



STANTON UNIVERSITY

2009 Benefits & Human Resources Compliance Update

Seminar Manual

November, 2009

Presented by



Gallagher Benefit Services, Inc.

t h i n k i n g a h e a d

Nov. 2009



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2009 Benefits & Human Resources Compliance Update

Seminar Learning Objectives/Outcomes

At the conclusion of the seminar, participants will be able to:

Apply key concepts of new and emerging regulatory compliance requirements related to COBRA, HIPAA, GINA, CHIPRA, MHPAEA, Section 125 Cafeteria Plans, Michelle's Law, HSA Comparability, ADA, FMLA, and the Lilly Ledbetter Fair Pay Act to improve their organizations' compliance

Chapter 1 COBRA

Important Dates

ARRA Passed: 2/17/09
 Effective Date: 2/17/09
 IRS Guidance: 3/31/09

ARRA Overview

The American Recovery and Reinvestment Act of 2009 (ARRA) makes a number of key changes to administrative requirements under COBRA and state continuation laws for group health plans. They include:

- Premium assistance subsidy of 65% to "Assistance Eligible Individuals" (AEIs), reimbursed to plans through credits on payroll taxes
- Extended election period to certain COBRA qualified beneficiaries
- "Plan enrollment option," or "buy-down"
- New model notices

Assistance Eligible Individual

The 65% premium assistance subsidy is available to "Assistance Eligible Individuals" (AEIs). An AEI is a COBRA qualified beneficiary (QB) who:

- Experienced a COBRA qualifying event that is *involuntary* termination,
- The event occurred between Sept. 1, 2008 and Dec. 31, 2009,
- *Is eligible for COBRA continuation coverage in this period, and*
- Elected COBRA

ARRA Sec. 3001(a)(3)

IRS Notice 2009-27
Q&A-10

Both the involuntary termination and eligibility for COBRA continuation coverage must occur during the period from Sept. 1, 2008 through Dec. 31, 2009. If the loss of coverage is after Dec. 31, 2009, the individual cannot become an AEI.

IRS Notice 2009-27
Q&A-13

An individual whose qualifying event occurred prior to Sept. 1, 2009, but whose COBRA continuation coverage would commence on or after Sept. 1, 2009 is *not* an AEI.

IRS Notice 2009-27
Q&A-12

If the employer provides health coverage for an involuntarily terminated employee on the same terms as for similarly situated active employees, the loss of coverage and commencement of COBRA depends on how the employer "treats" the situation:

IRS Notice 2009-27
Q&A-14

- The employer may treat the provision of coverage as deferring the loss of coverage - in this case, loss of coverage and eligibility for COBRA would occur when this provision of coverage ends
- The employer may treat the provision of coverage as part of its obligation to provide COBRA - in this case, the loss of coverage and eligibility for COBRA would occur when the employer begins making the provision of this COBRA coverage

Involuntary termination following a divorce or other qualifying event would not satisfy requirements to be an AEI.

IRS Notice 2009-27
Q&A-15

Both the involuntary termination and loss of coverage must occur during the period from Sept. 1, 2008 through Dec. 31, 2009.

IRS Notice 2009-27
Q&A-13

Involuntary Termination

Involuntary termination means:

A severance from employment due to the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services.

IRS Notice 2009-27
Q&As 1-9

Involuntary termination *includes*:

- An employee-initiated termination resulting from employer action that causes a material negative change in the employment relationship
- Voluntary termination or resignation where the employer would have terminated the employee's services and the employee had this knowledge
- Termination elected by the employee in return for a severance package where the employer indicates that a certain number of remaining employees will be terminated after the offer period
- Employer action to terminate employment while the individual is absent from work due to illness or disability
- Employer's failure to renew a contract at the time the contract expires if the employee was willing and able to execute a new contract with similar terms and conditions
- Layoff period with a right of recall, or a temporary furlough period
- Voluntary termination in response to an employer-imposed reduction in hours if this is a material negative change in the employment relationship
- Retirement, if the employer would have terminated the employee's services and the employee had this knowledge
- Termination for cause
- Resignation due to material change in geographic location of employment
- Employer-initiated lockout

Involuntary termination *does not include*:

- Death, divorce or dependent ineligibility
- Reduction in hours
- Absence from work due to illness or disability
- Termination due to gross misconduct
- Work stoppage due to strike initiated by employees or their representatives

Plans Eligible for ARRA Subsidy

Plans subject to COBRA are eligible for the ARRA subsidy, i.e., group health plans maintained by the employer under the COBRA provisions of ERISA, the Internal Revenue Code, or the PHSA.

ARRA Sec. 3001(A)(10)
 IRS Regs. §4980B-2,
 Q&A-1(a)
 IRS Regs. §4980B-2,
 Q&A-4

Also, continuation coverage provided under a State program that provides comparable continuation coverage.

Are eligible for subsidy:

- Health reimbursement arrangements (HRAs)
- Dental-only plans
- Vision-only plans
- "Mini-med" plans

Are not eligible for subsidy:

- Health flexible spending arrangements (HFSAs)
- Life insurance
- Disability insurance

IRS Notice 2009-27
 Q&As 27-29

Retiree coverage that does not differ from the coverage made available to similarly situated active employees.

Determination of Premium Subsidy Amount

The 35% share of the premium that must be paid by or on behalf of an AEI is the cost that would be charged to the AEI if the individual were not an AEI.

IRS Notice 2009-27
 Q&A-20

- If the AEI must normally pay 102% of the applicable premium, then he/she would be required to pay 35% of the 102%
- If the AEI must normally pay less than the maximum permissible COBRA premium (for instance, under a severance agreement where the employer subsidizes part of the premium), then the AEI would be required to pay 35% of amount actually charged to the AEI

Examples:

In both these examples, the "full" premium is \$980.39

In both these examples, the full COBRA premium is \$1,000 (102% of 980.39)

Example #1 - First 6 mos., employer continues coverage on the same terms as active employees, and recognizes loss of coverage *after* this period.

6/01/09	12/01/09	9/01/10
6 mos. - "non-COBRA" (No ARRA reimbursement) Employer "covers" \$680.39 Employee pays \$300 No ARRA reimbursement	9 mos. - COBRA (ARRA reimbursement period) Employer pays \$0 Employee pays \$350 Employer reimbursed for \$650	

Important Note: This situation may result in violation of an employer's plan terms - check with your GBS consultant, carrier and/or legal counsel.

Example #2 - First 6 mos., employer continues coverage on same terms as active employees, but offers COBRA *for* this period.

6/01/09	12/01/09	3/01/10
6 mos. - COBRA Employer pays "covers" \$680.39 Employee pays \$105 Employer reimbursed for \$195	3 mos. - COBRA ER pays \$0 EE pays \$350 ER reimb. \$650	

Premium “Bifurcation”

IRS Notice 2009-27
Q&A-23&25

In some cases, some individuals covered pursuant to COBRA in a given family unit may not be qualified beneficiaries. In this type of case, the premium reduction is not available to individuals who are not COBRA qualified beneficiaries.

Example:

Employee John and his children are covered under John’s employer’s plan. John was involuntarily terminated on November 20, 2009. He elected COBRA for himself and his children. On February 14, 2010, John marries Jane and adds Jane to his plan effective March 1, 2010. Jane is not a qualified beneficiary, and therefore not an AEI.

