



Broker Buzz - March 2009

March 19, 2009

COBRA Health Insurance Premium Subsidy Overview

On February 17, 2009, President Barack Obama signed into law The American Recovery and Reinvestment Act, commonly known as the "stimulus package." In addition to broad tax and spending incentives designed to promote economic development, the Act includes the most significant changes to group health plan continuation rules since the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). In general, the Act provides temporary and limited premium subsidies to help pay for the continuation of health coverage for certain individuals who lose their jobs, and it creates new opportunities for certain individuals to qualify for COBRA continuation coverage provided by a group health plan.

The following information provides a brief summary of the new rules applicable to health care continuation coverage under the Act. MVP recognizes the need for its customers and business associates to address these changes, and we will provide additional information as the new requirements are clarified and additional guidance is issued. Please note that this communication is for informational purposes only and is not legal or compliance advice.

Overview of the New Continuation Coverage Requirements

Eligibility

- The Act establishes new rights for individuals who were involuntarily terminated from employment for reasons other than misconduct between September 1, 2008, and December 31, 2009.
- The Act applies to federal COBRA continuation coverage, state group continuation coverage, and temporary continuation coverage offered through the Federal Employees Health Benefits Program (FEHB).
- All types of group health plan premiums (e.g., medical, dental, vision, etc.) subject to COBRA are eligible for the subsidy, with the exception of health flexible spending accounts offered through a cafeteria plan.
- Individuals who are eligible for coverage under a group health plan (except coverage consisting of only dental, vision, counseling, and/or referral services) or under Medicare, regardless of whether or not they are enrolled in such coverage, do not qualify for the subsidy.
- Starting March 1, 2009, the federal government will pay up to 65 percent of the COBRA health insurance premium for an eligible individual and his or her dependents.
- The subsidy starts with the period of coverage beginning on or after February 17, 2009. As a result, for most individuals currently receiving continuation coverage, the premium subsidy will begin with the coverage period on or after March 1, 2009.
- The subsidy does not last for the entire period during which the individual is eligible for continuation coverage. It ends at the sooner of: (1) nine months after the date the individual begins receiving the subsidy; (2) when the individual becomes eligible for other coverage under a group health plan (except for coverage only for dental, vision, counseling or referral services, coverage under a flexible spending arrangement, or limited coverage at certain on-site medical facilities maintained by the employer) or Medicare; or (3) when the individual fails to pay required premiums.
- Employers must provide notice to eligible individuals by April 18, 2009.

Payment and Recovery

- Eligible individuals are responsible for paying only 35 percent of the premium to their group health plan. The group health plan cannot claim a subsidy until after it has actually received the 35 percent premium from the individual or someone other than the employer on the individual's behalf.
- There is a 60-day "grace period" after March 1, 2009 for the subsidy to begin in the case of individuals who have already paid for continuation coverage. If an individual pays the entire premium during March or April, 2009, the entity that is responsible for claiming the subsidy may either refund the subsidy amounts to the individual or reduce subsequent premium amounts to account for the subsidy.
- In the case of a multi-employer group health plan, the subsidy is paid by the plan.

In the case of a group health plan that is either subject to federal COBRA requirements or is self-insured, the subsidy is paid by the employer.

- In the case of continuation coverage offered pursuant to state requirements, the subsidy is paid by the insurance carrier.

- The entity that pays the subsidy is then permitted to take the amount of any subsidy payments as an offset against its federal payroll tax liability. The Internal Revenue Service (IRS) has released a revised Form 941 and Instructions for reporting the amount of premium subsidy that is taken as a payroll tax credit. Repayment

Requirements for "High-Income Individuals"

- The subsidy generally will not be considered taxable income for qualifying individuals.
- However, an individual is not eligible for the subsidy if his or her modified adjusted gross income (AGI) exceeds \$145,000 for an individual income tax filer and \$290,000 for a joint income tax filer. Unless the individual permanently waives the subsidy and pays the entire COBRA premium, the subsidy may be subject to a recapture tax.
- Individuals who were eligible for, but did not elect, COBRA continuation coverage have a one-time special election period to enroll in COBRA.

Special Election Period

- Individuals who were involuntarily terminated after September 1, 2008 and eligible for federal COBRA coverage, but failed to enroll, are entitled to a one-time special enrollment period and may qualify for the premium subsidy. Individuals who initially elected COBRA coverage but were no longer enrolled on February 17, 2009 (because, for example, coverage ended due to non-payment of premiums) are also eligible for this special election period.
- Employers have 60 days to notify individuals of this special enrollment right. Individuals then have 60 days after the notice is provided to exercise this right.
- The COBRA enrollment will be retroactive to March 1, 2009; however, the special election does not extend the maximum coverage period.

