McGraw Wentworth

BENEFIT Advisor

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In This Issue

This final issue of our Benefit Advisor for 2010 reviews the important developments that affected employee benefit programs this year. It also reviews the year-end housekeeping issues organizations should revisit annually.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

"2010 Year-End Review"

This year turned out to be one busy year in terms of employee benefits. Health care reform acts were signed into law at the end of March. These reform laws brought sweeping changes to the tax code, health plans, providers, Medicare and others. Reform provisions were not the only issues employers had to consider in 2010.

Below is a summary of the key 2010 changes:

- Clarifications of Mental Health Parity Requirements
- HITECH changes to Privacy and Security Rules
- Health Care Reform Changes
  - Health Plan Changes
  - Tax Code Changes
- New Reporting Requirements – Form 8928

This *Advisor* summarizes each of these changes. It also reviews a host of housekeeping issues your organization should review every year.

Clarifications of Mental Health Parity Requirements

In October 2008 Congress passed the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* amending the *Mental Health Parity Act*. It provides true parity for the mental and substance abuse treatments that health plans cover. The *Wellstone Act* went into effect on the first day of the first plan year following October 3, 2009.

Because health plans and insurance carriers struggled with interpreting the *Wellstone Act*, the government issued interim rules on February 1, 2010. The interim rules affected plans on the first day of their first plan year on or after July 1, 2010. Most employers needed to adjust their compliance steps for *Wellstone* in light of the details released in February.

For all the details regarding these interim regulations, please read our *Benefit Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2010/BA_Issue_3.pdf. Following is a summary of this guidance:

- Because plans cover different services in different ways, employers have found it difficult to determine what should be considered equitable treatment. For example, the plan may require a deductible

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and coinsurance for an inpatient hospital visit while it covers office visits at 100% after the copay. The interim regulations discuss classifying benefits. The classifications include:

- Inpatient, in-network
- Inpatient, out-of-network (this classification applies when there is no network)
- Outpatient, in-network
- Outpatient, out-of-network (this classification applies when there is no network)
- Emergency care
- Prescription drugs

Following the release of these regulations, the Employee Benefit Security Administration released guidance allowing employers to consider office visits as a separate classification.

Generally, financial requirements or treatment limitations for mental health and substance abuse cannot be more restrictive than the predominant financial requirements or treatment limitations for all medical or surgical benefits in a particular benefit classification. The regulations include details on how to calculate the predominant financial requirement.

- For prescription drug benefits, plans can apply different financial requirements to different drug tiers as long as the same type of tiered copay arrangement also applies to medical and surgical benefits.
- Plans cannot apply a separate cumulative financial requirement or treatment limitation for mental health and substance abuse. The law does not allow the "separate but equal" approach. For example employers cannot have a $1,500 out-of-pocket maximum for mental health/ substance abuse and a separate $1,500 out-of-pocket maximum for medical/surgical services.
- Group health plans, in some situations, may limit coverage based on requirements other than financial or treatment limits. These requirements may include medical management standards, formularies, reasonable and customary fee schedules, step therapy requirements and so on. The general rule of thumb is that a plan cannot make non-quantitative treatment requirements for mental health and substance abuse more restrictive than those for medical and surgical benefits in the same benefit classification.
- Group health plans cannot require an employee to exhaust mental health visits under an EAP before the plan will cover mental health visits. Unless the same requirement applied to medical and surgical benefits, this arrangement would violate the *Wellstone Act*. Employers can keep an EAP with visit benefits; however, it must be the member's choice to either use visits under the EAP or use a different provider and submit claims to the health plan.

Although your plan may have complied with *Mental Health Parity* before these interim regulations were released, you may want to look again at your mental health and substance abuse benefits to determine whether you need to make any additional changes in light of this new guidance.

HITECH Changes to Privacy and Security Rules

The *Health Information Technology for Economic and Clinical Health Act* (HITECH) is part of the *American Recovery and Reinvestment Act* of 2009 (ARRA). HITECH made a significant financial investment to encourage health care providers to move to electronic health records. The move to electronic health records has been hotly debated. While it may decrease cost and improve quality, people are concerned, and rightly so, about privacy.

