By now you should be very familiar with the COBRA provisions contained within the American Reinvestment and Recovery Act (ARRA), but do you know about the HITECH Act that is also part of ARRA? Read this month’s Compliance Corner to learn more about these new HIPAA-related rules.

Speaking of ARRA, Ouida Peterson is here to provide clarification to several scenarios that still cause confusion for many employers. Remember - submit your questions to askouida@conexis.com and your answer may appear in a future edition of the Comment.

One last note...CONEXIS will be exhibiting at the 22nd Benefits Forum and Expo, September 13-15, 2009. This year’s expo is in Atlanta, GA. If you’re attending the show, please stop by and say hello. We’d love to see you.

Until next time, thanks for reading.

Jason Culp
Director of Marketing and Sales Operations

P.S. Be sure to respond to the readers’ poll to let us know your thoughts about potential limits to FSAs.

Health Information Technology for Economic and Clinical Health (HITECH) Act

HITECH Explained

The Health Information Technology for Economic and Clinical Health Act or “HITECH Act” is a part of the American Recovery and Reinvestment Act (ARRA) of 2009, signed by President Obama on February 17, 2009. The term ‘health information technology’ (HIT) refers to any hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information. The following information is only a highlight of certain elements of HITECH and is not an all-inclusive discussion of the Act.

HITECH Provisions

The Act introduced several provisions to the Health Insurance Portability and Accountability Act (HIPAA), namely with respect to civil monetary penalties and new security breach notification requirements associated with HIPAA violations. The HIPAA amendments are as follows:

Civil Monetary Penalties

- Where a person did not know that the violation occurred, at least $100 but no more than $25,000 for each violation.
- Where there was reasonable cause but no willful neglect, at least $1,000 but no more than $50,000 for each violation.
- Where there was willful neglect but the violation was corrected, at least $10,000 but no more than $50,000 for each violation.
• Where there was willful neglect and the violation was not corrected, at least $50,000 but no more than $1.5 million for each violation.

New Security Breach Notification Requirements
• ARRA requires the Department of Health and Human Services (HHS) to issue final regulations by August 16, 2009. Effective thirty days after these regulations are available, covered entities and business associates who handle PHI are required to notify individuals of any HIPAA violation.
• If more than ten individuals are affected and cannot be contacted directly, the covered entity or business associate is required to post a general notification of the breach on their Web site and notify local print media.
• If more than 500 individuals are affected by the breach, the covered entity or business associate must notify Health and Human Services and the responsible party must report to well-known media outlets of the breach.

Note: Notification requirements do not apply to PHI that is unreadable or indecipherable.

Conclusion
If your organization is subject to HIPAA compliance, Health and Human Services recommends making the following changes to ensure compliance with HITECH provisions:
• Update Notice of Privacy Practices to reflect changes in privacy and security policies
• Update HIPAA privacy and security policies accordingly
• Develop a comprehensive Breach Notification Policy that complies with HITECH and any state law counterpart to the breach notification provisions
• Update agreements with business associates to include the provisions

For further information, the Health and Human Services’ Health Information Technology Policy Committee released two documents, the *Meaningful Use Preamble* and *Meaningful Use Matrix*, pertaining to the definition of “meaningful use” on June 16, 2009. You can access these documents at [http://healthit.hhs.gov](http://healthit.hhs.gov).

Mercer Survey: Most Employers Against Tax-Free Benefit Restrictions

According to a survey conducted by Mercer and released earlier this month, sixty-one percent of employers do not favor health care legislation that imposes restrictions on tax-free benefits. Currently, employer-paid premiums are not included in an employee’s taxable income; however, potential legislation on such benefits would limit or eliminate the plans altogether, putting a damper on tax breaks for employees participating in the plans.

Among the respondents that are in favor of a health care tax cap, only eight percent judge it is a high priority, while thirteen percent see it as a medium priority, and eighteen percent believe it is a low priority.

Furthermore, most employers oppose the ‘Play or Pay’ model which requires employers to either provide health insurance to their workers or pay a penalty as a percentage of their payroll. The idea is that ‘Play or Pay’ will assist low- or moderate-income families to obtain quality and affordable health care.

In the Mercer survey, fifty-two percent of employers do not think ‘Play or Pay’ should be part of health care reform legislation at all. Meanwhile fourteen percent said it should be a high priority, twenty percent believe it is a medium priority and fifteen percent believe it is a low priority.

There are approximately forty-six million uninsured Americans. Legislators see these and other health care provisions as a way to produce revenue in order to provide health insurance premium subsidies for a part of the uninsured population. Many Washington observers believe employer mandates will very likely be part of health care reform; however, the details surrounding which mandates have yet to be determined.

CONEXIS can be reached at (877) CONEXIS (266-3947)
Five months after the signing of ARRA and questions on the legislation are still coming in. While there is less confusion than before, there are still situations to clarify.

If someone begins the COBRA continuation on July 1, 2009, they are eligible for the subsidy. However, will they only have it until December 31, 2009, or do they receive the full nine months? The law provides a full nine months of subsidy for participants whose termination of employment date was between September 1, 2008 and December 31, 2009 and their continuation begins by December 31, 2009. The subsidy does not actually end on December 31, 2009; for some it will go well into 2010, but their COBRA start date must be prior to December 31, 2009.

Do you think the subsidy will be extended? If so, why? There is no official word from the legislature, but I expect we will hear something before December terminations begin. Here’s why: many group contracts provide coverage until the end of the month in which a person was terminated which means their COBRA begins the first of the next month. For example, let’s say an employee is involuntarily terminated December 10, 2009 and their coverage continues until December 31, 2009. That means their COBRA begins January 1, 2010. Even though the individual was terminated before December 31, 2009, their continuation did not begin by December 31, 2009 and therefore they are not eligible for the subsidy.

An active employee’s dependents are covered by the group health plan and the employee is covered by Medicare. The employee was covered by Medicare prior to involuntary termination, so I know he is not eligible for the subsidy, but are his covered dependents eligible for the subsidy? You’re right, an employee already covered on Medicare (or any other coverage), is not eligible for the subsidy. However, any covered dependents are eligible for the subsidy as long as they are not eligible for other coverage. All qualified beneficiaries that lose coverage because of the involuntary termination of employment are Assistance Eligible Individuals (AEI).

A subsidy-eligible ex-employee goes to work for another employer, but is not yet eligible for their new group coverage. Does the employee still qualify for the subsidy? I know the individual was eligible for the subsidy before he went to work for new employer, but since he’s now employed would the subsidy cease and the employee begin paying 100% of COBRA premium?

If an individual is eligible for other coverage, they are not eligible for the subsidy. However, in this case, they don’t become eligible for the other coverage until they meet the employment waiting period on the new plan. This means during the new employer’s waiting period, the person is still eligible for the subsidy on the old plan because they are not eligible for other insurance.

If a dependent turns 25 years old and is required to come off of their parent’s group coverage, they are eligible for COBRA up to 36 months; however, would they be eligible for the subsidy? No, they are not eligible for the subsidy. Remember, there must be a termination of employment, not just termination of insurance benefits.
This quarter’s reader’s poll features questions about potential FSA limits and lets you select from a number of choices. The real-time results are available at the end of the poll, and we will share the final results in the next edition of the Comment.