

k&p benefits insider

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Kibble & Prentice

This issue of the KP Benefits Insider focuses on upcoming compliance deadlines for HIPAA and Medicare Part D. Additionally there is information pertaining to recent and proposed federal and state legislative changes that will impact employee benefit plans. Also included are carrier updates as well as information on our Benefit Resource Center.

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Two HIPAA Deadlines Fast Approaching

Security Rule - Deadline for Small Health Plans April 20, 2006

(reprinted from Technical Bulletin 3.13.06)

An employer sponsoring a group health plan that creates, maintains, or transmits protected health information through electronic media must comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule ("the Rule"). The compliance deadline for small health plans (those with annual receipts under \$5 million) is April 20, 2006.¹ Large health plans were to comply by April 20, 2005.

The Rule requires covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards surrounding electronically formatted protected health information (E-PHI), such as maintained under a group health plan. There are four general security requirements a covered entity must meet:

1. Ensure confidentiality, integrity and availability of all E-PHI that the covered entity creates, receives, maintains or transmits,
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information,
3. Protect against any reasonably anticipated uses or disclosures that are not permitted or required by the privacy regulations, and
4. Ensure the compliance of its workforce.

The Rule requires covered entities to establish policies and procedures to comply with standards and implementation specifications set forth

under the rule. Standards set the minimum level of security that must be met by covered entities. The standards are implemented through either "required" or "addressable" implementation specifications. A covered entity must comply with all required implementation specifications. Addressable implementation specifications must be implemented if they are reasonable and appropriate for the group health plan. If it is determined that the addressable specification is not reasonable or appropriate, then the covered entity must document why and provide a reasonable alternative. It is critical that the employer document that the plan complies with each standard and implementation specification. Failure to do so may result in legal ramifications.

The Rule requires, among other things, that the plan appoint a security officer; conduct a HIPAA security risk assessment, develop policies and procedures in handling E-PHI, and conduct training of the workforce.

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¹ Receipts are defined as:

- 1) Fully Insured: the amount of total premiums paid for health insurance in the plan's last full fiscal year.
- 2) Self Insured: total amount of paid for health care claims during the plan's last full fiscal year. Claims paid by the employer, plan sponsor or benefits fund, whichever is applicable.
- 3) Self Insured and Insured Options: plans that provide health benefits through a mixture of purchased insurance and self insurance should combine the total premiums paid and the total paid for health care claims in the plan's last full fiscal year.

Two HIPAA Deadlines Fast Approaching – continued from page 1

Following are the standards and implementation procedures as outlined under the regulation:

Standards	Sections	Implementation Specifications (R) = required, (A) = Addressable
Administrative Safeguards*		
Security Management Process	164.308(a)(1)	Risk Analysis (R) Risk Management (R) Sanction Policy (R) Information System Activity Review (R)
Assigned Security Responsibility	164.308(a)(2)	(R)
Workforce Security	164.308(a)(3)	Authorization and/or Supervision (A) Workforce Clearance Procedure Termination Procedures (A)
Information Access Management	164.308(a)(4)	Isolating Health Care Clearinghouse Function (R) Access Authorization (A) Access Establishment and Modification (A)
Security Awareness and Training	164.308(a)(5)	Security Reminders (A) Protection from Malicious Software (A) Log-in Monitoring (A) Password Management (A)
Security Incident Procedures	164.308(a)(6)	Response and Reporting (R)
Contingency Plan	164.308(a)(7)	Data Backup Plan (R) Disaster Recovery Plan (R) Emergency Mode Operation Plan (R) Testing and Revision Procedure (A)
Evaluation	164.308(a)(8)	Application & Data Criticality Analysis (R)
Business Associate Contracts and Other Arrangement	164.308(b)(1)	Written Contract or Other Arrangement (R)
Physical Safeguards*		
Facility Access Controls	164.310(a)(1)	Contingency Operations (A) Facility Security Plan (A) Access Control and Validation Procedures (A) Maintenance Records(A)
Workstation Use	164.310(b)	(R)
Workstation Security	164.310(c)	(R)
Device and Media Controls	164.310(d)(1)	Disposal (R) Media Re-use(R) Accountability (A) Data Backup and Storage (A)
Technical Safeguards*		
Access Control	164.312(a)(1)	Unique User Identification (R) Emergency Access Procedure (R) Automatic Logoff (A) Encryption and Decryption (A)
Audit Controls	164.312(b)	(R)
Integrity	164.312(c)(1)	Mechanism to Authenticate Electronic Protected Health Information (A)
Person or Entity Authentication	164.312(d)	(R)
Transmission Security	164.312(e)(1)	Integrity Controls (A) Encryption (A)
Policies and Procedures and Documentation Requirements**		
Policies and Procedures	164.316(a)	(R)
Documentation	164.316(b)	(R)
Organizational Requirements**		
Amend Plan Documents	164.314(b)	(R)

