



BENEFIT *Advisor*

In This Issue

In this final issue of the McGraw Wentworth Benefit Advisor for 2004, we will review the important developments that affected employee benefit programs in 2004. We also will review the housekeeping issues organizations should address annually.

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.

“2004 Year-End Review”

The number of rules and regulations affecting employee benefit plans seems to grow each year, and 2004 was no exception. This year brought a host of new rules that affected your benefit plans:

- Privacy Rule
- COBRA regulations addressing notice requirements
- Health Savings Account clarifications
- Medicare entitlement as a secondary qualifying event
- Taxability of disability benefits

This issue reviews these key legislative initiatives and their potential impact on your organization, as well as housekeeping issues for 2004.

The Privacy Rule

The Privacy Rule became effective for small group health plans on April 14, 2004.

Covered entities under the Privacy Rule include employer-sponsored group health plans. Employers are not named covered entities; however, because they sponsor a health plan, they have responsibilities under the rule.

This Rule protects the privacy of certain health information, called Pro-

tected Health Information or PHI that is created, maintained or transmitted by a group health plan. The goal of the privacy rule is to keep this information confidential, and ensure it is used only for permitted purposes. The Privacy Rule has different requirements for:

- Self-funded or insured group health plans that use PHI as part of plan administration.
- Fully insured plans that limit use of PHI to enrollment/disenrollment, summary health information and employee claim resolution.

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

If your plan uses PHI when it administers a group health plan, you will need to:

- Appoint a privacy officer.
- Establish a complaint contact.
- Establish a process for filing complaints and a procedure to investigate and respond to complaints.



- Establish contracts with the plan's business associates.
- Develop a process to handle the following individual rights:
 - Right to inspect PHI.
 - Right to amend PHI.
 - Right to accounting of disclosures.
 - Right to confidential communications.
 - Right to request restrictions.
- Create procedures to protect PHI. Explain in particular how the plan will use and disclose PHI as a part of plan administration.
- Draft a firewall document naming the persons or departments allowed access to PHI to perform plan functions.
- Amend the plan documents to explain how the plan will comply with the Privacy Rule and how the plan will use and disclose PHI.
- Draft a privacy notice stating all the plan's intended uses for PHI and intended disclosures of PHI. Also, determine how the privacy notice will be distributed to:
 - Current covered employees.
 - New hires and employees who elect coverage at open enrollment.
 - Employees who make mid-year plan additions because of family status changes.

- All employees if your plan makes a material change to notice.

The notice must be posted on your Internet or Intranet site if you post benefit information.

- Issue a plan sponsor certification. This certification is a simple statement to the group health plan verifying that plan document is amended and that PHI will be used only for plan administrative functions. If you are insured, your insurance carrier will provide this form. If you are self-funded, your TPA should provide this form.
- Review physical safeguards.
 - Review all the areas where PHI is actually stored. Are these locations safeguarded and is access limited to your "workforce members"?
 - Review all areas where PHI is received, including fax machine areas and mail rooms. Are these areas secure and is access reasonably limited to workforce members?

Keep a written record of the areas where PHI is actually kept and your action steps for



safeguarding and controlling access to these areas.

- Analyze electronic safeguards.
 - Review all the areas in your organization that keep PHI on an electronic system.
 - Ask your IT department how your electronic information is safeguarded.

➤ Determine whether the current measures adequately limit access to this electronic data to workforce members. Ask your IT staff for ideas on additional steps you can take to safeguard your electronic information.

Maintain a written record of your electronic system and the action steps necessary to safeguard it and control access to it.

- Develop a training program and adopt a training process:
 - Train your health plan workforce; the training should be specific to each employee's job function and how it uses PHI.
 - Document the training and determine how you will train new workforce members when necessary.

Fully Insured Plans with Limited Access to PHI

If you fully insure all elements of your group health plan and limit PHI access to enrollment/disenrollment information, sum-

NOTABLE THOUGHT

**GRATITUDE IS NOT ONLY THE GREATEST OF VIRTUES,
BUT THE PARENT OF ALL OTHERS.**

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mary health information and assisting with claims, you will need to:

- Create a limited privacy policy that includes:
 - A statement that the plan will not retaliate against or intimidate anyone who files a complaint.
 - A statement that the plan will not require a waiver of HIPAA rights to enroll in or have benefits paid by the group health plan.
- Develop policies and procedures for handling PHI when you are helping employees resolve claim issues.
- Amend your plan document to describe your plan's limited uses of PHI.

These are the steps that you must take to comply with the Privacy Rule. If you have not taken any steps to comply with HIPAA's Privacy Rule yet, it should be a priority for 2005.

