In This Issue

W

FOCUS

On Benefits

Final HIPAA Portability Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is landmark legislation introducing many legal requirements on a phased-in basis. First came portability requirements, later came requirements associated with discrimination on the basis of health status, and recently administrative simplification and privacy rules were introduced. HIPAA security rules will go into effect later this year.

The latest HIPAA regulations come in the form of both final and proposed regulations. Both can be found in the *New and Noteworthy* section of the Department of Labor web site at www.dol.gov/ebsa.

Final Regulations

Substantially the same as the interim rules first issued in April 1997, the agencies enforcing HIPAA's portability rules (Internal Revenue Service, Department of Labor, and the Department of Health and Human Services) have joined together to publish final regulations. These rules clarify certain issues that arose after the interim rules first appeared. The rules make changes in a few areas—most notably to the model certificate issued when group health plan coverage terminates.

Effective Date

The final regulations apply to health plans and insurers on the first day of the plan year beginning on or after July 1, 2005. Meanwhile, plan sponsors must continue to comply with the current interim rules.

Updated Certificate of Creditable Coverage

The final rules contain an updated certificate of prior group health plan coverage required for employees (and their covered dependents). An "educational statement" was added to more fully inform individuals of their HIPAA portability rights when seeking new health coverage.

Expanded Recognition of Creditable Coverage

Two new categories of health coverage now qualify as HIPAA creditable health coverage for individuals seeking to reduce or eliminate any preexisting condition limitation period under a new health plan. Coverage provided under a state children's health insurance plan (SCHIP) or coverage received under a foreign national health plan (such as may be found in Canada or Great Britain) now constitutes creditable coverage. Obviously, an employer who must ascertain whether coverage existed in a foreign national health plan will have an administrative headache. However, an employer may request documentation showing that the individual established legal residency in the foreign country before recognizing that coverage as creditable.

HIPAA Special Enrollment

Individuals have a right to HIPAA special enrollment through their employer's group health plan if they initially refused to enroll because they have other health coverage but later lost that coverage. The final regulations clarify applicable special enrollment rights for several situations.

- Lifetime limit: An individual is eligible for special enrollment in the employer's plan after the individual reaches the lifetime limit for all benefits under the individual's other coverage. The special enrollment period is available for 30 days after the earliest date that a claim is denied due to reaching the lifetime limit. Although this rule is new, many employers were already operating in this manner.

- Reacquired rights: Individuals may still be eligible for special enrollment even if they did not have other health coverage when they initially refused to enroll. These individuals become eligible for special enrollment if, after subsequently obtaining other coverage, they again choose not to enroll in their employer's plans at annual enrollment and later lose their other coverage.

- Switching benefit options: An employee who is already enrolled may enroll in a different benefit option under the plan if the employee's dependent has a special enrollment right because the dependent lost other health coverage.

- Limited HMO service area: An individual will be eligible for special enrollment if the individual no longer resides or works in the HMO's service area and if the individual has no access to other coverage from the HMO. Additional guidance is expected to consider how this rule would apply and interact in situations were COBRA benefits might be available.

Proposed Regulations

The enforcement agencies have also issued a new set of proposed rules that would change the 63-day break-in-coverage rule for:

- Individuals who do not immediately receive a HIPAA certificate from their prior health plan (the break-in-coverage calculation is tolled until a certificate is provided, but not beyond 44 days after the coverage ends), and

- Individuals who drop health coverage during FMLA leave (the FMLA time during which they maintain no health coverage is not counted against the 63-day break-in-coverage calculation).

There is proposed a special enrollment period for these individuals, allowing them sufficient time to make elections. The proposed rules also include a modification to the certificate of credible coverage. This change states that the certificate must disclose the special break-in-coverage treatment granted to individuals who are on FMLA leave, as well as the provision allowing such individuals to request a special enrollment under another plan within 30 days after FMLA leave.

The agencies have asked the public to submit written comments about these proposed changes to HIPAA's rules. The comment period will run through March 30, 2005.

Implications

Although these are only minor changes and clarifications to the current HIPAA rules, plan sponsors should ensure that appropriate compliance adjustments are integrated as necessary. Other employers may need to secure assurances from their claim administrators or other outside service providers for the same.

