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What's New!

March 1, 2010 Update (Revised 3/5/10)



Oregon makes all health insurance rate filings public

Rules adopted also implement improvements to rate review process

Salem, Oregon – The Department of Consumer and Business Services, Insurance Division, today finalized changes to its health insurance rate review process that make all information submitted as part of an insurance company’s rate request open to the public.

“Consumers now will be able to see everything their health insurer provides the state when they request a rate change,” said Teresa Miller, administrator of the Insurance Division. “We look forward to providing even more information to Oregonians about potential rate changes and receiving their input through a new public comment process.”

The Insurance Division must review health insurance rates for individual, small employer (2-50 employees), and portability plans before they take effect in Oregon. Portability plans are available to people who lose employer-sponsored coverage. As in many states, health insurance rates in Oregon have been rising by double digits, reflecting increases in medical spending. Experts expect that trend to continue in 2010, particularly for individual policies.

New rules adopted today put in place reforms passed by the 2009 Legislature. These include: A 30-day period for the public to comment on rate requests. Consumers can learn more at: <http://tinyurl.com/ORHealthRates>. More detail about what insurers spend on salaries, broker commissions, marketing and advertising, and other administrative expenses. Ability to consider an insurer's overall profitability rather than just costs for a particular type of insurance such as individual health plans.



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Oregon Insurance Rates Public Filing (continued)

All the changes are effective for rate requests filed on or after April 1. An advisory committee that included insurers, small businesses, and consumer groups worked with the division on the rules.

“Our department has been working for the past several years to make health insurance costs more transparent,” said Cory Streisinger, director of the Department of Consumer and Business Services. “Providing the public with information is key as we as a state and nation grapple with escalating health care costs.”

A law the department proposed in 2007 made health insurance rate review filings open to the public, and the new rules build on that effort to improve transparency. DCBS publishes an annual report called “Health Insurance in Oregon,” which provides financial and market data about Oregon’s major health insurance companies (available at <http://tinyurl.com/OrHealthIns2010>). Through other DCBS initiatives, Oregonians can now compare hospital costs, and find out their out-of-pocket costs for common medical procedures through an interactive Web site and toll-free phone number before getting treatment.

Source: Oregon Insurance Division Press Release February 16, 2010

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**NEW
INFO**

COBRA SUBSIDY EXTENDED (AGAIN)

On March 2, 2010, President Obama signed into law the Temporary Extension Act of 2010 ([HR 4691](#)) (TEA), extending the COBRA subsidy, yet again. The TEA extends eligibility for the subsidy to involuntary terminations occurring through March 31, 2010, and redefines “assistance eligible individuals” (AEIs) to include COBRA qualified beneficiaries that experience a reduction in hours on or after September 1, 2008, followed by an involuntary termination on or after March 2, 2010. The plan administrator must provide notice of the TEA provisions to this new type of AEI within 60 days after the termination of employment occurs. The Department of Labor will issue a model notice in the coming weeks.

For those AEIs who did not elect COBRA following the reduction in hours, or who elected, but subsequently dropped the coverage, the involuntary termination of employment is treated as a second qualifying event, which gives them a new chance to elect COBRA and receive the subsidy. The maximum duration of COBRA coverage in this situation, however, is measured from the date of the original reduction in hours. An AEI in this situation has no obligation to pay retroactive premiums (and presumably doesn't receive coverage) for the period in between the two qualifying events.

Finally, the TEA also includes a provision that gives deference to an employer's determination of whether an involuntary termination has occurred, as long as the determination is based on a reasonable interpretation of the law, and the employer maintains appropriate supporting documentation, including an attestation by the employer.