*"Appendix A to Subpart C of Part 164- Security Standards: Matrix," 68 Federal Register 34 (20 February 2003), pp.8380.

**45 CFR 164.316, 45 CFR 164.314

Two HIPAA Deadlines Fast Approaching

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The regulations can be viewed in their entirety at www.cms.hhs.gov/SecurityStandard/Downloads/securityfinalrule.pdf. If you need additional assistance to comply with HIPAA security requirements Agent 77, a developer of tools to assist HR with administration, compliance, and training, offers a HIPAA compliance tool. The HIPAA Now Toolkit is a narrated CD that covers the employer HIPAA compliance process step by step, beginning from determining whether or not a company is a "covered entity", through all of the checklists, job descriptions and forms necessary to be in compliance.

HIPAA Now Toolkits are available through Kibble & Prentice, with activation and payment handled directly on the Agent 77 website. Please contact Kellie Stone at 206-441-6300 or kellie.stone@kpcom.com if you are interested.

HIPAA Privacy Notice Mailing - Large Health Plans - April 14, 2006

HIPAA privacy rules require a health plan to provide a reminder about their privacy notice and how to obtain the notice at least once every three years. Large health plans must distribute a reminder by April 14, 2006, if they have not already done so. A large health plan is defined by having annual receipts in excess of \$5 million. The initial privacy notice deadline for large health plans was April 14, 2003. Health and Human Services (HHS) provided guidance as to the plan sponsor's flexibility in providing this notice. A plan sponsor may:

1. Resend the full Notice of Privacy Practices (NPP);
2. Mail a separate reminder regarding the NPP availability and how to obtain a copy; or
3. Include this information "in a plan-produced newsletter or other publication."

(HHA FAQ March 6, 2006) www.hhs.gov/ocr/hipaa/

Small health plans have until April 14, 2007, to comply with the above notice requirement.

Our Mission

Kibble & Prentice is dedicated to assisting clients in making sound decisions that create value and manage risk.

Medicare Part D - Upcoming Deadlines

Enrollment Deadline – May 15, 2006

The deadline for eligible individuals to enroll in the Medicare Part D prescription drug plan is quickly approaching. For Medicare eligible individuals that do not have 'creditable coverage' elsewhere, enrollment must be completed prior to May 15, 2006. Medicare eligible individuals that miss this deadline will have a higher premium for their Medicare Prescription drug coverage if they have more than 63 continuous days without creditable prescription drug coverage. The individual may also be required to wait until Medicare's next open enrollment period, which occurs in November. A prescription drug plan is considered creditable if it provides, on average, at least as much coverage as the standard plan under Medicare Part D.

Individuals covered under both Medicare and Medicaid will automatically be enrolled in the Medicare Part D prescription plan. Medicaid drug coverage officially ended December 31, 2005.

Individuals who applied and qualified for a Medicare Savings Program or Supplemental Security Income (SSI) will not automatically be enrolled in a Medicare prescription drug plan if they also have prescription drug coverage through an employer or union who is claiming them for the Retiree Drug Subsidy. These individuals must enroll in Medicare Part D on their own if they wish to elect a Medicare prescription drug plan.

