns' and Mothers' Health Protection Act of 1996

Other Prohibitions

A group health plan may not restrict the benefits for any portion of a hospital length of stay within specified period in a manner that is less favorable than the benefits provided for any preceding portion of the stay

Newborns' and Mothers' Health Protection Act of 1996

Penalizing Providers Prohibited

A group health plan may not directly or indirectly:

- Penalize or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a participant or beneficiary in accordance with Act; or
- Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a participant or beneficiary in a manner inconsistent with this section, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

Newborns' and Mothers' Health Protection Act of 1996

Notice Requirement

Must give written notice in accordance with 29 CFR 2520.102-3(u)

Newborns' and Mothers' Health Protection Act of 1996

Construction

- Stay not mandatory. Mother not required to give birth in a hospital; or stay in the hospital for a fixed period of time following the birth of her child

- Hospital stay benefits not mandated

- Act does not prevent a group health plan from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn under the plan or coverage, except that the coinsurance or other cost-sharing for any portion of the protected period of hospital length of stay may not be greater than that for any preceding portion of the stay

Newborns' and Mothers' Health Protection Act of 1996

Applicability In Certain States

Fully-insured plans that provides benefits solely through health insurance coverage, if the state law regulating the health insurance coverage meets any of the following criteria requirements of section 9811 and this section do not apply:

- **The state law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section**
- **The state law requires the coverage to provide for maternity and pediatric care in accordance with guidelines that relate to care following childbirth established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association**
- **The state law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph**

Newborns' and Mothers' Health Protection Act of 1996

Applicability In Certain States

- **Self-Insured/Partially-Insured Group health plans**
- **For self-insured plan that provides all benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the requirements of Act**
- **For a partially-insured plan that provides some benefits through health insurance coverage where any of the exemption criteria met requirements only to the extent the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage.**

FMLA Family Leave

- Final FMLA Regulations became effective on January 16, 2009

- New military family leave entitlements enacted under the National Defense Authorization Act for FY 2008
  - Permit a "spouse, son, daughter, parent, or next of kin" to take up to 26 workweeks of leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness."
  - Permits an employee to take FMLA leave for "any qualifying exigency (as the Secretary [of Labor] shall, by regulation, determine) arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation."
- Benefit and Cafeteria Plan Amendments, Notices & Administrative Form Updates Required

American Recovery and Reinvestment Act of 2009
COBRA Relief

- Applies To All Group Health Plans Subject To The Federal COBRA Continuation Coverage Requirements Or Similar Requirements Under State Law
- Includes Insured And Self-Insured Plans

ARRA COBRA Relief Highlights

- Group health plans must notify assistance eligible individuals of ARRA COBRA rights
- Requires COBRA Premium Discount For AEIs But Provides For Reimbursement of COBRA Premium Subsidy = 65% of COBRA premium For Qualifying AEIs
- 2nd Election Period For AEIs with pre 2/17/09 Qualifying Event Dates
- Group health plans offering different coverage options may be required to offer AEI option to change coverage election to elect a lower cost coverage option
- DOL published model notice; use by group health plans optional, requires tailoring to specific plan design
- Delay in notification extends period assistance eligible individual has to elect COBRA coverage, other rights

ARRA COBRA Relief Guidance Evolving

- **Recent Information** Collection Request Projects
- Submitting Documents for DOL Review of Subsidy Denials
- Premium Reduction Fact Sheet • en Español
- COBRA ARRA Model Notices
- Premium Reduction FAQs
- IRS Notice 2009-27
- Other IRS COBRA Premium Reduction Info
- HHS Info on COBRA Premium Reduction
- General COBRA FAQs for Employers

ARRA COBRA Relief

Assistance Eligible Individuals (AEI) Defined

- COBRA “qualified beneficiary” or individuals who apply for state continuation
- Is eligible for COBRA/state continuation coverage at any time during the period beginning September 1, 2008 and ending December 31, 2009;
- Elects COBRA coverage (when first offered or during the additional election period): and
- Has a qualifying event for COBRA coverage that is the employee’s involuntary termination during the period beginning September 1, 2008 and ending December 31, 2009.
- Includes involuntarily terminated employees & their dependents who lost coverage under a group health plan due to the involuntary termination
- Not apply if qualifying event was voluntary termination of employment
- No added definition of “involuntary” termination – fired only or other situations beyond control????
- In order to be an assistance eligible individual, the individual actually have coverage under the group health plan at the time of the involuntary termination of employment

ARRA COBRA Subsidy

Qualifying “Assistance Eligible Individuals” Who Are Eligible For COBRA Continuation Health Coverage Or Similar Coverage Under State Law Qualify For COBRA Premium Subsidy Equal To 65% Of COBRA Premium For Up To 9 Months For A Period Of Up To 9 Months Beginning With The First Coverage Period After February 16, 2009

ARRA COBRA Subsidy
Mechanics

- Assistance Eligible Individual Must Pay 35 Percent Of COBRA Premium For Coverage Elected - % Fixed By ARRA

- Group Health Plan Must Treat AEI As Meeting COBRA Contribution Requirement If Pay 35 Percent Of The Premium

ARRA COBRA Subsidy
Mechanics

- Employer/Other Recipient Of COBRA Premium Must Pay COBRA Premium Subsidy Equal To Remaining 65% Of COBRA Cost (COBRA Subsidy), Then Seek Reimbursement
  - Employer Must Initially Pay
  - Employer/Other Recipient Of Reduced COBRA Premium Recovers COBRA Premium Subsidies Paid By Claiming COBRA Premium Subsidy Payroll Tax Credit On Its Quarterly Employment Tax Return.
  - Employer May Provide The Subsidy — And Take The Credit On Its Employment Tax Return — Only After It Has Received The 35 Percent Premium Payment From The Individual
  - Form 941 Has Been Revised To Allow For This Credit

ARRA COBRA Subsidy
Mechanics

IRS Says Employer Must Pay Subsidy If Receives 35% Payment From AEI

"The subsidy requirement applies to group health plans that are subject to the Federal COBRA continuation coverage requirements or to similar requirements under State law. If you are an employer with such a plan and you receive a 35 percent payment from an assistance-eligible individual, you are required to make the remaining 65 percent payment."

ARRA COBRA Subsidy Rules Compliance Deadline

- Generally Apply To 1st Period of Coverage Beginning After 2/16/09

- "Period of coverage" is a month or shorter period for which the plan charges a COBRA premium. The premium reduction starts on March 1, 2009 for plans that charge for COBRA coverage on a calendar month basis.

- "Transition Rule"
  - Regular Premium Amount May Continue To Be Paid For Up To Two Months After Enactment (e.g. for March And April)
  - Then Provide Subsidy Retroactively

ARRA COBRA Subsidy

Premium Subsidy only applicable to qualifying assistance eligible individuals (QAEIs)

- ≠ AEI eligible for other group health coverage (such as a spouse's plan)
- ≠ AEI eligible for Medicare
- AEI COBRA Subsidy Eligibility Period Ended
- N/A For Periods of Coverage Before 2/17/09
- N/A if qualifying event occurs after Dec. 31, 2009
- AEI Must Pay 35% of Premium To Qualify For Subsidy

ARRA COBRA Subsidy

Premium Subsidy only applicable to qualifying assistance eligible individuals (QAEIs)

- The individual must have actual group coverage at the time of the qualifying event, i.e., the involuntary termination of employment
- The qualifying event must occur between Sept. 1, 2008, and Dec. 31, 2009 and
- The individual must be eligible for COBRA coverage at any time during that period

COBRA Premium Subsidy Period
9 Month Max

- Begins with 1st the first period of COBRA Coverage that begins after 2/16/09

- Ends On 1st day of the COBRA Coverage month that begins on or after the earlier of:
  - Eligibility for other group coverage or Medicare,
  - After 9 months of the reduction,
  - When the maximum period of COBRA coverage ends
  - When Law Ends, 12/31/09, Unless Extended

- Individuals paying reduced COBRA premiums must inform their plans if they become eligible for coverage under another group health plan or Medicare.

Expedited Review of Denials of Premium Reduction

- Individuals denied treatment as assistance eligible individuals/eligibility for the premium reduction (whether by their plan, employer or insurer) may request an expedited review of the denial by the U.S. Department of Labor
- DOL must make a determination within 15 business days of receipt of a completed request for review
- DOL has process and an official application form for appeals
- DOL outreach, education to promote compliance

ARRA COBRA Subsidy Income Limits

DOL Fact Sheet

- AEIs Having Modified Adjusted Gross Income For The Tax Year In Which The Premium Assistance Is Received > $145,000 (Or $290,000 For Joint Filers) Must Repay Amount Of The Premium Reduction During The Tax Year.

- For AEI With Adjusted Gross Income Between $125,000 And $145,000 (Or $250,000 And $290,000 For Joint Filers), The Amount Of The Premium Reduction That Must Be Repaid Is Reduced Proportionately.

- Individuals May Permanently Waive The Right To Premium Reduction But May Not Later Obtain The Premium Reduction If Their Adjusted Gross Incomes End Up Below The Limits.

