

In This Issue

In this final issue of 2003, we will review the most important legal developments impacting employee benefit programs and their administration. We will overview the key legislative updates that occurred in 2003 and look forward to 2004 to address compliance issues that may affect your organization.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

“2003 Year-End Benefit Review & Checklist” WHAT A YEAR!

Regulatory compliance seems to become a larger part of plan administration every year and 2003 did not disappoint. This year brought new regulations to contend with, new guidance on established legislation and new information that affects decisions regarding benefit plans. We will overview the major compliance activity from 2003:

- The Security Rule was finalized.
- Many plans faced compliance with The Privacy Rule this April. Small group health plans will need to comply by April 14, 2004.
- The IRS issued guidance on using debit cards for FSA and HRA plan administration.
- The DOL issued new COBRA regulations.
- The IRS issued guidance on covering over the counter medications on a tax-favored basis.
- The Electronic Transaction and Code Set Rules were effective October 16.

Once we overview these key legislative initiatives and their potential impact on your organization, we will review

housekeeping issues for 2003. Many of these issues should be addressed on an annual basis.

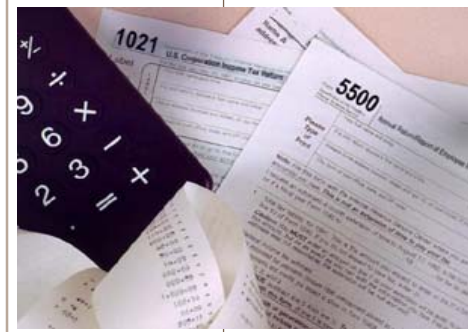
The Security Rule

On February 20, 2003, the Department of Health and Human Services

released the final text for the Security Rule. The Security Rule is the final installment of the Administrative Simplification Provisions of the Health Insurance

Portability and Accountability Act (HIPAA). The Security Rule will affect large group health plans April 21, 2005 and small group health plans, April 21, 2006. Although this is considerable lead time for compliance, these regulations are difficult. The Rule will require your organization to review your electronic systems in depth and write policies to address how your organization is meeting all the standards outlined in the Rule.

The Security Rule's intent is to protect the integrity, confidentiality, and availability of Protected Health Information (PHI) when it is in an elec-



NOTABLE QUOTES

PROMISE A LOT AND GIVE EVEN MORE.

ANTHONY J. D'ANGELO, WRITER

tronic form. The Rule is written as a companion piece the Privacy Rule. It affects the same covered entities, including your group health plan.

The Rule is comprised of specific organizational requirements as well as a series of standards that address administrative, physical and technical safeguards in regard to storing or transmitting electronic PHI (E PHI). The global goals of the Rule are to:

- Ensure the confidentiality, integrity and availability of E PHI that your health plan creates, receives, maintains or transmits.
- Protect E PHI against any threats to security.
- Guard against any uses or disclosures not permitted by the Rule.
- Ensure your workforce complies with your security policies and procedures.



The Rule encourages organizations to review the standards carefully to evaluate the practical and scalable approaches that the organization can adopt to comply with the Rule. When developing action steps for compliance, the following factors should be considered:

- What are the size, capabilities, and complexities of your organization?
- What is your organization's technical infrastructure and software security capabilities?
- How much will your proposed security measures cost?
- How likely are potential risks to E PHI? How critical are those risks?

Compliance with this Rule will require a thorough review of your current IT systems. Your organization will need to analyze how your current system meets the required standards of this Rule and review options to meet any requirement that is not addressed currently. Once an action plan is set forth, your organization should review the practical and cost implications for implementing any new processes and procedures.

This Rule will not be easy to integrate into your organization. It will require a significant amount of analysis and discussion. Although many plans have over a year or even two to develop a plan, it will take time to work thorough the action steps associated with this Rule.

For more detailed information on the Security Rule, please see Volume 6 Issue 6 of the McGraw-Hill *Benefit Advisor*.

