McGraw Wentworth

BENEFIT Advisor

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In This Issue

In this seventh issue of the McGraw Wentworth Benefit Advisor for 2007, we address checking your plan's compliance pulse. Over the last fifteen years, the complexity of administering benefits has increased substantially. Much of the increase in complexity is due to federal legislation impacting employers and their benefit plans.

It is a good idea every few years to step back and review your organization's procedures regarding complying with various federal laws. This Advisor will provide a summary of laws that may affect your organization and key compliance steps that your organization should be addressing.

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.

"Check Your Compliance Pulse"

The Employee Retirement Income Security Act or ERISA was a landmark piece of legislation in the early 1970s. It was the beginning of government oversight and involvement in employer-sponsored benefit plans. In the last fifteen years, legislation affecting employer-sponsored benefit plans has increased substantially. The laws were issued several years apart so they have not been overwhelming, but they certainly have made working in human resources more complex.

With so many legislative mandates, it is easy to lose track of all their requirements. During the next year, it may make sense to check your organization's compliance pulse; many of these regulations carry significant penalties for non-compliance. Because these rules may affect your day-to-day activities, it is a good idea to check your procedures every few years.

This *Advisor* summarizes the requirements of the following pieces of legislation to help your organization conduct a quick audit of your compliance practices:

- Employee Retirement Income Security Act – ERISA
- Consolidated Omnibus Budget Reconciliation Act – COBRA
- Family Medical Leave Act – FMLA
- Health Insurance Portability and Accountability Act – HIPAA
- Women's Health and Cancer Rights Act – WHCRA
- Newborn Mothers Protection Act – NMPA
- Mental Health Parity Act (MHPA)
- Uniformed Services Employment and Reemployment Rights Act (USERRA)
- Medicare Part D

Although it is not easy, your organization must keep up with the requirements of benefit plan legislation to ensure that your company's policies comply with federal rules.

Employee Retirement Income Security Act – ERISA

ERISA is a broad piece of legislation that affects employer-sponsored health and welfare plans and also pension plans. ERISA pre-empts plans from state-mandated benefits requirements for self-funded plans. It protects employers and employees when it comes to employee benefits, and

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it also sets forth fiduciary requirements for plan administrators to make sure benefit plans are managed responsibly.

In addition, ERISA requires employers to create the following documents:

- ***Plan Document***: The plan document establishes an employer's ERISA plan. ERISA is not an insurance carrier requirement but rather an employer requirement, and an ERISA plan often encompasses life, disability and health benefits as well as other types of coverage. To comply with ERISA rules, the employer must create an ERISA plan document and assign the ERISA plan a number. For health and welfare plans, this will be a 500 series number.
- ***Summary Plan Document (SPD)***: The SPD describes the plan's benefits. All plan participants must receive an SPD; you can issue separate SPDs for different benefits. ERISA requires the SPD to include very specific information. For more details on that information and all the distribution requirements, please read our *Benefit Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2007/BA_Issue_2.pdf.
- ***Summary of Material Modification***: These documents are amendments to your summary plan description. Any time your organization makes a change to your benefit plan, you must distribute a summary of material modification that outlines the change.

ERISA also requires certain reports be filed for the plan year:

- ***Form 5500***: The Form 5500 is an annual report required for plans with more than 100 covered participants. It provides the IRS and the Department of Labor with key financial information regarding the plan. The Form 5500 is due within seven months of the end of the plan year. For more information on the Form 5500, please see our *Benefit Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2006/BA_Issue_2.pdf.

- ***Summary Annual Report:*** This report summarizes the financial information reported on Form 5500. All plan participants must receive this report every year.

ERISA is an important piece of legislation designed to protect employers and employees alike. Make sure your organization has accurate and complete plan documents and summary plan descriptions. Also, if your organization has more than 100 covered participants, create a process to make sure your Form 5500 is filed on time. The penalties for failing to comply with ERISA requirements are significant.

Consolidated Omnibus Budget Reconciliation Act – COBRA

COBRA is a federal law requiring employers with 20 or more employees to offer continuation coverage to employees under the group health plan if employees lose coverage because of qualifying events. These events include losing coverage because employment has been terminated or work hours have been reduced. For dependents, qualifying events include divorce, death of the employee, legal separation, and loss of plan eligibility.

