

COBRA Premium Subsidy Extended From 9 to 15 Months

[Department of Defense Appropriations Act for Fiscal Year 2010, Pub. Law No. 111-118 (Dec. 19, 2009)] Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3326enr.txt.pdf

All eyes were on Congress as we approached the end of 2009. Employees that were currently on layoff and those expecting a pink slip in January, worried that the COBRA subsidy, set to expire 12/31/09, would not be available in 2010 to help them pay their health premiums. In what is believed to be a response to the unemployment statistics, Congress passed, and on December 19, 2009 the President signed, the Fiscal Year 2010 Department of Defense Appropriations Act ("Act"), which includes amendments to the COBRA premium subsidy that was created by the American Recovery and Reinvestment Act of 2009 (ARRA). The changes made by the Act are retroactive to the original February 17, 2009 ARRA enactment date. The following is a summary of the key provisions as it relates to the COBRA subsidy:

2 Month Extension of Eligibility Period. ARRA, as amended, provides a COBRA premium subsidy for certain employees (and their families), who are involuntarily terminated between September 1, 2008 through February 28, 2010.

6 Month Extension of Duration of Premium Subsidy. The maximum period for receiving the COBRA premium subsidy has been extended for an additional 6 months, to 15 months.

Additional Notification Requirements. Notification of the changes made by the Act must be provided within 60 days after the date of enactment (that is, by **February 17, 2010**) to:

- 1) Individuals who are assistance eligible individuals on or after October 31, 2009, and
- 2) Individuals who have a COBRA qualifying event that is termination of employment (voluntary or involuntary) on or after October 31, 2009.

In addition, notification of the changes must be included in any new election notices going to individuals who have a qualifying event after December 19, 2009 (the date of enactment).

Transition Period Rules. Special rules are included for treatment of two groups of assistance eligible individuals who exhausted their full 9 months of premium assistance before the period was extended to 15 months. These individuals fall into two groups.

1) **Cancelled COBRA because subsidy expired.** Those who dropped COBRA after their original 9-month subsidy period ended--must be permitted to maintain their COBRA coverage by retroactively paying premiums that were due during their "transition period." The term "transition period" appears to mean any period of coverage beginning before December 19, 2009 during which an assistance eligible individual would have been eligible for premium assistance had the extension been available earlier. Such individuals must make payment by February 17, 2010 or, if later, 30 days after notice of the extension is provided by their plan administrator.

2) **Overpaid COBRA because subsidy expired.** Those who paid an unsubsidized premium during their transition period--must be provided with a refund or credit against future premiums.

Plan administrators must provide a notice of the extended subsidy, including information about the right to make retroactive payments, to both groups of individuals within the first 60 days of the individual's transition period.

Eligibility Based on Timing of Qualifying Event. The Act clarifies that for purposes of an individual's eligibility for the subsidy, as well as the timing of notices, the qualifying event date is used rather than the loss of coverage date. That means the qualifying event must occur on or before February 28, 2010. (Note: This is a change to rules under ARRA, whereas the loss of coverage date triggered the subsidy eligibility.)

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Agencies Issue Additional Guidance on COBRA Premium Subsidy

DOL model notices: <http://www.dol.gov/ebsa/cobramodelnotice.html>

DOL fact sheet: <http://www.dol.gov/ebsa/newsroom/fscobrapremiumreduction.html>

IRS Q&As: <http://www.irs.gov/newsroom/article/0,,id=205373,00.html>

The DOL and IRS have both released updated information on the COBRA subsidy provisions, which were extended by the Fiscal Year 2010 Department of Defense Appropriations Act (2010 DOD Act).

DOL Model Notices. The DOL has released model notices that address the 2010 DOD Act changes. Three separate model notices are on the DOL website and are available as follows:

- 1) an updated general notice;
- 2) an updated alternative notice; and
- 3) a new premium assistance extension notice.

The **new premium assistance extension notice** is a short-form notice explaining the extension of the premium assistance:

1) for individuals who were already receiving premium assistance as of October 31, 2009; and

2) for individuals who became assistance eligible individuals, or who experienced a qualifying event that was the termination of a covered employee's employment, on or after October 31, 2009, but who were provided a notice that did not include the information about the extension as required by the 2010 DOD Act.