In this case, amounts paid for COBRA continuation coverage are allocated first to the cost of covering AEIs, and then to the cost of covering no-AEIs.

Examples - both presume a full COBRA premium of \$1000 for employee plus two or more family members:

Example #1 - John has two children on the plan

3 AEIs + 1 non-AEI

“Family premium” would apply with employee + 2 dependents

35% premium reduction applies to entire premium

Total premium payable = **\$350**

Example #2 - John has one child on the plan

2 AEIs + 1 non-AEI

Full EE + 1 COBRA premium = \$800

35% premium reduction applies to \$800

Total premium payable = **\$480** = (35% x \$800 + 100% x \$200)

Subsidy Period

The premium subsidy period applies as of the first period of coverage beginning on or after Feb. 17, 2009.

The subsidy period ends the earliest of:

- The first date the AEI becomes eligible for other group coverage or Medicare coverage
- The date that is nine months after the first day of the first month for which ARRA premium reduction apply
- The date the individual ceases to be eligible for COBRA (i.e., the individual fails to timely pay the required premium)

IRS Notice 2009-27
Q&A-33

The subsidy period ends when the AEI becomes eligible for other group coverage or Medicare regardless of whether or not the AEI actually enrolls. This would occur on the date coverage can take effect - i.e., at the end of a waiting period.

IRS Notice 2009-27
Q&A-35

Examples:

- The AEI starts a new job and becomes eligible for coverage through the new employer
- The AEI's spouse is employed and his/her employer provides health coverage (HIPAA special enrollment)
- The AEI's spouse starts a new job and his/her employer provides health coverage

IRS Notice 2009-27
Q&A-36

For retirees, the subsidy period would end if the employer offered retiree coverage that is not COBRA continuation coverage (under a different group health plan than the one under which COBRA continuation is being offered).

As of the date that the subsidized COBRA premium is received, the plan is entitled to reimbursement of the subsidy amount from the federal government.

For plans subject to COBRA, the employer maintaining the plan applies for reimbursement of the subsidy through claiming a credit against its payroll tax liabilities, usually filed quarterly. For this purpose, payroll taxes are defined as

- Federal income tax withholding
- Employee share of FICA tax
- Employer share of FICA tax

Internal Revenue Code
§ 6432
IRS Notice 2009-27
"Background"

Documentation, using Form 941, required to claim the reimbursement includes:

- Amount of taxes offset for the current period
- Estimate of expected offset for next period
- Tax ID number (Social Security number) of all covered former employees
- Amount of assistance for each former employee and qualified beneficiaries covered with him/her pursuant to COBRA
- Designation for each former employee whether coverage is single or family coverage

H.R. 3930

H.R. 3930

H.R. 3930 would make several key changes to COBRA and the ARRA COBRA subsidy - this bill would:

- Extend COBRA for individuals who experienced an “involuntary termination” COBRA qualifying event from 18 to 24 months. The period within which the qualified beneficiary’s COBRA event must occur for this extension to apply is unclear, given the ambiguity of the bill’s language.
- Extend the ARRA subsidy eligibility period to include individuals who experience an “involuntary termination” COBRA qualifying event up to June 30, 2010.
- Extend the maximum period of the ARRA COBRA premium assistance from nine months to fifteen months, not to extend past Dec.31, 2010.

Chapter 2 Health Insurance Portability & Accountability

Overview of ARRA "HITECH" Changes

Under the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), a number of significant changes were made to the Health Insurance Portability and Accountability Act privacy provisions. They include:

- Notification requirements in the event of a breach of unsecured PHI
- Privacy and security standards will be applicable to business associates
- A right for individuals to receive an accounting of protected health information (PHI) disclosures made by a covered entity from an electronic health record
- Heightened enforcement
- Guidance on a "minimum necessary" standard

Important Dates

ARRA Passed:	2/17/09
Effective Date:	Various
Breach Regs:	8/24/09

Breach Notification Requirements

On August 24, 2009, the U.S. Dept. of Health and Human Services (HHS) issued interim final regulations implementing HIPAA privacy breach notification requirements. These regulations provide guidance on these areas:

- What constitutes a "breach"
- To whom breach notification must be sent
- What information must be included in a notification
- When and how notices must be provided

45 CFR Parts 160 and 164, 74 Fed. Reg. 42740

Effective date of breach notification requirements: Sept. 23, 2009

Breach Definition

Under the regulations, a breach is defined as:

"The unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of the protected health information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information."

ARRA/HITECH requires notifications only when a covered entity or business associate experiences a breach of "unsecured" PHI. Unsecured PHI is PHI that is not secured through the use of a technology or methodology specified by HHS (i.e., encryption), or by destruction. Encryption, using specific National Institute of Standards and Technology (NIST) standards, is an "addressable" implementation specification under HIPAA security rules. "Redaction" is not an accepted alternative method to secure paper-based PHI.

Breach Definition (continued)

HHS's guidance provides the following regarding what constitutes a breach that triggers the notification requirement:

- The information breached must be PHI - de-identified information is not PHI.
- There must have been an unauthorized acquisition, access, use or disclosure of the PHI (i.e., not permitted under HIPAA privacy rules). It may be possible for a use or disclosure involving more than the minimum necessary information to qualify as a breach.
- The acquisition, access, use or disclosure must have "compromised" the security or privacy of the PHI. HHS defines the "compromised" standard as possessing "a significant risk of financial, reputational, or other harm to the individual." The covered entity or business associate will need to perform a risk assessment after a breach to determine if this has occurred. The risk assessment will likely need to consider the type and amount of PHI involved, who accessed the information, and the nature of the PHI, among other factors.

ARRA includes three exceptions to the breach rule in which a HIPAA privacy violation will have occurred, but the violation would not be considered a "breach" requiring notification:

- Unintentional acquisition, access or use of PHI made in good faith by an employee acting under the authority of a covered entity or business associate and within the course and scope of employment or other professional relationship, where there is no further use or disclosure.
- Inadvertent disclosure of PHI from a person who is authorized to access PHI at a facility to another similarly situated person authorized to access PHI at the same facility (or the same covered entity or a business associate) if the information is not further used or disclosed without authorization.
- The unauthorized person to whom PHI has been disclosed would not reasonably have been able to retain the information.

The covered entity has the burden of proof in making the determination as to whether or not a HIPAA privacy violation constitutes a breach requiring notification, and is required to document its risk assessment and findings.

To Whom Breach Notification Must Be Sent

In the event of a breach, the covered entity is required to send notices to affected individuals and HHS.

Individual Notifications. Following discovery of the breach of unsecured PHI, the covered entity must notify every individual whose unsecured PHI has been (or is reasonably believed by the covered entity to have been) accessed, acquired, used or disclosed.

HHS Regs. §164.404

Notification to Prominent Media Outlets. If the breach involves more than 500 individuals in a single state or jurisdiction, the covered entity is required to notify prominent media outlets where affected individuals likely reside.

HHS Regs. §164.406

Additional details:

- If the breach involves more than 500 individuals who live in different jurisdictions, media notification is not required.
- What constitutes “prominent” will differ depending on the state or jurisdiction involved. For instance, it could be a major general interest newspaper or a major television station. For larger geographical areas, the outlet must serve the larger area. In some cases, more than one media outlet will need to be notified.
- “Jurisdiction” is a geographic area smaller than a state, such as a county, city or town.