The Privacy Rule

The Privacy Rule affected large group health plans effective April 14, 2003 and small group health plans will need to be in compliance April 14, 2004.

Covered entities under the Privacy Rule include employer-sponsored group health plans. Employers are not named covered entities. By virtue of sponsoring a health plan, however, they will have responsibilities under the Rule.

The Privacy Rule's main goal is to protect the privacy of individually identifiable health information that is created, maintained or transmitted by a group health plan, formally called Protected Health Information or PHI. The Privacy Rule has different requirements for:

- Group health plans that are self-funded or insured that use PHI as part of plan administration.
- Fully insured plans that limit use of PHI to enrollment/disenrollment, summary health information and assisting employees' with claim issues.

Self-Funded Plans or Insured Plans that Use PHI in Plan Administration

Plans that use PHI when administering a group health plan will need to:

- Appoint a Privacy Officer.
- Establish a complaint contact.

- Establish a process for filing complaints and a simple procedure for complaint investigation and response.
- Record all the plan's business associates; establish business associate contracts; and execute contracts prior to Rule effective date.
- Develop process on how your organization will handle administration of individual rights:
 - Right to Inspect and Copy
 - Right to Amendment
 - Right to Accounting
 - Right to Confidential Communications
 - Right to Request Restrictions
- Develop a Privacy Policy.
- Develop a Uses and Procedures document (this document details how your plan will use PHI for plan administration and can be included in your privacy policy).
- Develop a Firewall Document (this document establishes the role of your employees that will perform plan administration functions).
- Amend the plan documents.
- Develop the plan's Privacy Notice.
 - Notice should include all the requirements and reflect on how the plan intends to use PHI for administration purposes.
 - Determine how Notice will be distributed to:
 - ✓ Current employees covered by plan
 - ✓ New hires and employees who elect coverage at open enrollment
 - ✓ Employees who make mid year plan additions

- due to changes in family status
- ✓ Redistributing the Notice if you make material changes

Don't forget: if your organization maintains group health plan information on an Internet or Intranet site, the Privacy Notice must be posted at that location as well.

- Execute a Plan Sponsor Certification (This is a simple statement that verifies to the group health plan that the employer has amended the plan document and that PHI will only be used for plan administrative functions. If you are insured, your insurance carrier will provide this form. If you are self-funded, many TPAs are providing this form.)



- Review physical safeguards:
 - Review all the physical areas where PHI is stored. Are these locations safeguarded and is access limited to your "workforce members"?
 - Review all areas where PHI is received—fax machines, mail room, etc. Are these areas secure and is access reasonably limited to "workforce members"?

Your plan should maintain a written review of the physical areas where PHI is kept and your action steps regarding

safeguarding and controlling access.

- Analyze Technological Safeguards.
 - Review all the areas in your organization that keep PHI on an electronic system
 - Discuss with your IT department the way your electronic information is safeguarded
 - Determine if the current measures adequately control access to this data in an electronic format to workforce members. Ask your IT staff for ideas on additional steps your organization can take to safeguard your electronic information.

Your plan should maintain

a written review of your electronic systems and your action steps regarding safeguarding and controlling access.

- Develop and Adopt a Training Process:
 - All members of workforce must be trained; training should be specific to an individual's job function.
 - Training must be documented.
 - The training process should be documented and address:
 - ✓ When current workforce members will be trained (must be before compliance date).

- √ How new workforce members will be trained (must be within a reasonable timeframe from hire date).
- √ If your organization will train non-workforce members.

Fully Insured Plans with Limited Access to PHI

If your organization fully insures all elements of your group health plan and limits access to PHI to enrollment/disrollment information, summary health information and assisting with claims, your plan's action steps are as follows:

- Create a limited privacy policy that includes:
 - Statement that the plan will not retaliate or perform intimidating acts against any individual that files a complaint.
 - The plan will not require a waiver of HIPAA rights to enroll or have benefits paid by the group health plan.
- Develop policy and procedures for handling PHI when you are assisting employees in claim resolution activities.
- Amend your plan document to address your plan's limited uses of PHI.