COBRA Regulations Finalized

In the May 26 edition of the Federal Register, the Department of Labor (DOL) released final COBRA regulations. They affect plans as of the first day of the first plan year following November 26, 2004. If your plan operates on the calendar year, the final regulations will affect your plan, January 1, 2005. The final COBRA regulations govern content, timing and delivery of COBRA notices. In summary, these regulations:

- **Establish the content, timing and delivery requirements of the General Notice** (formerly referred to as the initial notice of COBRA rights). The notice must be

delivered within the first 90 days a participant is covered under the plan. The notice must be delivered in a manner calculated such that it is reasonable to believe that both the employee and the spouse will have access to the notice. The information that must be included in the notice is outlined in the final regulations.

- **Confirm the notice requirements for employers.** An employer must notify a plan administrator of an employee's termination, reduction of work hours, entitlement to Medicare, or with respect to retirees only, the initiation of bankruptcy proceedings of the organization.
- **Expand employee and qualified beneficiary notice requirements.** Employees and potential qualified beneficiaries must notify a plan administrator of events such as divorce, legal separation, or loss of dependent eligibility within 60 days of the event. A qualified beneficiary must also notify the plan administrator of a social security approved disability. The timeframe for this notification is based on when the social security disability is determined.

A key requirement for these notifications is that the Summary Plan Description must disclose reasonable procedures for an employee or qualified beneficiary to inform

the plan of any of the above events. If the Summary Plan Description does not include this information, a participant may simply notify anyone who normally handles the plan's benefit issues. This person may very well be the plan's Third Party Administrator or insurance carrier.

- **Increase your plan administrator's notice requirements.** In addition to notifying employees of their COBRA election rights, administrators have two additional notice requirements:
 - **Ineligible for COBRA Notice:** If an employee or a family member not eligible for COBRA coverage notifies the plan of a qualifying event, the plan administrator must explain in writing why COBRA is not available.
 - **Early Termination of COBRA Coverage:** If a plan administrator terminates COBRA before the end of the maximum coverage period, the plan administrator must notify the qualified beneficiary in writing that COBRA was terminated.

The administrator must notify the employee of COBRA election rights within 30 days of receiving notice of a qualifying event. If the employer and the plan administrator are one and the same, the employer has 44 days to notify the employee.



This summarizes the key requirements of the new final COBRA regulations. You may need to review Volume 7, Issue 7 of our Benefit Advisor for more information on these COBRA regulations and the content required in notices.

HSA Guidance

This year the IRS and the Treasury Department released a host of guidance on the Health Savings Accounts or HSAs established under The Medicare Modernization and Improvement Act in December of 2003. HSAs are interest-bearing, tax-free accounts for those who meet the requirements (one requirement is coverage under a High Deductible Health Plan [HDHP]). Individuals can use these tax-free accounts to pay qualified medical expenses.



While the Medicare legislation explained these accounts broadly, it did not answer many specific questions. Therefore, this year has brought a wave of guidance on HSAs:

- **Clarification on what services are considered preventive care.**
- **Clarification on how to view HDHP pharmacy benefits:** HDHPs cannot cover prescriptions until the plan deductible is satisfied. Because most health plans do not operate this way, the Department of Treasury issued transitional relief. If a plan meets all HDHP requirements other than pharmacy benefits, the plan will be considered an HDHP until January 1, 2006. After

January 1, 2006, the pharmacy benefits must become a deductible expense.

- **Clarification on eligible HSA expenses:** The initial Medicare Act specified an HSA cannot cover expenses incurred before the HSA was established. At the beginning of this year, many individuals had health plan coverage that met the definition of an HDHP but could not find a vendor to sponsor their HSAs. The Treasury Department issued

transitional relief for 2004 allowing an individual to use an HSA to cover expenses incurred before

establishing the HSA, if the individual had qualifying HDHP coverage during 2004 when the expense was incurred.

- **Coordination of HSA/FSA/HRA:** There were also many questions on how HSAs would coordinate with other tax-favored vehicles. The Medicare Act requires merely that an individual be covered only by an HDHP in order to be eligible to contribute to an HSA. HRAs and FSAs in the traditional sense are considered "other health plan coverage." In order to coordinate with an HSA, the FSA or HRA can cover only specific services, for example:
 - Vision and dental benefits
 - Preventive care services
 - Services after the deductible is met
- **Other Administration Concerns:** In July, the IRS

answered many other questions on administrative concerns regarding these accounts. The questions are organized into eleven separate categories, including:

- Eligible individuals
- High Deductible Health Plans
- Preventive Care
- Contributions
- Distributions
- Comparability
- Rollovers
- Cafeteria Plans and HSAs
- Account Administration
- Trustees and Custodians
- Other Issues

The guidance on HSAs has clarified a number of issues regarding how these plans operate. Volume 7, Issue 5, and Volume 7, Issue 9, of our Benefit Advisor offer a detailed discussion of the guidance published this year.