Notification to HHS. All breaches must be reported to HHS. If fewer than 500 individuals are affected, the covered entity must keep a log and report the breach within 60 days of the end of the calendar year. If 500 or more individuals are affected, the covered entity must report the breach as soon as reasonably possible.

HHS Regs. §164.408

What Must Be Included in Individual Notices

Notices must be in “plain language” and contain these items:

- A brief description of what happened, including the date of the breach and the date of the discovery of the breach (if known)
- A description of the types of unsecured protected health information that were involved in the breach
- Any steps individuals should take to protect themselves from potential harm resulting from the breach
- A description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches
- Contact procedures for individuals to ask questions or learn additional information, which must include a toll-free number, an e-mail address, website, or postal address

HHS Regs. §164.404

Notices to HHS

Communication to HHS should be via the online form available at:

HHS Regs. §164.408

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html>

Five sections must be completed, including information on:

- Whether the breach affected 500 or more individuals or fewer than 500 individuals, and whether the form is an initial breach report or an addendum to a previous report.
- Information about the covered entity or business associate.
- Information about the breach, including its date, the date of discovery, the type of breach, the location of the breached information, the type of PHI involved, a brief description of the breach, and the safeguards in place prior to the breach.
- The date that individual notice was provided, as well as whether substitute and media notices were required, the actions taken in response to the breach, and a description of any other actions taken.
- An attestation of the person completing the form for the covered entity.

When Notices Must be Provided

HHS Regs. §164.404

Covered entities are permitted to take a “reasonable” amount of time to investigate breach circumstances, conduct a risk assessment, determine whether a notification-requiring breach has occurred, and collect relevant information. Individual notices must be provided “without unreasonable delay” and in no case later than 60 calendar days after the breach is discovered. Multiple notices may need to be sent, as information becomes available.

Breaches are treated as having been “discovered” on the first day that the breach is known by any person in the covered entity’s workforce, or by exercising reasonable diligence would have been known.

Covered entities should establish procedures to report incidents and to ensure that workforce members are adequately trained and aware of the importance of timely reporting.

How Notices Are to Be Provided

HHS Regs. §164.404

Individual notices. Individual notices must be sent via first class mail to the individual’s last known address. Written notice may be provided in the form of electronic mail, provided the individual agrees to receive electronic notice (and has not withdrawn agreement).

If the individual is a minor or lacks legal capacity due to a physical or mental condition, the notice may be sent to the parent or other person who is the personal representative of the individual.

How Notices Are to Be Provided (continued)

If the individual is deceased, notice must be sent to the last known address of the next of kin or a personal representative who has the authority to act on behalf of the decedent or the decedent's estate if the covered entity has contact information for that person rather than next of kin.

Insufficient contact information. In these cases, or where notices are returned as undeliverable, the covered entity is permitted to use a substitute form for the notice. Substitute notice must have the same contents and should be provided as soon as reasonably possible after the covered entity realizes that it has incomplete or out of date information. Substitute notice is not required for next of kin of a deceased individual if the covered entity has out of date or no contact information. If there are fewer than 10 individuals for whom the covered entity has incomplete or out of date address information, the covered entity may use an alternative form to provide notification such as telephone or e-mail depending on the information available to the covered entity.

Incomplete or out of date contact information. If this is the case for 10 or more individuals, then substitute notice must be provided through a conspicuous posting on the covered entity's web site. The posting must be on the home page or provide a prominent hyperlink to the notice on its home page and must include a toll free number for individuals to call with questions or to get more information. The hyperlink should be noticeable and worded to convey the nature and importance of the information. The notice may be located in the login page for existing account holders. The link must be on the web site for at least 90 days. If the covered entity does not have (or prefers not to use) a website, it may post the notice in major print or broadcast media where affected individuals are likely to reside. The notice must be continued for at least 90 days and include the toll free number.

Urgent situations. In urgent situations where there is a possible imminent misuse of the unsecured protected health information, the covered entity may also provide notice by other means such as telephone. This notice must be in addition to the written notice sent via first class mail.

Notification by a business associate. Business associates are required to notify a covered entity in the event of a breach of unsecured protected health information. Covered entities and business associates should determine when and how the required reporting will be accomplished. Procedures and time frames agreed upon will need to be incorporated into business associate agreements.

The business associate must provide the covered entity with the names of affected individuals to the extent the business associate has that information. Business associates are required to provide the covered entity with other information which the covered entity will need for the required notices. Covered entities and business associates are expected to continue to specify (in their written agreements) obligations such as when, how and to whom a breach will be reported and who will send the individual notifications.

Privacy/Security Standards and Business Associates

Effective date
February 17, 2010

Some HIPAA privacy requirements, and many HIPAA security standards, will be directly applicable to business associates, just as they presently apply to covered entities. Likewise, civil and criminal penalties for violating standards will also be directly applicable to business associates.

Accounting for Disclosure of Electronic Health Records

Effective dates
January 1, 2014
for covered entities
with EHRs
otherwise,
January 11, 2011
or date EHR acquired

An "electronic health record" is defined as an electronic record of health-related information on an individual that is created, gathered, managed and consulted by authorized health care clinicians and staff. (A health plan can have an electronic health record if the record is consulted or managed by health care staff working for the plan that performs activities such as utilization review, disease management, etc.)

Covered entities using electronic health records may be required by the subject of a record to provide an accounting of disclosures for treatment, payment or health care operations, covering the three-year period prior to the request.

HIPAA Enforcement

HITECH enforcement
provisions effective
February 18, 2010
Regulations issued
Oct. 30, 2009
Regulations effective
November 30, 2009

HITECH strengthens the civil and criminal enforcement of the HIPAA rules by:

- Establishing four categories of violations with increasing levels of culpability
- Establishing four corresponding tiers of penalty amounts that significantly increase the minimum penalty amount for each violation
- Establishing a maximum penalty amount of \$1.5 million for all violations of an identical provision
- Eliminating the bar on the imposition of penalties if the covered entity did not know and with the exercise of reasonable diligence would not have known of the violation
- Providing a prohibition on the imposition of penalties for any violation that is corrected within a 30-day time period, as long as the violation was not due to willful neglect.

"Minimum Necessary" Standard

Guidance expected by
August 17, 2010

Guidance is to be provided in 2010 on what constitutes the "minimum necessary" in connection with the use, disclosure, or request of PHI. Until that guidance is issued, the Act provides that covered entities and business associates should, to the extent practicable, limit the use, disclosure, or request of PHI to a limited data set or, if needed, to the minimum necessary to accomplish the intended purpose.

Chapter 3 Genetic Information Nondiscrimination Act

Overview

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits the use of genetic information in health insurance and employment. It prohibits group health plans and health insurers from denying coverage to a healthy individual or charging that person higher premiums based solely on a genetic predisposition to developing a disease in the future. The legislation also bars employers from using individuals' genetic information when making hiring, firing, job placement, or promotion decisions.

Important Dates

Statute Passed:	5/21/08
Effective Date:	Various
Regs Issued:	10/07/09 3/02/09

GINA and Health Plans

Regulations issued Oct. 7, 2009 by Treasury (IRS), Health & Human Services (HHS) and Labor (DOL) describe how group health plans and health insurance carriers are prohibited from discriminating on the basis of genetic information.

The interim final rules apply to group health plans for plan years beginning on or after December 7, 2009.

