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Washington Update: Legislative Happenings

After a teleconference with the American Benefits Council, we want to make note of the following legislative agenda items.

Mental Health Parity

Senator Pete Domenici (R-N. Mex.) will propose a bill that would extend the mental health parity mandate to include coverage for every condition for which there is a diagnostic code. Senator Domenici has personal reasons for reintroducing the legislation based on difficulties a family member encountered in seeking coverage. Domenici's proposal is similar to bills that have failed in the past, however, the senator has indicated that he would be willing to scale down the measure if that would help passage. His commitment to this bill's passage could whittle away the ability of employers to design their own benefit packages and make them more costly.

New Savings Vehicles

Expectations are that the President's proposal on the new savings vehicles: Employer Retirement Savings Accounts, Lifetime Savings Accounts, and Retirement Savings Accounts, will probably be permitted to die. Other than the investment community, there have been few willing to speak favorably about these proposals. Representative Earl Pomeroy (D-N. Dak.), often a champion of the employer-based retirement system, blasted the proposal. He stated that, at a time when many Americans say they do not have the disposable income to put into savings, a proposal to let them save even more on a tax-favored basis was not going to help.

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Accurate or not, it is an opinion shared by many and it is unlikely that this proposal will be pushed by the administration.

At a meeting of the Small Business Council of America, we learned that all of the proposals are first steps to get the tax system switched from an income based system to a consumption based system. A group of wealthy businessmen are spearheading this drive to completely eliminate income taxes. That may sound like "vast right-wing conspiracy" kind of talk, but coming from an individual with extensive contacts in Washington it warrants serious attention.

Nonqualified Deferred Compensation

Interest persists in limiting what executives can earn under nonqualified deferred compensation plans. The concern is that, as the plans have provided more and more employee control over the assets such plans, abuses have emerged and so such arrangements should not be permitted. The fact that there is no employer deduction until distribution is not a compelling argument for many lawmakers since the Enron/Global Crossing situations came to light.

Another item on the radar screen is the widespread use of corporate-owned life insurance that is insuring the lives of the rank and file members of the employer (so-called "janitor insurance"). Many Congressional staff members think it is an abuse and new legislative proposals are being readied to limit or prohibit that practice.

Judicial Relief for Abandoned Plans

With the growing number of failed companies, the "abandoned plan" phenomenon has grown large enough to gain the attention of the Department of Labor (DOL). Plans become abandoned when the employer that originally sponsored it goes out of business before terminating the plan and distributing the assets. With the employer gone, the individuals who might have been in charge of the plan have little incentive to take care of the administrative duties and fiduciary responsibilities that come with a plan termination. Outside service providers are reluctant to fill the void because they assiduously attempt to avoid fiduciary status whenever possible. Typically, these plans linger with the service providers maintaining the minimum documentation and administration requirements (and charging their fees against the plan assets). If nothing is done, the plan either continues on indefinitely or the assets are slowly reduced by the administration fees until they disappear. In either case, participants who did not quit before the company actually ceased operations are later unable to have their assets distributed.

The DOL has recently been active in obtaining relief for such plans by suing the plans and getting a court to appoint an independent trustee. Although not a perfect result, it is far superior to having the assets simply waste away with no recourse available to the participants.

HIPAA Insight

The Health and Human Services (HHS) National Conference on the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule consisted of four day-long meetings in four different cities

during which HHS representatives reviewed HIPAA requirements and answered questions. The privacy rules are set to become effective for larger plans (those with more than $5 million in annual receipts) on April 14, 2003. We were present at the well-attended New York meeting and found the following information particularly helpful.

Voluntary Compliance

Richard Campanelli, director of the HHS Office of Civil Rights, noted that they are focused on fostering voluntary compliance with the privacy rule. He stressed that the enforcement efforts in the first year of effectiveness will be complaint-driven. He explained that the most likely response will be to contact the covered entity to discuss the issue and obtain their agreement to comply. Although Campanelli did not go so far as to say that HHS would not seek monetary penalties, he emphasized that HHS would prefer to obtain compliance, rather than impose penalties.

Who Is Covered?

An attorney from HHS Office of General Counsel/Civil Rights Division said that employer plans providing even *minimal* health benefits will be covered by the privacy rules. For example, a long-term disability program that includes an employee assistance program that provides counseling in addition to referrals will be a health plan for purposes of the privacy rule. Likewise, an accident policy that covers the cost of medical evacuation from a foreign country will be a health plan. In both of these cases, the plan can be designated as a "hybrid plan" so that only the health benefits are subject to the privacy requirements.

