



Michelle's Law Takes Effect Later This Year

By Josh Norris (Atlanta)

Michelle's Law will take effect beginning October 9, 2009 (or January 1, 2010 for calendar year plans). It requires group health plans and group-health-plan-insurance issuers to continue coverage for dependent college students when they are forced to take a medically necessary leave of absence from school. The law was named after Michelle Morse, a college student in New Hampshire who was diagnosed with cancer but continued her studies on a full-time basis in order to avoid losing her health coverage under her parents' plan.

Dependent Child & Medically Necessary Leave of Absence

There are two requirements in order to take advantage of the new extension. An individual:

- must be qualified as a dependent child under the terms of the plan; and
- must have been enrolled in the plan, on the basis of being a student at a postsecondary educational institution, before the first day of the medically necessary leave of absence.

Additionally, the leave of absence must:

- commence while the child is suffering from serious illness or injury;
- be medically necessary; and
- cause the child to lose student status for purposes of coverage under the terms of the plan.

Michelle's Law also requires that written certification be provided by a treating physician of the dependent child certifying that the child is suffering from a serious illness or injury that would require a medically necessary leave of absence.

Provisions

Michelle's Law prohibits a group health plan, or a health-insurance issuer that provides health insurance coverage in connection with a group health plan, from terminating coverage of a dependent child due to a medically necessary leave of absence. Specifically, coverage cannot be terminated before the earlier of: 1) one year after the first day of the medically necessary leave of absence; or 2) the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

The new law requires group health plans and health-insurance issuers to provide notice of the requirements for obtaining the new continued coverage with any notice addressing requirements for receiving certification of student status under the plan.

This means employers should amend their plan documents, summary plan descriptions, and other employee communications to ensure compliance with the new law.

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Plan Amendments Done Right

By William Wright (Philadelphia)

Employers wishing to reduce labor costs during these rough economic times may be considering eliminating matching contributions or other employer contributions to their tax qualified profit sharing and 401(k) plans. While it's perfectly legal to make such changes, make sure that the plan documentation is properly and timely amended. Plan documentation includes the actual plan document, which can include both an adoption agreement and master plan document for prototype arrangements, and the Summary Plan Description.

Tagging All The Bases

The plan document should be modified by an appropriate written plan amendment properly authorized by those given authority to amend the plan. The plan documentation should specify who is authorized to amend the plan. Usually this would be the employer's board of directors, company officers or an employee benefits committee. Often plan amendments are made during meetings and recorded in some form of written minutes. While this may be sufficient from a legal standpoint, a plan amendment should be reduced to a written and signed document in order to ensure

compliance with the Internal Revenue Code requirement that tax qualified plans be in writing.

Amendments to tax qualified retirement plans generally should be made in the same plan year in which they are to become effective. But amendments concerning matching contributions that are made with each employee contribution in each pay period should only be on a going-forward basis and should not be retroactive.

For prototype plans, employers may not actually have immediate access to the master plan document, but it should be available from your recordkeeper. Sometimes the employer only has the adoption agreement that was completed at the time the plan was adopted or last amended. The provisions related to employer contributions, including matching contributions and profit-sharing formulas, will be found in the adoption agreement. In this case, the employer may simply amend the adoption agreement and will not need to modify the master plan document. It's important to properly notify the plan's recordkeeper and administrator of the changes.

Finally, plan sponsors must communicate changes to the plan's participants. Generally, these changes are required to be included in the plan's Summary Plan Description, which is appropriately modified with

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Plan Amendments Done Right

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each amendment by sending a written summary of the amendment to each participant. Best practices generally call for the summary to be sent before the effective date of the amendment, but no later than 210 days after the end of the plan year in which the amendment is adopted. Obviously, changes to expected employer contributions should be communicated to plan participants as soon as possible.

In today's economic climate, cost savings experienced by reducing employer contributions to its retirement plan can help avoid layoffs. But these cost savings can be lost if employers don't follow the rules required to maintain the plan's tax qualified status.