The rules implement GINA's group and individual market requirements, which generally parallel one another. Generally speaking, the term "genetic information" includes family medical history.

Three categories of activities are prohibited:

- Collecting genetic information either for underwriting purposes or prior to, or in connection with, health plan enrollment;
- Requesting or requiring genetic tests; and
- Adjusting group insurance premium or contribution rates.

Regulations:

IRS -
 § 54.9802-1
 § 54.9802-3T
 § 54.9831-1

DOL -
 § 2590.701-1
 § 2590.702
 § 2590.732

Health Plans Affected

The prohibitions under GINA apply to all group health plans. Going beyond HIPAA requirements, GINA protections also apply to self-funded nonfederal government plans (there is no opt-out option), and plans covering fewer than 2 current employees.

HHS -
 §144.101
 §146.101
 §146.121
 §146.122
 §146.145
 §146.180

The regulations clarify that the regulatory agencies "expect that most of the cost of complying with GINA and these regulations will be concentrated among the . . . group health plans that are associated with wellness and disease management programs that provide rewards and incentives to employees" that complete health risk assessments.

Prohibition Against Collecting Genetic Information

Group health plans and carriers are not permitted to collect genetic information prior to or in connection with enrollment or for underwriting purposes.

Information is considered collected “prior to enrollment” if it is collected before the individual’s effective date of coverage. “Enrollment date” is defined as “the first day of coverage under the plan or, if there is a waiting period, the first day of the waiting period.” Therefore, when a request for genetic information is permitted is based on whether the plan has a waiting period and, as to other enrollment times, when coverage is effective.

The rule applies to all types of enrollment:

- initial eligibility; or
- annual enrollment; or
- enrollment based on a change in status such as a HIPAA special enrollment.

However, information collected after any specific enrollment would not be considered “prior to enrollment” in a subsequent enrollment (e.g., the next annual enrollment) unless the information is (or will) be used to affect that later enrollment.

Incidental collection. There is an exception for genetic information that is collected “incidental” to the collection of other information, provided the information is not used for underwriting purposes. The collection request should explicitly state that genetic information should not be provided, as in this example: *“In answering this question, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease for which you believe you may be at risk.”*

Wellness programs that provide rewards for completing health risk assessments and request genetic information (including family medical history) violate the prohibition against requesting genetic information for “underwriting purposes.” A group health plan or carrier may collect genetic information as part of a health risk assessment as long as:

- No rewards are provided and
- The request is not made prior to or in connection with enrollment.

A group health plan may also provide rewards for completing a health risk assessment as long as the health risk assessment does not collect genetic information.

Requesting or Requiring Genetic Tests

Group health plans and carriers are not permitted to request or require an individual or a family member of the individual to undergo a genetic test. There are three exceptions to this rule, two of which do not affect group health plans. The third exception is that a plan or carrier may require genetic information if it is necessary to determine payment under the plan.

For example, if a medical service is covered under the plan based on medical appropriateness and the medical appropriateness of the service depends on the genetic makeup of the patient, the plan is permitted to condition payment for the service on the outcome of a genetic test. The plan may also refuse payment if the patient does not undergo the genetic test. However, the plan is permitted to request only the minimum amount of information needed to make a payment determination.

Adjusting Group Insurance Premium or Contribution Rates

GINA prohibits adjusting premiums based on genetic information. Carriers are still permitted to adjust premiums for an entire group based on the “manifestation” of a disease or disorder by an individual or individuals within the group. However, if one person in the group, such as an employee, manifests a disease or disorder and that employee has covered dependents, the carrier may not use the employee’s “manifestation” of a disorder that may be genetically passed on to his children as a risk factor to further adjust premiums for dependents unless those dependents also manifest the disease or disorder.

Similarly, group health plans may not adjust a participant’s contributions (or benefits such as increasing deductibles) based on genetic information.

It is unlikely that this will impact most employer-sponsored plans since most group health plans are already prohibited from discriminating based on eight health factors - one of which is genetic information. This may affect some self-funded nonfederal governmental plans (those that have opted out of some HIPAA requirements).

GINA's Employment Nondiscrimination Requirements

EEOC Regs. §1635

The proposed regulations do not specify an effective date. The EEOC is required to issue final regulations by May 21, 2009. The effective date of the statutory employment nondiscrimination requirements is November 21, 2009.

The EEOC issued proposed regulations on March 2, 2009 that address GINA's employment nondiscrimination requirements. These requirements prohibit use of genetic information in employment decisionmaking, restrict deliberate acquisition of genetic information, require that genetic information be maintained as a confidential medical record, and place limits on the disclosure of genetic information.

Employers are prohibited from discriminating against an individual on the basis of genetic information in regard to hiring, discharge, compensation, terms, conditions, or privileges of employment. Similar to the ADA, employers may not limit, segregate, or classify individuals because of genetic information in a way that might deprive them of employment opportunities. However, disparate impact claims will not be available under GINA.

An employer may not acquire genetic information except when an employer

- Inadvertently requests or requires genetic information of the individual or family member
- Offers health or genetic services, including those offered as part of a voluntary wellness program
- Requests family history to comply with the FMLA certification provisions or state or local family and medical leave laws
- Acquires genetic information from documents that are commercially or publicly available for review or purchase
- Acquires genetic information for use in genetic monitoring of the biological effects of toxic substances in the workplace
- Conducts DNA analysis for law enforcement purposes

The ADA permits disability-related inquiries and medical examinations as part of a voluntary wellness program. A wellness program is voluntary if employees are neither required to participate nor penalized for non-participation. At a recent meeting of the American Bar Association's Joint Committee on Employee Benefits, EEOC staff members indicated that the EEOC has not taken a position as to what level of inducement would make an inquiry involuntary.

A recent EEOC informal discussion letter addresses whether an employer's requirement that employees complete a health risk assessment in order to receive medical expense reimbursements from the employer's health reimbursement arrangement violates the ADA. Requiring all employees to complete a health risk assessment that includes disability-related inquiries as a prerequisite to obtaining health reimbursement arrangement reimbursements "does not appear to be job-related and consistent with business necessity" and would therefore violate the ADA.

EEOC Poster

The EEOC has revised its "Equal Employment Opportunity is the Law" poster. The new version has been updated to reflect current federal employment discrimination law, including GINA and the ADA. The revised poster also includes updates from the Department of Labor.

Chapter 4 Children's Health Insurance Program Reauthorization Act of 2009

Important Dates

Statute Passed: 2/04/09
Effective Date: 4/01/09
Regs Issued: None

Overview

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) includes several provisions that impact employers, group health plans, and group health insurance carriers. Employers with plans subject to ERISA as well as church plans will be required to comply. Self-funded non-federal government plans may make an annual election to opt out subject to HIPAA rules.

Special Enrollment Entitlement

Group health plans and health insurance carriers are required to permit an employee (or dependent of the employee) who is eligible, but not enrolled for coverage to enroll for coverage if:

- The employee (or dependent) is covered under a Medicaid or CHIP plan and coverage is terminated as the result of the loss of eligibility for Medicaid or CHIP coverage; or
- The employee (or dependent) becomes eligible for premium assistance to purchase coverage under the group health plan under the applicable state Medicaid or CHIP plan and the employee requests coverage no later than 60 days after the date eligibility is lost or the date the employee (or dependents) is determined to be eligible for state premium assistance.