New Plan Enrollment Option

- The Act allows but does not require employers that offer multiple medical plans to allow individuals a one-time opportunity to change to a different continuation coverage option prior to the annual open enrollment period. The medical plan options must be limited to those available to active employees, and only those with premiums less than or equal to the premium for coverage in which the individual was enrolled at the time of the qualifying event.

Required Reports

Entities that pay the 65 percent subsidy on behalf of an individual and claim the subsidy amount on the entity's payroll taxes are required to report the information below to the Department of the Treasury.

- An attestation of the involuntary termination of employment of each individual who receives the subsidy.
- The amount of payroll taxes that are offset for a given reporting period and an estimate of the amounts that will be offset for the next reporting period.
- The Social Security Numbers for all individuals who qualify for the subsidy.
- The amount of the subsidy paid for each individual.
- Whether the subsidy is for more than one person.

Out-of-Network Reimbursement

MVP members receive most of their care from providers in our network. When members choose to see an out-of-network doctor, the method for reimbursement is different and MVP is changing the way we reimburse providers in these situations.

New York's Attorney General Andrew Cuomo and MVP reached an agreement that supports his plan to establish a new not-for-profit organization to gather, maintain, and analyze provider reimbursement data for use by health insurers who choose to pay out-of-network providers using usual, customary and reasonable fees.

Like many other health insurers, MVP used Ingenix® data to establish usual, customary and reasonable (UCR) reimbursements for out-of-network providers because Ingenix was the industry standard. However, unlike many other insurers, MVP only used this database for a very small number of claims, less than 1 percent of the 12 million claims we process annually. Still, we recognize the Attorney General's concern about conflicts of interest inherent in the Ingenix database because it is owned by a health insurance company (United Health Group).

We agreed with the Attorney General that if we continue to pay out-of-network physicians using UCR methodology, we will base the payments on data from the Attorney General's new, not-for-profit replacement company for Ingenix, once that company is up and running.

We are working on a process to replace the UCR database with the federal government's database for Medicare fees. We would pay a percentage above those fees, and would make adjustments for regional differences, as the government does (i.e. Manhattan vs. Albany). This new process is estimated to be in place in July of this year. In the meantime, we will continue to use Ingenix, because it is the only database for UCR rates available to us, until our new process or the new not-for-profit database is available.

We agree that our members and providers will be well served by a new, more transparent system of paying out of network claims.

New Schedules and Riders Approved

The following has been approved for sale in New York for new groups effective May 1, 2009:

- Small Group EPO 100% Coinsurance schedules
- Small Group PPO 100% Coinsurance schedules
- Small and Large Group PPO 100% Coinsurance (In Network) schedules
- Small and Large Group EPO/PPO "No Coinsurance for Certain Preventive Services" riders which can be attached to existing plans.
- All Federally qualified plans can take advantage of these schedules and riders, and small group versions of these options will be available through our online quoting tool by the end of March.

To pair these coverage options with large group products, please contact your Sales Executive.

Using ProposalRequest@mvphealthcare.com

Last month, we told you about a new electronic mailbox we have created for the submission of proposals. We also sent all brokers a letter about the mailbox and how to use it to send proposals to us.

Please note that this mailbox should be used ONLY when you need a complete RFP.
Requests for rates and benefits only should still be sent directly to your Account Manager.

Pharmacy Formulary Information

The following information tells about changes to the formulary effective April 1, 2009. For the most up-to-date information, visit www.preferredcare.org and choose "Pharmacy".

New Drugs (newly approved by the Food and Drug Administration (FDA), prior authorization required)

Mozobil™
Banzel™

Promacta®

Drugs Added to Formulary

Astepro™
Pristiq®
sumatriptan (generic Imitrex®)
methylergonovine (generic Methergine®)
budesonide (generic Pulmicort Respules®)

Venlafaxine Ext-Release Tabs
Maxalt/MLT®
clobetasol lotion (generic Clobex®)
calcitonin-salmon (generic Miacalcin®
Nasal Spray)

Drugs Not Added to Formulary

TriLipix™
SCE-A Vaginal Cr
Apriso™

Relistor®
Cimzia®

Drugs Removed from Formulary*

Imitrex®
Pulmicort Respules®
Abilify®

Methergine®
Zorprin®
Zomig®

*Impacted members on drugs removed from the formulary will receive a separate letter if further action is required (i.e., contacting the prescriber for a formulary alternative)

Drugs That No Longer Require Prior Authorization

Relistor®
Pristiq®

Patanase®

Headache Therapy

Effective April 1, 2009, non-formulary medications to treat migraine headaches (Imitrex®, Zomig®, Amerge®, Axert®, Frova® and Treximet®) will require prior authorization. Covered formulary medications, subject to quantity limitations, will be sumatriptan, Maxalt/MLT® and Relpax®.

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