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Stimulus Bill's HIPAA Changes

By Callan Carter (San Francisco)

The American Recovery and Reinvestment Act ("ARRA"), signed into law by President Obama on February 17, 2009, included changes to the health information privacy and security rules under HIPAA, the Health Insurance Portability and Accountability Act of 1996.

ARRA imposes many privacy and security standards directly on business associates, requires new notification requirements for an unauthorized disclosure of protected health information (PHI), expands rights for individuals who are the subject of PHI, increases penalties and grants enforcement authority to states' attorneys general.

The New Rules

Generally, a "business associate" is an entity that provides services to a covered entity (a group health plan), such as claims processing, data analysis, recordkeeping, actuarial services, etc. Now, business associates are directly subject to the technical, physical and administrative provisions in the HIPAA security standards, just like covered entities have been for the last few years. This change requires business associates to complete a security risk analysis, appoint a HIPAA security official and develop written policies and procedures to govern the security of electronic PHI. Business associates are now subject to civil and criminal penalties for violations of HIPAA's privacy and security rules.

ARRA also added a notification requirement that applies to all covered entities and business associates. They must notify individuals of a breach of their "unsecured PHI" within 60 days of discovery of the breach (entities are deemed to have knowledge of a breach if they "should reasonably have known" about it). Notification must be written and sent by first class mail to the individual's last known address, or may be electronic mail if the individual previously consented to electronic notice.

If there is insufficient or out-of-date contact information, covered entities may satisfy the notice requirement with a conspicuous posting on its website or a notice in newspapers or broadcast media. This substitute notice must include a toll-free phone number that individuals can call to verify if their PHI was affected. Breaches that affect more than 500

individuals also must be reported to Health and Human Services, which will publicize the breach on the HHS website. For breaches that affect fewer than 500 people, covered entities must keep a log to be submitted annually to HHS.

Individuals may request an electronic copy of their PHI if the information is stored electronically, and the copy must be provided at cost. Individuals may restrict disclosures of their PHI to a health plan if the purpose of the disclosure is not related to treatment and the cost of the service has been paid in full. Finally, individuals also may request an accounting of disclosures of their electronic PHI if the disclosures were made for treatment, payment or health care operations.

The New Penalties

ARRA significantly increases civil monetary penalties for HIPAA violations and introduces a tiered penalty structure. Effective February 17, 2009, penalties, which were \$100 per violation before ARRA, are now \$1,000 per violation if due to "reasonable cause and not to willful neglect" (capped at \$100,000 per calendar year), \$10,000 for each violation due to "willful neglect" that is corrected (capped at \$250,000 per calendar year), and \$50,000 for each violation due to "willful neglect" that is not corrected (capped at \$1,500,000 per calendar year). Also, criminal penalties may apply to an individual or employee of a covered entity that obtains PHI without an individual's authorization. State attorneys general are now authorized to file suit on behalf of their residents in federal court.

HHS is now required to conduct periodic audits of covered entities and business associates to verify their compliance with HIPAA's privacy and security rules. This means HHS will soon be conducting random audits to ensure that covered entities and business associates have completed all of their required administrative steps (training, plan amendments, employer certifications, policies and procedures, privacy notices, etc.).

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Privacy Notice Reminder

By Callan Carter (San Francisco)

Group health plans that were required to comply with privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) by April 14, 2003 (i.e., large health plans) now have an obligation to notify individuals who are covered by the plan that the privacy notice is available, and to tell them how to obtain the notice. This reminder notice must be sent at least once every three years.

For most large plans (defined as \$5 million in claims for self-insured plans, and \$5 million in premiums for fully-insured plans) the reminder notice should have been sent by April 14, 2009. The notice can be hand-delivered or sent via U.S. mail to the named insured or covered

employee. The reminder notice can be sent via email only if the named insured or covered employee has agreed to receive the notice electronically.

Group health plans that have been providing an updated notice each year as part of the open enrollment materials will not have to provide a new Privacy Notice to those who already receive it as part of the enrollment package.

For more information about compliance with HIPAA, email the author at ccarter@laborlawyers.com or contact a member of the Employee Benefits Practice Group.