Notice to Employees

Employers maintaining group health plans in states that provide premium assistance through either Medicaid or a CHIP program will be required to provide employees with a new state-specific notice informing them of

- The availability of assistance
- How an employee may contact the appropriate agency and how to apply for assistance.

The employer may provide this notice along with other plan information as part of:

- Providing initial plan eligibility and coverage information
- During the annual open enrollment
- When furnishing the Summary Plan Description as required by ERISA

Employers will be required to provide these notices to employees beginning on the first day of the first plan year after model notices are issued by the Departments of Labor and Health and Human Services, in consultation with directors of state Medicaid and CHIP agencies. These agencies have been given until February 4, 2010 to develop model notices.

Coverage Coordination Disclosure to States

Upon request, group health plan administrators will be required to disclose to the appropriate state agency information about benefits available under the group health plan. The information disclosed must be sufficient for the State agency to:

- Determine the cost-effectiveness of providing medical or child health assistance through premium assistance to purchase coverage under the group health plan
- Provide any state required supplemental benefits.

The Departments Labor and Health and Human Services have been directed to create a working group that will have until September 1, 2010 to provide a report, including a model disclosure form to be used for this purpose. Group health plan administrators will be required to begin using these model forms starting with the first plan year beginning on or after the date the model coverage coordination disclosure form is first issued.

The model form will include the following information:

- A determination of whether the employee is eligible for coverage under the group health plan.
- The name and contact information of the group health plan administrator.
- The benefits offered under the plan.
- The premium and cost-sharing required under the plan.
- Any other information relevant to coverage under the plan.
- Any information that the working group determines is appropriate.

Chapter 5 Mental Health Parity and Addiction Equity Act

Overview

As part of the emergency economic recovery bill passed in 2008, the MHPAEA adds significant new parity protections under a group health plan including:

- Adds protection for substance use disorder benefits on the same basis as the protections for mental health benefits;
- Prohibits differences in copays, deductibles, coinsurance and out-of-pocket costs for mental health and substance use disorder benefits as are applied to medical/surgical benefits;
- Prohibits the use of day or visit limits for mental health and substance use disorder benefits that are more restrictive than treatment limitations applied to medical/surgical benefits; and
- Adds new requirements for employers seeking a cost exemption.

The new requirements will be effective on the first day of the first plan year starting on or after Oct. 4, 2009. In an October 2, 2009 letter to Senator Al Franken, Health and Human Services Secretary Kathleen Sebelius reports that the goal is to issue regulations by January 2010 that will "make it easier for health plans and issuers to take crucial steps toward full implementation of the protections of MHPAEA."

Substance Use Disorders

The MHPAEA does not require group health plans to provide substance use benefits, but if provided, they are subject to MHPA parity requirements. Plan sponsors have substantial discretion here, however many states have insurance mandates requiring coverage for substance abuse benefits.

Financial Requirements

Financial requirements such as deductibles, copayments and out-of-pocket limits must be the same for mental health and substance use disorder benefits (if provided) as they are for medical and surgical benefits. The plan's cost sharing provisions cannot be separate requirements that are applicable only to mental health or substance use disorder benefits.

Treatment Limitations

Treatment limitations such as number of visits or days of coverage applicable to mental health or substance use disorder benefits must be the same as the treatment limitations applied to medical and surgical benefits covered by the plan. The plan cannot have separate treatment limitations that are applicable only to mental health or substance use disorder benefits.

Important Dates

Statute Passed: 10/03/08

Effective Date: Various

Regs Issued: None

On December 23, 2008, President Obama signed into law a technical correction which clarifies that the mental health parity requirements will not apply to group health plans maintained pursuant to a collective bargaining agreement until the later of

- The date on which the last of the collective bargaining agreements relating to the plan terminates (without regard to any extension agreed to after October 3, 2008), or
- January 1, 2010.

Out-of-Network Providers

Plans that provide benefits for mental health and/or substance use disorders must provide coverage for services rendered by out-of-network providers on the same basis that medical and surgical benefits are provided for out-of-network providers.

Medical Necessity

If a plan covering mental health or substance use disorders uses a medical necessity standard for determining benefits, the criteria for those determinations must be available to the participant, the participant's spouse or dependents, or the provider upon request.

If the plan denies services for mental health or substance use disorders, the reason for the denial must be made available to the participant or the participant's spouse or dependents upon request.

Small Employer Exemption

Small employers remain exempt from the mental health parity requirements. The term "small employer" refers to 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. The MHPAEA makes a minor change to this definition. It deletes the requirement that the employer must employ at least 2 employees on the first day of the plan year and adds that the definition of small employer will also include employers in a state that permits small groups to include a single individual.

The aggregation rules for related employers of a controlled group under Internal Revenue Code Section 414 apply in determining the number of employees employed by a single employer.

Cost Exemption

Plans must comply for at least the first 6 months of the plan year to assess the cost impact before seeking an exemption. In the first year, if implementing the requirements of the MHPAEA results in an increase of more than 2% of total costs of all benefits under the plan (not just mental health or substance use disorder benefits), the plan may claim an exemption from the requirements for the following plan year. In subsequent years, if implementing the requirements results in an increase in total costs of more than 1%, the plan may claim an exemption for the following plan year.

The cost increase must be certified in a written report by an actuary. The report must be retained for at least 6 years. The plan must notify plan participants and beneficiaries, the appropriate state agencies, and the U.S. Dept. of Labor (ERISA plans) or the U.S. Dept. of Health & Human Services (non-ERISA plans).

Chapter 6 Section 125 Cafeteria Plans

Important Dates

Statute Passed: 1978
 Effective Date: Various
 Regs Issued: 8/06/07

Final Regulations

New proposed regulations on general cafeteria plan administration, qualified benefits, elections, flexible spending arrangements, expense substantiation and nondiscrimination were issued in 2007. These regulations were expected to be finalized by mid-year 2009. However, the IRS has not yet issued these final regulations. The proposed regulations are effective for plan years beginning on or after January 1, 2009 and may be relied upon pending the issuance of final regulations.

Red Flag Rule

The federal Identity Theft Red Flags Rule requires that certain businesses and organizations develop and implement identify theft prevention programs designed to detect warning signs of possible identity theft, and take action to reduce the risk of identity theft. The Rule applies to financial institutions and creditors with covered accounts.

The Rule was promulgated under the Fair and Accurate Credit Transactions Act, in which Congress directed the FTC and other agencies to develop regulations requiring "creditors" and "financial institutions" to address the risk of identity theft.

The Red Flags Rule requires a written program containing four elements:

- Reasonable policies and procedures to identify activities, patterns, or practices that indicate the possibility of identity theft.
- A design feature that detects red flags that the entity has identified.
- Actions that will be taken when red flags are detected.
- Periodic reevaluation of the program to assess possible new identity theft risks.

The definitions of terms like financial institutions and creditors are not clear. This, and other issues, prompted the FTC to announce a delay in the enforcement of the rule. Originally effective on January 1, 2008, full compliance was not required until August 1, 2009; the FTC first delayed enforcement to November 1, 2009, and on October 30, 2009, further delayed enforcement to June 1, 2010.

