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Supreme Court Opens HMO Provider Membership

In a unanimous decision, the U.S. Supreme Court said Kentucky's "any willing provider" laws were *not* preempted by ERISA. [*Kentucky Association of Health Plans v. Miller*, 2003 U.S. LEXIS 2710 (April 2, 2003).] This ruling means that states may require HMOs to open their networks to any doctor in the region who agrees to abide by the plan's rules.

About half of the 50 states have laws requiring health-care plans to admit any medical provider in the area who is willing to abide by the terms of the plan. The laws generally reflect state efforts to address concerns about health care cost, availability, and choice. Many experts anticipate that this new decision will spur a flurry of legislation as other states move to adopt similar laws.

Legal Background

A group of seven HMOs plus a state HMO trade group challenged the law which had been adopted in 1994 as part of the Kentucky Health Care Reform Act. HMOs, which seek to contain costs by using only a select group of doctors and providers, have argued such laws would raise costs substantially.

HMOs attempted to challenge the law by using a highly technical argument about whether a state law is "specifically directed" at the insurance industry or not. Under their argument, to the extent that a law did not specifically regulate insurance, ERISA preemption would automatically kick in. In *Miller*, the HMOs tried to assert that the Kentucky law had a general application on doctors and other health care providers as well as HMOs.

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May 2003
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Subsequently they contended that this meant the law was of "general application" and stretched the law beyond mere insurance enough to trigger ERISA's preemption power.

The Supreme Court was not persuaded. The Court said, in upholding the Kentucky law, that the statute plainly did regulate insurance and as a result fell into the exception to the ERISA preemption rule.

DOL Rules on Participant Loans to Officers and Directors

The Sarbanes-Oxley Act of 2002 added a new provision to the securities law [subsection (k) to Section 13 of the Securities Exchange Act of 1934 (the '34 Act)]. That provision made it illegal for public companies to make loans to officers or directors. The law speaks to "issuers" under the '34 Act and, although the Department of Labor does not interpret securities law, it recognized that many people concluded that the term "issuers" includes the 401(k) plans of the public companies. If so, that means that it would be illegal for a public company's 401(k) plan to make loans to the executive officers (directors should not be participants in a 401(k) plan unless they are also employees of the employer). To deny a set of participants the ability to make a loan from the plan violates a standard under ERISA that requires plan loans to be available to all participants on a reasonably equivalent basis. So, theoretically, denying plan loans to the affected group to comply with a reasonable interpretation of the '34 Act would violate ERISA.

To solve that dilemma, the DOL indicates in a Field Assistance Bulletin that the plan fiduciary can prohibit plan loans to the executive officers and not violate ERISA. The DOL, without indicating whether those people really are prohibited from borrowing from the plan, stated that it would be reasonable for a plan fiduciary to make that interpretation. Because the plan fiduciary has a responsibility to adhere to other federal laws, then it would *not* be a violation of ERISA to follow that interpretation and deny plan loans to the affected officers.

Informed parties have indicated that Sarbanes-Oxley was not intended to reach the employer plans. Borrowing from the 401(k) plan is essentially like borrowing from oneself so there would not appear to be any public policy purpose served by denying plan loans to those executives. Nevertheless, there has been no guidance on the issue from the SEC and this might be an unintended consequence following a rushed legislative proposal.

Another omission from the Act is a definition of executive officer. Although not defined, many believe that term to be consistent with the definition in Exchange Act Rule 3b-7, at least until the SEC says otherwise. Rule 3b-7 defines an "executive officer" as the president, any vice president in charge of a principal business unit, division or function (such as sales, administration or finance), any other officer who performs a policy making function, or any other person who performs similar policy making functions. Executive officers of subsidiaries may be deemed executive officers of the parent if they perform such policy making functions for the parent.

What should a plan do?

It will be difficult to tell the executive officers that they cannot borrow from the 401(k) plan. However, given the lack of authority from the securities enforcement agencies and the general high current visibility

of executive compensation issues, the conservative option would be to deny the executive officers the ability to take the loans. Our recommendation is to closely monitor loan activities and implement safeguards which assure that only eligible employees receive plan loans. Consult with your legal counsel to determine if that is the best practice for your plans. If an employer determines that executive officers should no longer be able to borrow from the 401(k) plan, the plan should be amended accordingly.