These are the steps that plans need to take to comply with the Privacy Rule. If your plan's compliance date was April 14, 2003, it is a good idea to review your Privacy compliance

steps to make sure your policies and procedures are complete and reflect how your plan uses PHI.

If your group health plan's compliance date is April 14, 2004, your organization should be working through your compliance steps now. The Rule requires a significant amount of contemplation and policy development; it is a good idea to start the process early.

Using Debit Card for FSAs and HRAs Claim Payments

In May of this year, the IRS released Revenue Ruling 2003-43 to address using debit cards to process claims under a medical Flexible Spending Account (FSA) or a Health Reimbursement Arrangement (HRA). The technology to use debit cards for this purpose has been in place for

many years, but many employers balked at implementing these arrangements because it was not clear that the IRS would find the debit card process

met the claim substantiation requirements under the Internal Revenue Code.

The Revenue Ruling outlines acceptable claim procedures that need to be established for use of a debit card to meet its approval. The IRS expects that all claims processed through the debit card meet certain claim substantiation requirements. A plan that implements debit card technology must include the following key characteristics:

- **Participant Certification:** Participant must verify that the card will be used solely for eligible medical expenses.

- **Card Limit:** The card limit must be set at the annual election to the FSA and must be adjusted in real-time as claims are paid throughout the year.

- **Restricted Use:** The card may only be used at specific merchant codes. These merchant codes are primarily related to health care.

- **Claims Substantiation**

Procedures: All claims must meet some level of review. For the majority of claims, the plan participant will have to submit the necessary claim forms after using card. In limited circumstances, however, claims can be considered automatically substantiated if:

- An expense exactly equals a co-payment under the plan, such as a prescription or office visit co-payment.
- Expense is recurring and matches exactly in amount and frequency a claim that has previous been approved for payment.
- Expense is verified in real-time by a provider that it is for an eligible medical expense.

- **Plan Document Requirements:** The plan document must outline the claim procedures related to the debit card. It must address how the plan will manage improper payments. Improper payments are payments that a participant does not provide the required documentation or an expense that is not covered by the plan.

Many organizations are under the impression that using debit cards reduces paperwork and administrative complexity. This simply is not the case. If your organization is con-



templating using debit cards in the future, please review Volume 6, Issues 5 and 11 for more detailed discussion regarding using debit cards for FSAs and HRAs.

Important Notice: The new Medicare legislation removes the requirement for plans to issue 1099's to certain providers paid directly with the debit card. The new Medicare legislation will be discussed in our first *Benefit Advisor* in 2004.

New COBRA Requirements

In the May 27, 2003 edition of the Federal Register, the Department of Labor (DOL) released new proposed COBRA regulations. The new proposed regulations primarily addressed the notice delivery requirements and notice content requirements.

The regulations were proposed to take effect the first day of the first plan year that occurs on or after January 1, 2004. The DOL noted that until Final regulations are issued, plans were expected to operate in good faith compliance with the proposed regulations as of the effective date.

The DOL also offered a comment period on the proposed regulations that ended July 28, 2003. The DOL received a number of comments and to date, Final regulations have not been issued. Recently, in response to employers' concerns regarding these proposed regulations, the DOL clarified that employers would be given six months following the issuance of Final regulations to update their notices and procedures to comply with the new Final regulations.

However, the DOL expects good faith compliance with your plan's interpretations of the proposed

NOTABLE QUOTES

LIFE IS THE ART OF DRAWING SUFFICIENT CONCLUSIONS FROM INSUFFICIENT PREMISES.

SAMUEL BUTLER

regulations as of January 1, 2004 effective date.