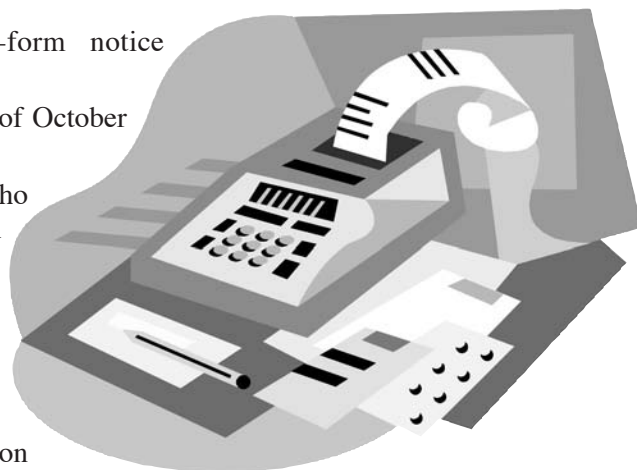
Notice for these individuals must be provided **by February 17, 2010**, which is 60 days from the December 19, 2009 date of enactment.

Transition Period Individuals. The new premium assistance extension notice may also be used to satisfy the requirement to notify "transition period" individuals (those that likely cancelled COBRA because subsidy expired) of their right to reinstate COBRA coverage by making a retroactive, reduced payment. This notice requirement is subject to a different timing rule as it must be provided within the first 60 days of the transition period.

DOL Fact Sheet. The DOL has posted an updated fact sheet relating to the premium subsidy extension on its COBRA webpage. Updates include an explanation of the transition rule noting that individuals who had reached the end of their 9-month reduced premium period (before the 2010 DOD Act extended it to 15 months) will have an extension of their grace period to pay the reduced premium so long as those 9 months ended before December 19, 2009.

IRS Q&A on Reimbursement Revised. An existing IRS Q&A relating to form preparation has been revised to note that certain small employers and agricultural employers may use Form 944 and Form 943, respectively, in order to be reimbursed for the COBRA subsidy that they provide to eligible individuals (other employers use Form 941 to claim the credit).

Note: Employers who would have already filed their 2009 4th quarter payroll tax forms, and subsequently have employees that will now take advantage of the subsidy extension retroactively, will offset their payroll taxes in the first quarter of 2010 for any months that had not been previously recorded. ■



More COBRA Changes brewing?

Adding to the complexity are additional proposed changes to the ARRA COBRA premium subsidy that are included in the **Jobs for Main Street Act** (H.R. 2847), recently passed by the House. These proposed changes include, among other things, an extension of eligibility for the program until June 30, 2010, and inclusion of certain reductions in hours as a qualifying event for assistance eligible individuals. The Senate is expected to turn to the Jobs Act COBRA extension in January, but it isn't clear at this point whether additional notification will be required if it is enacted. Stay Tuned. ■

Important W-2 Reporting Reminders

Box 10 of the W-2 must include any amounts withheld for **Dependent Care Assistance Plans (DCAP)** under a Section 125 plan. Employees use this information to file Schedule 2441, which is used to report their Dependent Care provider on the Federal tax return, as well as determine any additional dependent care tax credit (DCTC).

Note: Employees who exclude \$5,000 of DCAP reimbursements for 2009 (the maximum exclusion for married taxpayers filing jointly) can still take a partial DCTC up to \$1,000 of their 2009 dependent care expenses over \$5,000 if they have two or more qualifying individuals and meet other DCTC requirements.

Box 12 of the W-2 must include any employer contributions to a **Health Savings Account (HSA)**. For this purpose, “employer contribution” means any dollars that an employer contributes directly into a HSA, plus any pre-tax amounts that an employee contributes through the Section 125 cafeteria plan. Employees use this information to file Schedule 8889 with their federal tax return and to report any taxable state income (if applicable). ■



Important Changes to Medicare Secondary Payer (MSP) reporting for HRAs

The Employer Council on Flexible Compensation (ECFC) has been communicating with the Center of Medicare (CMS) for the last year on behalf of employer plan sponsors relative to the broad application of the MSP reporting requirements and the new inclusion of data for Health Reimbursement Arrangements (HRA). Many HRAs have not customarily collected HICNs and SSNs, registration and reporting requirements for reporting entities who only have HRA coverage will be effective in 2010 (HRA data will not be subject to reporting until after October 1, 2010).