ARRA COBRA Subsidy Income Limits

IRS Fact Sheet – Taxable Consequences to AEI

- **Premium Subsidy Generally Not Included In Individual's Taxable Income**
- **Phase Out Of Premium Subsidy May Require AEIs Modified Adjusted Gross Income > $125,000 ($250,000 For Those Filing Joint Returns) To Repay Premium Subsidy To U.S. Government:**
  - **Tax Liability Is Increased, To Achieve Repayment Of A Portion Of The Subsidy, For Those Taxpayers Whose Modified Adjusted Gross Income Is Between $125,000 And $145,000 (Or $250,000 And $290,000 For Those Filing Joint Returns)**
  - **If A Taxpayer's Modified Adjusted Gross Income Exceeds $145,000 ($290,000 For Those Filing Joint Returns, The Full Amount Of The Subsidy Must Be Repaid As An Additional Tax.) There Is No Additional Tax For Individuals With Modified Adjusted Gross Income Less Than These Income Levels**

Getting Reimbursed For Premium Subsidy Requirement To Maintain Supporting Documentation

Must Keep

- Information on the receipt, including dates and amounts, of the assistance eligible individuals' 35% share of the premium.
- In the case of an insured plan, copy of invoice or other supporting statement from the insurance carrier and proof of timely payment of the full premium to the insurance carrier required under COBRA.
- In the case of a self-insured plan, proof of the premium amount and proof of the coverage provided to the assistance eligible individuals.

(cont.)

Getting Reimbursed For Premium Subsidy Requirement To Maintain Supporting Documentation

Must Keep

- Attestation of involuntary termination, including the date of the involuntary termination (which must be during the period from September 1, 2008, to December 31, 2009), for each covered employee whose involuntary termination is the basis for eligibility for the subsidy.
- Proof of each assistance eligible individual's eligibility for COBRA coverage at any time during the period from September 1, 2008, to December 31, 2009, and election of COBRA coverage.

Getting Reimbursed For Premium Subsidy Requirement To Maintain Supporting Documentation

Must Keep

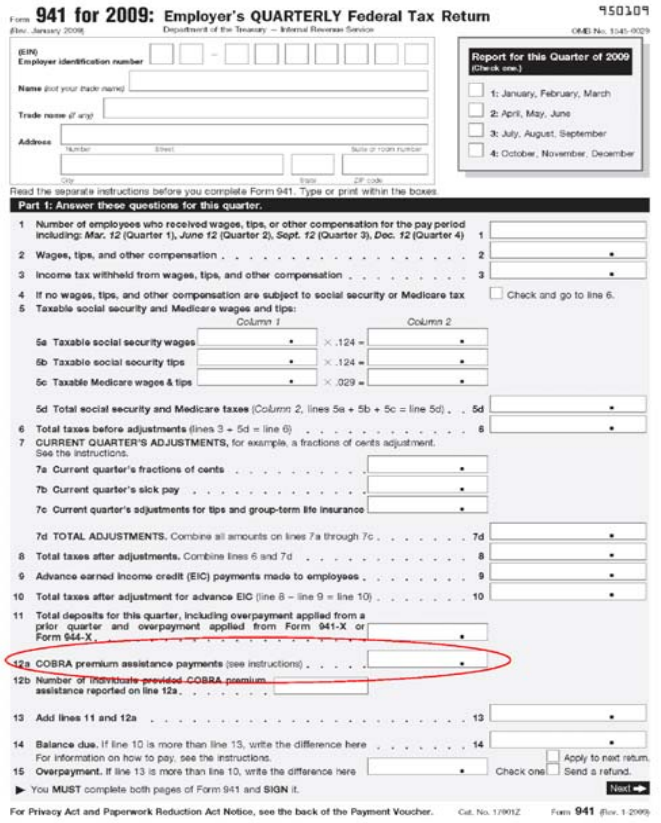
- A record of the SSN's of all covered employees, the amount of the subsidy reimbursed with respect to each covered employee, and whether the subsidy was for 1 individual or 2 or more individuals.
- Other documents necessary to verify the correct amount of reimbursement.

Payroll Services Providers Must Ensure That Clients Keep Required Documentation

Claiming Payroll Tax Credit

- Claim Payroll Tax Credit On Revised Form 941, Employer's Quarterly Federal Tax Return Beginning With The First Quarter Of 2009

- Revised Form Posted At http://www.irs.gov/pub/irs-pdf/f941.pdf



Form **941 for 2009: Employer's QUARTERLY Federal Tax Return** 950109

(Rev. January 2009) Department of the Treasury — Internal Revenue Service OMB No. 1545-0029

(EIN) Employer identification number

Name (not your trade name)

Trade name (if any)

Address Number Street Suite or room number

City State ZIP code

Report for this Quarter of 2009 (Check one.)

1: January, February, March
2: April, May, June
3: July, August, September
4: October, November, December

Read the separate instructions before you complete Form 941. Type or print within the boxes.

Part 1: Answer these questions for this quarter.

1 Number of employees who received wages, tips, or other compensation for the pay period including: *Mar. 12* (Quarter 1), *June 12* (Quarter 2), *Sept. 12* (Quarter 3), *Dec. 12* (Quarter 4) 1

2 Wages, tips, and other compensation 2

3 Income tax withheld from wages, tips, and other compensation 3

4 If no wages, tips, and other compensation are subject to social security or Medicare tax ☐ Check and go to line 6.

5 Taxable social security and Medicare wages and tips:

	Column 1		Column 2
5a Taxable social security wages		× .124 =	
5b Taxable social security tips		× .124 =	
5c Taxable Medicare wages & tips		× .029 =	

5d Total social security and Medicare taxes (Column 2, lines 5a + 5b + 5c = line 5d) 5d

6 Total taxes before adjustments (lines 3 + 5d = line 6) 6

7 CURRENT QUARTER'S ADJUSTMENTS, for example, a fractions of cents adjustment. See the instructions.

7a Current quarter's fractions of cents

7b Current quarter's sick pay

7c Current quarter's adjustments for tips and group-term life insurance

7d TOTAL ADJUSTMENTS. Combine all amounts on lines 7a through 7c 7d

8 Total taxes after adjustments. Combine lines 6 and 7d 8

9 Advance earned income credit (EIC) payments made to employees 9

10 Total taxes after adjustment for advance EIC (line 8 – line 9 = line 10) 10

11 Total deposits for this quarter, including overpayment applied from a prior quarter and overpayment applied from Form 941-X or Form 944-X

12a COBRA premium assistance payments (see instructions)

12b Number of ~~individuals provided~~ COBRA premium assistance reported on line 12a

13 Add lines 11 and 12a 13

14 Balance due. If line 10 is more than line 13, write the difference here 14
For information on how to pay, see the instructions.

15 Overpayment. If line 13 is more than line 10, write the difference here Check one: ☐ Apply to next return. ☐ Send a refund.

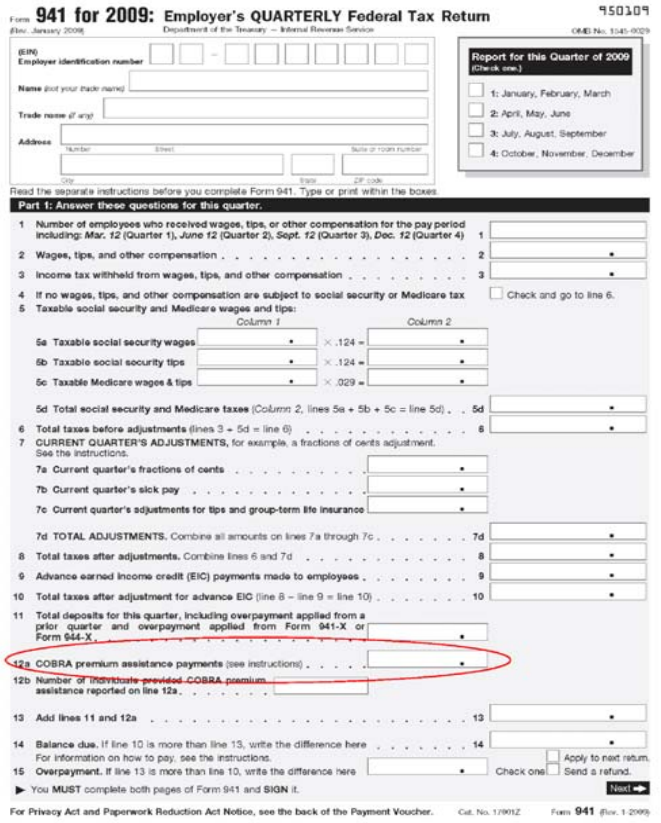
▶ You MUST complete both pages of Form 941 and SIGN it. Next ▶

For Privacy Act and Paperwork Reduction Act Notice, see the back of the Payment Voucher. Cat. No. 17001Z Form 941 (Rev. 1-2009)

Curran Tomko Tarski LLP

Claiming Payroll Tax Credit

- Payroll tax credit must be claimed on the employer's payroll tax return, whether the quarterly filed Form 941 or the annually filed Form 943 or 944
- Payroll tax return is the only means to claim credit and be reimbursed for the COBRA subsidy.