In summary, the new proposed regulations:

- Establish timeframes and delivery requirement for the General Notice (formerly referred to as the Initial Notice of COBRA Rights).
- Created two new notice requirements for COBRA administrators:
 - **Ineligible for COBRA Notice:** If a plan is notified of a qualifying event by an employee or a family member and that individual is not eligible for COBRA coverage, the plan administrator must explain in writing why COBRA is not available.
 - **Early Termination of COBRA Coverage:** If a plan administrator terminates COBRA prior to the end of the maximum coverage period, the plan administrator must notify the qualified beneficiary in writing that COBRA was terminated.
- Provided new model language for the general notice of COBRA rights and a COBRA election notice.

It appears that the Final regulations may differ significantly from the new proposed regulations. However, much of the information required by the new proposed regulations is important for communicating COBRA rights clearly to your employees and potential qualified beneficiaries.

Review Volume 6, Issue 8 of the *Benefit Advisor* for more information on the new proposed COBRA regulations.

We will update your organization on the Final regulations when they are released.



Over the Counter Prescriptions—Approved Expense under FSAs and HRAs

The IRS reversed its position on the deductibility of over-the-counter medication, which was exciting news for many. In a Revenue Ruling issued in September, the IRS outlined a scenario in which an employee purchases an antacid, an allergy medication, a pain reliever and a cold medication. These items were purchased to treat the medical conditions of employee and covered family members. The employee submits a receipt and certifies the items were purchased to treat medical conditions. The employee is reimbursed

Continued on Page 6

these expenses under a flexible spending account.

With so many medications moving to "over-the-counter" status, the IRS felt pressure to allow over-the-counter expenses to be eligible expenses under employer sponsored health plans.

The new Ruling will affect most flexible spending accounts and health reimbursement arrangements. Employers need to review the administrative issues surrounding allowing over-the-counter medications as eligible expenses under the plan. The requirements and concerns for allowing over-the-counter medications to be covered under a FSA or HRA are outlined in Volume 6, Issue 10 of the *Benefit Advisor*.

Electronic Transaction and Code Set Rules

On October 16, 2003, the Electronic Transaction and Code Set Rules became effective. These Rules are part of the Administrative Simplification Provisions of HIPAA. They apply to covered entities:

- Healthcare Providers who conduct certain transactions electronically.
- Healthcare Information Clearinghouses.
- Group Health Plans.

Basically, these Rules specify the format in which electronic data must be arranged if it is being traded in an electronic format:



MEDICARE INFORMATION

Medicare Part A Annual Deductible	\$876.00
Hospital Per Day Copay	
60 to 90 day stays	\$219.00
90 + day stays	\$438.00
Skilled Nursing Facility Per Day Copay (after 20 days)	\$109.50
Medicare Part B Monthly Premiums	\$66.60
Medicare Part B Annual Deductible	\$100.00

- Between two covered entities.
- Applicable to a covered transaction.

Covered transactions primarily are related to the claim payment activities, and include:

- Health claims or equivalent encounter information.
- Health care payment and remittance advice.
- Coordination of benefits.
- Health care claim status.
- Enrollment and disenrollment in a health plan.
- Eligibility for health plan.
- Health plan premium payments.
- Referral certification and authorization.

Most of these transactions do not involve employer group health plans directly. Many organizations, however, have spent the last several years modifying their systems to meet the requirements of these Rules. As the October 16th compliance date approached, there was

concern that the health care system would be seriously affected by the conversion. Most entities had been working diligently on meeting the requirements, but as the formats moved to the testing phase, many organizations were experiencing serious difficulties.

While the effective date for compliance was not changed, the enforcement methodology allowed organizations to continue using their proprietary formats, providing they continued to work at meeting the standard formats.

The Transaction and Code Set Rules have very little effect on group health plans directly, but providers and clearinghouses continue to struggle to use the standard transaction formats.

Annual Reminders and Updates

- **2003 Medicare Information** - The Department of Health and Human Services released the Medicare information for 2004. Please see table located at top of page.
- **Group Term Life Insurance: Section 79** - Each year,

employers need to review their employer-provided life coverage to determine if they need to assess tax liability to any of their employees. Employers only have to impute income for the value of the life insurance plan in a few instances:

- If the employer provides employer-paid life insurance that exceeds \$50,000.
- The life plan discriminates in favor of key employees.
- The employee-paid optional life plan's rate tables straddle Table I rates.