Health providers and health plans must protect electronic health information according to HIPAA's privacy and security rules. Because the consensus was that those rules do not go far enough, HITECH changed HIPAA Privacy and Security Rules to ensure greater protection for health information and more accountability for firms that use health information. Most of the HITECH changes became effective February 17, 2010.

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For details on these interim regulations, please read our *Benefit Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2009/BA_Issue_5.pdf.

Below is a summary of this guidance:

- HITECH significantly changed business associates' responsibilities. HIPAA privacy and security rules and the penalties for violating them now apply directly to business associates; previously business associates only needed to provide satisfactory assurances that they were protecting health information.
- HITECH substantially increased the penalty for noncompliance. It depends on the violation and the cause of the violation, but in the worst case, the penalty can reach up to $1,500,000.
- HITECH also strengthened enforcement. The Office of Civil Rights has expanded authority to investigate HIPAA violations. HITECH requires a formal investigation and fines for deliberate violations.
- State attorneys general can sue anyone violating HIPAA privacy and security rules in federal court.
- HITECH added reporting requirements for breaches.

Covered entities must take very specific action when a breach of unsecured protected health information occurs. They must investigate these incidents and, in some cases, they must notify anyone affected by the breach within 60 days after they discover the breach. In addition, they must notify the Department of Health and Human Services, and they may even need to notify the media. Organizations should have a procedure in place for handling these breaches.

Employers should review their privacy and security policies and procedures in light of HITECH and make the necessary adjustments.

Health Care Reform Changes

Health care reform has dominated health benefit news this year. Many employers have implemented the first wave of changes (those effective on the first day of the first plan year following September 23, 2010) and have also addressed the tax code changes that will be effective on January 1, 2011.

The required health care reform changes can be overwhelming. To comply, the first step should be to determine whether your plan is grandfathered. Health care reform delays ***some*** of the effective dates for grandfathered plans. A grandfathered plan is a plan that was in place on March 23, 2010, and did not make any changes causing it to lose its grandfathered status. More information on the rules can be found in our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/Reform_Update_10.pdf.

Any change in insurance carrier for a group health plan effective on or after November 15, 2010, will not cause a loss of grandfathered status.

The following required health plan changes become effective the first day of the first plan year following September 23, 2010, (grandfather-delayed effective dates noted):

- Plans must remove lifetime dollar limits and cover employees who are eligible but have lost coverage because they had already reached the lifetime dollar limit.
- Plans cannot have unreasonable annual dollar limits on their coverage for essential benefits. The annual plan dollar limits must be at least the following depending on the plan year:
    - September 23, 2010 to September 23, 2011: $750,000
    - September 23, 2011, to September 23, 2012: $1,250,000
    - September 23, 2012 to September 23, 2013: $2,000,000

  By 2014, no annual dollar limits will be permitted on essential benefits. Essential benefits are only broadly defined in the health reform acts and include:

    - Ambulatory patient services
    - Emergency services

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- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

- Rescissions of coverage are only permitted in fraud and non-payment situations.
- Health plans must cover adult children up to age 26. The plan cannot have dependency requirements, such as requiring residency, full-time student status, tax dependency and so on. Employers cannot charge different employee contribution amounts based on a child's age, but they can charge a "per child" contribution rate. Grandfathered plans can exclude adult children covered through their employers. This limit applies only to grandfathered plans and will only be permitted until 2014. Employers must notify employees of this expanded eligibility and allow newly eligible individuals 30 days to enroll in the plan.

- Plans must cover specific preventive care services. This provision can be delayed for grandfathered plans. More details of this requirement can be found in our *Reform Updates* at http://www.mcgrawwentworth.com/Reform_Update/Reform_Update_12.pdf.
- Some plans will need to modify how they require participants to choose a primary care physician. This provision can be delayed for grandfathered plans and only applies to plans that require members to make that choice. For the most part, your health plan vendor will need to handle this issue.
- New requirements apply to how the group health plan covers emergency room visits. This requirement can be delayed for grandfathered plans. Plans cannot require preauthorization for emergency room visits if participants would then have to pay a penalty for not obtaining this preapproval. For copayments and coinsurance requirements, services received in an out-of-network emergency room must be covered just as if the emergency room was in-network.
- Fully-insured plans will now need to meet the same somewhat complicated Section 105(h) non-discrimination requirements that have always applied to self-funded medical plans. This provision can be delayed for grandfathered plans. The premise of the Section 105(h) nondiscrimination requirements is that plans cannot favor highly compensated employees. Employers can conduct the Section 105(h) nondiscrimination tests to determine whether they need to make any plan changes to comply with this provision. Keep in mind, organizations offering different groups of employees different benefit plans are not necessarily favoring certain employees.
- All health plans will need to have an internal claim review and appeal process and an external review process. This requirement can also be delayed for grandfathered plans. The changes you may need to make depend on whether your group is subject to ERISA or not and whether your group is fully insured or self-funded. More details of these requirements can be found in Issues 13 and 15 of our *Reform Updates* at http://www.mcgrawwentworth.com/resources_reformupdate.html.