Source: Vigilant Employers Trust



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New Benefit Plan Requirements for 2010

A number of new federal laws and regulations affecting employee benefit plans were enacted and adopted in 2008 and 2009 that will have 2010 compliance implications for many employers. Here's an overview of new requirements clients should be aware of for the 2010 plan year.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

The federal departments of Labor, Health and Human Services and Treasury issued an interim final rule to implement the Genetic Information Nondiscrimination Act of 2008 (GINA) in October 1, 2009 went into effect on December 7, 2009. The new law and rule prohibit group health plans from discriminating on the basis of genetic information and strictly limits the collection of any information that could possibly contain genetic information by employers. Unfortunately, the rules extend these prohibitions to family-history questions on health-risk assessment (HRA) forms used to place people in appropriate employer-based wellness and disease management programs. They also prohibit providing any incentive or reward for employees who complete an HRA.

This is an interim final rule, which means while it could be changed for 2011, its requirements are in effect for the 2010 plan year. Since its effective date was just December 7, 2009, it is very important for health insurance agents and brokers to make sure that your employer clients are not unintentionally out of compliance. The majority of employer-sponsored health benefit plans are based on the calendar year, and many calendar-year plans have already distributed HRAs that include questions about family medical history as part of their open enrollment materials for the 2010 plan year. These plans may or may not have expectation of getting these documents back before January 1, 2010, and may have rewards already planned and promised to employees for completion to be distributed after the start of the new plan year. If this is the case, please take steps to correct your client's wellness or disease management programs right away!



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Mental Health Parity

For most group benefit plans (all calendar-year plans), the Wellstone-Domenici Mental Health Parity and Addiction Equity Act goes into effect on January 1, 2010. The law applies to employers of more than 50 people who provide mental health and substance abuse services as part of the employee benefits program. While large employers are not required to provide those benefits to employees, those who do may not impose any stricter financial requirements on mental health or substance use coverage than the predominant financial requirements for medical and surgical coverage under the plan. Generally, this means plans may not have higher cost sharing provisions for mental health and substance abuse benefits (e.g., deductibles, co-payments and out-of-pocket requirements) than those that apply to medical and surgical coverage. In addition, plans may not have stricter annual and lifetime dollar limits or any more restrictive coverage limits on the number of office visits or similar restrictions on the duration of coverage for mental health or substance use services than there are for medical or surgical treatment generally. And if the plan provides out-of-network benefits for medical and surgical services, then they also have to provide them for mental health and substance abuse, and they cannot be subject to stricter financial requirements or treatment limitations than those that apply to out-of-network medical and surgical services.

Michelle’s Law--Coverage for College Students

Michelle's Law, which was signed in 2008, also goes into effect on January 1, 2010 for calendar year plans. It applies to all most all group plans if they cover dependents and use student-status as a means of determining whether or not an individual is a dependent. This measure prohibits group health plans from terminating a college student who is on medical leave from school or has had to reduce their college status to part-time for medically necessary reasons for one year after the first day of the medically necessary leave of absence, or until the date coverage otherwise would terminate under the terms of the plan (like exceeding the plan's age limits).



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Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

The passage of CHIPA last year created special enrollment rules, effective April 1, 2009, that require employers to amend their plans to allow special enrollment rights (similar to a qualifying event under HIPAA) for individuals that become eligible for state-paid coverage under CHIP or lose their CHIP eligibility. In addition, if your state offers a CHIP premium assistance program to help subsidize employer-sponsored coverage as an alternative to CHIP enrollment, employers must provide their employees with annual notification of the existence of the premium assistance program.

Protecting the Privacy of Medical Information

Privacy and security rules under the Health Insurance Portability and Accountability Act (HIPAA) were extended this year, so that they now cover all business associates of entities covered by HIPAA, including health care plans as well as third-party administrators and other vendors. The potential civil penalties for HIPAA violations were also substantially increased and a tiered penalty structure based on categories of violations became effective on November 30, 2009, and applies to violations occurring on or after February 18, 2009. Also, interim final rules on the breach notification requirements and guidance on encrypting/decrypting protected health information became effective September 23, 2009, but the Department of Health and Human Services has announced they will not begin enforcement of the rules for failure to provide notifications that are discovered before February 22, 2010. Until then, covered entities are expected to attempt to comply and DHHS will help covered entities through technical assistance and voluntary corrective action.



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