ECFC's efforts resulted in a partial victory with regard to MSP reporting for HRAs. ECFC was able to convince CMS of the appropriateness of a partial exemption for some HRAs as well as additional helpful clarification. The GHP Reporting Guide had been updated with respect to reporting requirements for HRAs and it is good news overall.

You can find the updated guide at: <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/GHPUserGuideV3.pdf> and you will find the HRA specific information on page 68.

The following is a brief overview of the applicable updates:

1. Registration for HRA administrators (i.e., "required Reporting Entities or "RREs") that have not previously registered should begin May 1, 2010 so that registration is completed by June 30, 2010.
2. Reporting for HRAs begins in the 4th quarter 2010 "for HRA effective dates of October 1, 2010." **No retroactive reporting is required.** This is good news for all HRA administrators and HRA Plan Sponsors. Prior conversations with CMS indicated that administrators should look to the effective date of the individual's account--not the effective date of the HRA itself.

Note: Additional clarification is needed with regard to the scope of the phrase "for HRA effective dates of October 1, 2010". Is it the effective date of individual HRA accounts or the plan year effective date for 2010 on October 1, 2010? If the latter, all HRAs in effect prior to 10/1/2010 would not be reported until the first quarter of 2011.

3. An "HRA" for purposes of reporting is a medical expense reimbursement arrangement funded entirely by the employer **without regard to whether it has a carry over or not.** Thus, arrangements that have no carryover (such as deductible reimbursements plans or "DRPs") would qualify for the delayed reporting date and \$1000 exemption below. In addition, FSAs with employer credits would not be required to report.
4. Only free standing HRAs with an annual benefit of \$1000 or more need to be reported as a separate file. Presumably, the \$1000 exemption would be lost based on the coverage level and not claims that are actually paid.
5. Embedded HRAs (i.e. HRAs linked with a traditional group health) should be reported in the same file as the group health plan in which the HRA is embedded.

Note: For 2010, we are **still** collecting dependent information until further notice, whereas some HRA's may not be required to gather dependent SSN, we will still need some detail for claim processing in our system.

Continued next page

Important Changes to Medicare Secondary Payer Cont.

Note: Does this mean that if the HRA is linked to the deductible, only the Group Health Plan needs to report? What if the HRA is administered by a separate TPA and not by the Group Health Plan?

6. Routine dental services, dentures, acupuncture, chiropractic services, routine hearing exams and hearing aids are not covered benefits in the Medicare program. Any Health Reimbursement Arrangements (HRA) that cover only those expenses would not be required to report to CMS either.

Keep in mind...

If you don't qualify for an exemption, Reporting entities (Plan Sponsors for self administered HRA and TPAs) must provide the HICN or SSN for all subscribers at the start of the mandatory reporting, together with the HICN or SSN for all spouses and family members (collectively referred to as dependents) who are active covered individuals and whose initial date of coverage is October 1, 2010 or later.

CMS has advised that subscribers and dependents should routinely cooperate in furnishing HICNs/SSNs to reporting entities. Under the safe harbor, if an individual refuses to furnish a HICN or SSN, the reporting entity will be compliant for its next file submission to CMS if it (1) has provided the model language to the individual and has obtained a signed copy from the individual, (2) has the model language (with the picture of the Medicare ID card) re-signed and dated at least once every 12 months, and (3) retains the documentation. The model language includes a place for individuals to explain their refusal to provide requested information, but it also warns that noncomplying Medicare beneficiaries may be in violation of the Medicare Secondary Payer rules. Reporting entities that fail to comply with the mandatory reporting requirements face civil monetary penalties of \$1,000 per day of noncompliance, among other consequences.

Editor's note: Because this information was hot off the press at the time we went to print, we were unable to provide clarification to all the questions raised by the CMS update. We will continue to keep you posted on developments and clarifications that we receive with regard to these reporting requirements.