The employer can require the employee to pay for the coverage during the COBRA continuation period. The employer can charge up to 102% of the insured rate or expected cost of the coverage. For self-funded plans, this is typically the fully insured rate equivalent. The continuation period is 18 months for some qualifying events and 36 months for other qualifying events. Coverage can be extended for 29 months if a qualified

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Notable Thoughts

Destiny is not a matter of chance; it is a matter of choice. It is not a thing to be waited for; it is a thing to be achieved.

William Jennings Bryan (1860-1925)

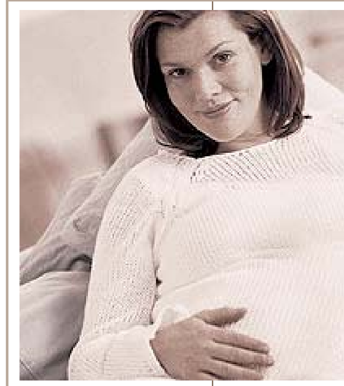
beneficiary is determined to be social security disabled within the first 60 days of the qualifying event.

Under COBRA employers need to comply with a series of administrative requirements. In fact, employers should have a written procedure for administering COBRA requirements. Following is a list of notices that employers should include in their COBRA administration:

- ***General COBRA Information***: A summary of COBRA requirements. The employer must include this notice in the Summary Plan Description.
- ***General Notice***: A notice sent to employees enrolling in the group health plan. It outlines the employer's requirements and the participant's responsibility to notify the employer of a qualifying event. The employer must send the notice to the participant when he/she initially enrolls for health plan coverage. The General Notice should be sent by first class mail, and it must be addressed to all covered individuals at the home.
- ***COBRA Notice of Election Rights***: A notice of COBRA rights stating the time limits for electing COBRA and paying premiums. The employer must send this notice when a participant experiences a qualified event and loses health plan coverage.
- ***Notification of Ineligibility for COBRA:*** Sometimes participants will notify employers of qualifying events when they are not eligible for COBRA for one reason or another. If an employer receives notification, they must send a letter to the participant explaining that he/she is not eligible for COBRA.
- ***Notice of Termination of COBRA:*** A notice the employer must send to the COBRA qualified beneficiary when COBRA has been terminated before the end of the maximum continuation period. It must include any information on conversion plans available.

The notices are a primary step for COBRA administration. For more information on the COBRA notice requirements, please see our *Benefit Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2004/BA_Issue7.pdf.

Employers need to manage many administrative details to comply with COBRA. The best strategy is to create a process that includes all the key steps COBRA requires and integrate those steps into the organization's administrative process.



You may choose to use an outside vendor to administer COBRA. If you decide to administer COBRA in house, however, your organization will need to establish effective procedures.

Family Medical Leave Act – FMLA

The Family Medical Leave Act (FMLA) is a federal law that requires employers to allow employees up to 12 weeks unpaid leave during a 12 month period. The leave must be due to one of the following reasons:

- Birth or adoption of a child.
- The serious health condition of an immediate family member.
- An employee's serious health condition.

The FMLA has caused many employers significant headaches. The administration process for the FMLA seems simple, but in practice it can be cumbersome. The key areas employers need to consider include:

- ***Posted Notice***: FMLA requires employers to post a notice of FMLA rights in a conspicuous place where employees are likely to see it.
- ***FMLA Policy:*** Employers need to issue employees a written policy of FMLA rights and requirements. This policy needs to include general information about their leave rights and also employer specific policies and procedures to request a leave. If the employer has created an employee handbook, the FMLA policy information must be included in the handbook.
- ***Specific Notice***: Once an employee requests a leave, the employer must determine whether the leave qualifies under FMLA. If it does, the employer needs to specify it as an FMLA leave and explain the employee's rights and responsibilities. The specific notice must include certain information and must be specific to the individual's leave.