For additional information regarding plan sponsor options and operational guidance, visit www.cms.hhs.gov/medicarereform/pdbma/employer.asp. This website provides information regarding:

- The statute, regulations and guidance relating to employer coverage.
- Information about creditable coverage disclosures.
- Educational materials to help in deciding what options to consider in the future.
- Frequently asked questions and answers.
- A link to subscribe to email notifications regarding updates and new developments.

Plan Sponsor Notification- March 31, 2006

Plan sponsors have until March 31, 2006 to notify the Centers for Medicare and Medicaid Services (CMS) whether prescription drug coverage under a group plan is creditable or non-creditable for purposes of Medicare Part D. Plan sponsors can satisfy the notification

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requirement by completing an online form and electronically submitting it to CMS. The online form is available at <https://www.cms.hhs.gov/apps/ccdisclosure/default.asp>.

Proposed Washington State Mandated Health Benefits

State mandated health insurance benefits have once again been a focal point of legislation. Following are a few of the mandates currently under legislative review:

- **Age Limitations for Dependent Health Care Coverage (SB6186)** This bill would require health plans that provide dependent coverage to give the option of covering unmarried dependents to age 25 (or to age 30 if a veteran), regardless of whether or not the dependent is enrolled in school. This bill is currently being reviewed by the Senate. To date, a companion House bill has not been introduced.
- **Prostate Cancer Screening (SB6188)** This bill would mandate coverage for prostate cancer screening, provided that the screening is delivered upon the recommendation of a patient's physician, advanced registered nurse practitioner or physician assistant. The application of standard policy provisions applicable to other benefits, such as deductibles would still be allowable and the policy could still require contracting with specific providers for rendering the screening services. Additionally, this bill directs the Department of Health to implement a prostate cancer public awareness and education campaign. This bill was passed by the Senate and House and is pending review by Governor Gregoire.
- **Hearing Aids (SB5277 / HB1336)** This legislation would require plans that provide coverage for prostheses to also provide coverage for hearing aids. This legislation was introduced last year and has been reintroduced for 2006.
- **"Any Willing Pharmacy" Legislation (SB5628 / HB1842)** This legislation would require health care insurers to have open pharmacy networks, so that any qualified provider who meets the terms of the contract and wishes to be a recognized provider under the policy can do so, and thus provide patients more choice. This legislation would not allow the health care insurer to differentiate between pharmacies by requiring different copayments, coinsurance levels, deductibles or prescription quantity limits by the covered pharmacy patient. This legislation was introduced last year and has been reintroduced for 2006.

State of the Union: Health Care Issues

On January 31, President Bush gave his annual State of the Union address, outlining the Administration's top priorities. These priorities included a number of health care issues, two of which are outlined below.

Expanding Health Savings Accounts (HSAs)

Since January 2004, more than three million Americans have enrolled in HSAs. These plans are more affordable and provide consumers with greater choice in how they spend their health care dollars. The President proposes to build on this framework and expand HSAs by giving individuals purchasing HSAs the same tax advantages as those offered under an employer-sponsored HSA plan. These tax advantages include allowing premiums for HSA-compatible insurance policies to be deductible from income taxes and an income tax credit to offset payroll taxes paid on premiums for HSA policies. The President also proposes eliminating all taxes on out-of-pocket health care expenses by allowing individuals and their employers to make annual contributions to their accounts to cover all out-of-pocket expenses under their HSA policy, not just their deductible as allowed under current law.

Making Health Insurance More Portable

The President also proposes that employers have the ability to offer employees a portable HSA policy, which employees would be able to take wherever they went. The premiums on these plans would be tax-free and would not increase based on the individual's health status at the time they changed jobs, left the labor force or moved. Employers could contribute to new employees' portable HSA policies – no matter where the policy was originally purchased. Employers would have the option to contribute to these plans, if desired, on a tax-free basis. The President also proposes allowing Americans to purchase health insurance across state lines to provide more choice to consumers and increase competition amongst health care insurers.