COBRA Clarification on COBRA Secondary Qualifying Events

At the beginning of this year the IRS released Revenue Ruling 2004-22 to clarify whether Medicare entitlement should be treated as a secondary qualifying event under COBRA. The Revenue Ruling presented a scenario in which an employee retires at age 64. He and his wife are covered by the group health plan. His wife elects COBRA for the initial 18 month continuation period. When the former employee turns 65, the Revenue Ruling stipulates that his wife is not eligible to extend her maximum coverage period to 36 months.

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According to the new revenue ruling, a covered employee's Medicare entitlement can only be considered a secondary qualifying event for a dependent qualified beneficiary if, and only if, Medicare entitlement would be the reason a qualified beneficiary loses coverage under a group health plan. For practical purposes, this should never occur. Medicare secondary payer rules require the group health plan to be the primary payer for current employees eligible for group health coverage (for groups with 100+ employees). Medicare entitlement would almost never be the reason a working aged employee would lose coverage under a group health plan. Since Medicare entitlement would not cause a current employee to lose coverage, it cannot be considered a secondary qualifying event under COBRA.

As you review your plan's COBRA notices and SPD language, it is important to make sure your plan does not communicate Medicare entitlement as a secondary qualifying event.

IRS Clarifies the Tax Treatment of Disability Benefits

This year the IRS released Revenue Ruling, 2004-55 on taxing disability benefits. The Revenue Ruling is consistent with how most plans currently administer their disability plans and is consistent with Private Letter Rulings the IRS has released in the past.

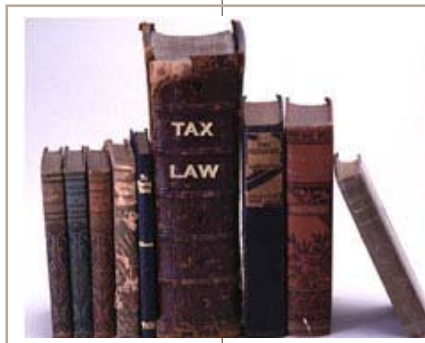
Disability benefits can include benefits paid from a short- or long-term disability plan. The general guidelines are as follows:

- If an employee pays for the coverage with after-tax dollars, the benefits are not taxable.
- If an employee pays for the disability coverage with pre-

tax dollars, the benefits are taxable.

- If the employer pays for the disability coverage, the benefits, for the most part, are taxable.

For example, an employee decides at the beginning of the plan year whether to have the employer pay the disability premiums with pre- or post-tax dollars. If the employee becomes disabled after choosing post-tax payment, the benefits are not taxable. If an employee becomes disabled after choosing pre-tax payment, the benefits are taxable.



The key plan parameters are:

- The employee's choice to pay with either pre- or post-tax dollars must be made for an entire plan year and is irrevocable for that year.
- The employer can continue to abide by the employee's original choice year after year unless the employee affirmatively decides to change it.

The Ruling applies separately to short- and long-term disability benefits. For example, suppose the employer allows the employee to choose to pay for long-term disability benefits with either pre- or post-tax dollars, but the employer pays 100% of the premium for short-term disability benefits. In this situation, the short-term disability benefit would be taxable. The long-term disability benefits would be taxable only if the employee has chosen to pay the premiums with pre-tax dollars.

What if both the employer and employee contribute toward the cost of long-term disability benefits?

If both employee and employer pay for disability benefits, the "three-year look back" rule will apply. Under this rule, an employee is taxed on the percentage of the premium the employer has paid for the three years before the employee becomes disabled. For example, if the total premium for an employee's disability coverage for the three years before the disability was \$250 and the employer paid 40% of that premium, then 40% of the disability benefit would be taxable using the three-year look back rule. This assumes the employee portion is paid post-tax.

This Revenue Ruling merely formalizes the approach many plans have taken for years. Your plan should outline the pre- and post-tax payment options for disability benefits. It should also make it clear that the employee must decide before the beginning of the plan year, and the decision is irrevocable for that year.

Annual Reminders and Updates

- **2005 Medicare Information**
The Department of Health and Human Services released the following Medicare information for 2005 (please see table on next page).

At the end of 2003, President Bush passed the Medicare Modernization and Improve-

ment Act. This Act changed substantially the structure of the Medicare program.