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The employer must protect the job of any employee on a qualified FMLA leave. The employer must also continue group health plan coverage for the employee on leave. However, the employer can require the employee to pay the employee contribution in order to continue coverage. FMLA also requires the employer to reinstate any benefits not continued during the leave, effective the first day back to work following an approved FMLA leave.

For more information about FMLA, please see our *Benefit Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2007/BA_Issue_4.pdf.

Health Insurance Portability and Accountability Act – HIPAA

The Health Insurance Portability and Accountability Act affects many aspects of employer group health plans. This massive piece of legislation has four separate areas pertaining to employers and almost all group health plans.

Portability Requirements: The portability portion of HIPAA prevents employers from limiting coverage because of a pre-existing condition. Initially, it was designed to eliminate "job lock," a situation where employees with serious health conditions were stuck in their jobs because a new employer could limit coverage for their condition—a common situation under group health plans in the past.

Employers need to consider the following key aspects of the portability requirements:

- ***Pre-existing condition limitations***: Any pre-existing condition limitations must meet HIPAA requirements. The look back period can be no longer than 6 months and it must be measured from the employee's enrollment date, which is basically the employee's date of hire. The limitation period is measured from the enrollment date and it cannot exceed 12 months.

  Employers also must give employees credit if they have already met the pre-existing condition limitation under the previous employer's health plan. The credit needs to be applied, providing the employee has not had more than a 63-day break in creditable coverage. Time spent in a new hire waiting period does not count toward the 63-day break. To qualify, employees must prove they were covered under the previous plan. A Certificate of Creditable Coverage is the proof required (see next bullet for more information). An employer that offsets any portion of a pre-existing condition limitation with previous coverage must notify employees how much of the limitation period will apply.

  If the plan limits coverage for a pre-existing condition, employers must notify their employees before the employees enroll. If employers fail to notify their employees, they cannot apply the pre-existing condition limitation.

- ***Certificate of Creditable Coverage***: All employers must issue a Certificate of Creditable Coverage when coverage ends. The certificate states how long the employee was covered under the plan and lists covered dependents. Employers and insurance carriers typically share this responsibility. If your organization is not sending out these certificates, you should make sure your insurance carrier is issuing them. Employers often send out these certificates with the COBRA election notice.

Non-Discrimination Requirements: The non-discrimination requirements prevent group health plans from basing eligibility for coverage on an individual's health. These provisions affected a common practice in employee benefit plans, the actively at work requirement. If your plan still has an actively at work requirement, it must be applied regardless of the reason an individual was not actively at work to meet HIPAA non-discrimination requirements. For example, if my regular work week is Monday through Friday and my coverage becomes effective on Sunday, coverage would not begin until I return to work on Monday. This is an acceptable actively at work provision.

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However, most organizations find these provisions difficult to administer. The actively at work provision historically was tied to the employee's health. For example, suppose the employee is not actively at work because of a medical condition or a disability, and coverage doesn't begin until the employee returns to active work. In this case, eligibility depends on health status and thus is not permitted by the non-discrimination requirements. For an actively at work provision to meet HIPAA rules, it cannot condition enrollment on health status.

The non-discrimination rules also affect incentives for achieving certain health goals under a wellness plan. Health plans must take numerous steps under these rules to provide incentives or rewards for achieving specific health goals.

More details on the final HIPAA non-discrimination rules can be found in our *Benefit Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2007/BA_Issue_1.pdf.

Special Enrollment Rights: Employers are not obligated to offer open enrollment under their health plan. Back before HIPAA was implemented, it was very common for health plans to require employees who did not enroll in the health plan when they were initially eligible to provide proof of good health to enroll in the plan late. The nondiscrimination rules ban employers from making enrollment dependent on an employee's health. Therefore employers have a choice to make: the employer could add an open enrollment period to allow employees the option of enrolling in the plan once a year or the employer can simply not allow employees to enroll in the plan after they waive their initial right to participate. If an individual enrolls in a plan late, the plan can assess an 18-month limitation period for pre-existing conditions.