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(Rev. January 2009) Department of the Treasury — Internal Revenue Service

950109

OMB No. 1545-0029

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Curran Tomko Tarski LLP

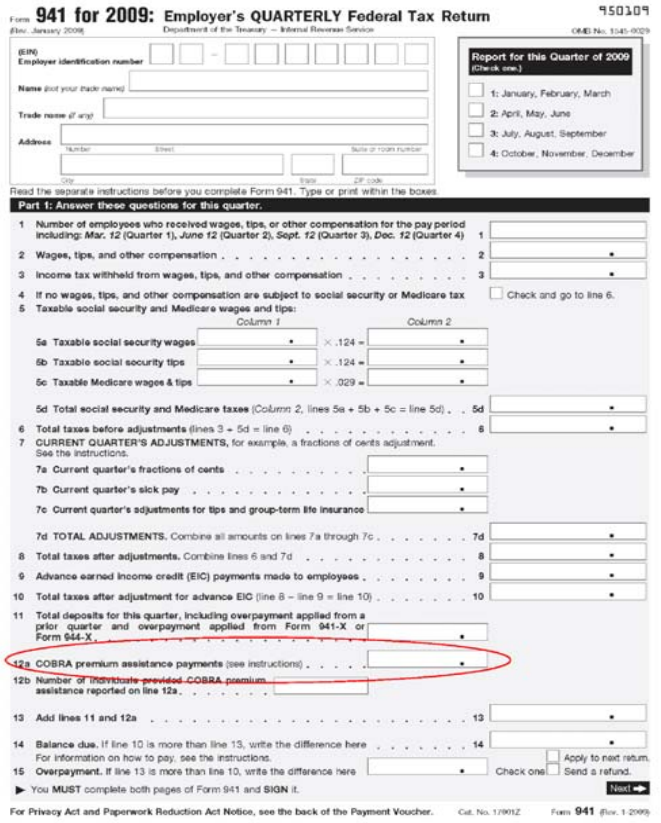
Who Claims Payroll Tax Credit?

- In some cases, a person other than the employer is the proper party to provide the subsidy and take the credit on its Form 941
  - If employer sponsors the group health plan, generally it pays the Premium Subsidy then claims payroll credit
  - If the COBRA coverage is provided by a multiemployer plan, the plan provides the subsidy and is reimbursed by taking a credit on Form 941
  - Where more than one party collects the reduced COBRA Premium, the person entitled to claim the payroll credit is:
    - ✓ The multiemployer group health plan; or
    - ✓ Tithe employer maintaining a group health plan that is subject to Federal COBRA continuation coverage requirements or that is self-insured, or
    - ✓ The insurer providing coverage under a plan not included in (1) or (2).
- Only this person is eligible to offset its payroll taxes by the amount of the subsidy.

Claiming Payroll Tax Credit

Form 941 Filer:

- Claim The Credit Is Claimed On Line 12a Of January 2009 Revision Of The Form 941, Posted On The IRS website on Feb. 20.
- Provides Number Of Individuals Provided COBRA Premium Assistance On Line 12b.



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950109

(Rev. January 2009) Department of the Treasury — Internal Revenue Service OMB No. 1545-0029

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5c Taxable Medicare wages & tips	.	× .029 =	.

5d Total social security and Medicare taxes (Column 2, lines 5a + 5b + 5c = line 5d) 5d .

6 Total taxes before adjustments (lines 3 + 5d = line 6) 6 .

7 CURRENT QUARTER'S ADJUSTMENTS, for example, a fractions of cents adjustment. See the instructions.

7a Current quarter's fractions of cents .

7b Current quarter's sick pay .

7c Current quarter's adjustments for tips and group-term life insurance .

7d TOTAL ADJUSTMENTS. Combine all amounts on lines 7a through 7c 7d .

8 Total taxes after adjustments. Combine lines 6 and 7d 8 .

9 Advance earned income credit (EIC) payments made to employees 9 .

10 Total taxes after adjustment for advance EIC (line 8 – line 9 = line 10) 10 .

11 Total deposits for this quarter, including overpayment applied from a prior quarter and overpayment applied from Form 941-X or Form 944-X .

12a COBRA premium assistance payments (see instructions) .

12b Number of ~~individuals provided COBRA premium~~ assistance reported on line 12a .

13 Add lines 11 and 12a 13 .

14 Balance due. If line 10 is more than line 13, write the difference here 14 .
For information on how to pay, see the instructions.

15 Overpayment. If line 13 is more than line 10, write the difference here . Check one: ☐ Apply to next return. ☐ Send a refund.

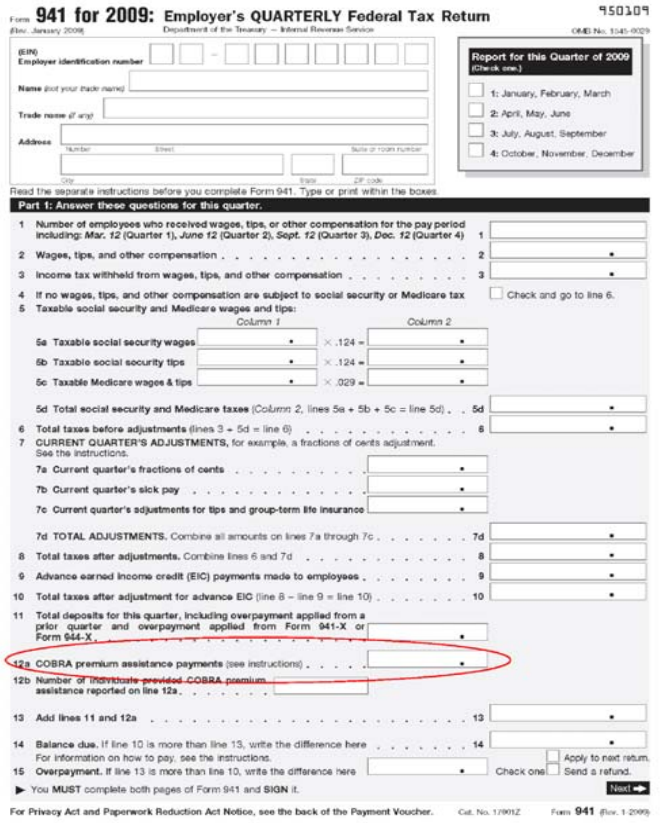
▶ You MUST complete both pages of Form 941 and SIGN it. Next ▶

For Privacy Act and Paperwork Reduction Act Notice, see the back of the Payment Voucher. Cat. No. 17001Z Form 941 (Rev. 1 2009)

Curran Tomko Tarski LLP

Claiming Payroll Tax Credit

- Line 12b of the revised Form 941 must indicate the number of individuals who received the total COBRA subsidy reported on Line 12a of the Form 941.
- If there is no tax credit amount because no subsidy was provided, then the entry on Line 12b would be zero.



Form **941 for 2009: Employer's QUARTERLY Federal Tax Return** 950109

(Rev. January 2009) Department of the Treasury — Internal Revenue Service OMB No. 1545-0029

(EIN) Employer identification number

Name (not your trade name)

Trade name (if any)

Address Number Street Suite or room number

City State ZIP code

Report for this Quarter of 2009 (Check one.)

1: January, February, March
2: April, May, June
3: July, August, September
4: October, November, December

Read the separate instructions before you complete Form 941. Type or print within the boxes.

Part 1: Answer these questions for this quarter.

1 Number of employees who received wages, tips, or other compensation for the pay period including: *Mar. 12* (Quarter 1), *June 12* (Quarter 2), *Sept. 12* (Quarter 3), *Dec. 12* (Quarter 4) 1

2 Wages, tips, and other compensation 2

3 Income tax withheld from wages, tips, and other compensation 3

4 If no wages, tips, and other compensation are subject to social security or Medicare tax ☐ Check and go to line 6.

5 Taxable social security and Medicare wages and tips:

	Column 1		Column 2
5a Taxable social security wages		× .124 =	
5b Taxable social security tips		× .124 =	
5c Taxable Medicare wages & tips		× .029 =	

5d Total social security and Medicare taxes (Column 2, lines 5a + 5b + 5c = line 5d) 5d

6 Total taxes before adjustments (lines 3 + 5d = line 6) 6

7 CURRENT QUARTER'S ADJUSTMENTS, for example, a fractions of cents adjustment. See the instructions.

7a Current quarter's fractions of cents

7b Current quarter's sick pay

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9 Advance earned income credit (EIC) payments made to employees 9

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12a COBRA premium assistance payments (see instructions)

12b Number of individuals provided COBRA premium assistance reported on line 12a

13 Add lines 11 and 12a 13

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For information on how to pay, see the instructions.

15 Overpayment. If line 13 is more than line 10, write the difference here Check one: ☐ Apply to next return. ☐ Send a refund.

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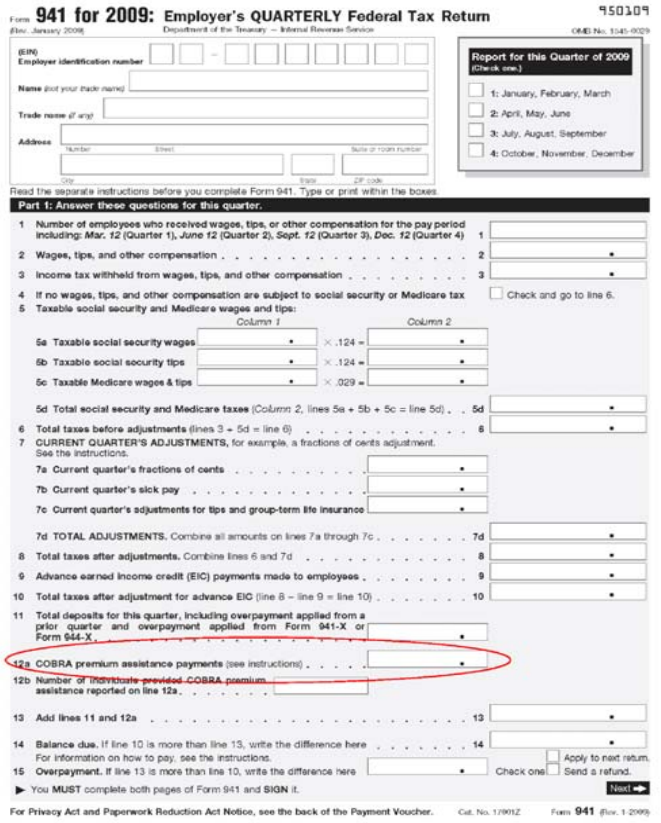
Curran Tomko Tarski LLP

Claiming Payroll Tax Credit

- If Line 12a is larger than Line 10, Line 13 would also be larger than Line 10, resulting in an overpayment that can applied to the next return or requested as a refund.
- The employer can decide either to offset its payroll tax deposits or claim the subsidy as an overpayment at the end of the quarter



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2 Wages, tips, and other compensation 2 .