IRS Releases 2009 Versions of HSA Form 8889 and Publication 969

Form 8889: <http://www.irs.gov/pub/irs-pdf/f8889.pdf>

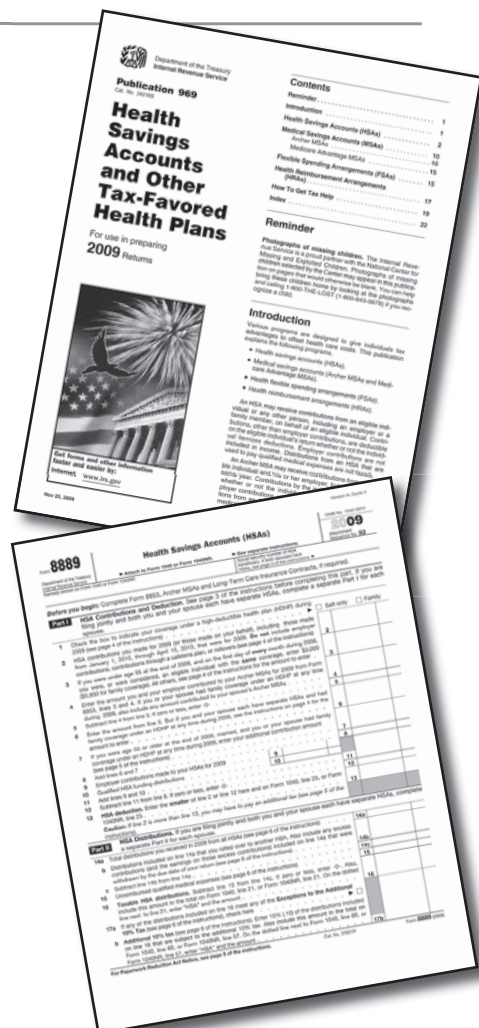
Instructions: <http://www.irs.gov/pub/irs-pdf/i8889.pdf>

Pub. 969: <http://www.irs.gov/pub/irs-pdf/p969.pdf>

The IRS has released the 2009 versions of Form 8889 (Health Savings Accounts (HSAs)) and its Instructions, as well as Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

Form 8889 and Instructions. HSA holders (and beneficiaries of deceased HSA holders) must attach Form 8889 to their Form 1040s to report HSA contributions and distributions. The form is also used to calculate HSA deductions and any income and additional 10% tax triggered by failing to remain HSA-eligible throughout the applicable testing period for qualified HSA distributions, qualified HSA funding distributions, or the full-contribution rule. The 2009 versions of Form 8889 and its Instructions are substantially similar to the 2008 versions.

Publication 969. This publication provides basic information about HSAs, HRAs, health FSAs, Archer MSAs, and Medicare Advantage MSAs, including brief descriptions of benefits, eligibility requirements, contribution limits, and distribution issues. The 2009 version has been revised to reflect the indexes applied to HSAs for 2009, as well as includes an explanation of what employers must do to meet the comparability requirements when eligible employees have not established HSAs by the last day of the year. Additionally, the health FSA and HRA sections include a note referencing that debit cards cannot be used at stores with the "Drug Stores and Pharmacies" merchant category code (MCC) after June 30, 2009, unless the store meets certain criteria.



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Dependent Status and Imputed Income

The State of Wisconsin on January 1, 2010 expanded the definition of dependent for purposes of health plan coverage. Adult, unmarried children can be covered under a parent's health plan up to the age of 27 in Wisconsin if they don't have access to coverage or the coverage under the parents plan is less costly. Other states have passed similar laws.

Caution: This may cause income tax consequences for the parent. In addition, remember generally HRA and FSA programs can only reimburse employees with tax free dollars for services incurred by the employee and their eligible Section 152 TAX dependents. The IRS definition of tax dependent will likely be different than individual states expanded definition of dependent. In addition, even though the payroll deduction may not change to add the child to the coverage, there is a fair market value that must be considered as a taxable benefit to the parent. As an illustration of how this might work, please see the following example.



Employee pays \$100 per month pre-tax for health insurance premiums for family coverage.

Employee has a 25 year old unmarried child that will enroll under her family coverage January 1, 2010 under the new Wisconsin law.

The fair market value of the coverage must include what an employer would pay towards coverage. The conservative approach would be to use the COBRA rate for Single coverage to determine the fair market value for coverage.

Assume that the COBRA rate for Single coverage under the plan is \$500 (actual rate would be determined by the COBRA rate for the specific employer).

Assume that the 25 year old unmarried child stays on the parents plan throughout 2010 (12 months).

If the Employee continues to pay premiums pre-tax throughout the year, the employer must include the fair market value of the health coverage on the Employee W-2 ($\$500 \times 12 = \$6,000$).

An alternative way that this could be handled is the Employee could elect to pay their share of the premium (\$100 per month) with after tax dollars each month.