New Responsibilities to Veterans

President Bush signed the Veterans Benefits Improvement Act of 2004 (VBIA) into law last December. The VBIA expands some existing benefits and creates new rights and benefits for reemployed servicemen and women. Although the VBIA centers on improving housing, education and other benefits for veterans, the law addresses some obligations under Uniformed Services Employment and Reemployment Rights Act.

Continued Health Plan Coverage

USERRA's continuation coverage stipulates that members of military active service may continue group health coverage for themselves (and their spouses and dependents) for up to 18 months. The new law extends that continuation period to 24 months. This extension will be provided for individuals electing coverage starting on or after the law's December 10, 2004 enactment date.

Notice Requirement

VBIA requires employers to notify those who are eligible for USERRA rights and benefits. The notice requirement may be satisfied by posting a notice where other required notices are customarily posted. The text of this notice is not yet available; however, the Secretary of Labor is directed to provide the text by March 10, 2005.

FSA Forfeiture Rule Remains

Last year, Senator Chuck Grassley (R-Iowa) sent a letter to the Treasury Department asking the IRS to change the use-it-or-lose-it rule in the cafeteria plan regulations. This rule requires any unused amounts in an employee's health care expense flexible spending account (FSA) to be forfeited. Several legislative initiatives have been proposed to permit some of the unused amounts to be rolled over to the following year. Despite wide support, they have not been attached to legislation that has passed and legislators do not feel strongly about the rule.

Although employers would be able to pay lower FICA and FUTA taxes if employees used more salary reductions, not all are in favor of allowing any rollover. They fear that the risk attached to employees using the full amount in their accounts even if they have not yet been funded is too great. The forfeiture rule allows unused amounts to revert to the employer — somewhat balancing their upfront risk.

Slower Government Spending Suppresses Rising Health-Care Costs

The *Wall Street Journal* reports that U.S. spending on health care grew more slowly in 2003 than it had in seven years, spurred by a slower rise in spending by Medicare and Medicaid. Specific data appear in the January/February issue of the *Journal of Health Affairs*. Overall, health-care spending reached $1.7 trillion in 2003, an average of $5,670 per person. Health spending was up 7.7 percent, slowing from the 2002 pace of 9.3 percent.

Government economists said the slower rate largely reflected one-time state cutbacks in Medicaid and the expiration of higher payments to health-care providers under Medicare. The increase in hospital spending, which accounts for almost one-third of the nation's total health tab, slowed to 6.5 percent from 8.5 percent in 2002 — the first deceleration since 1998 — largely due to slower government spending. Growth in private health-insurance premiums slowed for the first time since 1996, to 9.3 percent from almost 11 percent in 2002. Still, health spending expanded faster than the economy overall or the growth in pay, which means more tough choices.

Despite this slight slowdown, in 2003 out-of-pocket spending accelerated to 7.6 percent (from six percent in 2002) as employers shifted costs to employees and more went without health insurance. Almost one-quarter of this was related to prescription drugs, compared with 17 percent in 1998. While consumers spent more money on prescription drugs, retail sales of prescription medication rose 10.7 percent in 2003: much less than the almost 15 percent growth seen in 2002.

Certified Mail Meets COBRA Obligation

FOCUS readers often ask us how COBRA notices should be delivered. As a best practice we continue to recommend that employers send material via first class mail to the qualified beneficiaries' last known address, *plus* we suggest that the employer obtain a "certificate of mailing" from the post office. This costs about 80 cents. It is a green receipt on which the post office copies the mailing address and date stamps the document. This certificate can later be used to demonstrate that the item was delivered into the U.S. postal system. When an item is sent via first class mail, the courts apply a long-established legal presumption that an accurately addressed item will arrive at its destination.

Would a certified letter be better? Not always. When a qualified beneficiary fails to collect his certified letter that item is returned to the mailer. This often leads to the question of what obligations apply when a certified letter is returned.

One court recently examined that question and decided that an employer need not follow up if a certified letter is returned. The case is *Powell v. Paterno Imports, Ltd.*, 2004 WL 2434225 (N.D. Ill., Oct. 28, 2004). The court sided with the employer by ruling that the COBRA notice obligation had been fulfilled by sending a COBRA notice via certified mail to an ex-employee's last known address. The fact that the ex-employee did not pick up the notice because he didn't recognize the address of the sender (which was the third-party administrator) was of no consequence. The court noted that COBRA does not require employers to "ensure that the notice is forwarded in an envelope with a return address familiar to the employee."