Who Is a Business Associate?

Discussion with several of the HHS representatives about the circumstances in which various parties would be business associates of a covered entity resulted in consensus. In all cases, they stressed that the test is functional — whether the service provider is performing services on behalf of a covered entity (or providing certain types of services for a covered entity) and whether those services involve the use of protected health information.

Business Associate Monitoring

The HHS representatives made clear that plans have no responsibility under the privacy rules to actively monitor their business associates' compliance with contract provisions. Responsibility only arises if the plan becomes aware of a violation of the contract. In that case, the plan must require the business associate to correct the situation and take certain actions if the business associate does not do so. Conversely, it was noted that there is no responsibility of any business associate to monitor a covered entity's compliance with the privacy rules.

What is Protected Health Information?

Christina Heide, a privacy program and policy specialist with HHS, said that employers must identify the source of health information to determine whether it is protected by HIPAA. For example, if the employer requires drug testing, the results of those drug tests come from a provider that is probably

covered by the privacy rules. That provider must treat those results as protected health information, and must have the employee's authorization to release the information to the employer. Once the employer receives those results there is no obligation under HIPAA to protect the privacy of that information. Still, the employer will have obligations under the ADA and other authorities to protect the confidentiality of those test results.

Who Can Receive Family Member's EOB's?

Ms. Heide said that several employers wanted to know whether sending an explanation of benefits (EOB) on a claim for services provided to an employee's spouse or adult child to the employee created problems under privacy rules. According to Ms. Heide, sending the EOBs to the employee is acceptable under the privacy rules as a payment function of the plan even if the EOB contains protected health information on the employee's spouse or adult child. It was also noted that any dependent can request that an EOB for their claims be sent separately or to a different address. The plan would be required to accommodate that request if the dependent indicated that sending the EOB to the employee could endanger the dependent.

New Compliance Tools and Workshops for Health Plans

The Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) has issued several new publications to assist employers and health plans to comply with the portability of coverage provisions under the Health Insurance Portability and Accountability Act (HIPAA), as well as the standards added to ERISA by the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, and the Mental Health Parity Act.

Included in the new DOL compliance materials is a self-audit guide to allow employers and health plans to conduct their own compliance check, sample language for the laws' notice requirements, and tips for avoiding the 15 most common compliance mistakes concerning these benefit laws. According to an EBSA statement on their findings, the "most significant non-compliance related to the laws' various notice requirements."

As part of the new compliance assistance effort, EBSA also announced six regional workshops to provide further assistance in translating the federal health requirements into plan standards and documents. A schedule for the workshops and registration forms are available along with the compliance assistance tools on the DOL Web site, www.dol.gov

FDA Warns Pharmacy Importing Drugs from Canada

The U.S. Food and Drug Administration (FDA) is cracking down on mail-order pharmacies importing and distributing less-expensive Canadian prescription drugs.

Importing U.S.-made and approved drugs from outside the country for resale in the United States is illegal. Last month, the FDA put such importers, and insurers who pay for imported drugs, on notice that anyone aiding that practice could face legal action. Now, in its first formal action against the increasingly common practice of filling American prescriptions with cheaper Canadian drugs, the FDA issued a

"warning letter" to a mail order pharmacy chain operating in the Midwest. The FDA asserts that the company is violating federal law by facilitating the purchase of Canadian drugs. News reports indicate that the company was given 15 days to defend itself before the FDA takes additional steps to permanently halt sales. In its warning letter, the FDA said the company not only violated federal drug-importation laws, but it lied to customers on a Web site that falsely said the drugs were approved by the FDA.

The government's action validates exactly what we have been saying about "going to Canada for drugs" since this matter first emerged as an issue for employers. It's important to note that although the FDA took steps against a drug retailer and not an employer sponsored drug plan, the same legal principles would apply to plan sponsors. Plan sponsors should therefore realize that they are prevented from structuring programs which entice participants to buy drugs in Canada, in violation of federal law and which also risk the health of plan participants. Nevertheless, because of the marketing attempts of certain insurance companies and the incorrect claims that some HMOs have touted, consumers and plan participants are often still drawn to these programs. Employers should review their plans to ensure they are not encouraging employees to illegally import prescription drugs.