DOL Proposes Revisions to FLSA

The Department of Labor (DOL) has published a proposal to update regulations defining the overtime and minimum wage exemptions under the Fair Labor Standards Act (FLSA) for executive, administrative, professional, and outside-sales employees. (These exemptions are sometimes collectively referred to as the "white collar" exemptions.) The proposed changes, if implemented, are likely to have far-reaching consequences for many employers.

Minimum Salary

The proposed rules would raise the minimum weekly salary necessary to qualify for the executive, administrative, and professional exemptions. Under the current rules, an employee earning as little as $155 per week may still qualify as an exempt employee. The proposed rules would increase this minimum salary to $425 per week. The $270 increase is expected to dramatically reduce the number of workers who would qualify for consideration of meeting the criteria for an FLSA exemption. The DOL has not raised FLSA's minimum weekly salary amount since 1975.

Salary Deductions

Designed to help employers better manage their workforce, the proposed rules would eliminate some of the restrictions on salary deductions that apply to exempt salaried workers while retaining rules which currently prohibit deductions from exempt salary for partial day absences.

The DOL proposes to allow deductions from the salary of exempt employees for full-day absences taken for violations of any workplace conduct rule. Currently, exempt workers' salaries are subject to deduction for violations of safety rules of "major significance" and for unpaid disciplinary suspensions for one or more full work weeks.

Modification of the Duties Tests

Perhaps the most significant FLSA changes center on streamlining tests currently used to determine exempt status. Under the current regulations, two alternative tests are used to determine whether an employee can be classified as an exempt executive, administrative, or professional employee. The long test generally applies to lower salaried employees and imposes a greater number of requirements that must be met for exempt status to apply. In contrast, the short test is generally reserved for higher salaried employees and imposes fewer requirements. The proposed rules would eliminate the dual testing approach and instead adopt a single standard test for each category of exempt employees.

Exemption for Executives

For example, the proposed duties test for executive employees has three requirements:

- The employee's primary duty must be managing the enterprise or a recognized department or subdivision;
- The employee must direct the work of two or more employees; and
- The employee must have authority to hire or fire, or the employee's recommendations regarding hiring, firing, and other employment-status changes must be given particular weight.

This new standard test reflects elements of both the current long and short tests but is designed to help identify employment positions that clearly fall outside FLSA's reach. Bear in mind, however, that some workers who are currently considered exempt executive employees may no longer qualify for exemption under the proposed rule.

Exemption for Administrative Duties

The proposed rules would replace the discretion and independent judgment test, which has generated a considerable amount of confusion and litigation, with a new test which requires that employees must hold a position of responsibility. For purposes of the proposed rule, holding a "position of responsibility" would be defined as:

- Performing work of substantial importance, or
- Performing work that requires a high level of skill or training

Exemption for Professionals

The proposed regulations also modify the duties tests applicable to exempt professional employees, including computer professionals. The proposed revisions expand the concept of exempt "learned professionals" to include workers who gain specialized knowledge and skills through a combination of work experience and intellectual instruction that could include military training, attending a technical school or a course of study at a community college.

Practical Implications

To assess the potential impact of these changes, you should seriously consider reevaluating the status of all exempt employees to determine whether they would remain exempt under the proposed rules.

In an agency press statement, the DOL indicated that the increase of the minimum salary level for the executive, administrative, and professional exemptions would likely disqualify 1.3 million low-wage employees from minimum wage and overtime exemptions. Ten million others are expected to lose exempt status and qualify for overtime due to the revisions of the duties tests. Despite the potential

negative economic impact, the proposed regulations may, in the long run, help employers by better reflecting workplace realities and clarifying the frequently complicated requirements that govern exempt status.

When would the rules go into effect?

The DOL has published these possible FLSA revisions but will not implement them until after a comment period. The DOL invites the public to weigh in with comments and will review comments received by June 30, 2003. Once all comments have been evaluated, the DOL promises to consider revisions to its proposed rules without retroactive applications.

