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Issue 21-2009

Health Care Reform

House Is Poised To Act On Health Care Reform

Congress is making decisions *now* on unprecedented changes to our health care system. We encourage you and your clients to engage in the debate by emailing or calling your two U.S. Senators and your House Member. Below are details on how to contact Congress and some message points for you to use in your communication, if you wish.

Let's make sure that Washington enacts meaningful reforms that build on the employer-based system to extend coverage to everyone, bring costs under control and improve the quality of care.

How to Contact Your Legislators:

You can find congressional contact information and key messages at www.gethealthreformright.org - a site created by the Blue Cross Blue Shield Association. There are tools on this site that allow you to communicate directly with your members of Congress.

For more information on reform from the producer community, you can also visit <http://capwiz.com/nahu/home/> - a site created by the National Association of Health Underwriters. There are also tools on this site that allow you to communicate directly with your members of Congress.

Or, you can contact your members of Congress directly on this issue by going to www.house.gov or www.senate.gov. At these Web sites you will be able to type in your ZIP code to identify your legislators and then click on their names to go directly to their Web site, where you will be able to contact them via e-mail or telephone.

Message Points on Reform:

- We support reforms that build on today's employer-based system to ensure everyone is covered and costs are brought under control.
- We are concerned about a new, government-run health plan that would threaten the employer-based system that now serves 160 million Americans.
- We are particularly concerned about the House reform proposal that includes a government-run plan that would pay providers based on Medicare rates.
- The Lewin Group estimates that under the House bill, 114 million Americans would be shifted into the government plan within three years.
- A new government plan would undercut reform by exacerbating cost shifting. Medicare currently underpays doctors by 20 percent and hospitals by 30 percent, which in turn adds almost \$1,800 to working families' premiums per year. Low Medicare payments would drive the cost of private coverage higher and would unravel the employer-based system as the cost shift forces those with private coverage into the government plan.
- A new government plan would jeopardize delivery system reforms critical to controlling costs and making real reform possible.
- Reforms must focus on improving quality and lowering costs. According to the nonpartisan Congressional Budget Office (CBO), the reforms being considered would do nothing to "bend the cost curve", but would in fact increase overall health care costs.

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"Let's make sure that Washington enacts meaningful reforms"

Government Mandates

Mini-COBRA

As you are probably aware, Pennsylvania's new "mini-COBRA" law took effect on July 10, 2009. This law, like the Federal COBRA legislation that has been in effect for more than 20 years, allows certain employees and dependents who lose their group health insurance to elect to continue their coverage.

To help our smaller employer groups understand how they are affected by this new law, in the next few days we will send a mailing to smaller groups that are not part of an association. The mailing provides a very brief overview of the law as well as information about the assistance HM Insurance Group can provide to help employers fulfill their responsibilities under this new law. Also included is a form employers can use to indicate their intent to contract with HM Insurance Group for mini-COBRA administration. The form should be completed by the employer and returned directly to HM Insurance Group.

Since your clients may contact you as a result of this mailing, we have attached a copy of the materials in this mailing. If you or your clients have questions about the new mini-COBRA law or the services HM Insurance Group provides, please contact your Small Group Client Manager.

Employee Count Form

As referenced in Producer News #20, various laws require that we periodically collect employee count information from groups that contract directly with us or indirectly through an association or other multi-employer plans. Later this week we will begin mailing the Employee Count cover letter and form to all Highmark accounts. The accounts will be asked to complete the form and return it to Highmark by FAX or in the return envelope that will be provided. The cover letter and form are attached for your reference.

If your clients contact you with questions about the Employee Count Form, please encourage them to respond in a timely basis. If they have additional questions, please refer them to the Centers for Medicare and Medicaid Services (CMS) Web site, www.cms.hhs.gov and search for Medicare Secondary Payor.

What Highmark Needs

In order to timely and accurately process claims for Medicare-eligible members, we need to know the appropriate Employer Identification Number or Tax Identification Number and the total number of employees in each group account. For this purpose, the employee count should include all employees under a common ownership or corporation who are subject to FICA (social security) taxes – or would be if the employer were not otherwise exempt from FICA taxes. For common ownership or corporation purposes, in general, two or more individuals or corporations are considered to be separate employers under Internal Revenue Code § 52(a) or (b) if they file separate income tax returns, and a single employer if they file a consolidated tax return.