Many mail-order pharmacies and Internet pharmacies claim to provide the same drugs that could be acquired in the U.S. at a much higher price. American consumers who use such services are not necessarily receiving brand name drugs. They very likely may receive untested and unapproved foreign "equivalents" of U.S. brand name drugs.

One drug manufacturer, GlaxoSmithKline (GSK), has taken a drastic step to halt the direct supply of cheap drugs to the U.S. Early this year, GSK told several large Canadian drug wholesalers that they would no longer receive GSK drug treatments if they continued to funnel GSK drugs to pharmacies sending the drugs to American consumers. The Canadian drug wholesalers which were approached by GSK felt that they needed to comply with GSK's ultimatum. Otherwise, GSK drugs would not be available for Canadian consumption.

Since You Asked — Pre-Tax Plans and Contribution Shortages

A *FOCUS on Benefits* reader contacted us about a situation that may surface for employers with relatively low-paid workers. This employer maintained a cafeteria plan through which workers can pay for coverage on a pre-tax basis. Administrative problems arise when, due to irregular schedules or earnings, these workers' paychecks are too small to cover their required health plan contributions.

Two means of collecting the shortage from the employee seem administratively feasible. The first route: require the employee to write a check for the shortage. This results in the employee making after-tax payments for the periods when the employee's paycheck does not cover the full contribution. This option arguably violates the prohibition against mid-year cafeteria plan election changes. The second route: deduct the shortage from future paychecks in the same year, taking the make-up contribution on a pre-tax basis. This solution raises very few tax or compliance issues, but leaves the employer in the position of providing coverage for which contributions ultimately may not be collectible.

Available authorities offer no clear answer to the question of whether accepting payment by check violates cafeteria plan rules. A cafeteria plan expert at the IRS told us that, in these shortfall situations,

the two options noted above generally are equally acceptable. It appears that the IRS would not consider the after-tax payment by check to be an impermissible election change so long as it results from the employee's pay being insufficient to collect the full premium *and* all employees in this situation are required to make such payments. That is, an employee failing to make a required payment by check would lose coverage due to non-payment of premiums, and shortfall amounts would never be collected from subsequent paychecks on a pre-tax basis.

Unfortunately, if an employer has a self-insured plan, the above response does not answer all of the compliance issues raised by the payment-by-check solution. If the self-insured plan that will be accepting the checks does not have a trust, ERISA concerns arise. Under such plans, the employer generally collects employee contributions from employees' pre-tax pay and pays all claims under the plan from its general assets. Under ERISA, the pre-tax employee contributions generally are considered plan assets that become subject to ERISA's trust requirement as soon as they are segregable from the employer's general assets. Because the employees' contributions are made under a cafeteria plan, however, a DOL non-enforcement policy applies. Under that policy, the DOL will not enforce the ERISA trust requirement against welfare plan solely because it fails to hold participant contributions in trust if participants make contributions to that welfare plan through a cafeteria plan. The DOL has indicated that, if a plan otherwise qualifies under the non-enforcement policy, the plan will not stop qualifying just because it accepts some after-tax payments like COBRA payments and retirees' contributions. It is unclear whether, technically, after-tax payments from current employees (like the checks in the payment-by-check solution) can be disregarded for this purpose. Because these after-tax contributions are relatively small amounts they are usually spent to cover claims costs under the plan before they are received. So, any ERISA violation due to failure to hold these amounts in trust will not cause any loss to plan participants and would be unlikely to result in any DOL enforcement action.

Massachusetts Assessing a Prescription Surcharge

The Massachusetts legislature has enacted a pharmacy assessment that applies to all non-Medicare and non-Medicaid prescriptions. Under the new law, between January 1, 2003 and June 30, 2003, an assessment of $1.30 will be levied on prescriptions. The surcharge is projected to generate $36 million over the six-month period. The proceeds from the prescription assessment will be credited to the state Health Care Security Trust Fund and will be used to fund the state's Medicaid prescription program.

Except for hospital inpatient and certain other pharmacies, all Massachusetts pharmacies including mail-order that are both registered and licensed by the state must pay the assessment. Most pharmacies are electing to pass the $1.30 charge on to consumers, but some large pharmacy chains have chosen to absorb the prescription assessment and to not pass the charge onto customers.