Issue Spotlight — Notice of Privacy Practices

Several readers have contacted us asking whether an employer providing insured health benefits is required to send a notice of privacy practices to participants. The answer is that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules do not require an employer to send a notice of privacy practices regarding insured benefits, even if the plan that includes those benefits is using the long route version of compliance. More recently, we have heard reports indicating that insurers have sent their notices to employers and told the employers to distribute them to participants. In one case, the carrier posted the notice on its Web site and referred employers to it. Again, HIPAA requirements put the burden for distributing these notices on the *insurer*, not the employer.

We were puzzled by these carrier efforts, and carrier assertions that employers were responsible for distributing these notices. After doing a little detective work we found a logical answer. An insurance representative explained that the provisions of its contract with employers make the employer responsible for distributing any legally required notices. The carrier representative cited a provision which stated that the client is responsible for "distribution to enrollees any disclosure forms, plan summaries, or material that may be required to be given to plan subscribers by any regulatory authority."

This means that any carrier contracts with this type of provision are correct when they require the employer to distribute the notice of privacy practices to participants. If you receive such a notices, you should check the contract before refusing to distribute notices on behalf of the carrier. An employer who refuses to distribute the notices could later have liability under the contract if the carrier incurs penalties or other damages due to the failure to distribute the notices.

Since You Asked — Responding to Enrollee Inquiries

One of the many confusing issues under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules is the extent to which an employer can discuss health information regarding an enrollee via telephone or even in person. Employers usually encounter this issue when asked to intervene in a claims dispute. The person requesting help may be the enrollee whose claim is at issue, in which case the employer can discuss the enrollee's health information with him or her so long as the health plan verifies the identity of the person to whom they are speaking. When the enrollee makes a request by telephone, this can be difficult. Third Party Administrators (TPAs) and other claims payers have

developed systems for individuals to provide passcodes or various pieces of identifying information in order to verify identity. For most employers, these systems will be time-consuming to create and put in place, and will be used fairly infrequently.

Accordingly, many employers are adopting a policy of referring all inquiries to their TPA unless the individual asking for assistance signs an authorization that meets the requirements of the privacy rules. If an employer wanted an additional margin of certainty on this issue, the employer could require submission of identification along with the authorization (e.g., a copy of a driver's license or other government-issued identification having both a picture of the individual and a sample of the individual's signature).

The concerns about claims discussions are compounded when an individual other than the enrollee asks for assistance with a claim (such as a spouse asking about an employee's claim, or vice versa). Under the privacy rules, a health plan (and the employer by extension) generally is prohibited from discussing an individual's health information with anyone else. The exceptions to this rule are:

1) A plan can discuss an individual's health information with that individual's personal representative, and

2) A plan can discuss health information with an individual's friends or family members who are involved in the individual's health care to a limited extent.

In most cases, a health plan would need to verify the identity of the person asking for information on an individual, as described above, and also would need to determine what authority the person has to receive information on a particular enrollee.

Determining whether a person is a personal representative of an enrollee or is a friend or family member involved in an individual's health care can be very difficult and complex. This is compounded for health plans, which generally do not have face-to-face interactions with either the individual or someone asking for information about the individual. TPAs and other claims payers have developed extensive spreadsheets listing the identifying information (e.g., passcode, claim number, date of service, etc.) callers who claim a particular relationship with an enrollee must be able to provide in order to get particular pieces of information.

Due to this complexity, many employers are also adopting an authorization policy in order to discuss an enrollee's claims with someone other than the enrollee. In this case, the authorization would be provided by the enrollee or the enrollee's personal representative. If signed by someone other than the enrollee whose claims are at issue, the authorization requires that the signer state what authority he or she has to sign for the enrollee. In order to be able to give an authorization for another person, the signer must be that person's personal representative. That is, the enrollee's parent (if the enrollee is a minor child and several other circumstances are met), or the enrollee's legally appointed representative in the case of an enrollee who is incapacitated or dead. The employer will need to establish the identity of the person giving the authorization. In addition, the employer will need to verify, through copies of birth certificates, court orders, death certificates, etc., that the signer has the authority claimed with respect to the enrollee whose information is to be disclosed.

