



the BENEFIT report



MULTIPLE BENEFIT SERVICES, INC.

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New Benefits Law Changes

Mental Health Parity

The recently signed emergency economic stabilization legislation signed on October 3rd by President Bush expanded the mental health parity requirements for group health plans. The legislation amends the mental health parity provisions of ERISA, the PHS Act and the IRC to eliminate the sunset provision under which the existing requirements would have expired on December 21, 2008.

The addition of new requirements for group health plans providing coverage for substance use disorder benefits apply for plan years beginning after October 3, 2009. This means that calendar year plans must comply by January 1, 2010. Special rule exists for plans maintained pursuant to a collective bargaining agreement. We expect more guidance to come but such guidance will not delay the effective date of these regulations.

This Act (Mental Health Parity and Addiction Act of 2008) does not require group health plans to offer mental health and substance abuse benefits, but if it does the benefits must be equivalent to benefits for other medical conditions.

The parity requirement goes beyond annual and aggregate lifetime limits of mental health benefits and is expanded to include the same parity to substance use disorder benefits.

Substance Use Disorders – will now enjoy the same parity as medical/surgical benefits and mental health benefits.

Financial Requirements – plans may not 1) have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits such as deductibles, copayments, coinsurance, and out-of-pocket expenses; or 2) have more restrictive financial requirements for mental health or substance use disorder benefits.

Treatment Limitations – plans may not have treatment limitations that apply only to mental health or substance use disorder benefits that are less than the applicable lifetime limit for substantially all other medical or surgical benefits, such as limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. If the plan does not include a limit on substantially all benefits, one may not be imposed on mental health or substance use disorder benefits.

Plan Information – plans may not have different criteria for any determination of coverage including medical necessity determinations. Criteria and the reasons for any denial of benefits for mental health or substance use disorder benefits shall be made available upon request to participants, beneficiaries and providers.

Out of Network Providers – plans that provide coverage for out-of-network providers for medical/surgical benefits must also provide coverage for out-of-network providers for mental health and substance use disorder benefits.

Small Employer Exemption – the parity requirement maintains an exemption for certain small employers. The new definition now includes employers that employed an average of at least 2 employees (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) but no more than 50 employees during the preceding calendar year (applies on a controlled group basis).

Cost Exemption – The cost exemption has been changed and is available only if the plan has complied with the parity requirements for the first six months of the plan year involved. A plan will qualify for the exemption for the following year, if the increased cost of applying the parity requirement exceeds:

- 2% or more of the actual plan costs in the first plan year in which the parity requirements apply, and
- 1% in each of the subsequent plan years.

Cost increases must be made and certified

by qualified and licensed actuaries. Plans that qualify for and elect the exemption must promptly notify appropriate governmental agencies, participants, and beneficiaries.

The cost exemption appears to be only good for the following plan year. After that, the plan will need to comply with the parity requirements again to determine if the plan qualifies for exemption after complying with the parity requirements for the first 6 months of the plan year in 2010, the exemption applies for the following plan year in 2011. Then, in plan year, 2012, the plan will again need to comply with the parity requirements for the first 6 months to determine if the plan will qualify for an exemption again, which would then apply in plan year 2013. Basically, this means the plans that qualify for exemption would in essence be exempt every other year and will incur the ongoing cost of the actuarial certification.

Michelle's Law

On October 9th, President Bush signed Michelle's Law (named after a college student) which permits seriously ill full-time college students, who are covered dependents under group health plans to continue coverage for up to one year while on a medical necessary leave of absence. The legislation amends ERISA, PHSA and IRC and is effective for plan years beginning on or after October 9, 2009. This means that the effective date for calendar year plans is January 1, 2010. This law applies to fully insured, self-funded and governmental plans.

Medical Necessity - The extension applies to a dependent child who is enrolled at a post-secondary educational institution (including colleges and universities) upon a medically necessary leave of absence that causes them to lose full-time student status.

Continued Coverage - Coverage continues until the earlier of:

- 1 year from the start of the medically necessary leave of absence; or
- The date on which such coverage would otherwise terminate under the terms of the health plan.

Dependent Child – The student must be enrolled as a dependent under the health plan and qualify for coverage immediately before the first day of the medically necessary leave of absence.

Certification by Physician – Requires written certification by a treating physician of the medically necessary leave or absence.

Notice – Notice of the student's right to continue coverage under Michelle's Law must be provided alongside any requirement for certification of student status.

No Change in Benefits – The student is entitled to the same level of benefits during a medically necessary leave of absence as entitled to before taking the leave. In addition, any changes made to the plan during the leave will apply to the student as long as coverage remains available to dependent children.

ADA Amendments Act of 2008

On September 25, 2008, President Bush signed into law the Americans with Disabilities Act (ADA) Amendments which modifies the definition of disability and makes other changes to the ADA effective January 1, 2009.

Employers with 15 or more employees for each working day in at least 20 calendar weeks in the current or preceding calendar year must comply. The Act substantially changes how employers are to view a disability.

Basic Definition of Disability

- A physical or mental impairment that substantially limits one or more major life activities
- A record of such impairment, or
- Being regarded as having such an impairment.