3 Income tax withheld from wages, tips, and other compensation 3 .

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5c Taxable Medicare wages & tips	.	× .029 =	.

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Deadlines For Claiming Subsidy

- Employer reducing payroll taxes in a quarter based on COBRA subsidy **must** claim the credit for that subsidy amount on Form 941 for the quarter during which its payroll tax deposits were reduced.

- Employer may not claim credit for the same subsidy amount on Forms 941 for more than one quarter.

Must employer claim the credit on Form 941 for the same quarter during which the COBRA subsidy is provided to assistance eligible individuals? (NO)

Employer generally can claim credit either:

- On Form 941 for the quarter during which the COBRA subsidy is provided
- On Form 941 for a later quarter in the same calendar year
- If employer has not claimed the credit on the original Form 941 for the quarter during which the COBRA subsidy was provided, file Form 941X for that quarter.

Is there a specific date when employers can no longer take this credit? (Sort of)

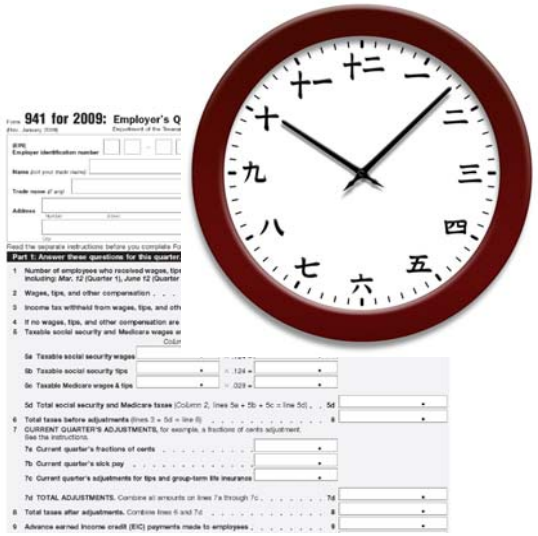
- An individual can be eligible for the COBRA subsidy based on an involuntary termination of employment that occurs as late as Dec. 31, 2009 (the qualifying event), and the subsidy can apply for up to nine months of COBRA coverage, which generally begins shortly after the qualifying event
- Government expects that eligibility for the subsidy will be exhausted by the end of 2010 and Form 941 for the fourth quarter of 2010 will be the last time to take the subsidy credit
- Will Congress extend subsidy??????

Claiming Payroll Tax Credit

- The amount of the COBRA subsidy the employer provides during the quarter (based on the 35 percent premium payments received from assistance eligible individuals during the quarter) is treated as deposited on the first day of the quarter and applied against the employer's deposit requirements.

- Since IRS deems timely claimed credit for subsidy up to the amount of the subsidy as equivalent to a payment timely made during the quarter, regardless of the otherwise applicable due dates for deposits, doesn't matter when in the quarter the Form 940 credit filing is made.

- **Caution:** If amount of the subsidy the employer provides during the quarter will be less than the total amount of the employer's required deposits during the quarter. In that case, the employer will be required to make timely deposits during the remainder of the quarter to make up the difference.



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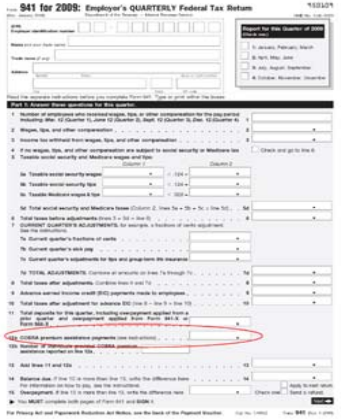
Claiming Payroll Tax Credit

- COBRA credit will not affect future deposit frequency computations.

- Frequency of deposits and look back periods are computed from Line 8 of Form 941, before taking into account any credits, including the COBRA credit. Therefore the


941 for 2009: Employer's QUARTERLY Federal Tax Return

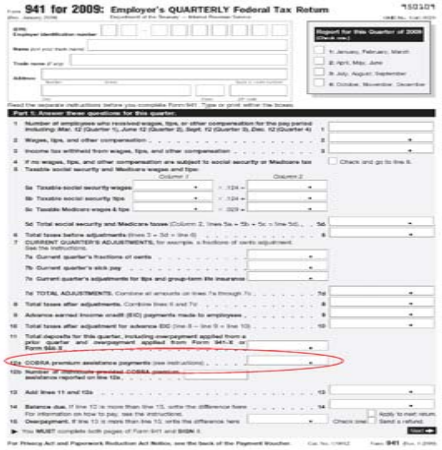
Curran Tomko Tarski LLP

Claiming Payroll Tax Credit

If the 35 percent premiums are paid and the subsidy is provided at a point in the quarter where there are no additional federal tax deposits due for the quarter, should the employer claim the credit on the current quarter or the subsequent quarter? (Yes)

Although an employer may reduce its payroll tax deposits during a quarter by the amount of subsidy provided during the quarter, claiming the credit on Form 941 for the quarter is not dependent on reducing deposits during the quarter. Therefore, even if no additional deposits are due for the quarter, the employer can claim credit for the full amount of the subsidy provided during the quarter on its Form 941 for the quarter. If the amount of the subsidy entered on Form 941 exceeds the employer's tax liabilities for the quarter, the employer can choose to have the excess either refunded or applied to the next quarter.

Claiming Payroll Tax Credit


941 for 2009: Employer's QUARTERLY Federal Tax Return

If the employer chooses to have the excess refunded, will the IRS send a notice before refunding the credit? (NO)

If the full amount of the excess is to be refunded to the employer, the IRS will not send a notice before making the refund

Schedule B Will Continue To Reflect The Total Payroll Tax Liabilities For The Quarter, Without Reduction For The COBRA Subsidy Credits

- The Schedule B is used to report an employer's payroll tax liability for each payroll period, not the amount of the employer's payroll tax deposits. Therefore, when the employer reduces a deposit by the amount of the COBRA subsidy, this has no affect on the liabilities the employer reports on Form 941, Schedule B (or the monthly totals in Part 2 of Form 941). The employer should still reflect on Schedule B (or in Part 2, Form 941) the total liabilities for all wages reported on Form 941.

- Example: Employer is a semi-weekly schedule depositor with a total liability of $75,000 for the payroll period ended on Feb. 27, 2009. Employer's regular deposit of $75,000 would be due on March 4, 2009. Because of a COBRA subsidy obligation of $5,000, Employer is allowed to reduce the deposit amount to $70,000, so Employer makes a timely deposit of $70,000 by March 4, 2009. When Employer completes Schedule B of Form 941 for the first quarter of 2009, Employer must enter the total liability, $75,000, on Day 27 of Month 2. As always, the total liability reported on Schedule B must equal the total taxes reported on Line 10 of Form 941. Employer will reflect the total COBRA subsidy for the quarter on Line 12a of Form 941.

2nd COBRA Election Period For Some AEIs

- Assistance eligible individuals who previously did not elect or elected then dropped COBRA coverage before February 17, 2009 got 2nd chance to enroll in COBRA coverage
- 2nd Election Period = 60-day period beginning on the date the group health plan provides the required notice of the ARRA COBRA rights
- COBRA coverage for assistance eligible individuals making these second chance elections must begin with the first period of coverage beginning after February 16, 2009 (March 1, 2009 for most plans)
- Coverage prospective after election
- Audit to confirm notices provided; if not, catch up!

2nd COBRA Election Period For Some AEIs

- This special election period does not extend the period of COBRA continuation coverage beyond the original maximum period (generally 18 months from the employee's involuntary termination).

- This special election period opportunity does not apply to coverage sponsored by employers with less than 20 employees that is subject to State law.

Switching Benefit Options

Group Health Plan Must Offer AEI enrolled/enrolling in COBRA Coverage between 2/17/09 and 12/31/09 option to elect to enroll in a different coverage option, if any, offered under the Plan other than the one in which enrolled on the date of the Qualifying Event, if:

- The Plan That Offers A Choice Between Different Coverage Options,
- The Premium For Such Different Coverage Does Not Exceed The Premium For Coverage In Which AEI Was Enrolled At The Time The Qualifying Event Occurred;
- The Different Coverage In Which AEI Elects To Enroll Is Coverage That Is Also Offered To The Active Employees Of The Employer At The Time At Which Such Election Is Made;
- The Different Coverage Is Not:
  - Coverage That Provides Only Dental, Vision, Counseling, Or Referral Services (Or A Combination Of Such Services);
  - A Flexible Spending Arrangement (As Defined In Section 106(c)(2) Of The Internal Revenue Code Of 1986); Or
  - Coverage That Provides For Services Or Treatments Furnished In An On-site Medical Facility Maintained By The Employer And That Consists Primarily Of First-aid Services, Prevention And Wellness Care, Or Similar Care (Or A Combination Of Such Care).