Much debate is expected around these topics. We will continue to monitor these issues and provide updates as decisions are made or new information is available.

HIPAA and “Bona Fide” Wellness Incentives

Employers remain concerned about the rising cost of healthcare even though healthcare inflation has decreased some in the last two years. There are some options that may help to further slow the rise in cost. A growing trend in health benefits is to offer employees financial incentives to entice them to take health risk assessments or participate in wellness programs. These programs help individuals reduce risk factors and have been known to reduce health care costs and workplace absenteeism. Furthermore, wellness programs can help to improve workplace safety and employee productivity. The positive, measurable Return on Investment (ROI) of workplace wellness programs has increased employer interest and stimulated the adoption of a variety of incentive strategies designed to reward employees for making healthy lifestyle choices.

Before implementing a wellness program, employers should be aware that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains provisions that prohibit group health plans and insurers from discriminating against individuals based on health factors.

However, HIPAA Regulations allow for the use of wellness incentives to encourage participants to participate in disease prevention programs and health promotion to attain specific

outcomes. These “bona fide wellness program” provisions define specific situations where it is permissible to provide discounts, rebates or modify co-payments or deductibles in return for participation in wellness and disease management programs. The term “bona fide” implies that something is genuine. This means, a bona fide wellness program is intended to be one that genuinely

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strives to improve the health and wellness of employees.

The Internal Revenue Service, Labor Department and the Health and Human Services Department published the following proposed rules:

- A company is prohibited from offering financial incentives of more than 20% of the total employee only premium if an employee participates in a “bona fide wellness program”.
- A “bona fide wellness program” must be reasonably designed to promote good health or prevent disease. Each employee must have the opportunity to qualify for a financial incentive or reward at least once per year. A program cannot base its rewards or penalties on health factors that are present when an individual first enrolls, without providing

- an opportunity, at least annually, for individuals to re-qualify.
- A program is not considered a “bona fide wellness program” if an employee is unable to attain a program goal due to a health factor. However, this can be resolved by offering a reasonable alternative standard in order to offer the reward to any individual for whom the program’s standard is

unreasonably difficult due to a medical condition.

- All materials describing the terms of the program must disclose the reasonable

alternative standard. However, this disclosure merely needs to outline their availability and specific details are not required.

Source: Department of Health and Human Services –T.A.

Although these regulations have existed for a few years, many remain unaware of their relevance. Because they can be critical to the design and management of health benefits, it is important to observe these guidelines in the plan design process.

Prior to HIPAA, there was very little regulation or guidance related to employer-sponsored wellness programs. The proposed regulations under HIPAA define a “safe harbor” for employer sponsored wellness program to confidently utilize significant financial incentives to promote healthy behaviors.

Washington State Family Leave Act

Background

Washington led the nation with the state's Family Leave Act (FLA) of 1989. This act guaranteed job security and 12 weeks, during a 24-month period, of unpaid leave for the birth of a new baby or to care for a terminally ill child, for employers of 100 or more employees. This legislation was almost completely superseded by the federal Family Medical Leave Act (FMLA) of 1993, which applies to employers of 50 or more employees and allows 12 weeks during a 12-month period to care for a child, parent, spouse or employee's own serious health condition. Because the federal FMLA, in most areas, provides the same or more family leave rights than Washington's FLA, in 1997 legislature directed the cessation of administration and enforcement of the Washington FLA. However, there are exceptions where the Washington state law is more protective than the FMLA, and thus, per RCW 49.78.005, should still be administered, as follows:

- An eligible employee who takes leave for care of a newborn, adoption of a child under age 6, or care of a terminally ill child under age 18, has a right to be returned to a work place within 20 miles of the employee's work place when leave began.
- The leave allowed for disability due to a pregnancy or childbirth is in addition to FMLA leave to care for a newborn or for any other FMLA-qualifying reason. The leave for disability due to pregnancy or childbirth is not concurrent with the FMLA leave.