The following required tax code changes are effective January 1, 2011:

- Non-prescribed over-the-counter medications will no longer be eligible for coverage under employer group health plans, medical flexible spending accounts, health reimbursement arrangements, health savings accounts and Archer medical saving accounts. All employers will need to inform their employees of this change in the tax code because it will likely affect employee elections to spending accounts. More

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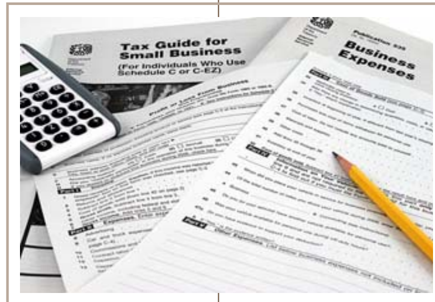
details of this requirement can be found in our *Reform Updates* at http://www.mcgrawwentworth.com/Reform_Update/Reform_Update_16.pdf.

- The excise tax penalty levied on employees using HSA funds for non-medical reasons increases to 20%. Employers offering a consumer driven health plan paired with an HSA should inform their employees of this change.



The sheer number of changes employers and health plans must make to comply with all the requirements of health care reform is overwhelming. Even with all the regulations that have been issued during the year, employers will need to sort their way through many gray areas. It is likely more guidance will be released throughout 2011 to help employers comply with health care reform.

New Reporting Requirements – Form 8928

The IRS established a new process for employers to self-report excise taxes in the case of very specific compliance failures. This self-reporting requirement took effect on January 1, 2010. Employers should use Form 8928 to report any required tax penalties.

For the most part, the excise taxes this form is designed to collect have been around for years. However, in the past employers were assessed the tax penalty only if the IRS happened to catch them. The IRS rarely sought out potential violations. This self-reporting requirement now makes the employer responsible for reporting violations. Employers will have to pay a larger fine for non-compliance if they knew of a compliance failure and did not pay the original penalty.

All the details of how to submit Form 8928 and the specific compliance failures that should be reported can be found in our *Benefit Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2010/BA_Issue_9.pdf.

The IRS does allow an exception to assessing fines on specific compliance failures. No tax penalty is due if the failure was reasonable and not deliberate. To show a failure was reasonable employers must:

- Establish that no one liable for the penalty "knew or if he/she had exercised reasonable diligence would have known" the compliance failure had occurred.
- Correct the failure within 30 days of discovering the problem.

It appears employers with no reportable failures within the year would not need to file Form 8928. If an employer does need to file Form 8928, it must be done before the due date for filing the corporate tax return.

Annual Reminders and Updates

2011 Medicare Information

The Department of Health and Human Services released the Medicare information for 2011 (see table at bottom of page).

Part B premiums are higher for Medicare beneficiaries in a higher income range. The income range and the premiums are adjusted annually. For 2011, the income adjusted premiums will be as shown in the table at the top of page 6.

Many Medicare beneficiaries have their Part B premiums deducted directly from their Social Security checks. In this case, there is a "hold harmless" provision that applies when projected premium increases exceed the cost of living increase under Section 215(i). This provi-

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Medicare Information

Medicare Part A Deductible (per benefit period)	$1,132.00
Hospital **Per Day** Copay (per benefit period) 60 to 90 day stays 90+ day stays	 $283.00 $566.00
Skilled Nursing Facility **Per Day** Copay (after 20 days)	$141.00
Medicare Part B Monthly Premiums	$115.40
Medicare Part B Annual Deductible	$162.00

sion applies to anyone entitled to Social Security benefits under Section 202 or Section 223 of the Old Age and Survivors Insurance Benefit and the Disability Insurance Benefit. If Part B premiums are deducted directly from a Social Security or SSI check, this provision reduces premium increases so that the amount of the person's net monthly check does not go down.