However, HIPAA requires employers to offer special enrollment rights to employees in these specific circumstances:

1. ***Loss of other coverage***: If an employee initially waived coverage because he or she had coverage available through another source and then lost that coverage because:
   - COBRA coverage has ended.
   - Eligibility for the other coverage has ceased.
   - Employer contributions for other coverage have ceased.
2. ***Acquisition of a new dependent***: If the employee acquires a new dependent through marriage, birth, adoption or placement for adoption, the plan must allow enrollment. The special enrollment right applies to the employee and any eligible dependent – it is not limited to the acquired dependent.

HIPAA allows employers to require employees to notify them in any of the above circumstances within 30 days of the event if the employees wish to qualify for special enrollment rights. In addition, HIPAA requires employers to explain special enrollment rights in the plan's SPD.

Privacy and Security Requirements:

The final piece of HIPAA that concerns employers is the HIPAA Privacy and Security requirements. A great deal of information is used to process claims and manage eligibility for health plans. HIPAA secures a plan participant's protected health information as it moves through the various parts of the health care delivery system, especially in electronic transactions. The privacy requirements protect health information in any format (written, oral, electronic). The security provisions protect only electronic data. Both the Privacy and Security rules apply to group health plans.

The privacy rule only applies to specific information called "protected health information" or PHI. PHI is individually identifiable health information that is created, maintained or transmitted by the group health plan. If that data is stored electronically, it is called EPHI and it must be protected under the security rule. Privacy and Security are similar in concept but the provisions differ.

The privacy rule:

- Dictates when group health plans can use and disclose PHI.
- Creates administrative requirements for the plan to meet in order to use and disclose PHI.
- Requires a group health plan to safeguard PHI both physically and technologically.

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- Grants individuals the right to access PHI records, request amendments to PHI and receive an accounting of how the PHI is used or disclosed.

The privacy rule's broad objective is to ensure an individual's health information remains private. For group health plans specifically, the goal is to ensure that any information an employer obtains through the group health plan will not be used in an employment-related function.

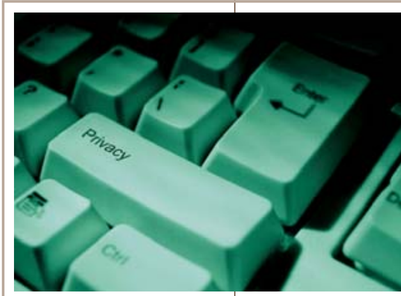
Health plans are permitted to use and disclose PHI for the following:

- Treatment, Payment and Healthcare Operations (TPO).
- When an individual is given the right to object.
- For public policy purposes.
- If employees request access to their own PHI.

If the rule does not permit a certain use, a group health plan can ask the individual to authorize it. The plan should have the individual complete a HIPAA compliant authorization form.

However, in order to use PHI for the above purposes, employers need to meet HIPAA privacy requirements. These requirements differ depending on your plan funding (self-funded or fully insured) and your access to PHI (extensive access or limited access). The requirements for self-funded plans or fully insured plans with extensive access to PHI include:

1. Appointing a Privacy Officer.
2. Establishing a complaint contact and complaint process (filing, investigation and resolution).
3. Developing HIPAA privacy policies and procedures.
4. Creating the workforce – the employees in the organization that need to use PHI in plan administration.
5. Amending the SPD to indicate PHI will be used for plan administration.



6. Establishing business associate contracts with vendors that use PHI on behalf of the health plan.
7. Distributing a notice of your health plan privacy practices. This notice must be provided to newly hired employees.
8. Creating a process for addressing an individual's rights to access or amend PHI and also to receive an accounting of certain disclosures of PHI.
9. Reviewing physical and technological safeguards.
10. Training the workforce on privacy requirements; training must be documented.

Once employers tackle the privacy requirements, they have to meet the security rule requirements to protect EPHI.

The security rule requires employers to:

- Ensure the confidentiality, integrity and availability of EPHI that a covered entity creates, receives, maintains, or transmits.
- Protect EPHI against any threats to security.
- Protect against any uses or disclosures of EPHI not permitted by the rule.
- Ensure your workforce complies with your procedures.

The rule sets forth a series of standards a group health plan must meet to safeguard EPHI. The standards are divided into separate implementation specifications providing more detailed guidance on meeting the standard.