The count should also include individuals employed:

- Locally and out of the area
- Full-time, part-time, intermittently and/or on a seasonal basis

If Accounts Don't Respond

The cover letter that accompanies the Employee Count Form explains the purpose of the count and emphasizes the importance of responding in a timely manner. Accounts that don't respond will be sent a follow-up request, reminding them of the importance of completing the form. If an Account fails to provide the information, Highmark will have no choice but to take appropriate action because such failure places the Account and /or Highmark at risk for the imposition of fines or penalties.

How you can help

If your clients contact you with questions about the Employee Count Form, please encourage them to respond on a timely basis. If they have additional questions, please refer them to the Centers for Medicare and Medicaid Services (CMS) Web site, www.cms.hhs.gov and search for Medicare Secondary Payor.

Thank you for your support with this important effort.



”...accounts will be asked to complete the form and return it to Highmark...”

Important Information about Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 (MHP) was signed into law October 3, 2008 as part of the Emergency Economic Stabilization Act. The MHP Act prohibits a group health plan of 51 or more employees from applying financial requirements, treatment limitations or network limitations to mental health and substance abuse (MH/SA) benefits that are more restrictive than the "predominant" requirements or limitations applied to "substantially all" medical/surgical benefits. MHP leaves the provisions of the 1996 Mental Health Parity Act intact and further expands it to include substance abuse disorder benefits.

The intent of the MHP Act is to provide true parity between MH/SA and medical/surgical benefits. The MHP Act has the following requirements:

- Groups are prohibited from applying financial requirements or limitations to MH/SA benefits that are more restrictive than or do not apply to "substantially all" medical/surgical benefits.
- Groups are prohibited from applying treatment requirements or limitations to MH/SA benefits that are more restrictive than or do not apply to "substantially all" medical/surgical benefits.
- If the group provides out-of-network coverage for medical/surgical benefits, the same level of out-of-network coverage must be provided for MH/SA benefits.

In other words, coverage for MH/SA benefits must be equal to or greater than coverage for medical/surgical benefits. The MHP Act does not require the following:

- Parity in medical management techniques. Groups may continue to utilize medical management to assist them in controlling costs.
- A provision for MH/SA benefits. Groups that provide MH/SA benefits either by mandate or by choice (ASO/ASC) must comply.

Group Implementation Details

For groups with 51 or more employees, the compliance date depends on how the plan is set up:

- Groups with calendar year plans need to comply by January 1, 2010.
- Groups with contract year plans need to comply by their first renewal that occurs on or after November 1, 2009.
- Groups with health care benefits provided as part of a collective bargaining agreement need to comply by January 1, 2010, or upon the expiration of their last bargaining agreement that was ratified before October 3, 2008, whichever date is later.

In addition, as more health insurance companies provide MH/SA benefits that are equal to medical/surgical benefits, Highmark will also provide mental health parity compliant benefits to groups with 50 or fewer employees upon renewal beginning October 1, 2009.

Highmark will automatically bring group plans into parity as follows:

- Beginning with October 2009 renewals for groups with **50 or fewer employees**.
- Beginning with November 2009 renewals for all mandated **groups of 51 or more employees**.

Your Role

You can assure clients that their benefits will be in compliance with the MHP Act. Here are examples of some of the changes clients may begin to see with their MH/SA benefits:

- Inpatient hospital day limits and maximums for MH/SA will match the medical/surgical inpatient hospital day limit and maximum.
- Outpatient visit limits and maximums for MH/SA will match the outpatient visit limit and maximum for medical/surgical.
- Specialist copayment for MH/SA services will match the specialist copayment for medical/surgical services.
- Network coinsurance for MH/SA services will match the network coinsurance for medical/surgical services.
- Out-of-network coinsurance for MH/SA services will match the out-of-network coinsurance for medical/surgical services.

A comprehensive employer guide is available to assist groups in understanding the law and their compliance with the law. You can order the guide, called "Understanding the Mental Health Parity Law" on the Producer Portal by entering the item number 24642.

For more information about Mental Health Parity, contact your Highmark client manager.

Group Administrator Manual

Highmark provides a Group Administrator Manual to clients as an aid to their daily administration of their benefit programs. For your reference, a copy has been attached to the email accompanying this Producer News.

If you have any questions concerning this issue of Producer News, please contact your Highmark client manager.

Sincerely,



Reginald E. Brown
Director, Producer Affairs, West

Attachments:

Mini-COBRA:

Mini COBRA Association Letter.doc

Mini COBRA Group Letter.doc

HM Mini-COBRA Notice to Policyholder (final 072009) (3).pdf

102002_HM_miniCOBRA_Flier_fa.pdf

Employee Count Form:

employee count cover letter.pdf

employee count form.pdf

Western GAM Manual.pdf