In 2010 and 2011, there has been no cost of living adjustment to Social Security income. Therefore, some Medicare beneficiaries' Part B premiums will not increase because of the hold harmless clause.

The indexed parameters for Medicare Part D for 2011 can be found at the bottom the page.

Health care reform made substantial changes to Medicare Part D, but did not directly change the Standard Part D benefit plan design. Beginning in 2011, the government and the manufacturers of brand name prescriptions will help pay for drugs when a Medicare beneficiary reaches the coverage gap.

INDIVIDUAL RETURN	JOINT RETURN	2011 PART B MONTHLY PREMIUM
$85,001-$107,000	$170,001-$214,000	$161.50
$107,001-$160,000	$214,001-$320,000	$230.70
$160,001-$214,000	$320,001-$428,000	$299.90
>$214,000	>$428,000	$369.10

The government will subsidize 7% of the cost for generic drugs purchased in the coverage gap; Medicare beneficiaries will be responsible for the remaining 93% of the cost. The full cost of the generic drug will apply to the true out-of-pocket cost limit. Brand name drug manufacturers will charge Medicare beneficiaries half of the negotiated rate during the coverage gap. The full cost of the brand name drug will apply to the true out-of-pocket cost limit. These changes will decrease Medicare beneficiaries' costs in the 2011 coverage gap. The government subsidies will increase over the next 10 years and by 2020, Medicare beneficiaries will be responsible for only 25% of the drug cost in the coverage gap.

Medicare Part D Standard Plan	2011
Annual Deductible (amount the beneficiary pays before benefits are payable)	$310
Initial Coverage Limit (once the beneficiary meets the deductible, the plan pays 75% and the beneficiary pays 25% until the total prescription expense - paid by plan and beneficiary - reaches the initial coverage limit)	$2,840
True Out-of-Pocket Maximum (once the beneficiary has paid the true out-of-pocket cost, Medicare catastrophic coverage will pay most of the prescription drug cost). The standard plan pays no part of expenses after the initial coverage limit until the true out-of-pocket maximum is reached.	$4,500
Total Covered Part D Expenses before Catastropic Coverage (if the beneficiary has no coverage other than the Medicare Part D plan)	$6,447.50
Catastrophic Coverage (Medicare pays most of the prescription drug expense once the catastropic coverage level is reached.) The Medicare beneficiary pays the greater of 5% of drug cost or a $2.50 generic or $6.20 brand name copay.	

Medicare Part D may also affect employers sponsoring retiree drug plans. If their drug benefits are as good as or better than Medicare benefits, employers can apply for a government-paid subsidy based on a percentage of claims paid. The subsidy equals roughly 28% of prescription claims for Medicare Part D covered medications that fall between the cost threshold and cost limit. The cost threshold and cost limit are also indexed and the 2011 amounts are as follows:

	2011
Cost Threshold	$305
Cost Limit	$6,200

As of January 1, 2013, the retiree drug subsidy will be taxable. Organizations not normally required to pay taxes will not be affected.

In addition, Medicare beneficiaries can change their Medicare Part D plan during an annual open enrollment period. The open enrollment period runs from November 15 to December 31 each year. In 2011, the open enrollment period will run from October 15 to December 7.

Medicare Part D Notice Requirements

Employers need to issue two Medicare Part D notices annually.

One notice concerns the creditable coverage status of your prescription benefits and must be sent to Medicare eligible participants. As

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a rule, Medicare beneficiaries must enroll in a Medicare Part D plan when they become eligible or pay a late enrollment penalty. However, if your health care plan is creditable and the Medicare beneficiary maintains creditable coverage, the late enrollment penalty will not apply. More details on the wording of the latest model notice can be found in our Special Alert at http://www.mcgrawwentworth.com/Special_Alert/2009/Special_Alert_Issue_1.pdf.

More details on the delivery requirements for the Medicare notices can be found at http://www.mcgrawwentworth.com/Special_Alert/2007/Special_Alert_Issue_4.pdf.