- 90 Day Election Period Begins On Date Notified Of Option

Switching Benefit Options

Group Health Plan Must Offer AEI enrolled/enrolling in COBRA Coverage between 2/17/09 and 12/31/09 option to elect to enroll in a different coverage option, if any, offered under the Plan other than the one in which enrolled on the date of the Qualifying Event, if:

- The Plan That Offers A Choice Between Different Coverage Options,
- The Premium For Such Different Coverage Does Not Exceed The Premium For Coverage In Which AEI Was Enrolled At The Time The Qualifying Event Occurred;
- The Different Coverage In Which AEI Elects To Enroll Is Coverage That Is Also Offered To The Active Employees Of The Employer At The Time At Which Such Election Is Made;
- The Different Coverage Is Not:
  - Coverage That Provides Only Dental, Vision, Counseling, Or Referral Services (Or A Combination Of Such Services);
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- 90 Day Election Period Begins On Date Notified Of Option

Switching Benefit Options

- If an employer offers additional coverage options to active employees, the employer may (but is not required to) allow assistance eligible individuals to switch the coverage options they had when they became eligible for COBRA

- To retain eligibility for the ARRA premium reduction, the different coverage must have the same or lower premiums as the individual's original coverage. The different coverage can not be coverage that provides only dental, vision, a health flexible spending account, or coverage for treatment that is furnished in an on-site facility maintained by the employer

Plan administrators must provide written notice:

- About the premium reduction to individuals who have a COBRA qualifying event during the period from September 1, 2008 through December 31, 2009 about:
- Of special 2nd COBRA election period to eligible individuals within 60 days following February 17, 2009
- May provide notices separately or along with notices they provide following a COBRA qualifying event.
- Notice must go to all individuals, whether they have COBRA coverage or not, who had a qualifying event from September 1, 2008 through December 31, 2009

Plan administrators must provide written notice:

- DOL published model notice, forms
- Adopting of model forms and notice not substitute for ERISA plan amendments
- Most plans need tailoring of forms, information to fit plan and operations

Medicare, Medicaid, and SCHIP Extension Act of 2007 Medicare Registration & Reporting Requirements

Effective 1/1/09

- Self-insured And Fully-insured Group Health Plans Required To Collect And Report Certain Participant Data On A Quarterly Basis On An Ongoing Basis To The Centers For Medicare And Medicaid Services (CMS)

- Signed Into Law On December 29, 2007

- Purpose To Help CMS Enforce The Medicare Secondary Payer (MSP) Rules About Coordination Of Group Health Plan Benefits With Medicare By Requiring Reporting Of Information Needed To Identify Individuals With Respect To Whom Medicare Is A Secondary Payer Under The MSP rules.

Medicare, Medicaid, and SCHIP Extension Act of 2007 Medicare Registration & Reporting Requirements

Effective 1/1/09

- Penalty For Noncompliance With The New MSP Reporting Requirements Is $1,000 Per Day For Each Individual With Respect To Whom Information Should Have Been Submitted

- Noncompliance With MSP Rules For Coordination of Benefits With Medicare Exposes Gives Rise To Liability For Repayment of Benefits, Civil Sanctions, Excise Taxes, & Liabilities For Breaches of Fiduciary Duties

- Plans Not Already Voluntarily Reporting Are Required To Register With Medicare During April, 2008 And Then Report Per The Assigned Schedule

Medicare, Medicaid, and SCHIP Extension Act of 2007 Medicare Registration & Reporting Requirements

Effective 1/1/09

- Section 111 requires an entity serving as an insurer or third party administrator for a group health plan, or a plan administrator or fiduciary in the case of a self-insured and self-administered group health plan, to:
  - Collect from the plan sponsor and plan participants such information as specified by the US Department of Health and Human Services (HHS) and
  - Submit such information in the form and manner (including frequency) specified by HHS.
- On August 1, 2008, CMS issued a supporting statement for Section 111 of the Act (the "Statement that specifies what information must be collected from plan sponsors and plan participants, and the form and manner in which such information must be reported to CMS.

Medicare, Medicaid, and SCHIP Extension Act of 2007 Medicare Registration & Reporting Requirements

Effective 1/1/09

Required Data Elements

HIC number (HICN; Medicare ID Number
Beneficiary Social Security number (required if HICN not available)
Beneficiary surname (first five letters required)
Beneficiary first initial
Beneficiary date of birth
Beneficiary sex code
Document control number (assigned by the insurer)
Transaction type (add, delete, or update)
Type of insurance coverage
Effective date of current coverage
Termination date of current coverage

Relationship to policy holder
Policy holder's first name
Policy holder's last name
Policy holder's social security number
Employer size
Small employer MSP exception
Group policy number
Individual policy number,
Employee coverage election (who the policy covers)
Employee status (reason why the group health plan is primary)
Employer EIN and business address
Insurer EIN and business address.

Medicare, Medicaid, and SCHIP Extension Act of 2007 Medicare Registration & Reporting Requirements

Effective 1/1/09

Optional Data Elements

For Prescription Drug Coverage

- Rx insured ID number
- Rx group number
- Rx PCN
- Rx BIN number
- Rx toll free number (to call with questions regarding Rx coverage)
- Person code (assigned by insurer)

Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP")

- Enacted 2/4/09
- Purpose of CHIP is to provide funding for Children's Health Insurance under Medicaid and State Children's Health Programs.
- Added new special enrollment rights established under HIPAA as a result of the enactment of CHIP for periods after **March 31, 2009**
- Provides For Medicaid & CHIP Coverage To Be Secondary To Group Health Plan Coverage

CHIP

After March 31, 2009, HIPAA Special Enrollment Rights Allow Eligible Employee To Enroll &/Or Disenroll If:

- He/his dependent is covered under Medicaid or a CHIP Plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage; or
- He/his dependent becomes eligible for premium assistance to purchase coverage under the Plan under the applicable state Medicaid or CHIP Plan.
- Eligible Employee must request coverage no later than 60 days after the date eligibility is lost or the date you or a dependent are determined to be eligible for state premium assistance.
- If employer elects only to receive payments from the applicable CHIP Program through Employee Salary Reduction Contributions under a cafeteria plan, a CHIP assistance eligible employee's contributions may be withheld from pay and the employee thereafter be required to collect available CHIP premium assistance directly from the state.
- The new special enrollment rules do not apply to the health flexible spending account ("FSA") plans or qualified High Deductible Health Plans ("HDHPs").

CHIP

- Eases ability of States to offer premium subsidies to CHIP/Medicare enrolled individuals to purchase coverage under employer plans
- Includes group health reforms in furtherance of reforms

CHIP
Premium Subsidy Notices

- Employer maintaining group health plan in State that provides CHIP/Medicaid Premium Assistance to pay employer plan premiums must provide written notice of opportunities then currently available in the State where the employee resides for premium assistance for the employee and/or his dependents
- Requirement Effective First Plan Year That Begins After Date Initial Model Notices First Issued
- May Use State Specific Model Forms To Be Developed under ERISA 701(f)(3)(B)(i)(II) By 2010
- Option to provide in SPD and/or concurrent with provision of other plan materials
- DOL Assess $100 Civil Penalty Per Day Penalty From Date of Employer's Failure To Provide Notice To Employee, Failure To Provide Info To State

CHIP

- Plan administrator must disclose to State on request information about benefits available under the plan with sufficient specificity to permit the State to determine cost-effectiveness of State providing premium assistance and for State to provide supplemental benefits with respect to CHIP/Medicare eligible employee or dependent

CHIP

EFFECTIVE DATES

- DOL/HHS developing initial model notices under section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974
- DOL to provide such notices to employers within 1 year after enactment of this Act
- Each employer shall provide the initial annual notices to such employer's employees beginning with the first plan year that begins after the date on which such initial model notices are first issued.

Genetic Information Nondiscrimination Act of 2008

- Health Plan Rules Effective Plan Years On Or After 5/21/09
- Employment Rules Effective 11/ 21/09
- EEOC Proposed Regulations Published 3/2/09 Available At http://edocket.access.gpo.gov/2009/pdf/E9-4221.pdf

Genetic Information Nondiscrimination Act of 2008

GINA Title I Applies To:

- Group Health Plans Sponsored By Private Employers, Unions, And State And Local Government Employers
- Issuers In The Group And Individual Health Insurance Markets;
- Issuers Of Medicare Supplemental (Medigap) Insurance.

Genetic Information Nondiscrimination Act of 2008

- Title I of GINA amends ERISA, the Public Health Service Act (PHS Act), the Internal Revenue Code of 1986 (Code), and the Social Security Act (SSA) to prohibit discrimination in health coverage based on genetic information

- Adds To Existing HIPAA Prohibition Of Health Status Discrimination

Genetic Information Nondiscrimination Act of 2008

The new requirements were added to Part 7 of Subtitle B of Title I of ERISA, Title XXVII of the PHS Act, Subtitle K of the Code, and section 1882 of the SSA.

Genetic Information Nondiscrimination Act of 2008

- Group health plan/health insurance issuer cannot shall not request, require, or purchase genetic information for underwriting purposes
- Underwriting purposes" means
  - Rules for, or determination of, eligibility for enrollment and continued eligibility for benefits under the plan or coverage
  - Computation of premium or contribution amounts under the plan or coverage
  - Application of any pre-existing condition exclusion
  - Any other activities related to the creation, renewal or replacement of a contract for health insurance or health benefits

Genetic Information Nondiscrimination Act of 2008

Group health plans, health insurance issuers in the group market (group health plans) prohibited from using genetic information to adjust premium or contribution amounts for the group covered under the plan.