Another Trend — Branded Generics

Moving to generics has been seen as one way for the health industry to offset pharmaceutical increases with the lower priced generic brands.

The *Wall Street Journal* reports that some off-shore drug manufacturers are seeking to avoid patented drug restrictions by producing generics before the patent expires. By changing ingredients other than the active ingredient, they have successfully argued that they are not violating the patent. The branded generic can then be sold more cheaply than the patented drug before the patent expires. Although not as inexpensive as true generics (which are direct copies made after the patent expires), these branded generics are one more attempt to lower prescription drug costs.

Branded generics are expected to become increasingly controversial as drug manufacturers themselves have sought patent extensions based on adjustments of inactive ingredients. Some legal experts argue that if drug manufacturers win patent extensions based on subtle changes to prescription formula, branded generics will have a basis on which to argue that their generic versions should be approved.

FDA Continues to Pursue Mail-Order Drugstores

The *Los Angeles Times* reports that Discount Drugs of Canada, one of many Internet and mail-order drug stores, has been threatened with federal drug importation violations and other charges regarding their sale of prescription drugs to senior citizens and others in the United States. The allegations reported in the *Times* follow on the heels of other recent pronouncements from the U.S. Food and Drug Administration (FDA) which indicate that the government is beginning to take this issue seriously.

According to the article, drugs imported from Canada are cheaper than those manufactured in the United States because Canada has a cap on drug prices and because the U.S. dollar has more buying power in the Canadian market, FDA officials are warning consumers that drugs imported from Canada may be contaminated. One store targeted by the government has also been accused of falsely indicating that certain drugs had been approved by the FDA when, in fact, the FDA had not approved them. Although some stores are backing away from the mail-order service, the American Association of Retired Persons (AARP), the Massachusetts Council on Aging, and other groups are encouraging senior citizens to import their medications from Canada in an effort to save money.

It's important to note that, although the FDA is taking enforcement actions against drug retailers and not an employer sponsored drug plan, the same legal principles would apply to plan sponsors. As a result, plan sponsors should note the very real legal issues connected to any arrangement which would entice participants to violate the law by encouraging them to fill their prescriptions outside the United States.

We continue to support efforts to change the regulations. Through the Board of the American Benefits Council and the Employers Council on Flexible Benefits, we have established excellent contacts with legislative and regulatory staff and continue to lobby for changes to make the provision of healthcare more affordable. In the meantime, it is important that employers operate their plans in scrupulous compliance with the current rules and seek other ways to reduce their costs.

Since You Asked — Women's Health and Cancer Rights Act

Does an employer have to provide a *separate* mastectomy notice to plan participants each year, or is it sufficient if the notice is included in their benefits booklet? Although a booklet containing the notice would seem sufficient the rules clearly require a separate annual notice even if the Summary Plan Description (SPD) contains the same notification language.

Background

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans that cover mastectomies to offer benefits for follow-up care for mastectomy patients. The required benefits are:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgical reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of mastectomy.

In addition, plans cannot impose penalties or provide incentives to induce attending providers to provide care mandated under the WHCRA.

WHCRA Notice Requirements

WHCRA requires all plans to satisfy extensive notice requirements. Employers must notify plan participants about these mandated benefits upon enrollment in a group health plan *and annually thereafter*.

- The enrollment notice must describe any deductibles and coinsurance applicable to the coverage of the mandated benefits.
- If a plan or health insurance issuer provides an appropriate enrollment notice to a participant upon enrollment in the plan, then the plan or issuer does not have to provide that participant with an annual notice for the plan year during which that participant enrolled. It would be required annually in later years.
- WHCRA does not require plans to use the same notice to fulfill the enrollment and annual notice requirements; however, plans may satisfy the annual notice requirement by using the enrollment notice and delivering it to participants on an annual basis. By contrast, the annual notice cannot be used to meet the enrollment notice requirement because the Department of Labor (DOL) model annual notice is not as comprehensive as the enrollment notice.

Although the DOL continues to require that an annual notice be distributed to meet WHCRA requirements, many benefit professionals hope that in the future plan sponsors will be able to meet their

obligation by featuring a prominently placed notice inside their SPD. Meanwhile, the WHCRA notice also should appear in the SPD.

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