Facts

In April 2003, Charles Powell was terminated from employment with Paterno Imports, but was involved in severance negotiations with the company through mid-July 2003. During the period, Powell was still covered under the company's group health plan.

Once the employer decided to terminate health coverage, it instructed its TPA to proceed with COBRA. Powell was notified three times by the postal service that he had certified mail at the post office. He said that he never accepted the mail because he didn't recognize the sender's name. Powell ultimately sued the employer for COBRA notice violations.

The federal district court noted that COBRA's good-faith standard is met when notification methods are used that are reasonably calculated to reach the former employee. The court noted an employer's obligation is satisfied by sending the required notice by first class mail, including certified mail. Although Powell chose not to pick up the notice, his employer's obligation under COBRA had been satisfied.

Implications

The *Powell* case helps strengthen the legal position of employers who choose to use certified mail to deliver notices. The issue remains a controversial matter in which not all courts have uniformly agreed. Consequently, the certified mailing practice is not as reliable a practice as mailing notices via first class mail.

Issue Spotlight: Workplace Dress Codes

Imposing a workplace dress code can be tricky business, particularly in situations where employees have not previously been subject to such rules. In many situations the issue is not just an employee relations concern, but legal protections may also apply as illustrated by the following case.

In *Jesperson v. Harrah's Operating Co., Inc.*, No. 03-15045, Ninth U.S. Circuit Court of Appeals, Darlene Jesperson worked as a bartender and was considered an outstanding employee for almost 20 years. She was fired when she refused to wear makeup, which was required under Harrah's dress code/appearance policy. Harrah's had never formally implemented an employee appearance standard until 2000. In response to the dress code requirements, Jesperson wore makeup for a short period of time, but in her court claim, she said that she soon quit wearing it because of feeling "sick, degraded, exposed and violated."

Jesperson brought a Title VII Civil Rights action against her employer and claimed that the dress code/appearance requirements were discriminatory based upon sex. When the dress code/appearance requirements were created, they applied to both men and women. Female servers were required to wear makeup, stocking hosiery, colored nail polish and had to style their hair in a "becoming manner." Male servers were prohibited from wearing makeup or colored nail polish and were required to have short hair and neatly-trimmed fingernails.

Jesperson eventually brought suit against Harrahs's. Her complaint stated that the employer's appearance standards placed a greater burden on female employees than it did on male employees because of the nature of the expectations and the cost of the personal care. Ultimately, the court determined that the appearance standards were not discriminatory. The rationale behind the decision centered a subtle distinction: while career advancement cannot be linked to discriminatory stereotypes, an employer's personal appearance and grooming expectations may be linked to sex stereotypes. In Jesperson's case, she was not held back from advancement; she was merely disciplined for her failure to follow company dress code/appearance standards.

Although the employer prevailed in this case it is still important for employers to carefully scrutinize the language used to communicate dress and appearance code requirements. Employers obviously enjoy the legal authority to enforce such standards, but nevertheless, clear, effective and neutrally toned language may help prevent workers from seeking to challenge employers with regard to such policies.

The Ninth Circuit consists of Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington, Northern Mariana Islands, and Guam.

HHS Report on Drug Importation

For the last several years *FOCUS on Benefits* has been providing updates on the various drug reimportation efforts that have evolved because of the difference in prices for certain brand name drugs in the U.S. and Canada. Canada has price limits on those drugs and since the U.S. does not, they are typically more expensive in the U.S.

The U.S. Department of Health & Human Services (HHS) recently published a study reaffirming that the administrative costs of assuring that the imported drugs were safe would offset any cost savings from the price caps from the other countries. The complete study is available online at http://www.hhs.gov/importtaskforce/Report12-20.pdf.

HHS determined that the current system for regulating drugs is very effective. The U.S. has one of the safest drug supplies in the world and the U.S. consumer generally has first access to breakthrough drugs. There are real risks associated with large scale reimportation proposals. Many of the transactions occur over the Internet from bogus pharmacies and with counterfeit drugs that are either harmful or do not provide effective treatment. Individuals who travel to Canada to purchase their drugs may not encounter these risks. Nevertheless, HHS feels that protections would be necessary to ensure that the drugs are safe and effective. Still, the report concludes that the associated costs would essentially eliminate any savings.