- Plans and issuers in the group market are still allowed to increase the premium rate for an employer based on the manifestation of a disease or disorder of an individual enrolled in the plan, but they are prohibited from using the manifested disease or disorder of one individual as genetic information about other group members to further increase the premium.

Genetic Information Nondiscrimination Act of 2008

Group health plans prohibited from requesting/requiring individual or family member to undergo genetic test

- Providers may request
- Plan covering test permitted to obtain results of genetic test for payment determination if only request minimum necessary for purpose
- Research Exception Met

Genetic Information Nondiscrimination Act of 2008

Group health plans prohibited from collecting genetic information before enrollment

- Can't request, require or purchase genetic information with respect to any individual before his enrollment in the plan
- If obtain genetic information incidentally to the request of information about a person not a violation if not requested, purchased, or required
- Prohibition against collection applies to all plans

Genetic Information Nondiscrimination Act of 2008

- GINA not to be construed to limit the ability of a health insurance issuer offering health insurance coverage in connection with a group health plan to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan.
- In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

Genetic Information Nondiscrimination Act of 2008

Genetic Information means information about:

- Genetic tests about individual or family members of individual
- Includes any request for, or receipt of genetic services or participation in clinical research which includes genetic services by any individual or his family member
- ≠ Information about age/sex of individual

Genetic Information Nondiscrimination Act of 2008

Genetic test defn = analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations or chromosomal changes other than:

- Analysis of proteins/metabolites that does not detect genotypes, mutations, or chromosomal changes
- Analysis of proteins/metobolites directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in field of medicine involved

Genetic Information Nondiscrimination Act of 2008

Genetic information about an individual or family member includes:

- Genetic information about fetus or embryo of any pregnant woman
- Embryo legally held by an individual or family member using assisted reproductive technology

Genetic Information Nondiscrimination Act of 2008

For plan years beginning after May 21, 2009 - DOL Penalties For Violation

- Generally $ 100 for each day in the noncompliance period with respect to each participant or beneficiary to whom such failure relates.
- Minimum penalties where 1 or more failures with respect to a participant or beneficiary are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and which occurred or continued during the period involved, the amount of penalty shall not be less than $2,500 ($15,000 if violations more than de minimis)

Genetic Information Nondiscrimination Act of 2008

DOL Penalties For Violation Not Apply If

- Established to the satisfaction of the Secretary that the person otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed
- Failure was due to reasonable cause and not to willful neglect; and corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed

Genetic Information Nondiscrimination Act of 2008

Overall limitation for unintentional failures

For failures due to reasonable cause and not to willful neglect, the penalty imposed shall not exceed the amount equal to the lesser of--

- 10 percent of the aggregate amount paid or incurred by the plan sponsor (or predecessor plan sponsor) during the preceding taxable year for group health plans; or
- $ 500,000.

GINA Title I Regulations
(Health Plan & Privacy Mandates)

- Interim Health Plan Regulations Released October 1
  http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=22511
- GINA Proposed Privacy Regulation Amendments Released October 1
  http://www.federalregister.gov/OFRUpload/OFRData/2009-22492_PI.pdf

GINA

Definitions

- Genetic information means information (other than age and sex) about an individual about the following unless excluded:
  - The individual's genetic tests;
  - The genetic tests of family members of the individual;
  - The manifestation of a disease or disorder in family members of the individual;
  - Any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or any family member of the individual
  - With respect to a pregnant woman (or a family member of the pregnant woman), genetic information of any fetus carried by the pregnant woman; and
  - With respect to an individual (or a family member of the individual) who is utilizing an assisted reproductive technology, genetic information of any embryo legally held by the individual or family member.

- The term genetic information does not include information about the sex or age of any individual.

GINA

Small Plan Exception For HIPAA Portability Not Apply To GINA Provisions

- The GINA Nondiscrimination Rule applies to all group health plans and group health insurance coverage.
- The general exception to the HIPAA Portability Rules for small group plans with fewer than 2 participants does not apply to any group health plan (and group health insurance coverage).

GINA Definitions

Genetic services means

- A genetic test;
- Genetic counseling (including obtaining, interpreting, or assessing genetic information); or
- Genetic education.

GINA Definitions

Genetic test:

- = an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes.
- ≠ analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition.

Illustration

- = test to determine whether an individual has a BRCA1 or BRCA2 variant is a genetic test
- = test to determine whether an individual has a genetic variant associated with hereditary nonpolyposis colorectal cancer is a genetic test
- ≠ an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test.

GINA Definitions

Manifestation/manifested

- = individual has been or could reasonably be diagnosed with the disease, disorder, or pathological condition by a health care professional with appropriate training and expertise in the field of medicine involved
- Not manifested if a diagnosis is based principally on genetic information
- Regs. provide examples

GINA Definitions

Family member

- A dependent of the individual; or
- Any other person who is one of the following categories of relative of the individual or of a dependent of the individual:
  - First-degree relatives include parents, spouses, siblings, and children
  - Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces
  - Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins
  - Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins. Labor Regulation § 2590.702-1(a)(2).

GINA Definitions

Family member

- For purposes of determining who qualifies as family member under GINA, relatives by affinity (such as by marriage or adoption) are treated the same as relatives by consanguinity (that is, relatives who share a common biological ancestor)

- In determining the degree of the relationship, relatives by less than full consanguinity (such as half-siblings, who share only one parent) are treated the same as relatives by full consanguinity (such as siblings who share both parents)

GINA Definitions

Collect means, to request, require, or purchase such information

GINA

Premiums/Contributions Discrimination Based on Genetic Information Prohibited

- Group health plan/health insurance issuer must not adjust premium or contribution amounts for the plan, or any group of similarly situated individuals under the plan, on the basis of genetic information. Labor Regulation § 2590.702-1(b)(1), 45 C.F.R. § 146.122(b)(2), Treas. Reg. §54.9802-3T(b)(2).

GINA

Premiums/Contributions Discrimination Based on Genetic Information Prohibited

- Does not limit health insurance issuer ability to increase the premium for a group health plan or a group of similarly situated individuals under the plan based on manifestation of a disease or disorder of individual enrolled in the plan
- Manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members to further increase the premium for a group health plan or a group of similarly situated individuals under the plan

GINA

Premiums/Contributions Discrimination Based on Genetic Information Prohibited

- Does not limit health insurance issuer ability to increase the premium for a group health plan or a group of similarly situated individuals under the plan based on manifestation of a disease or disorder of individual enrolled in the plan
- Manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members to further increase the premium for a group health plan or a group of similarly situated individuals under the plan
- Regs. Provide Examples

GINA

Prohibit Group Health Plans/Issuers From Requesting Or Requiring Genetic Testing In Eligibility/Premium

- Must not request or require an individual or a family member of the individual to undergo a genetic test except as allowed by the GINA Regulations
- Health care professional may recommend a genetic test. GINA does not limits the authority of a health care professional who is providing health care services to an individual to request that the individual undergo a genetic test
- The GINA Regulations examples illustrate these rules

GINA

Genetic Testing/Information Required For Payment Purposes

- Collection prohibition does not preclude health plan from obtaining and using the results of a genetic test in making a determination regarding "payment" provided that the request for information is limited to the minimum amount of information necessary to make the determination

- If a plan or issuer conditions payment for an item or service based on its medical appropriateness and the medical appropriateness of the item or service depends on the genetic makeup of a patient, then the plan or issuer is permitted to condition payment for the item or service on the outcome of a genetic test. The plan or issuer may also refuse payment if the patient does not undergo the genetic test

- "Payment" & "minimum necessary" defined by Privacy Regulations

GINA

Genetic Testing Research Exception

A plan or issuer may request, but not require, that a participant or beneficiary undergo a genetic test if:

- The plan or issuer makes the request pursuant to research, as defined in 45 CFR 46.102(d) that complies with 45 CFR Part 46 or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research;
- The plan or issuer makes the request in writing; and
- The request clearly indicates to each participant or beneficiary (or, in the case of a minor child, to the legal guardian of the beneficiary) that:
  - Compliance with the request is voluntary; and
  - Noncompliance will have no effect on eligibility for benefits (as described in § 2590.702(b)(1) of this Part) or premium or contribution amounts.
- No genetic information collected or acquired under can be used for underwriting purposes
- The plan or issuer completes a copy of the “Notice of Research Exception under the Genetic Information Nondiscrimination Act” authorized by the Secretary and provides the notice to the address specified in instructions

GINA

Prohibitions On Collection Of Genetic Information for Underwriting Purposes

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, must not collect genetic information for underwriting purposes.

GINA

Prohibitions On Collection Of Genetic Information for Underwriting Purposes

Underwriting purposes means:

- Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program;
- The computation of premium or contribution amounts under the plan or coverage (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program);
- The application of any preexisting condition exclusion under the plan or coverage; and
- Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits

GINA

Request of Minimum Necessary Genetic Information For Medical Appropriateness Determinations Not Underwriting

- If an individual is not seeking a benefit, the medical appropriateness exception to the definition of underwriting purposes does not apply.
- If an individual seeks a benefit under a group health plan or health insurance coverage, the plan or coverage may limit or exclude the benefit based on whether the benefit is medically appropriate, and the determination of whether the benefit is medically appropriate is not within the meaning of underwriting purposes.
- If an individual seeks a benefit under the plan and the plan or issuer conditions the benefit based on its medical appropriateness and the medical appropriateness of the benefit depends on genetic information of the individual, then the plan or issuer is permitted to condition the benefit on the genetic information provided that the plan or issuer requests only the minimum amount of genetic information necessary to determine medical appropriateness.
- The plan or issuer may deny the benefit if the patient does not provide the genetic information required to determine medical appropriateness.