That would reduce the value of the taxable health benefit by \$100 each month. The employer would still need to consider the fair market value of the coverage, however, the calculation would be $\$500 - \100 taxable premium = $\$400 \times 12$. The fair market value of the taxable health benefit would be \$4,800.

There is no way to avoid the income tax consequences. The employer contribution towards health insurance and the employee share towards health insurance can only be tax free for IRS Section 152 tax dependents. The definition of dependent under the health plan is disregarded when determining the tax deductible status of the coverage.

For more information on Wisconsin's new law, see Frequently Asked Questions Regarding Coverage of Dependents, under s. 632.885, Stat., and s. Ins 3.34, Wis. Adm. Code Available on Wisconsin Commission of Insurance Website: <http://oci.wi.gov/rules/0334em09.pdf> ■

2010 Medical Mileage Rate For Transportation Decreases

[Rev. Proc. 2009-54 (Dec. 3, 2009)]

For a copy: <http://www.irs.gov/pub/irs-drop/rp-09-54.pdf>

For a copy of the press release:

<http://www.irs.gov/newsroom/article/0,,id=216048,00.html>

The standard mileage rate for use of an automobile to obtain medical care (which may be deductible under Code Section 213 if it is primarily for, and essential to, medical care) will be 16.5 cents per mile for 2010. This is a 7.5 cent **decrease** from the 2009 rate of 24 cents. An IRS press release attributes the decrease to a general reduction in transportation costs. Parking fees and tolls related to the use of an automobile for medical or moving expense purposes, however, may be deductible as separate items. ■



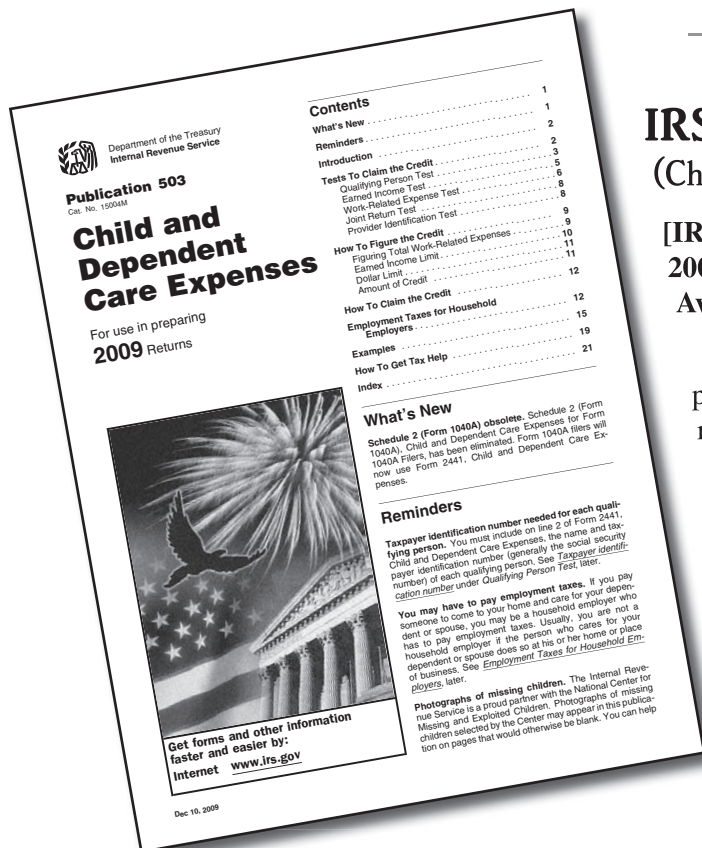
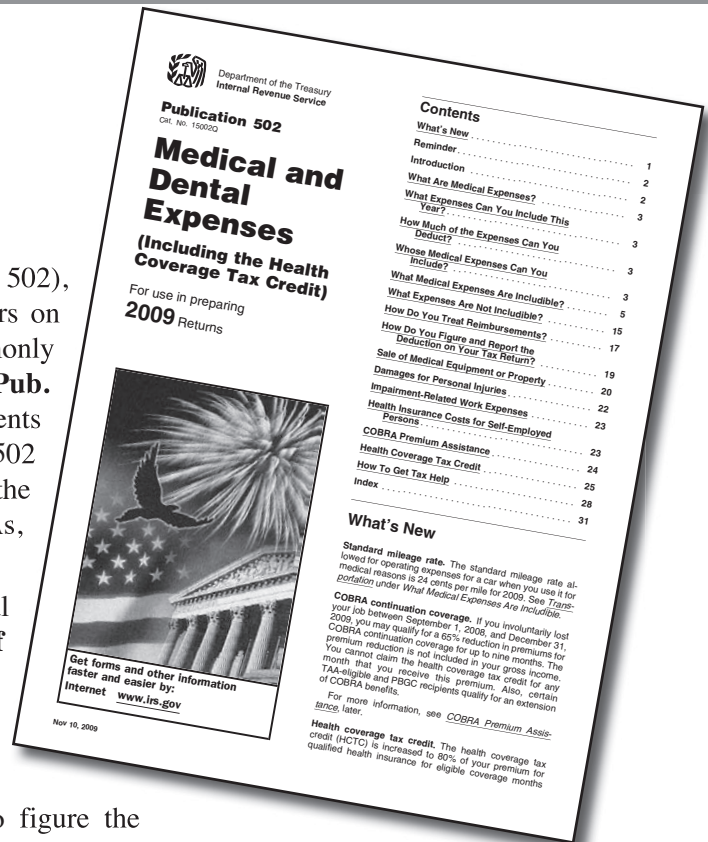
IRS Issues 2009 Version of Pub. 502 (Medical And Dental Expenses)