The state law requires that all prescription drugs (name brand or generic), over-the-counter drugs, syringes, and durable medical equipment that are dispensed by a pharmacist are subject to the pharmacy assessment.

Because the law is directed at licensed pharmacies and not employer benefit plans, ERISA preemption arguments are weak. Plan sponsors should have the option of deferring the surcharge expense to

prescription drug plan participants. Plan sponsors may wish to specifically exclude such changes to ensure that the plan will not be responsible for the assessment.

Issue Spotlight: COBRA Documentation

With the DOL taking a wide-range approach during its compliance audits, employers often second guess their COBRA administrative practices. This article offers a summary of key COBRA compliance requirements, as well suggestions for a strong recordkeeping trail.

Duration

COBRA's statutory language does not specifically say how long COBRA records must be kept. However, employers who are subject to ERISA can look to the general ERISA recordkeeping rules for guidance. ERISA requires that plan administrators maintain records justifying the information in any report that must be filed for an employee benefit plan (such as an annual Form 5500). This information must be maintained for at least six years *after* the filing date of the plan. As a practical matter, this really represents an ERISA obligation to hold records for seven years — six years plus one additional year to reflect the current plan year period of operation.

Another reason for keeping COBRA records for a minimum of six years is that there is no fixed rule on how long a person has to bring a COBRA claim. Most experts and court cases suggest that a claim must be brought within the time period outlined under state contract laws. Absent any longer state limits, employers should consider retaining documents for at least six years.

What to Keep

The short answer is that the employer, or plan administrator, must keep everything relevant to establishing or supporting compliance. As a practical matter, that may not always be feasible. A typical list for each participant would include the following records:

- Date of birth, date of hire, and date of initial plan eligibility.
- Date of plan enrollment and type of coverage.
- Loss of coverage date, and dates of other events affecting the period of coverage continuation.
- Copies of all COBRA notifications (and proof of mailing and other documentation of receipt for the initial notice).
- Original COBRA election forms.
- Claims-related forms.
- Dates and amounts of premium payments received.
- Letters rejecting COBRA coverage.
- Postmarked envelopes relating to correspondence from qualified beneficiaries.

A crucial aspect of COBRA compliance is that employers and administrators must be able to demonstrate that COBRA notifications were adequate and sent on time. Unfortunately, employers will find the volume of records that must be kept can quickly create storage and retrieval problems. Employers or administrators might consider contracting for some acceptable alternative means of storage or using a

third-party record keeper to maintain hard copies of all COBRA-related documents for a required period. This may be preferable to administering COBRA in-house with related recordkeeping costs, as long as the employer can be assured that the records can actually be retrieved when needed.

Considerations

No uniform standard format exists for retaining COBRA-related documents. The easy answer is to keep originals of everything. Given space constraints this is often not possible. An alternative is to maintain hard copies of current documents (three years or so) with "adequate copies" (for example, microfilm) maintained for longer periods. Some employers and administrators will keep records on microfiche, microfilm or by computerized methods. All of these methods are generally permissible under ERISA and the tax code. However, as a practical manner, the employer should maintain the information in a manner that can be easily retrieved. If information is kept in computer form (database programs or computer listings), the employer should also have documented procedures to demonstrate how information accuracy is ensured.

Although computers may be useful for storing data, employers should be leery of exclusively relying on computer systems. Even "secure" computer systems can sometimes be compromised; consequently, some courts may view such records as less credible than hard copy documents.

Noncompliance Penalties

Penalties may apply for a failure to maintain documents demonstrating COBRA compliance. Moreover, the DOL has indicated that the penalty for a failure to maintain records for the six-year period may vary depending on the facts of the particular case. Employers should also note that ERISA penalties can be applied by a court, in its discretion, when a COBRA notice is not provided or a plan administrator does not respond to a participant's request within 30 days. Courts will often impose a per day penalty under the statute. However, they will usually reduce it from the maximum $110 for each day of the failure to a more modest, though still painful, amount. Additionally, an excise tax of $100 per day may be awarded.

An employer's records and preparedness in the event of a lawsuit by an employee could drastically affect the court's perception of employer practices. If an employer cannot produce records, a court would likely view this as a presumption *against* the employer and in favor of the employee. The absence of adequate records could also be used in determining an employer's bad faith when a court assesses damages and attorney's fees. Conversely, easy retrieval and organized documentation can help shift the presumption to one that demonstrates the employer's proper compliance with the full range of COBRA requirements.

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