The report further explores what might be counter productive. First, generic drugs are generally cheaper in the U.S. than in other countries and emphasizing their use would have a greater overall impact than reimporting patented drugs. In addition, HHS feels that by permitting the reimportation, the effect on the flow of new drugs will be negatively affected as manufacturers' research and development expenditures will be reduced. Finally, HHS is concerned about the impact on the intellectual property rights of the drug manufacturers and about the potential liability issues.

The conclusions of the report are not surprising but it does highlight real issues with the safety and efficacy of the imported drugs that need to be resolved. Congressmen who have gone on record as favoring reimportation schemes have, predictably, trivialized the report's findings. It will be interesting to see how the politics develop and we will continue to follow them.

DOL: Cash Contributions to HSAs Okay

The Department of Labor (DOL) will soon confirm that contributions of certain cash credits to an account holder's health savings account are not prohibited transactions.

The DOL determined that putting a cash incentive of $100 in an individual's health savings account (HSA) to secure a high deductible health plan (HDHP) would not be a prohibited transaction. The situation involved an insurance company providing an HDHP coupled with an HSA at a bank. Either the bank or the insurance company could automatically credit the HSA with $100. The insured would not have to do anything but establish the HSA.

Additionally, the premiums payable under the HDHP may not vary based on the individual's choice of HSA custodian or trustee, the advisory opinion said. Administrative fees charged to the account holder with respect to his or her HSA will neither increase nor decrease as a result of the credit to his or her HSA.

This ruling will provide additional comfort to employers who can now be certain that they can credit account in HSAs for their employees without any ERISA violation.

Since You Asked: Medicare and the Over-65 Employee

In 1981 the Medicare Secondary Payer program was created to force employers to continue as primary coverage providers for employees who were eligible for Medicare. This shifted costs to employers and allowed Medicare to maintain a secondary position with regard to health care claims. Should a Medicare-eligible person elect to drop employer coverage in favor of Medicare, then Medicare becomes primarily liable for providing health care. Because an employee has the ability to choose the source of primary coverage, the Medicare Secondary Payer program also expressly prohibits employers from targeting Medicare-eligible employees with enticements and incentives for them to drop the employer-sponsored health coverage.

Caveat Emptor

One of our readers received rate increase information for the up-coming year. Shocked at the double-digit cost increases, the employer became prey for an illegal cost-reduction scheme. A small insurance broker presented health insurance rates that were substantially lower than could be obtained elsewhere. The catch: all 65-and-older employees of the employer would have to be taken off of the group health plan and put into a Medicare supplement benefit. This option was offered to the employer with a straight face, and the cost savings were significant. As appealing as that sales pitch might be, the solution was illegal and could subject the employer to very significant financial penalties under Medicare's Secondary Payer rules.

If the employer had followed through, the action would amount to discrimination and violate the Medicare Secondary Payer rules. If the following categories of individuals are covered by discrimination rules:

- Individuals who are 65 or older if the employer has at least 20 employees. Such an employer *must* provide health coverage to employees who reach age 65 or older (and/or their spouses who reach age 65 or older) on the same basis as it provides benefits to younger employees.

- Individuals who have end-stage renal disease. An employer of any size may not reduce or terminate coverage to such a person and must pay primary to Medicare until Medicare becomes primary.

- Individuals who are disabled if the employer has at least 100 employees. Such an employer *must* provide health coverage, and the coverage may not take into account the Medicare eligibility of any disabled person covered by the plan.

Examples of Prohibited Discrimination

Keep in mind that it is always permissible for employees to drop the employer group health plan in favor of Medicare; penalties apply when the group health plan sponsor has any part in swaying the employee to make that decision. The following employer actions are ones to avoid:

- Offering a Medicare supplement policy or other "free" coverage to Medicare-entitled individuals. It is permissible for employees to purchase a Medicare supplemental policy from a source other than the employer.