The security rule requires employers to take ten key action steps:

1. Appoint a Security Officer.
2. Determine where EPHI is housed on your systems.
3. Review your current security measures in the areas where EPHI is used or stored, and conduct a risk analysis to identify any potential weaknesses.
4. Review all the standards and determine what actions your organization can take under each standard to strengthen your security measures.
5. Consider all of the implementation specifications.
6. Train your workforce on your security procedures; provide security reminders for important key points.
7. Amend your business associate agreements to include security rule requirements.

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8. Establish a discipline policy for workforce members who violate your security requirements.
9. Amend plan documents to show your plan will be using EPHI in plan administration.
10. Review your security procedures regularly; consider system changes, technological changes and vendor changes.

The privacy and security aspects of HIPAA have challenged many employers. Some employers never get through completing compliance action steps. If a participant files a complaint against your health plan, you'll need the appropriate documents proving your group health plan has implemented the key HIPAA privacy and security requirements.

Women's Health and Cancer Rights Act – WHCRA

The Women's Health and Cancer Rights Act was passed in 1998. It requires employer group health plans that cover mastectomies to also cover certain reconstruction and other post-mastectomy benefits. Any of the plan's deductible and coinsurance requirements for services can be applied to these benefits.

In addition to providing the reconstruction benefits, employers need to notify plan participants of these benefits when they initially enroll in the medical plan and every year thereafter. The annual notice can be brief and be as simple as the following:

As required by the Women's Health and Cancer Rights Act, this plan covers the following services related to a mastectomy:

- *Breast reconstruction for the breast on which the mastectomy was performed.*
- *Surgery or reconstruction of the other breast to produce a symmetrical appearance.*
- *Prostheses.*
- *Treatment of physical complications from the mastectomy, including lymphedema.*

Call your plan administrator at ______ for more information.

Most organizations include this annual notice in their open enrollment materials.

Newborn Mothers Protection Act – NMPA

The Newborn Mothers Protection Act, signed into law on September 26, 1996, protects mothers and their newborn children. The law specifies the minimum length of the hospital stay following childbirth. Group health plans, insurance companies and health maintenance organizations (HMOs) subject to the Newborns' Act must cover a hospital stay of at least 48 hours after a vaginal delivery or 96 hours following a cesarean section. However, the physician may decide to send the patient home earlier, if she agrees.

Moreover, the health plan cannot offer the attending physician or the patient any incentives or disincentives to send the patient home before the minimum time period elapses. This includes reducing the patient's out-of-pocket costs if she leaves the hospital before the minimum allotted stay times. What's more, a health plan cannot require the health care provider to prove the minimum hospital stay is medically necessary. Also, the plan cannot require the hospital stay be pre-authorized if there is a penalty associated with failure to secure a pre-authorization.

The health plan must administer the claims properly and the information regarding the Newborn Mothers Protection Act must be included in the plan's SPD.

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Notable Thoughts

THE BEST AND MOST BEAUTIFUL THINGS IN THE WORLD CANNOT BE SEEN OR TOUCHED. THEY MUST BE FELT WITH THE HEART.

HELEN KELLER

Sample language would include the following:

Under federal law group health plans and health insurance issuers generally must cover a hospital stay of at least 48 hours after a vaginal delivery or 96 hours following a cesarean section. However, the physician may decide to send the patient home earlier, if she agrees. Plans and issuers cannot require a provider to obtain authorization to keep the patient for 48 hours (or 96 hours).

Mental Health Parity Act

The Mental Health Parity Act of 1996 (MHPA) is a federal law that prevents group health plans from placing annual or lifetime *dollar* limits on mental health benefits that are lower than annual or lifetime dollar limits for the medical and surgical benefits the plan covers. The term "mental health benefits" means benefits for mental health services as defined by the health plan.

The law applies to employers with 50 or more employees. This law does not require health plans to cover mental health services. It also does not apply to any substance abuse benefits the plan provides. Health plans may include limits on the number of outpatient mental health office visits. It can also include day limits for inpatient hospital stays. The key is these limits cannot be expressed in dollar amounts.