Any impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active, and is to be determined without regard to the ameliorative effects of mitigating measures such

as medication, equipment, prosthetics, etc. The Act defines the terms "major life activity" and "regarded as having such an impairment" as:

Major Life Activity

- Major Life Activity includes activities such as, but not limited to caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.
- Major Life Activity also includes the operation of a major bodily function including but not limited to functions of the immune system, normal cell growth, digestive bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

Regarded as having such an Impairment

In order to determine if an individual should be "regarded as" having an impairment, the impairment cannot be transitory (an impairment with an actual or expected duration of 6 months or less) and minor. It provides rules to apply when determining if an individual has a disability and that the definition of disability must be construed in favor

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of broad coverage.

There is no ADA violation when a group health plan provides benefits equally to individuals with disabilities and individuals without disabilities even if there are differences in health benefits as long as the differences are not the result of a “disability-based distinction” or if benefits are provided through a bona fide benefit plan that is not a subterfuge to evade the purposes of ADA.

Medicare Secondary Payer Mandatory Reporting Requirements

The Medicare Secondary Payer (MSP) statute and regulations contain rules for determining whether Medicare is the primary payer for an individual who has both Medicare and other health care coverage.

Beginning January 1, 2009, Insurers, TPAs, self funded and self administered plans (in other words, organizations that pays claims) will be required to collect and report quarterly information from plan sponsors and plan participants to help CMS (Centers for Medicare and Medicaid Services) identify situations in which the plans are or have been secondary to Medicare.

CMS has indicated that the majority of group health plans with MSP involvement already report some information to CMS. However, expect some disruption with business as usual as we expect the additional reporting requirement of the plan sponsor’s federal tax identification number (EIN) and the social security number (SSN) of each “active covered individual” including dependents (and those Medicare-entitled due to disability or end-stage renal disease), while those of a spouse or domestic partner will be requested by claim payers in the very near future. Enrollment forms may change to help collect this information from new clients and existing clients will be contacted and requested to provide this information.

Failure to comply and report eligibility data and Social Security numbers may subject the claim payers to civil monetary penalties up to \$1,000 for each day of noncompliance for each individual for which data is re-

quired. The purpose of this increased exchange of eligibility data is designed to allow for a more efficient and streamlined process and should help avoid some of the costly interest payments that result when Medicare pays as the primary payer in error.

Massachusetts’s Health Care Reform Law Reporting

Massachusetts’s comprehensive health care reform law requires that residents age 18 and older must record on their annual state income tax return that they have health insurance coverage.

Individual declarations will be matched against membership reports submitted by insurers to the Department of Revenue (DOR). Form MA 1099 – HC has been designed to include the specific information needed to comply with this law. The Health Care Access Bureau within the Department

of Insurance will maintain the data base that will be used to confirm coverage reported on the state income tax forms.

Insurers will use enrollment information on file for all affected individuals to produce these MA 1099 – HC forms by January 31st of each year in addition to the annual report that must be submitted to identify all residents who were provided coverage during the previous year. It is crucial that employers keep their records and that of the insurers up to date to assure that all active members receive this form. Additional information may be found on the DOR’s Website at www.dor.state.ma.us.

This newsletter briefly summarizes a few of the many 2008 changes that may effect your group health plan. If you have any questions or need any additional information, please contact your account manager at 770.424.5777 or 888.517.3659.

Social Security Wage Base Rises

The Social Security Administration has announced that the wage base for computing the Social Security Tax (OASDI) in 2009 rises from \$102,000 to \$106,800; an increase of 4.7%. The \$4,800 increase is due to an increase in average total wages.

New limits for HSA Plans for 2009

The IRS has released the cost-of-living adjustments for HSA amounts for calendar year 2009.

- The annual HSA contribution limit for individuals with self-only HDHP coverage is \$3,000 (up \$100 from 2008).
- The annual HSA contribution limit for family High Deductible Health Plan (HDHP) coverage is \$5,950 (up \$150 from 2008).

- The required minimum annual HDHP deductible is \$1,150 for self-only coverage (up \$50 from 2008) and \$2,300 for family coverage (up \$100 from 2008).
- The maximum HDHP out-of-pocket expense limit is \$5,800 for self-only coverage (up \$200 from 2008) and \$11,600 for family coverage (up \$400 from 2008).

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From Multiple Benefit Services, Inc.

The Benefits of Walking

- Walking at a brisk pace is considered a moderate activity
- Moderate activities, like walking, can help strengthen your heart, lungs, bones and muscles
- Walking can also help your body fight off illnesses, and can increase your energy level, and your mood
- Moderate activity should be done for at least 30 minutes a day, 5 or more days a week
- Walking in intervals of 10 minutes, or more, during the day gives you the same benefits as one long walk
- Start with short term goals and gradually increase your minutes or steps
- Start your walk with a warm up period, then increase your pace during the walk, end with a cool down period

Be sure to check with your health care provider before beginning any exercise program.

The information provided in this publication is for general purposes only and is designed to be accurate in relation to the material discussed. If specific questions regarding your plan arise please call our office. If legal or tax advice is required, please obtain the services of a competent professional.