New 2006 Family Leave Legislation

On March 15, 2006, Governor Gregoire signed Washington State family leave legislation SB6185/HB2392 into law. The Family Leave Coalition promoted this legislation to ensure the continuation of protections employees and their families in Washington State now have under the federal Family Medical Leave Act. The U.S. Department of Labor (DOL) is considering changing the rules for the FMLA, including revising the definition of "serious medical condition" from a standard three days of incapacity and medical treatment to 10 days, and eliminating the ability to take intermittent leave. By requiring an employee take a full leave day at a time, family leave time would be used up more quickly.

The new Washington State law preserves the protections Washington employees and their families receive by mandating:

- Up to 12 weeks of unpaid time off to care for a new child, seriously ill child, spouse, parent, or the employee's own serious health condition, or for the placement of a child with the employee for adoption of foster care;
- Job protection while on leave;
- Terms for use of intermittent leave currently in the U.S. DOL rules, including for the birth or placement of a child; a serious health condition requiring periodic treatment; and where the employee or family member is incapacitated or unable to perform essential functions of the position because of a chronic health condition;
- Is available to employees who have worked a full year and at least 1,250 hours, in companies with 50 or more employees.

When this legislation was originally introduced, it extended rights to employees in companies with 25 or more employees (down from 50), matching Oregon, Vermont and Utah, and included domestic partners as covered family members. However, these provisions were removed from the later versions of the House and Senate bills and are not included in the final legislation.

The new legislation takes effect June 7, 2006.

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Form 8889

The purpose of the Form 8889 is to report Health Savings Account (HSA) contributions, calculate the HSA deduction and report distributions from the HSA.

An employer and/or an employee who made contributions in 2005 to an HSA is required to file Form 8889 with their 1040. Additionally, if an individual acquired an interest in an HSA because of the death of the account holder in 2005, they must file Form 8889. This Form must be filed by the employee even if contributions made to the HSA were from the employer or the spouse's employer.

HSA account holders must attach Form 8889 to their 1040 to report HSA contributions and distributions. Each spouse filing jointly but having a separate HSA must complete a separate Form 8889. Following is the website address to locate Form 8889:

www.irs.gov/pub/irs-pdf/i8889.pdf

IRS Publication 969, which HSA participants can use as a resource to prepare Form 8889 as well as 1040s, can be found at the following website address:

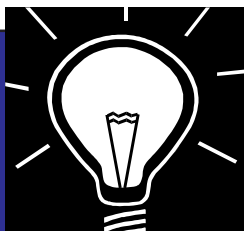
www.irs.gov/pub/irs-pdf/p969.pdf

The Benefit Resource Center Is Here To Assist

The Benefit Resource Center at Kibble & Prentice is here to assist you and your employees. Our services include investigating benefit claims, resolving escalated issues, and providing assistance with benefit interpretation. We work through each inquiry to completion, allowing Human Resources to avoid potential HIPAA compliance concerns when handling employee's personal health information. Further we serve as an advocate to your employees in getting swift and helpful resolution to their benefit claim issues.

The Benefit Resource Center assisted nearly 4,000 callers in 2005. We are available Monday through Friday 8:00 a.m. to 5:00 p.m. Pacific Standard Time. If we're not available, leave us a message. A benefit specialist will return your call by the end of the next business day. For your convenience, we are also available via email.

Our email address is 4ourbrc@kpc.com.



Ideas??

If you have questions or ideas for future issues of the **K&P Benefits Insider** we would like to hear from you! Please e-mail us at techteam@kpc.com.

Governor Gregoire Signs Anti-Discrimination Bill into Law

The Washington Law Against Discrimination (WLAD) has been amended to prohibit sexual orientation discrimination in employment, credit and insurance transactions, places of public resort, accommodation, or amusement, and in real estate transactions. The amendment becomes effective June 8, 2006 unless delayed by the referendum process.