The details addressing when an employer must impute income and how to calculate imputed income are covered in detail in our most recent *Benefit Advisor* (Volume 6, Issue 12).

- **W-2 Forms for STD Benefits** - An issue many employers forget to address at year end is accounting for any disability benefits or earnings paid to disabled employees during the year. W-2s need to be issued to all employees who received short term disability benefits under your short term disability ("STD") plan in 2003. Some STD insurers and administrators will issue W-2s directly to participants who received benefits during the year. Many carriers and administrators, on the other hand, will provide the employer with a quarterly or annual reports, including the information necessary to issue each claimant's W-2.

Your organization should check with your STD insurer or administrator to determine

if they will issue W-2s for your claimants. If the W-2 is issued separately by the insurer, it is wise to let your employees who had claims in 2003 know that they will receive a separate W-2 from the disability vendor.

It is more common for disability vendors to advise employers of the amount paid in disability benefits and then have the income added to the employees' W-2. If this is the case and your organization uses a payroll service, make sure your payroll vendor is aware that each STD plan participant who received benefits during 2003 will have additional compensation that needs to be included on their W-2.

If you self-fund STD benefits, you will need to include any STD benefits in the claimant's 2003 W-2.

- **2004 Indexed Plan Limits** - The Table below summarizes the 2004 indexed plan limits.

Conclusion

Good luck in addressing the year-end compliance issues that affect your organization's benefit plans. May you have a happy and prosperous New Year! **MW**

INDEXED PLAN LIMITS

PLAN LIMITS	2003	2004
Section 401(k) or SAR-SBP	\$12,000	\$13,000
Section 402(g) maximum pre-tax contribution by employees for elective deferrals	\$12,000	\$13,000
Age 50+ Catch-Up Contributions	\$2,000	\$3,000
Section 403(b) Plan	\$12,000	\$13,000
Section 408(p)(2)(A)SIMPLE Plan Contributions	\$8,000	\$9,000
Section 457(b)(2) Limit	\$12,000	\$13,000
Section 415 Limit for:		
Defined Contribution Plans (calendar year)	\$40,000	\$41,000
Defined Contribution Plans (non-calendar year)	\$40,000	\$41,000
Defined Benefit Plans	\$160,000	\$165,000
Highly Compensated Employees Section 414(q)	\$90,000	\$90,000
Includible Compensation - Section 401(a)(17)	\$200,000	\$205,000
Annual Excess Distributions-Section 4980(c)(1)(b)	N/A	N/A
FICA Taxable Wage Base		
Social Security (Tax Rate 6.2%)	\$87,000	\$87,900
Medicare (Tax Rate 1.45%)	No Limit	No Limit

MCGRAW WENTWORTH TEAM

PRINCIPALS	SR. PLAN ANALYSTS
ACCOUNT DIRECTORS	PLAN ANALYSTS
DIRECTOR OF TECHNICAL SERVICES	DIRECTOR OF ADMINISTRATION
MANAGER, CLIENT SERVICES	IT MANAGER
ASSISTANT MANAGER, CLIENT SERVICES	ADMINISTRATIVE SUPPORT
ACCOUNT MANAGERS	MARKETING DEPARTMENT

Our technical bulletins are written and produced by McGraw Wentworth staff and are intended to inform our clients and friends on general information relating to employee benefit plans. They are not intended to provide either legal or tax advice. Before implementing any welfare or pension benefit program, employers are urged to consult with their benefits advisor and/or legal counsel for advice that is appropriate to their specific circumstances.

McGraw Wentworth
 3250 West Big Beaver Road, Suite 500
 Troy, MI 48084
 Telephone: 248-822-8000 Fax: 248-822-4131
www.mcgrawwentworth.com