- Terminating coverage when an individual becomes entitled to Medicare. It is permissible for an employer to terminate COBRA continuation coverage when an individual affirmatively enrolls in Medicare after having elected COBRA.
- Denying the Medicare-entitled individual the opportunity to enroll or renew enrollment in the group health plan.
- Imposing higher premiums, deductibles, or copays on an individual when he/she becomes entitled to Medicare.
- Limiting the benefits available to Medicare-entitled individuals when benefits are not limited for other, similarly situated individuals who are not entitled to Medicare.
- Imposing a longer waiting period on Medicare-entitled individuals before they can be covered under the group health plan.
- Limiting health care reimbursements to health care providers only where a Medicare-entitled individual's claim is at issue.
- Providing misleading or incomplete information that leads a Medicare-entitled individual to reject the employer's group health plan.
- Including claim filing instructions on health insurance cards, claim forms, or plan materials that instruct providers and suppliers to bill Medicare first, for Medicare beneficiaries without stipulating that such action should be taken only when Medicare is the primary payer.

Very recently, many employers have asked about providing "informational pieces" to employees that discuss the merits of Medicare over the group health plan coverage. These are often incomplete and do not inform employees that dropping the group health plan in favor of Medicare will mean that there will not be any secondary group health plan coverage. Please remember you must fully explain the consequences of rejecting an employer's plan.

Penalties

Penalties fall into two categories, and both penalties can be assessed against and errant plan sponsor:

1) Excise Taxes. The plan sponsor can be taxed in an amount equal to 25 percent of the employer's expenses incurred during the calendar year for each group health plan to which it contributes.

2) Double Damages. The federal government may pursue an action against the plan sponsor for failure to pay on a primary basis. In addition, individuals have a private right of action for double damages if the plan fails to pay benefits on a primary basis.

U.S. Benefit Office Locations

Anchorage, AK
(907) 562-2266

Atlanta, GA
(404) 224-5000

Austin, TX
(800) 861-9851

Baltimore, MD
(410) 527-1200

Bethesda, MD
(301)530-5050

Birmingham, AL
(205) 871-3871

Boston, MA
(617) 437-6900

Cary, NC
(919) 459-3000

Charlotte, NC
(704) 376-9161

Chicago, IL
(312) 621-4700

Cleveland, OH
(216) 861-9100

Columbus, OH
(614) 766-8900

Dallas, TX
(972) 385-9800

Denver, CO
(720) 932-8137

Detroit, MI
(248) 735-7580

Eugene, OR
(541) 687-2222

Florham Park, NJ
(973) 410-1022

Ft. Worth, TX
(817) 335-2115

Grand Rapids, MI
(616) 954-7829

Greenville, SC
(864) 232-9999

Houston, TX
(713) 625-1023

Jacksonville, FL
(904) 355-4600

Knoxville, TN
(865) 588-8101

Lake Mary, FL
(407) 805-3005

Lexington, KY
(859) 223-1925

Long Island, NY
(516) 941-0260

Los Angeles, CA
(213) 607-6300

Louisville, KY
(502) 499-1891

Memphis, TN
(901) 818-3263

Miami, FL
(305) 373-8761

Milwaukee, WI
(414) 271-9800

Minneapolis, MN
(763) 302-7100

Mobile, AL
(251) 433-0441

Montgomery, AL
(334) 264-8282

Mountain View, CA
(650) 944-7000

Naples, FL
(239) 514-2542

Nashville, TN
(615) 872-3700

New Orleans, LA
(504) 581-6151

New York, NY
(212) 344-8888

Orange County, CA
(714) 953-9521

Philadelphia, PA
(610) 964-8700

Phoenix, AZ
(602) 787-6000

Pittsburgh, PA
(412) 586-1400

Plainview, NY
(516) 941-0260

Portland, OR
(503) 224-4155

Raleigh, NC
(919) 459-3000

Rochester, NH
(603) 332-5800

Roswell, NM
(505) 317-3397

St. Louis, MO
(314) 721-8400

San Diego, CA
(858) 455-4888

San Francisco, CA
(415) 981-0600

San Juan, PR
(787) 756-5880

Seattle, WA
(206) 386-7400

Tampa, FL
(813) 281-2095

Washington, DC
(301) 530-5050

Wilmington, DE
(302) 477-9640

Other Willis Locations:

Willis has offices in more than 20 other U.S. cities and in 73 countries around the world, with a total of 260 offices worldwide.

FOCUS is produced by Legal & Research Group of Willis: willis.focusonbenefits@willis.com or 877-4WILLIS (toll-free). *FOCUS* is not intended to provide legal advice. Please consult your attorney regarding issues raised in this publication. Willis publications appear on the internet at: www.focusonbenefits.com.