Group health plans may apply for an increased cost exemption under the Mental Health Parity Act. The health plan must apply for the exemption with the Department of Labor and demonstrate the removal of dollar limitation on mental health coverage will result in more than a 1% increase in health plan costs.

In general, most employers simply restated their mental and nervous coverage in terms of day and visit limits instead of applying for the exemption. The Mental Health Parity Act includes a sunset provision; however, each year the deadline is extended an additional year.

Uniformed Services Employment and Re-Employment Rights Act – USERRA

USERRA prohibits discrimination in reemployment, retention, or any other employment based benefit for employees in the United States military. USERRA also protects employment privileges and benefits for employees called to "active duty in the uniformed services." When an employee completes active duty and returns within the applicable timeframe, the employer must offer the employee his or her previous position and reinstate all employee benefits.

USERRA has many employment and benefit obligations. The benefit obligations are as follows:

- Employers must offer continuation coverage to any employee called to active duty for more than 30 days. If the leave is more than 30 days, employers need to offer continuation coverage to the employee under their group health plan at the employee's expense. The maximum continuation period is 24 months. If the military leave is less than 30 days, the employer must continue the employee's current health benefits. The employer can require the employee pay the employee contribution during that time.
- Employers must also notify employees of their USERRA rights and obligations. To meet this requirement, employers can simply post a notice in the same areas they generally post other required notices, such as the FMLA rights notice. If they prefer, employers may choose to notify each affected employee individually. Many employers include USERRA continuation requirements with COBRA notices.

These are the two benefit-related requirements. Employers should make sure they correctly notify employees called to active duty of their USERRA and COBRA continuation options.

For more information on USERRA's impact on your benefit plan, please see our *Benefit Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2005/BA_Issue2.pdf

Medicare Part D

Medicare Part D added coverage for outpatient prescription drugs to the Medicare program. It was landmark legislation that made the first major change to Medicare coverage since its inception. The program is complicated. To learn more of the details about the Medicare Part D program, please read our *Benefit*

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Advisor at http://www.mcgraw wentworth.com/Benefit_Advisor/2006/BA_Issue_5.pdf.

The Medicare Part D legislation also impacts employers in a few ways:

- Every year active group health plans as well as retiree health plans covering Medicare eligible employees or dependents need to notify their Medicare eligible participants whether the plan is prescription coverage is creditable or not-creditable. For more information on the notices and how to determine whether the health plan prescription coverage is creditable, please see our *Special Alert* at: http://ww.mcgraw wentworth.com/Special_Alert/2007/Special_Alert_Issue_4. pdf. Employers must determine creditable coverage status every year and send the appropriate notice. In addition, if the prescription plan changes mid-year, employers must reevaluate the creditable coverage.
- Retiree health plans have to decide how to work with Medicare Part D. Options available to employers range from applying for a government subsidy of a portion of the plan's drug expenses to eliminating prescription drug coverage. The details on retiree plan options are outlined at http://www.mcgrawwentworth.com/Benefit_Advisor/2005/BA_Issue6.pdf.
- Active group health plans and retiree plans that do not apply for the subsidy also need to advise CMS (Centers for Medicare and Medicaid Services) of their plans' creditable coverage status. This must be done within 60 days after the beginning of the plan year and can only be done electronically. Instructions for the annual CMS filing can be found at http://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp#TopOfPage.

Medicare Part D added an important benefit to the Medicare program but also brought employers more headaches. Employers must now notify Medicare eligible participants of creditable or non-creditable coverage status every year. Employers must also notify CMS every year. Because it is easy to overlook the annual notification to CMS, it makes sense to put an annual reminder in your calendar.

Conclusion

Checking your organization's compliance pulse feels more like major surgery than a simple office visit. All of these major pieces of legislation have added major responsibilities to human resources, and your organization must satisfy the intent and requirements of these laws.

Reviewing your procedures as they relate to each law may be an overwhelming project. However, if you divide the work by focusing on one law every one or two months depending on its complexity, you will be in much better compliance shape this time next year.

If you have any questions regarding this Benefit Advisor, please contact your McGraw Wentworth Account Manager. MW

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