GINA

No Request/Collection of Genetic Information Allowed Before or With Enrollment Unless Incidental Exemption Applies

- Group health plan/issuer must not collect genetic information with respect to any individual except for incidental collections as permitted by the GINA Regulations:
  - Before coverage effective under that plan or coverage or
  - In connection with the rules for eligibility that apply to that individual.
- Whether or not an individual's information is collected prior to that individual's effective date of coverage is determined at the time of collection.

GINA

No Request/Collection of Genetic Information Allowed Before or With Enrollment Unless Incidental Exemption Applies

- If group health plan/issuer obtains genetic information incidental to the collection of other information concerning any individual, the collection is not a violation of the prohibition against collection if:
  - The collection is not for underwriting collection and
  - It is not reasonable to anticipate that health information will be received unless the collection explicitly states that genetic information should not be provided.

- GINA Regulations illustrate with examples

GINA

No Request/Collection of Genetic Information Allowed Before or With Enrollment Unless Incidental Exemption Applies

- If group health plan/issuer obtains genetic information incidental to the collection of other information concerning any individual, the collection is not a violation of the prohibition against collection if:
  - The collection is not for underwriting collection and
  - It is not reasonable to anticipate that health information will be received unless the collection explicitly states that genetic information should not be provided.

- GINA Regulations illustrate with examples

Genetic Information Nondiscrimination Act of 2008

Genetic Information Made PHI For Purposes Of HIPAA Privacy & Security Rules

Genetic Information Nondiscrimination Act of 2008

Privacy Rules

- Genetic Information Made PHI For Purposes Of HIPAA Privacy & Security Rules
- Amend health plan, health plan underwriting, health care operations rules
- Make other changes

Michelle's Law

Public Law 110-381
Plan Years & Medically Necessary School Leaves
Beginning After 10/9/09

- Prohibits group health plan/health insurance issuer from terminating dependent coverage for dependent for taking "medically necessary leave of absence" from post-secondary educational institution after receiving treating physician's certification until earlier of:
  - 1 year after 1st day of medically necessary leave or
  - Date dependent coverage otherwise would end regardless of leave

Michelle's Law

Public Law 110-381

- Plan may require written certification from treating physician that:
  - Child is suffering from serious illness or injury; and
  - Leave of absence from school (or other change in enrollment) is medically necessary

Michelle's Law

Public Law 110-381

- Plan/issuer must include with any notice regarding a requirement for certification of student status for coverage under the plan, a description of medically necessary leave requirements of Michelle's Law
- Coverage to be provided same as similarly situated dependents who have not taken medically necessary leave

Mental Health Parity

ERISA § 712, IRC § 9812

Evolving History Finally Leads To Permanent Rule

Mental Health Parity

Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008

Public Law 110-343

Interim Regs Issue 1/29 Require Compliance For Plan Years Beginning After 6/30/2010

Curran Tomko Tarski LLP

Mental Health Parity

Caution: Provisions Not Yet Reviewed Against Interim Regulations

- **Mental health benefits means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.**
- **Substance use disorder benefits means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.**

Mental Health Parity

- Applies to group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits
- Does Not:
  - Require a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or
  - If a group health plan provides mental health benefits, affect terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits
- N/A to small employer" e.g. a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

Mental Health Parity

Aggregate limit

- Plan providing medical and surgical benefits cannot place aggregate lifetime limit on mental health benefits unless places same aggregate limit on substantially all medical and surgical benefits

Mental Health Parity

Lifetime limit

Plan must either:

- Apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or
- Not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit
- If different limits on medical and surgical, substitute for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories as per DOL regulation

Mental Health Parity

Annual Limits

- If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.
- If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable annual limit"), the plan or coverage shall either--
  - apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or
  - not include any annual limit on mental health benefits that is less than the applicable annual limit.
- If plan has different limits for medical/surgical substitute for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories

Mental Health Parity

Financial requirements parity

Where group health plan provides both medical and surgical benefits and mental health or substance use disorder benefits, must ensure deductibles, copayments, coinsurance, and out-of-pocket expenses and other “financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits

Mental Health Parity

Treatment Limits Parity

- Where group health plan provides both medical and surgical benefits and mental health or substance use disorder benefits, must ensure the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

- The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

Mental Health Parity

Predominant Limit

- Financial requirement or treatment limit considered “predominant” if the most common or frequent of such type of limit or requirement

Mental Health Parity

Out-of-network providers

- Plan or coverage that provides coverage for medical or surgical benefits provided by out-of-network providers must provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in same

Mental Health Parity

Availability Of Plan Information

- Plan administrator/insurer must make criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits available by the plan administrator in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request

- Reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator/ health insurance issuer to the participant or beneficiary in accordance with regulations

Mental Health Parity

1 Year Cost Exemption

- 1 Year Exemption Year Following Year of Compliance Where Written Actuarial Determination Shows 2% Increase In Total Plan Cost 1st Year (1% 2nd Year) 6-month determinations
  - Determinations must be made after plan (or coverage) has complied with this section for the first 6 months of the plan year involved
  - Requirement to notify DOL, appropriate State agencies, and participants and beneficiaries of election of cost exemption

Mental Health Parity

Cost exemption

- **Cost exemption determinations cannot be made until after the plan has complied with ERISA 712 for the first 6 months of the plan year involved**

Mental Health Parity

Cost exemption

- **ERISA § 712 will not apply during a plan year if qualified and licensed American Academy of Actuaries actuary certifies that application ERISA § 712 to group health plan during prior plan year increased actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits by an amount that exceeds:**
  - ✓ **2 percent in the case of the first plan year section applies; or**
  - ✓ **1 percent in each subsequent plan year**

Mental Health Parity

Cost exemption

- **Actuary must make and certify cost increase.**
- **All such determinations shall be in a written report prepared by the actuary.**
- **Must notify Department of Labor**
- **The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification to Department of Labor made**

Mental Health Parity

Required Notification

- **Group health plan/issuer that elects to implement the exemption must shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.**

Mental Health Parity

Required Notification

Exemption is not effective until 30 days after notice has been sent.

Notice must include

- **Description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage)**
- **For both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan and**
- **For both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.**

Mental Health Parity

Regulation's Requirement For Notice To Participants of Exemption

Group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

- Statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;
- Name and telephone number of the individual to contact for further information;
- The plan name and plan number (PIN);
- The plan administrator's name, address, and telephone number;
- For single-employer plans, the plan sponsor's name, address, and telephone number and the plan sponsor's employer identification number (EIN);
- The effective date of the exemption;
- The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and
- The availability, upon request and free of charge, of a summary of the information.

Mental Health Parity

Regulation's Requirement For Notice of Exemption

- Plan may use a summary of material reductions in covered services or benefits to provide the required notice if it includes all required information

- Delivery in accord with ERISA rules to provide notice

Mental Health Parity

Availability Of Plan Information

- Plan administrator/insurer must make criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits available by the plan administrator in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request.
- Reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator/ health insurance issuer to the participant or beneficiary in accordance with regulations.

(5)

ADA Amendments Act of 2008
DOL Proposed Regulations

- Prohibit employment discrimination against a qualified individual on the basis of disability as compared to the current law prohibition of employment discrimination against a qualified individual with a disability because of the disability

- Prohibit the use of qualification standards, employment tests, or other selection criteria based on an individual's uncorrected vision unless the standard, test, or other selection criteria, as used by the covered entity, is shown to be related to the position and is consistent with business necessity

- Redefine the term "disability," by redefining "major life activities" and "being regarded as having such an impairment" in a manner that will make it easier for some employees to qualify as disabled under the ADA

- Updated guidance on HRAs from EEOC

ADA Amendments Act of 2008
DOL Proposed Regulations

- Requires ADA construction of definition of "disability" be construed in favor of broad coverage of individuals under the Act;
- Specifies impairment that substantially limits one major life activity need not limit other major life activities in order to be a disability;
- Specifies impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active;
- Requires determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of specified mitigating measures

HIPAA Privacy & Data Security

ARRA Amendments: Breach Regs Reflect Govt. Views Plan Document, Policies, Notices & Agreement Updates As Mandatory

- Broadens the applicability of the HIPAA's Privacy Rules and penalties to include business associates;
- Adds specific obligations upon these entities to provide certain notifications in the event the security of Protected Health Information ("PHI") is breached;
- Clarifies that HIPAA's criminal sanctions apply to employees or other individuals that wrongfully use or access PHI held by a covered entity;
- Increases criminal and civil penalties for HIPAA Privacy Rules violators;
- Allows State Attorneys General to bring civil damages actions;
- Modifies certain HIPAA use and disclosure and accounting requirements and risks;
- Prohibits sales of PHI without prior consent;
- Tightens certain other HIPAA restrictions on uses or disclosures;
- Tightens certain HIPAA accounting for disclosure requirements;
- Clarifies the definition of health care operations to excludes certain promotional communications; and
- Expands the Business Associates Agreement Requirements

HIPAA Privacy & Data Security

ARRA Amendments

- OCR Frequently Asked Questions About the Disposal of Protected Health Information 2/18/09
- Frequently Asked Questions About Family Medical History Information 1/13/09
- CVS $2.25 Million Resolution Agreements
- Provident $100,000 Resolution Agreement
- Criminal Convictions
- Don’t Forget Old Stuff: Distribute Privacy Practices at Least Every Three Years
- Training
- Plan Amendment and Certification
- Compliance Overall