The FTC's answers to "frequently asked questions" include these comments:

- Neither the employer sponsoring a health flexible spending arrangement nor a third-party administrator administering it becomes a "creditor" under this Rule (even though the uniform coverage rule results in, in some cases, employees receiving reimbursements that exceed their contributions).
- An employer that administers a flexible spending account and gives "customers" a debit card to access benefits would be considered a financial institution subject to the rule.

The Rule is also unclear regarding debit cards with health FSAs and HSAs - if these activities trigger the application of the rule, is it the plan sponsor, the third party administrator, or another involved entity that is responsible for implementation of the Rule?

Imputing Income

Under the 2008 proposed regulations, the IRS clarified that it is permissible for a cafeteria plan to allow an employee to elect health coverage for an individual who is not the employee's spouse or tax dependent. In this situation, the benefit attributable to the non-tax-dependent is taxable to the employee. This is typically accomplished by "imputing" the fair market value of the coverage to the employee as regular (taxable) income.

ABA Joint Committee
on Employee Benefits,
Meeting with IRS and
Treasury Department
Officials
May 7-9, 2009

At a meeting of the American Bar Association's Joint Committee on Employee Benefits, IRS officials were asked about an employer's procedure of imputing income equal to the fair market value of coverage, using the actuarially determined applicable COBRA premium.

The IRS officials clarified that imputing income would avoid the implications of Internal Revenue Code Sec. 105 nondiscrimination rules and result in tax-advantaged benefits for employees. However, the officials declined to express an opinion on how fair market value should be determined. They did, however, note that the fair market value of a non-tax dependent's coverage must be included in the employee's income, even if adding the non-tax dependent does not change the overall cost of coverage.

Over-the-Counter Items

IRS Information Letter
July 14, 2009

A July (2009) IRS information letter provides insight on various over-the-counter items and whether or not they may be reimbursed by a health flexible spending arrangement or health reimbursement arrangement.

- Sunscreen, medical-grade face masks, skin products, anti-bacterial hand sanitizers, fluoride rinses, petroleum jelly, fiber supplements, or probiotics that are used to maintain general health are considered personal items, not medical care. However, if it can be shown that such items are being used to treat or alleviate a disease or injury, and would not have been purchased "but for" the disease or illness, they may qualify as medical care.
- Treatments for acne, incontinence, arthritis, constipation, colds and sinus problems, dehydration, indigestion and eczema most likely will qualify as medical care expenses because they have no purpose but to treat existing conditions. Also, support braces and shoe inserts for injured or weakened body parts as well as wheelchair cushions may also qualify as medical expenses.
- The excess cost of an otherwise personal item that is specially designed to treat or alleviate a medical condition, such as the excess cost for diabetic socks, compression hose, or orthopedic shoes may be an allowable medical expense; however they may also have a personal or preventative use.
- The cost of food that substitutes for the food an individual would normally consume to meet nutritional requirements does not qualify as a medical expense. Whether food thickeners constitute a medical care expense is a question of fact that must be determined on a case-by-case basis.

Chapter 7 Michelle's Law

Important Dates

Statute Passed: 10/09/08
Effective Date: Various
Regs Issued: None

Overview

Michelle's Law applies to health plans governed by ERISA, the Internal Revenue Code and the Public Health Services Act. It allows seriously ill college students covered as dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The law is effective for plan years beginning on or after October 9, 2009 and to medically necessary leaves of absence beginning during such plan years.

No regulations or other agency guidance has been issued interpreting the requirements of Michelle's Law other than final regulations on excise tax reporting.

Medically Necessary Leave of Absence

The extension of coverage applies to a dependent child's leave of absence from, or any other change in enrollment at, a postsecondary educational institution on account of a serious illness or injury from which the child is suffering while covered under a health plan that would otherwise cause the child to lose dependent status for purposes of coverage.

Definition of Dependent Child

The child must be enrolled as a dependent under a health plan and qualify for coverage on the basis of being a student at a postsecondary educational institution, immediately before the medically necessary leave of absence involved.

Length of Continued Coverage

The extension of coverage continues until the earlier of:

- One year from the start of the medically necessary leave of absence, or
- The date on which coverage would otherwise terminate under the terms of the health plan

Certification by Physician

Written certification must be provided by a treating physician of the child certifying that he/she is suffering from a serious illness or injury that would require a medically necessary leave of absence.

Notice

The health plan (and a health insurance issuer providing coverage in connection with a health plan) is required to provide notification, in plain language, describing the terms of the continued coverage available under this law. This notification should be included with any notice regarding a requirement for certification of student status for coverage under the plan.

Benefits & Coverage

A dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to dependent children under the plan.

Chapter 8 Health Savings Account Comparability

Final Regulations

On Sept. 8, 2009, the Internal Revenue Service issued final regulations on Health Savings Account (HSA) comparability rules, finalizing guidance provided in 2008 regarding employer contributions to employees' HSAs. The final comparability regulations apply to employer contributions made for calendar years beginning on or after January 1, 2010.

The final regulations reflect changes to the HSA comparability rules made by the Tax Relief and Health Care Act of 2008 (TRHCA). Key provisions include:

- An employer may make larger annual HSA contributions for non-Highly-Compensated Employees (HCEs) than for HCEs who are within the same group of comparable participating employees. However, comparable contributions are required for all non-HCEs who are within the same group and for all HCEs who are within the same group.
- An employer may make a full year's worth of HSA contributions under TRHCA's full-contribution rule for mid-year eligible individuals, as long as contributions are made on an equal and uniform basis for all comparable mid-year eligible individuals.
- An employer may make a larger HSA contribution for employees with a higher tier of family HDHP coverage than to those with a lower tier (for instance, self-plus-two is a higher tier than self-plus-one) even if all the employees in the higher tier are HCEs and all the employees in the lower tier are non-HCEs.
- An employer that offers qualified HSA distributions (a.k.a., direct rollovers to HSAs from health flexible spending arrangements or health reimbursement arrangements) to any eligible employee covered under any high-deductible health plan, the employer must offer qualified HSA distributions to all such employees. An employer may limit qualified HSA distributions to eligible employees who are covered under the employer's HDHP.

Important Dates

Statute Passed: 12/09/06
 Effective Date: Various
 Regs Issued: 9/08/09

§ 54.4980B-2
 § 54.4980D-1
 § 54.4980E-1
 § 54.4980G-1
 § 54.4980G-3
 § 54.4980G-4
 § 54.4980G-6
 § 54.4980G-7

Exemption from Comparability Rules

The HSA comparability rules do not apply to employer HSA contributions made “through a cafeteria plan.” Comparability regulations clarify that employer contributions to an employee's HSA are made “through a cafeteria plan” if, under the terms of the written cafeteria plan, the employees have the right to elect to receive cash or other taxable benefits in lieu of all or a portion of an HSA contribution (i.e., that all or a portion of the HSA contributions are available as pre-tax salary reduction amounts), regardless of whether any employee actually elects to contribute any amount to his/her HSA by salary reduction.

Therefore, all employer HSA contributions (including any nonelective employer contributions and any flex credits, whether cashable or noncashable) should be considered as made “through a cafeteria plan” when HSAs can be funded by additional pre-tax salary reductions (i.e., when there is a salary reduction option for HSA contributions under the cafeteria plan for eligible participants).