IRS Publication 502-Medical and Dental Expenses (for 2009 Tax Returns)

For a copy: <http://www.irs.gov/pub/irs-pdf/p502.pdf>

The IRS has released the latest version of Publication 502 (Pub. 502), which describes what medical expenses are deductible by taxpayers on their 2009 federal income tax returns. This is the list most commonly referred to claim itemized medical deductions on Form 1040. **Use Pub. 502 with caution** relative to Health Reimbursement Arrangements (HRA) and Flexible Spending Accounts (FSA) because Pub. 502 addresses only what expenses are deductible and it doesn't describe the different rules for reimbursing medical expenses under health FSAs, HSAs, or HRAs.

Changes include the following: 1) Clarification that medical expenses include amounts **paid for the prevention and alleviation of dental disease**, and that preventive treatment includes the services of a dental hygienist or dentist for procedures such as teeth cleaning, application of sealants, and fluoride treatments to prevent tooth decay; 2) A new section discusses the COBRA premium assistance subsidy and includes a worksheet for higher-income taxpayers to figure the **taxable portion of their premium assistance**; 3) Provisions relating to the HCTC have been updated to reflect **changes to the HCTC** that were made earlier this year; and 4) Clarification that explains that **taxpayers can include medical expenses for an individual who would have been a dependent but for the fact that** (1) the individual received gross income of \$3,650 or more in 2009, (2) filed a joint return for 2009, or (3) the taxpayer (or spouse if filing jointly) could be claimed as a dependent on someone else's 2009 tax return. Revisions have also been made to reflect changes to the Code's definition of qualifying child that were made by 2008 legislation.



IRS Issues 2009 Version of Pub. 503 (Child and Dependent Care Expenses)

[IRS Publication 503 (Child and Dependent Care Expenses (for 2009 Tax Returns))]

Available at: <http://www.irs.gov/pub/irs-pdf/p503.pdf>

The IRS has updated Publication 503 (Pub. 503) for use in preparing 2009 tax returns. The 2009 version has been revised to remove references to the now-obsolete Schedule 2 ("Child and Dependent Care Expenses for Form 1040A Filers"), and to include a reminder that Form 1040A filers will now report their child and dependent care expenses on Form 2441. In addition, the discussion of the rules for determining who can treat a child as a qualifying individual when the child's parents are divorced, separated, or living apart has been updated to reflect IRS regulations that provide additional guidance and clarifications on these rules. **If the child is with each parent an equal number of nights, it is the parent with the highest adjusted income that is deemed the custodial parent.**

New Law Expands FMLA Leave Rights

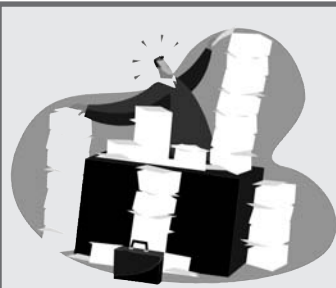
For Employees Who Are Relatives Of Veterans And Members Of The Armed Forces

[National Defense Authorization Act for Fiscal Year 2010, Pub. L. No. 111-84 (Oct. 28, 2009)]

For a copy: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h2647enr.txt.pdf

An employee's entitlement to **qualifying exigency leave** has been changed to reflect that the employee's spouse, son, daughter, or parent must be on "covered active duty" (a new term) in the Armed Forces (or have been notified of an impending call or order to such duty). For members of a regular component of the Armed Forces, covered active duty means duty during deployment to a foreign country; for members of a reserve component, it means duty during deployment to a foreign country under a call or order to active duty pursuant to specified provisions of federal law.