Changes that may affect beneficiaries in 2005 include:

- Indexing feature for Medicare Part B deductible. The deductible under Part B increased from \$100 to \$110, January 1, 2005. The Part B deductible will be adjusted every year to reflect inflation.
- Medicare now covers certain preventive services such as screenings for heart disease and diabetes. It will also cover a "Welcome to Medicare" routine physical for beneficiaries entering the program.
- This summer Medicare also launched a discount program for buying prescription drugs. For an annual fee, Medicare beneficiaries will receive a discount card to provide a 15-20% discount on their pharmacy-filled prescriptions.



- **Group Term Life Insurance: Section 79 (see Volume 7, Issue 12 of our Benefit Advisor)**
Each year, employers need to review their employer-provided life coverage to determine whether their employees must pay tax on the value of their life insurance. Employers have to impute the life insurance value

MEDICARE INFORMATION	
Medicare Part A Annual Deductible	\$912.00
Hospital Per Day Copay	
60 to 90 day stays	\$228.00
90+ day stays	\$456.00
Skilled Nursing Facility Per Day Copay (after 20 days)	\$109.50
Medicare Part B Monthly Premiums	\$78.20
Medicare Part B Annual Deductible	\$110.00

as income in only 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 on imputed income and how to calculate it are covered in detail in our most recent Benefit Advisor.

- **W-2 Forms for STD Benefits**
Remember to account for any disability benefits or earnings paid to disabled employees during the year. You need to issue W-2s for all employees who received short-term disability benefits under your short-term disability (STD) plan in 2003. Reporting for this income is generally handled in one of two ways:
 - Sometimes disability carriers and/or third party administrators will issue W-2s directly to participants who

received benefits during the year.

- Sometimes carriers and/or administrators will provide the employer with a quarterly or annual report, including the information necessary to issue each claimant's W-2.

Ask whether your STD insurer or administrator will issue W-2s for your claimants. If the insurer issues W-2s separately, it is wise to let employees who had claims in 2004 know that the disability vendor will send a separate W-2. Disability vendors commonly notify employers of the amount paid in disability benefits and employers then adds that income to the employees' W-2s.

If your organization self-funds STD benefits, you will need to include any STD benefits in the claimant's 2004 W-2. If you use a payroll service to issue W-2s, make sure your payroll vendor includes the additional compensation on 2004 W-2s.

- 2005 Indexed Plan Limits**
 The table at the bottom of the page summarizes the 2005 indexed plan limits.
- HSA Indexed Parameters**
 The government released the 2005 plan parameters for HSAs. The changes are outlined in the table on the right.

Conclusion

While many of these issues are considered only once a year, you need to understand how these new rules and general housekeeping issues can affect your plans and your organization.

Good luck in dealing with these complex year-end compliance issues. The staff of McGraw Wentworth wishes you and your family, a happy and prosperous New Year!

This article is written solely to provide useful information. It is not intended to be, nor does it constitute, legal advice. Before implementing any welfare or pension benefit program, employers are urged to consult their benefits advisors and/or attorneys. MW

HEALTH SAVINGS ACCOUNTS (HSA) INDEXED PLAN PARAMETERS

Plan Parameter	2004	2005
Self-Only Deductible	\$1,000	\$1,000
Family Deductible	\$2,000	\$2,000
Self-Only Out-of-Pocket Maximum	\$5,000	\$5,100
Family Out-of-Pocket Maximum	\$10,000	\$10,200
Self-Only Maximum Annual Contribution	\$2,600	\$2,650
Family Maximum Annual Contribution	\$5,100	\$5,250
Catch-Up Contribution (55 and older)	\$500	\$600

INDEXED PLAN LIMITS

Plan Limits	2004	2005
Section 401(k) or SAR-SEP	\$13,000	\$14,000
Section 402(g) maximum pre-tax contribution by employees for elective deferrals	\$13,000	\$14,000
Age 50+ Catch-Up Contributions	\$3,000	\$4,000
Section 403(b) Plan	\$13,000	\$14,000
Section 408(p)(2)(A) SIMPLE Plan Contributions	\$9,000	\$10,000
Section 457(b)(2) Limit	\$13,000	\$14,000
Section 415 Limit for:		
Defined Contribution Plans (calendar year)	\$41,000	\$42,000
Defined Contribution Plans (non-calendar year)	\$41,000	
Defined Benefit Plans	\$165,000	\$170,000
Highly Compensated Employees Section 414(g)	\$90,000	\$95,000
Includible Compensation - Section 401(a)(17)	\$205,000	\$210,000
FICA Taxable Wage Base:		
Social Security (Tax Rates 6.2%)	\$87,900	\$90,000
Medicare (Tax Rate 1.45%)	No Limit	No Limit

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