Chapter 9 Americans with Disabilities Act

Important Dates

ADAAA Passed: 9/25/08
 Effective Date: 1/01/09
 Regs Issued: 9/23/09

The ADAAA's Intent

"The question of whether an individual's impairment is a disability under the ADA should not demand extensive analysis." - Congress

The ADAAA's intent is to shift the focus in ADA cases from whether an individual meets certain criteria to whether there is a need for an accommodation.

"Substantially Limits" Standard

The ADAA directs courts and agencies to *reject* the standard created by the U.S. Supreme Court in *Toyota v. Williams* in which it was determined that in order to be "substantially limited," an "individual must have an impairment that *prevents or severely restricts* the individual from doing activities that are of central importance to most people's daily lives." (emphasis added)

EEOC Regulations
 § 1630.1 - § 1630.10

The Act provides that "[t]he definition of disability in this Act shall be construed in favor of broad coverage of individuals under this act to the maximum extent permitted by the terms of this Act." The proposed regulations' guidance on this issue is a statement that a common-sense standard should be used, without resort to scientific or medical evidence.

A substantial limitation of a major life activity need not be permanent. Even impairments that are expected to last for fewer than six months can meet this standard.

The regulations identify impairments that will consistently meet the definition of disability (though this list is not exhaustive):

Deafness	Blindness	Intellectual disability
Missing limbs	Autism	Cancer
Cerebral palsy	Diabetes	Epilepsy
HIV or AIDS	Multiple sclerosis	Muscular dystrophy
Mobility impairments requiring the use of a wheelchair		
Psychiatric disorders such as major depression, bipolar disorder, post-traumatic stress disorder, obsessive-compulsive disorder, and schizophrenia		

Regulations also list examples of impairments that may be disabling for some individuals, but not for others, such as: asthma, high blood pressure, learning disabilities, back or leg impairments, psychiatric impairments such as panic disorder, anxiety disorder or forms of depression other than major depression, carpal tunnel syndrome and hyperthyroidism.

Temporary, non-chronic impairments of short duration with little or no residual effects are usually not disabilities, such as the common cold, seasonal or common influenza, a sprained joint, minor and non-chronic gastrointestinal disorders, and a broken bone that is expected to heal completely.

Episodic or In Remission

An impairment that is episodic or in remission must be considered a disability so long as that impairment, in its active state, would be substantially limiting.

Major Life Activities

Major life activities include:

Prior to the passage of the ADAAA, a “major life activity” was understood to be an everyday activity an average person can perform with little or no difficulty

Caring for oneself	Performing manual tasks	Seeing
Hearing	Hearing	Eating
Sleeping	Walking	Standing
Sitting	Reaching	Lifting
Bending	Speaking	Breathing
Learning	Reading	Concentrating
Thinking	Communicating	Working

The EEOC regulations also add “interacting with others” to this list.

The addition of “major bodily functions” to the ADA appears to be in response to court decisions finding that individuals with potentially severe medical conditions were not disabled under the ADA because they could not show they were limited in one or more major life activities.

Major bodily functions. Major life activities now also include the operation of major bodily functions such as functions of the immune system; special sense organs and skin; normal cell growth; and these functions: digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal and reproductive.

“Normal cell growth” as a major bodily function, and therefore as a major life activity, is expected to impact decisions dealing with cancer.

Impairments that require individuals to take drugs that have the side effect of suppressing the immune system may now qualify as disabilities because of the inclusion of “functions of the immune system.” We await clarifying EEOC regulations on this issue.

Another concern for employers stemming from changes in “qualified disability” is the potential charge that an employer terminated an employee suffering from conditions related to “major bodily functions” (example: cancer) because they feared the impact that the employee’s medical expenses might have on insurance costs.

Working. Regulations now explain that an impairment substantially limits the major life activity of working if it substantially limits an individual’s ability to perform, or to meet the qualifications for, the type of work at issue. Type of work means the job the individual has been performing and jobs with similar qualifications or requirements that the individual would be substantially limited in performing because of the impairment.

Mitigating Measures

The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures, except for ordinary eyeglasses or contact lenses.

“Mitigating measures” would include medications, hearing aids, assistive technology, reasonable accommodation, learned behavioral or adaptive neurological modifications, surgical interventions that do not permanently eliminate an impairment, equipment, low-vision devices, and prosthetics.

“Being Regarded As”

The ADAAA now establishes that the ADA protects an individual whether he/she has an actual or perceived impairment, even if the impairment is not believed to limit a major life activity.

The Act states that “an individual meets the requirement of ‘being regarded as having such an impairment’ if the individual establishes that he or she has been subjected to an action prohibited under this Act because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.”

A plaintiff will be able to demonstrate that his/her employer took adverse action against him/her because of an actual or perceived impairment, so long as the impairment is not transitory and minor. It will not be necessary to demonstrate that the impairment limits or is perceived to limit a major life activity.

An employer who takes prohibited action because of mitigating measures used by the employee or applicant, or because of the symptoms of the impairment, will be considered to have regarded the individual as having a disability whether or not the employer knew or perceived what the impairment was. Further, this provision may apply even if the employer did not know that there was any impairment (i.e., a decision was made based on a symptom of an impairment).

No Reasonable Accommodation Required

The ADAAA now states that “A covered entity . . . need not provide a reasonable accommodation . . . to an individual who meets the definition of disability . . . solely under [the ‘regarded as’ prong] of such section.”

Interactive Process

The ADA Amendments Act of 2008 places the emphasis of inquiry squarely on the “interactive process” with respect to determining whether an accommodation is necessary and can be provided without undue hardship. Courts have placed a great deal of importance on this activity as well.

The interactive process is an informal meeting between the employee and management to discuss how the employee’s limitations affect his or her ability to work, and what can be done to keep the employee on the job.

The focus for this meeting should be on performing the job’s essential functions - how circumstances can be changed to enable the employee to do it. If the function in question is not an essential one, the employer must determine how to restructure the job to adjust responsibilities for non-essential functions so that the non-essential function(s) that is problematic for the disabled employee is shifted to another employee.

Bottom line - is it critically important for employers/managers to engage in good-faith, face-to-face interactive discussion with employees who have difficulty with one or more job requirements - and to document the content and outcome of these discussions. This type of discussion is important from a performance management perspective, and may be critically important to the employer’s legal defense should there ever be a charge of disability discrimination.



Chapter 10 Family and Medical Leave Act

Important Dates

NDA passed: 10/28/09

Effective Date: 10/28/09

Regs Issued: None

Qualifying Exigencies

Under the National Defense Authorization Act for FY 2008, FMLA leave entitlements were expanded to include leaves for an employee whose spouse, son, daughter, or parent is on active duty or call to active duty status for a *qualifying exigency*.

Active duty means call in support of a contingency operation (designated by Secretary of Defense for military actions, operations or hostilities) as a member of:

- National Guard (Army or Air)
- Reserve (Army, Navy, Marine, Air Force, Coast Guard)
- Retired member of Regular Armed Forces or Reserve

Under the National Defense Authorization Act for FY 2010, this has been expanded to include members of the Regular Armed Forces deployed to a foreign country.

Qualifying exigencies:

- Short-notice deployment
- Military events and related activities
- Childcare and school activities
- Financial and legal arrangements
- Counseling
- Rest and recuperation
- Post-deployment activities
- Additional activities (agreed on by employer and employee)

Injury or Illness of Servicemember

Under the National Defense Authorization Act for FY 2008, FMLA leave entitlements were expanded to include leaves for an employee who is the spouse, son or daughter, parent, or next of kin of a servicemember. Entitlement is for 26 workweeks of leave during a single 12-month period which begins on the first day of leave for this purpose, and is applied on a per-covered-servicemember, per-injury basis.