An **employee's entitlement to leave** to care for a covered servicemember with a serious injury or illness has been expanded to apply when the employee is the spouse, son, daughter, parent, or next of kin of 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 (including the National Guard or Reserves) at any time during the five-year period preceding the date of the treatment, recuperation, or therapy. In addition, the definition of serious injury or illness has been expanded to include injuries or illnesses that existed before a servicemember's active duty began and were aggravated by service in the line of duty on active duty in the Armed Forces. For veterans, a serious illness or injury is a "qualifying injury or illness" (as defined by the DOL) that was incurred in the line of duty on active duty in the Armed Forces (or that existed before the beginning of active duty and was aggravated by service in the line of duty on active duty) and that manifested itself before or after the servicemember became a veteran. ■



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Health Care Reform Update

The current Senate version (including the managers amendment released before Christmas recess) of health care reform that will be merged with the House version, (as of mid-January) still includes revenue generators that would require changes to tax advantaged employee benefit plans as follows:

Imposes Excise Tax on High-Cost Plans: Beginning in 2013, imposes a **40 percent** excise tax on plans that exceed \$23,000 for families and \$8,500 for individuals [Note: The previous version set the excise tax threshold at \$21,000 and \$8,000, respectively.] All health related premiums, COBRA rate for HRAs and contributions to FSAs, HSAs, and MSAs would be included in determining the threshold for the excise tax. Whereas, Congress believes that they are targeting rich benefit plans, by including all health related benefits under the same threshold, it will be difficult for most employers to stay under the thresholds. In particular, small businesses that have health plans that include older workers and/or workers with chronic medical conditions will find it very difficult to stay within the parameters set forth in the bill.

Caps Flexible Spending Accounts (FSAs): Beginning January 1, 2011, caps contributions to FSAs at **\$2,500** with indexing to CPI-U for future inflation. Indexing for inflation set to begin in 2012. [Note: Not including an index for inflation would have meant that the Medical FSA would lose value over time. The Dependent Care FSA limit of \$5,000 set over twenty years ago does not include an index for inflation and has not kept pace with true Dependent Care costs today. Most Dependent Care participants find that the limit barely covers the cost of one child in daycare.]

Requires Prescription to Receive Reimbursement for Drugs Under Account-Based Plans (FSA, HRA and HSA): Over-the-counter medications appear to be safe for now and will remain tax deductible for 2010. However, the Senate version, beginning January 1, 2011, would require individuals to **obtain a prescription for drugs**, including over the counter medicines, as a requirement for reimbursement. [Note: Previous versions made this provision effective on January 1, 2010. The House version of the bill currently would eliminate OTC as tax deductible.] ■

The Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information. GINA is effective for plan years beginning after May 21, 2009 (January 1, 2010 for calendar year plans). Regulations implementing the provisions of GINA were made public on October 1, 2009.

How does GINA affect Health Risk Assessments (HRAs)?

- HRAs are used to assess risk factors, promote early detection, and identify opportunities for interventions to manage conditions.
 - Many HRAs solicit or require information prior to enrollment about family medical history, which is genetic information.
- GINA restricts plans from refusing coverage or offering premium reductions or other economic awards for participating in a HRA that asks for genetic information.
- Plans are prohibited from requesting genetic information in a HRA prior to the Employees enrollment in the plan.
- A plan or insurer can collect genetic information through a HRA as long as no rewards are provided for giving answers, and if the request is not made prior to or in connection with enrollment.
- A plan or insurer can also provide rewards for completing a HRA as long as the HRA does not collect genetic information.
- Wellness programs **CANNOT** provide rewards for completing HRAs that request genetic information, including family medical history. Prohibited rewards include: premium discounts, changes in deductibles, rebates, cash bonus incentives. ■



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