Heroes Earnings Assistance And Relief Tax Act of 2008

Effective June 17, 2008

- Amended Code § 125 To Allow "Qualified Reservist Distribution" of Unused Benefits In Health FSA Without Disqualifying Plan Under Code § 125
- Health FSA May Permit Distribution of All/Part of Unused Balance in Employee's Health FSA to Individual if:
  - Ordered/Called To Active Duty For > 179 Days Or For Indefinite Period and
  - Distribution Made During Period Beginning on Date of Order/Call and Last Date Reimbursements Otherwise Could Be Made For the Plan Year That Includes The Date of Order/Call

Heroes Earnings Assistance And Relief Tax Act of 2008

Effective June 17, 2008

- Amended Code § 125 To Allow "Qualified Reservist Distribution" of Unused Benefits In Health FSA Without Disqualifying Plan Under Code § 125
- Health FSA May Permit Distribution of All/Part of Unused Balance in Employee's Health FSA to Individual if:
  - Ordered/Called To Active Duty For > 179 Days Or For Indefinite Period and
  - Distribution Made During Period Beginning on Date of Order/Call and Last Date Reimbursements Otherwise Could Be Made For the Plan Year That Includes The Date of Order/Call

Other Selected Developments

- Supreme Court's June 19, 2008 *Metropolitan Life Insurance Co. v. Glenn* ruling on how conflict of interest affects standard of review/deference
- DOL February 14, 2008 Guidance On Application Of The Nondiscrimination Requirements Of The Health Insurance Portability And Accountability Act (HIPAA) To Wellness And Disease Management Programs
- Contracted/Non-Contracted Provider Litigation Developments
- Vendor Performance Issues
- Court Decisions
- Enforcement Actions
- Other

Don’t Forget The Old Stuff

- Fiduciary Responsibility
- Bonding
- Claims Administration
- Plan Document
- Trust Requirements
- Eligibility Mandates
- Benefit Mandates
- Nondiscrimination
- SPD and Other Notification Requirements, e.g.
  - Triannual HIPAA Privacy Reminder April 14, 2009 (Except Small Plans, April 14, 2010)
  - Annual Medicare Part D Notices to CMS In March and To Participants In November
  - Other
- Coordination of Benefits, Medicare/Medicaid/Tricare Secondary Payer Rules
- More

RISK MANAGEMENT & COMPLIANCE REVIEW

- Fiduciary Status
- Plan Documents Contents & Language
- HIPAA Privacy & Security Policies, Notices, BA Agreements & Practices
- Initial Notifications
- Summary Plan Description Contents & Language
- Administrative Procedures & Forms
- Required Returns & Filings
- Compliance Plan
- BA Agreements, Standards of Performance, Prudent Selection & Oversight, Indemnification
- Errors & Omissions Insurance
- Training
- Monitor For Updates

Guilt by Association.

You can't choose your relatives

BUT you CAN choose your clients, vendors & other relationships.

Let the buyer beware.

Not all business is worth having.

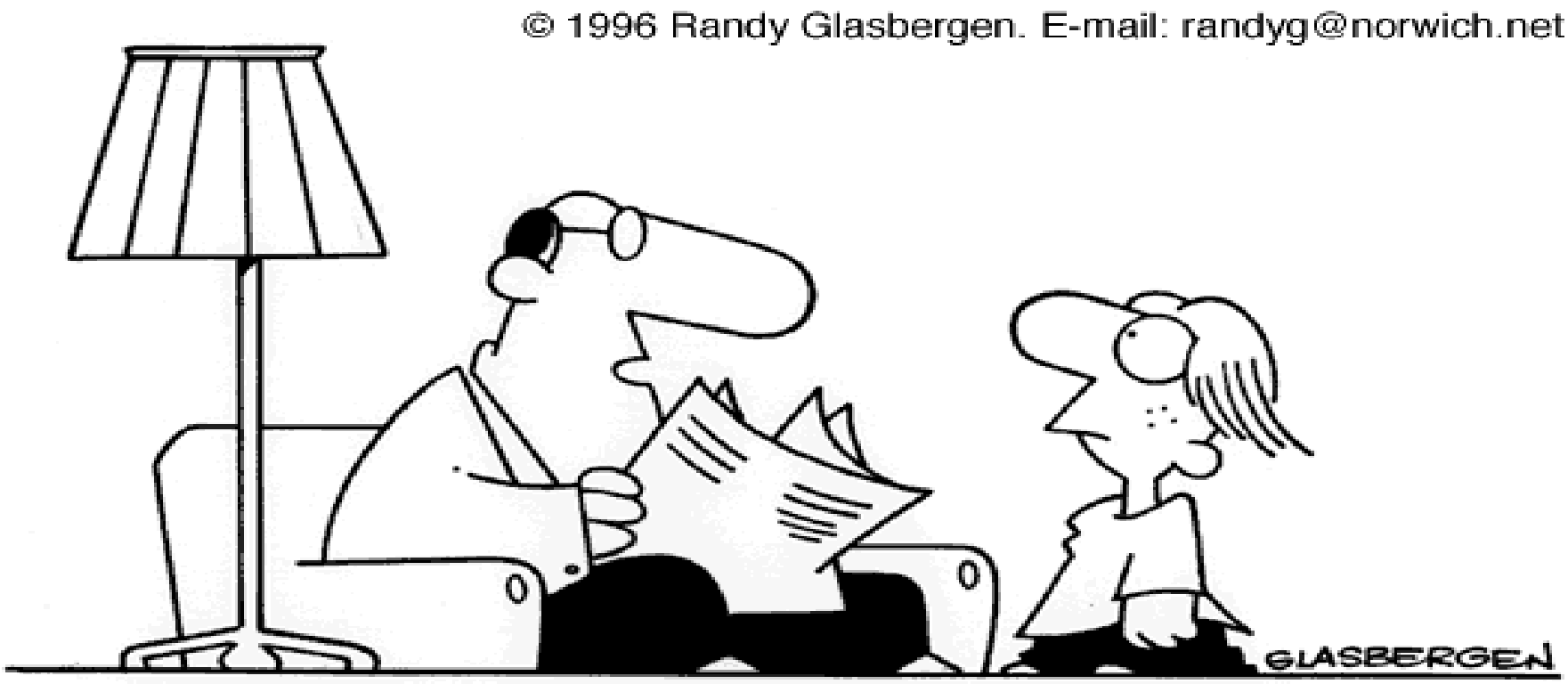
Partner with care

Vendor/Plan Sponsor Contracting:

- Fiduciary Status
- Performance Standards
- Business Associate Agreements & Compliance Plan
- ERISA Trust & Prohibited Transaction Requirements
- Indemnification
- Errors & Omissions
- Termination
- Federal Sentencing Guidelines Safeguards

Plan & Implement For Success

Have Disaster Recovery Plan



"Remember son, if at first you don't succeed, make it look like someone else's fault then sue them."

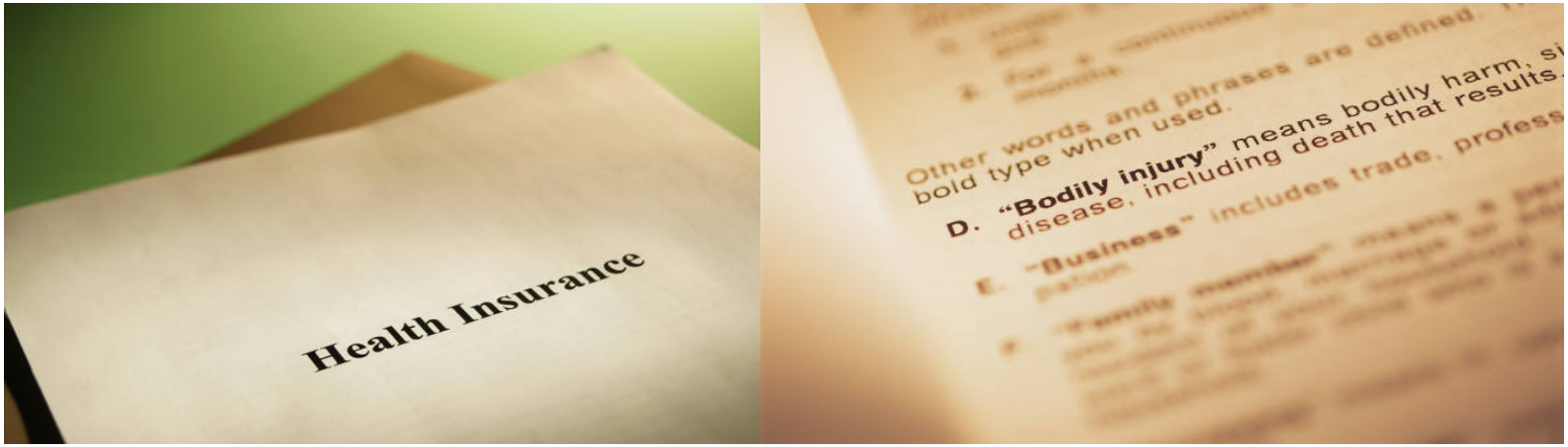
Register For Updates

CTT Alerts at cttlegal.com

SLP HR & Benefits Updates at http://slphrbenefitsupdate.wordpress.com/

LinkedIn Health Plan Compliance Group

How Can We Help You?



Plan Document Changes for Latest Regulatory Developments

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