

# Benefits Report

OCTOBER 2008

## Special Alert

### Health Plan Update

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**D**uring the past month, several new laws have been enacted that will affect the benefits that health and welfare plan sponsors provide to employees and their dependents. This *Special Alert* describes these new laws and the recent guidance on the new Medicare Secondary Reporting requirements, which will apply to group health plans beginning January 1, 2009.

#### Mental Health Parity

The Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008 was recently enacted as part of the Emergency Economic Stabilization Act of 2008. This new law generally applies to plan years beginning on and after October 3, 2009; for calendar year plans, the law applies beginning January 1, 2010. For collectively bargained plans, the law applies to plan years beginning after the later of:

- January 1, 2009; or
- the date on which the last collective bargaining agreement terminates (if the collective bargaining agreement was ratified prior to October 3, 2008).

While the law does not require health plans to provide mental health or substance use disorder benefits, it requires plans of employers with 50 or

more employees to ensure that the financial requirements and treatment limitations that apply to mental health and substance use disorder benefits are no more restrictive than those that apply to substantially all medical/surgical benefits covered by the plan. Regulations are expected to be issued by the Secretary of Labor, Secretary of Health and Human Services and Secretary of the Treasury within the next year.

The following are the highlights of the law's requirements:

- ***Parity in Financial Requirements***

Health plans may not impose financial requirements on mental health and substance use disorder benefits that are more restrictive than the predominant financial requirements that apply to substantially all medical and surgical benefits covered by the plan. These financial requirements include deductibles, copayments,

coinsurance rates, and out-of-pocket expenses or other separate cost sharing requirements. For example, a plan may not impose a deductible on mental health benefits that is higher than the deductible that applies to medical benefits.

- ***Parity in Treatment Limits***

To the extent that a health plan limits the frequency of treatments or the number of visits or days of coverage, or imposes other similar limits on the scope or duration of treatment, the plan may not impose limits on mental health and substance use disorder benefits that are more restrictive than those that apply to medical/surgical benefits. Thus, a plan may not limit substance use disorder treatment benefits to one in-patient stay in a facility if the plan does not impose a similar limitation on medical/surgical benefits.

- ***Parity in Out-of-Network Benefits***

If a health plan provides out-of-network coverage for medical/surgical benefits, the plan must also provide out-of-network coverage for mental health or substance use disorder treatment benefits.

- ***Substance Use Disorder Benefits***

The protections of the current Mental Health Parity Act, which was enacted in 1996, do not apply to substance use disorder benefits. However, the new law now extends parity requirements to substance use disorder benefits. Therefore, plan sponsors will need to evaluate their current substance use disorder benefits and ensure that any limits on such benefits are permissible.

- ***Disclosure of “Medical Necessity” Determination Criteria***

The law requires plans to furnish their respective criteria for making medical necessity determinations upon request by a participant or beneficiary or a contracting provider. Such rationale must also be disclosed if a mental health or substance use disorder benefit claim is denied.

- ***Cost Exemption***

An exemption from complying with the law is available to a plan if the actual costs of providing mental health/substance use disorder benefits exceed 2% of the plan’s total costs in the first plan year and 1% in subsequent plan years. To obtain the exemption, a plan must obtain actuarial certification of the cost increase using data from the first six months of the plan year. Moreover, the plan must notify plan participants, the Department of Labor and Internal Revenue Service if it takes the exemption, and subject itself to audit by such agencies to verify compliance with the exemption.

We note that the law defines “mental health benefits” as 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. The term “substance use disorder benefits” is similarly defined by reference to the plan and applicable law. This means that ERISA governed self-funded plans are generally free to define the extent of their mental health and substance use disorder coverage while plans that provide coverage pursuant to insurance policies will have to comply with any state mandates on such coverage.

## ***New Bicycle Commuter Benefit***

Also included in the Emergency Economic Stabilization Act of 2008 is a provision that allows employers to provide employees with a new qualified bicycle commuting reimbursement benefit under Internal Revenue Code section 132(f), beginning January 1, 2009. The new law permits employers to reimburse employees up to \$20 per month tax free for the reasonable expenses they incur during a calendar year for the purchase of a bicycle and for bicycle improvements, repair and storage if the bicycle is regularly used for travel between the employee’s residence and place of employment. The bicycle commuter benefit is not available if the employee receives other commuter benefits, such as transit passes or parking benefits.

