



Electronic Dispatch

Employee Benefits Law Action Memo

November 2008

[Go to BS&K Employee Benefits Law Home Page](#)

HEALTH PLAN CHANGES FOR 2009 AND 2010

A number of new laws and regulations will affect the design and administration of group health plans beginning in 2009.

Change in Definition of Dependent

A “dependent” for purposes of group health plan coverage is typically defined by reference to section 152 of the Internal Revenue Code (“Code”), which describes dependent status based on whether an individual is a “qualifying child” or a “qualifying relative.” Effective January 1, 2009, the Fostering Connections to Successful and Increasing Adoptions Act of 2008 changed the definition of “qualifying child” under Code Section 152(c).

Two new requirements are added to the definition of “qualifying child:”

1. The child must be younger than the taxpayer claiming the individual as a dependent; and
2. The child must not have filed a joint return (other than only for a refund claim) with the child’s spouse for the taxable year in question.

The new law also allows a non-parent to claim the child as a dependent, as long as the parents do not, and the non-parent’s adjusted gross income is higher than the highest adjusted gross income of any of the parents.

Massachusetts Creditable Coverage Requirements

Residents of Massachusetts must have health insurance that is “creditable coverage” or else pay a significant penalty to the Commonwealth. Regulations describing what constitutes minimum creditable coverage were recently issued by the Commonwealth Health Insurance Connector Authority. Although the regulations do not directly apply to group health plans sponsored by employers, an employer with a group health plan that is not “creditable coverage” will be under significant pressure from its employees to improve coverage.

Effective January 1, 2009, a health plan must provide “core services” (i.e., physician services, inpatient acute care, day surgery and diagnostic treatment and tests) and, at a minimum,

- Preventive and primary care;
- Emergency services;
- Hospitalization;
- Ambulatory patient services;
- Prescription drugs; and
- Mental health and substance abuse services.

Effective January 1, 2010, the list of required services increases.

The plan can impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network benefits, as well as co-payments, deductible and co-insurance; however, limits apply. In addition, a health plan

Bond, Schoeneck & King, PLLC ■ New York ■ Albany Buffalo Garden City Ithaca New York Oswego Syracuse Utica ■ Kansas ■ Overland Park
Bond, Schoeneck & King, P.A. ■ Florida ■ Bonita Springs Naples

This document may be considered “Attorney Advertising” under the rules of some states.
The hiring of a lawyer is an important decision that should not be based solely upon advertisements.



may not impose an overall aggregate annual maximum benefit limitation or an annual cap on core services. Further, preventive care services may not be subject to a deductible (co-payments or co-insurance consistent with primary or routine physician office visits are permissible).

The regulations do not address the date as of which "creditable coverage" is determined, so it is unclear whether mid-year amendments to a health plan to bring it up to the regulatory standards will avert the employee penalty. Finally, the regulations impose no requirement that employers inform employees whether the health plan is "creditable coverage," but employers should be ready to answer questions on the subject.

Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was enacted as part of the Emergency Economic Stabilization Act of 2008. Although the new law does not require group health plans to provide benefits for mental health and substance abuse, it requires those plans that offer both medical/surgical and mental health/substance abuse benefits to do so on an equal basis.

- The financial requirements of the plan, such as deductibles and copayments, can be no more restrictive for mental health or substance use disorder benefits than those that apply to substantially all medical and surgical benefits covered by the plan;
- Mental health and substance abuse benefits cannot be subject to separate cost sharing requirements;
- Any treatment limitations applicable to such mental health or substance use disorder benefits can be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan; and
- There can be no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.
- A plan must provide out-of network coverage for mental health or substance use disorder benefits if the plan provides coverage for medical or surgical benefits provided by out-of network providers.

The financial parity requirements of the law do not apply if, after complying with the Act for a minimum of six months, an actuary determines and certifies that compliance with the new law results in an increase in the total costs of coverage (medical and surgical benefits and mental health and substance use disorder benefits) of more than 2% for the first plan year and 1% for each subsequent plan year. If the exemption is claimed, a notification must be sent to plan participants and beneficiaries, the Secretary of Health and Human Services, and appropriate state agencies.

In addition to financial parity provisions, the new law requires the plan administrator to disclose the criteria for medical necessity determinations and the reason for any denial of reimbursement or payment for services made under the plan with respect to mental health or substance use disorder benefits.

The new law is effective for plan years beginning on or after October 3, 2009 (January 1, 2010 for calendar year plans). For collectively bargained plans, the law applies to plan years beginning on or after the later of January 1, 2009 or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after October 3, 2008).

Michelle's Law

Group health plans that extend coverage for dependents based on full-time student status must continue that coverage for one year (or until coverage would otherwise end for all dependents, regardless of student status, or earlier) if the dependent is on a medically necessary leave of absence from the educational institution. A medically necessary leave of absence is a leave of absence or other change in enrollment that (a) begins while the dependent is suffering from a severe illness or injury; (b) is certified by a physician as medically necessary; and (c) causes the dependent to lose student status under the terms of the group health plan.

When requesting certification of student status, a group health plan must describe the extension of coverage during a medical leave of absence. In addition, a summary of material modifications must be provided to plan participants describing the plan amendment that implements Michelle's Law.

Michelle's Law is effective for plan years beginning on or after October 9, 2009 (January 1, 2010 for calendar year plans).

If you have any questions about this memorandum, please contact Amelia M. Klein in our Albany office (518-533-3217, aklein@bsk.com) or any of the other members of our Employee Benefits and Executive Compensation Practice Group listed below.

In Central New York, call 315-218-8000 or e-mail:

Susan L. Dahline	sdahline@bsk.com
Stephen C. Daley	sdaley@bsk.com
Brian K. Haynes	bhaynes@bsk.com
Richard D. Hole	rhole@bsk.com
Ted Lewkowitz	tlewkowitz@bsk.com
Aaron M. Pierce	apierce@bsk.com

In Buffalo / Niagara Falls call 716-566-2800 or e-mail:

Darcie A. Falsioni	dfalsioni@bsk.com
John C. Godsoe	jgodsoe@bsk.com

On Long Island, call 516-267-6300 or e-mail:

Terry O'Neil	toneil@bsk.com
--------------	--

In New York City, call 646-253-2300 or e-mail:

Michael P. Collins	mcollins@bsk.com
--------------------	--

In the Rochester Region, call 585-362-4700 or e-mail:

Robert H. Kirchner	rkirchner@bsk.com
--------------------	--