The amendment defines "sexual orientation" broadly to include heterosexuality, homosexuality, bisexuality, and gender expression or identity. Gender expression or identity is defined as having or being perceived as having a gender identity, self-image, appearance, behavior, or expression different from that traditionally associated with the sex assigned to that person at birth.

How does this law affect me as an employer?

The prohibition on sexual orientation discrimination will apply to all aspects of employment currently covered by WLAD including recruitment,

advertisements and job postings, application forms or pre-employment inquiries, hiring, discharging, and compensation or other terms and conditions of employment, including workplace harassment based on sexual orientation.

Employee handbooks and personnel policies may require revision so that they cover all aspects of sexual orientation as defined in the amended WLAD. The law does not expressly speak to employee benefits for domestic partners; however, it is likely there will be some affect. The amendment, for example, may require employers who choose to provide domestic partner coverage, to allow coverage for both same-sex and opposite-sex couples.

A referendum has been proposed to repeal the amendments prohibiting sexual orientation discrimination. If enough signatures are collected by June 8, 2006, the referendum will appear on the next general election ballot.



Premera Blue Cross

Introducing two new dental online tools:

1. Dental Cost Estimator – go2dental gives members quick and easy price comparisons on dental procedures anywhere in the state.
2. Online provider directory – new dentist comparison tool compares dentists to established norms and industry standards for dental procedures nationwide.

Mental Health Benefits for Fully Insured 51+ groups:

Premera received additional clarification regarding the mental health parity law from the Office of the Insurance Commissioner (OIC) that will require new and existing 51+ fully insured groups to change their mental health benefits. The current mental health benefit Premera offers, 12 outpatient visits and 8 inpatient days, is no longer an eligible option. The new benefit for all new and renewing groups will be 20 outpatient visits and 10 inpatient days, which meets mental health parity requirements.

Groups that have already completed their 2006 renewal will be transitioned to the new benefit immediately with no change in their rates. Affected groups will be issued an amendment noting the revised benefit for their 2006 benefit booklet

The Hartford

Hartford outlined its compliance plan for the State of California's 2005 Domestic Partner Legislation (AB 2208). AB 2208 requires:

- Insurers to offer equal coverage and benefits to registered Domestic Partners (DP) and spouses.
- Children of registered DPs and spouses must be treated the same.

- Insurers cannot require more documentation for Register DPs than they do for spouses.

For Hartford clients, the law affects those who can be covered as dependents and those whom can receive death benefits when no beneficiary survives under group Life/AD&D or travel accident plans. This also applies to the survivor income benefit under LTD plans. The Hartford has determined that these requirements apply to all California residents, regardless of where an employer is located.

LifeWise Oregon

LifeWise Health Plan of Oregon is now providing the following online services:

- All groups renewing January 1, 2006 and thereafter will now be able to access their benefit booklets online at www.lifewiseor.com.
- The Group must have a secured Member portal to access the benefit booklets since these documents are specific to the plan.
- The Master Group Contract will now be available online for Group administrators to view

LifeWise Health Plan of Oregon will continue to provide printed member booklets and Master Group Contracts as they have before.

WDS

WDS is making the following "evidence-based" benefit modifications to their community pooled group benefit plan designs for 2006:

- Coverage limitations for a complete series of x-rays is changing from once in a three-year period to once in a five-year period. Also, instead of twice in a benefit period, coverage for bitewing x-rays will now be covered once in a benefit period.
- Age limitations for sealants and replacements of sealants has been removed.
- Following periodontal surgery or other covered periodontal procedures if dispensed within 180 days preceding a dental office visit, prescription-strength fluoride toothpaste and antimicrobial mouth rinse is now a covered benefit. If prescribed and administered by a dentist, this is also available to pregnant women even without a periodontal procedure.
- The replacement benefit for veneers, crowns, inlays and onlays on the same tooth will change to once in a seven-year period.