Covered servicemember means a current member of armed forces, National Guard or Reserves.

Under the National Defense Authorization Act for FY 2010, "covered servicemember" also means a veteran who is undergoing medical treatment, recuperation or therapy for a serious injury or illness and who was a member of the Armed Forces, the National Guard or Reserves at any time during the five-year period preceding the treatment, recuperation or therapy.

"Serious injury or illness" means an injury or illness incurred by the member in the line of duty on active duty that may render the member medically unfit to perform the duties of the member's office, grade, rank or rating.

Under the National Defense Authorization Act for FY 2010, this definition is expanded to include a pre-existing injury or illness that was aggravated by the covered servicemember's service in the line of duty on active duty. Also, in the case of veterans, a serious injury or illness includes a qualifying injury or illness that was incurred or aggravated in the line of duty on active duty in the Armed Forces and that manifested itself before or after the member because a veteran.

Next of kin definition:

- Nearest blood relative other than the covered servicemember's spouse, parent, son or daughter, in this order:
 - Blood relatives granted legal custody
 - Brothers and sisters
 - Aunts and uncles
 - First cousins
- Unless the servicemember has specifically designated someone else in writing

When no designation has been made and there are multiple family members with the same level of relationship, all such family members shall be considered next of kin and may take FMLA leave to care for the servicemember

Notification Requirements

Posted notice must be posted in a conspicuous place on the premises. Given the new FMLA entitlements, the current DOL poster does not provide an accurate statement of FMLA entitlements relating to military family leave. Pending updated guidance from the U.S. DOL, employers should review and revise their policies and consider providing information about the new FMLA entitlements.

General notice (using text from posted notice) should be in employee handbook, distributed to all employees. If no employee handbook, distribute upon hiring.

Eligibility and Rights & Responsibilities notice must be provided within *five business days* after the employee requests leave. This notice should be accompanied by certification form if employer requires it.

Designation notice:

- Must be provided within *five business days* of having enough notice to determine whether the leave is FMLA-qualifying (after receipt of certification, if required, immediately if no certification required).
- Must be provided in a language in which the employee is literate
- May be done retroactively, unless failure to provide in five business days could result in actual harm to the employee
- Must include amount of leave counted against employee's FMLA entitlement
- List of employee's essential functions should accompany notice if fitness-for-duty certification will be required

Certification

There are now four certification forms - each for a different purpose:

- Employee's own serious health condition
- Care for a family member with a serious health condition
- Leave for a "qualifying exigency"
- Leave for a servicemember with a serious injury or illness

The U.S. DOL model certification forms pertaining to military family leave are no longer entirely accurate. The DOL is expected to change these model forms soon. Until then, employers should make necessary notations on the old forms as appropriate.

Wisconsin Leave Changes

Under Wisconsin law, employees have six weeks of protected leave for the birth/adoption of a child; up to two weeks' leave for the care of a child, spouse or parent with a serious health condition; and up to two weeks' leave for the employee's own serious health condition.

The two weeks' leave for the care of a family member with a serious health condition has been expanded to include care of the employee's domestic partner, as well as care for an employee's spouse's parent, and care for the parent of the employee's domestic partner.

Domestic partner means an individual in a domestic partnership, which means a relationship between two individuals that satisfies all of the following:

- Each individual is at least 18 years old and otherwise competent to enter into a contract
- Neither individual is married to, or in a domestic partnership with, another individual
- The two individuals are not related by blood in any way that would prohibit marriage
- The two individuals consider themselves to be members of each other's immediate family
- The two individuals agree to be responsible for each other's basic living expenses
- The two individuals share a common residence

The domestic partnership threshold may also be met if the employee and partner have signed and filed a declaration of domestic partnership in the office of the register of deeds of the county in which the partner resides.

Wisconsin Family Leave Law changes are effective June 30, 2009

Chapter 11 Lilly Ledbetter Fair Pay Act

Important Dates

Statute Passed:	1/09/09
Effective Date:	1/09/09
Regs Issued:	None

Overview

The Lilly Ledbetter Fair Pay Act, in short, makes it easier to claim wage discrimination, and makes it far more likely that current or former employees may successfully sue employers for wage discrimination.

Therefore, it is important that employers continuously monitor/audit their procedures for determining employee compensation, ensure that compensation decisions are non-discriminatory, and create and maintain documentation demonstrating non-discriminatory pay practices.

Statute of Limitations

The Act amends the statute of limitations for filing compensation discrimination claims under the Civil Rights Act of 1964 (race, color, national origin, religion and gender), the Age Discrimination in Employment Act (employees over 40), and the Americans with Disabilities Act and the Rehabilitation Act (disability). This statute of limitations can run up to 300 days in some "deferral states" (such as Wisconsin and Minnesota).

Under the new legislation, compensation-related discrimination occurs at any of three possible times:

- When a discriminatory compensation decision or other practice is adopted
- When an individual becomes subject to a discriminatory compensation decision or practice
- When an individual is affected by application of a discriminatory compensation decision or other practice, including each time wages, benefits or other compensation is paid, resulting in whole or in part from such a decision or other practice

The third prong described above means that each paycheck or receipt of benefits resets the statute of limitations "clock". The two-year limit for potential back pay recovery is not changed by this new law, but punitive and emotional distress damages would be available under the new, extended statute of limitations.

This means that an employee may successfully file a compensation discrimination claim based on a pay- or benefits-related decision that was made many years earlier, if it can be shown that the employee's current pay or benefits are still negatively affected by the decision.



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Chapter 12 Wrap-Up

Resources

IRS Notice 2009-27 on ARRA premium subsidies & administration

<http://www.irs.gov/pub/irs-drop/n-09-27.pdf>

HIPAA HITECH Regulations on breach notifications

<http://edocket.access.gpo.gov/2009/pdf/E9-20169.pdf>

GINA group health plan regulations

<http://edocket.access.gpo.gov/2009/pdf/E9-22504.pdf>

<http://edocket.access.gpo.gov/2009/pdf/E9-22492.pdf>

EEOC Regulations on employment requirements under GINA

<http://edocket.access.gpo.gov/2009/pdf/E9-4221.pdf>

New Equal Employment Opportunity is the Law poster

<http://www1.eeoc.gov/employers/poster.cfm>

CHIPRA

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h2eas.txt.pdf

MHPAEA

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h1424enr.txt.pdf

Section 125 cafeteria plans proposed regulations

<http://edocket.access.gpo.gov/2007/pdf/E7-14827.pdf>

FTC Red Flags Rule

<http://ftc.gov/os/2009/10/091030redflagsrule.pdf>

Michelle's Law

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h2851enr.txt.pdf

HSA Comparability

<http://edocket.access.gpo.gov/2009/pdf/E9-21225.pdf>

ADAAA Regulations

<http://edocket.access.gpo.gov/2009/pdf/E9-22840.pdf>

Lilly Ledbetter Fair Pay Act

http://www.eeoc.gov/laws/statutes/epa_ledbetter.cfm

Action Plan

- Review seminar manual
- Review regulations & guidance
- Highlight areas of concern and address with
 - Counsel
 - Professional advisors/brokers

Thank you!



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