The other notice must be filed directly with CMS. It states your plan's creditable coverage status. It must be sent electronically within 60 days of the beginning of the plan year. Completing the online notice does not take much time; the toughest part is remembering to do it. You can file the notice online at https://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp.

Group Term Life Insurance: Section 79

Each year employers need to review the group term life coverage they offer to determine whether employees need to pay taxes on it. Employers have to impute income for the value of the life insurance plan in only a few instances:

- If the employer-paid life insurance exceeds $50,000.
- If the life plan favors key employees (only key employees pay taxes).
- If the employee-paid optional life plan rate table straddles Table I rates.
- If the employer allows voluntary term life coverage to be paid with pre-tax dollars.

The most recent *Benefit Advisor*, available on our website, explains when and how to calculate imputed income.

W-2 Should Include Short Term Disability Benefits

At year end, organizations need to report disability benefits or earnings they paid to disabled employees during the year. Although in many cases, disability carriers pay the benefits, employers need to make sure to include these benefits on the employee's W-2.

The income from these benefits is generally reported in one of two ways:

- Disability carriers or third party administrators may issue W-2s directly to participants who received benefits during the year.
- Carriers or administrators may send you a quarterly or annual report with the information you must include on each employee's W-2.

Let your employees know if your disability vendor is issuing them a separate W-2. More often, disability vendors inform employers of the amount paid in disability benefits and then employers add the benefit income to the employee's W-2.

If your organization self-funds short term disability benefits, you will need to include those benefits in the employee's 2010 W-2. If you use a payroll service to issue W-2s, your payroll vendor must include the additional compensation on the employee's W-2.

2011 Indexed HSA Limits

Each year the IRS releases indexed limits for health savings accounts (HSAs) and high deductible health plans (HDHPs). The limits for the last three years can be found in the table at the top of the page.

Indexed Health Saving Account Limits	2009	2010	2011
HDHP Minimum Deductible			
Self Only Coverage	$1,150	$1,200	$1,200
Family Coverage	$2,300	$2,400	$2,400
HDHP Maximum Out-of-Pocket			
Self Only Coverage	$5,800	$5,950	$5,950
Family Coverage	$11,600	$11,900	$11,900
HSA Statutory Contribution Maximum			
Self Only Coverage	$3,000	$3,050	$3,050
Family Coverage	$5,950	$6,150	$6,150
Catch-Up Contribution (age 55 and older)	$1,000	$1,000	$1,000

2011 Indexed Plan Limits

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The table to the right summarizes the 2010 and 2011 indexed plan limits.

Conclusion

This year has been hectic as all of us have spent timing learning about health care reform and its effect on organizations and their health plans. Year-end is typically a very busy time. With health care reform requiring significant work from almost all organizations, year-end in 2010 is likely to be more demanding than usual. With so many issues arising at year-end, it makes sense to create a work plan to ensure you have covered all the critical requirements. If an issue is not urgent but still needs to be considered, place it on the action plan for next year.

Good luck in handling the year-end compliance issues that affect your organization's benefit plans. The McGraw Wentworth team wishes you and your family a happy, healthy and stable 2011! MW

Indexed Plan Limits		
Plan Limits	**2010**	**2011**
Section 401(k) or SAR-SEP	$16,500	$16,500
Section 402(g) maximum pre-tax contribution by employees for elective deferrals	$16,500	$16,500
Age 50+ Catch-Up Deferral Limit	$5,500	$5,500
Section 403(b) Plan	$16,500	$16,500
Section 408(p)(2)(A) SIMPLE Plan Contributions	$11,500	$11,500
Section 457(b)(2) Limit	$16,500	$16,500
Key Employee Determination - Officers' Earnings Threshold	$160,000	$160,000
Section 415 Limit for:		
Defined Contribution Plans (calendar year)	$49,000	$49,000
Defined Benefit Plans	$195,000	$195,000
Highly Compensated Employees		
Section 414(g)	$110,000	$110,000
Includible Compensation - Section 401(a)(17)	$245,000	$245,000
FICA Taxable Wage Base:		
Social Security (Tax Rates 6.2%)	$106,800	$106,800
Medicare (Tax Rate 1.45%)	No limit	No limit

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