## Extension of Coverage to Seriously Ill or Injured Students

“Michelle’s Law” was enacted for the purpose of requiring health plans to continue coverage for seriously ill or injured college students who would otherwise lose coverage because they must leave school on a full-time basis as a result of their illness or injury. This law is effective for plan years that begin on and after October 7, 2009 (*i.e.*, January 1, 2010 for calendar year plans). The law requires health plans governed by ERISA or the Public Health Service Act to continue coverage for a dependent child who commences a medically necessary leave of absence from a postsecondary educational institution until the earlier of:

- one year after the first day of the child’s leave of absence due to the medical necessity; or
- the date on which coverage would otherwise terminate under the terms of the plan (*i.e.*, the child’s attainment of age 23).

A plan can require written certification by a physician of the child’s serious illness or injury and need for medical leave. Plans must also include a notice of this coverage provision in any notice that requires dependents to certify their student status for coverage under the plan.

## Clarification of Who Qualifies as a Dependent Child

Under the Fostering Connections to Success and Increasing Adoptions Act of 2008, the definition of a “qualifying child” under Section 152(c) of the Internal Revenue Code has been amended to clarify that a taxpayer may not claim a child who is married as a tax-dependent. Effective as of January 1, 2009, this change may affect plans that extend benefits to married dependent children, as this coverage may not be provided on a tax-favored basis.

## Medicare Secondary Reporting Requirement

In August 2008, the Centers for Medicare and

Medicaid Services (“CMS”) posted a new website (<http://www.cms.hhs.gov/MandatoryInsRep/>) that is intended to provide information and forms to assist plans in complying with the new Medicare secondary payer reporting requirement that was enacted in late 2007 to help CMS determine whether it is correctly paying Medicare benefits. Beginning January 1, 2009, group health plans will be required to collect and report data to CMS for Medicare coordination of benefits purposes or be subject to a \$1,000 per day penalty for non-compliance. CMS has stated that reporting will likely be required no more than quarterly, and that submissions will likely be in electronic format. According to the group health plan user guide issued by CMS as of October 14, 2008, it appears that a group health plan that does not currently share information with CMS pursuant to a Voluntary Data Sharing Agreement or Voluntary Data Exchange Agreement (“VDSA/VDEA”) must register with CMS during the month of April 2009, and transmit its initial report with data regarding coverage as of January 1, 2009 during the third quarter of 2009 (*i.e.*, during the period from July 1 to September 30, 2009). A group health plan that has a VDSA/VDEA in place with CMS must transmit its initial report no later than March 31, 2009.

We understand that the website will be updated to include guidance on the types of information that must be reported, a model for collecting Medicare beneficiary information, user guides for submitting data, information on record layouts, and other guidance. Since the website’s launch, CMS has posted guidance on registering with CMS to provide the required notices and guidance on the types of individuals who must be included in a plan’s quarterly report. Included individuals are covered individuals who are:

- age 45 and older and whose coverage is based on their own or a spouse’s employment;
- receiving kidney dialysis or who have received a kidney transplant; and
- under age 45 and whom the plan knows are entitled to Medicare.

The website also includes information about seminars that CMS has scheduled on the new reporting requirement.

## Effect on Plan Sponsors

In anticipation of the effective date of these new laws, plan sponsors may wish to analyze the extent to which the laws will affect plan costs, especially with respect to the new mental health parity law. Plan sponsors will need to amend plan documents,

summary plan descriptions and any other relevant employee communications. In addition, new notices may need to be developed. Please contact [Julie Burbank](#) or [Tiffany Santos](#) if you have any questions regarding these new laws.

### REMINDER

**Health plans that provide prescription drug coverage must send out their annual Medicare Part D creditable/noncreditable coverage notices before November 15.**

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The Trucker ♦ Huss *Benefits Report* is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of *Benefits Report* are posted on the Trucker ♦ Huss web site ([www.truckerhuss.com](http://www.truckerhuss.com)).

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