k&p benefits insider

THE QUARTERLY NEWSLETTER OF KIBBLE & PRENTICE

Summer 2005; Volume 8, Issue 2

Kibble & Prentice

A significant amount of change occurred over the last quarter impacting employee benefit plans. In this edition of the *K&P Benefits Insider*, we focus on a number of Federal and State legislative decisions that impact employer-sponsored health and welfare plans.

Table of Contents

3 New HIPAA Portability Regulations

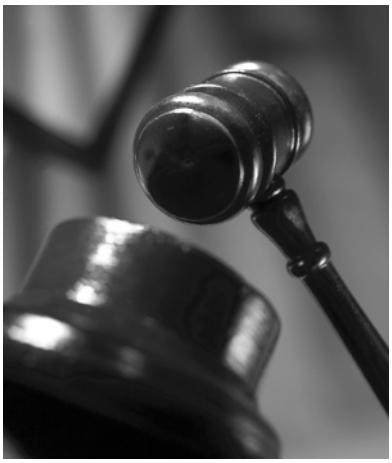
4 Carrier Updates

5 Medicare Part D

6 Washington Legislation

Modification to the "Use It or Lose It" Rule

On May 18, 2005, the IRS issued guidance (Notice 2005-42) modifying the current prohibition on deferred compensation for Section 125 plans, otherwise known as the "Use It or Lose It" rule. The purpose of this change is to limit account forfeitures and make participation in a Flexible Spending Account (FSA) more appealing to eligible employees.



Defining the Grace Period

Notice 2005-42 provides for a grace period, an additional period at the expiration of the plan year for participants to use their benefits and contributions in a cafeteria plan before those amounts are forfeited. The grace period immediately follows the current plan year and cannot exceed 2 months and 15 days. During the grace period, participants may access unused amounts in their spending accounts to pay for qualified expenses incurred during the grace period. While the grace period must apply equally to all cafeteria plan participants, an employer may limit it to only one benefit of their cafeteria plan (for example only the Health Flexible Spending Account), as long as all employees have an equal opportunity to elect that plan.

Implementing the Grace Period

Determining whether to provide a grace period under a cafeteria plan is left to the discretion of the employer. A grace period can be implemented for the current plan year through an amendment to the plan document prior to the end of the plan year. Retrospective amendments are not permissible.

To be eligible to incur claims during the grace period, an employee must be an eligible participant in the plan on the last day of the plan year, whether as an active employee or as a terminated employee who has elected COBRA coverage on the plan. The employee does not have to participate in the subsequent plan year to be eligible for the grace period for the previous year.

Some Considerations

Adding the grace period on the Dependent Care Assistance Plan (DCAP) may present negative tax consequences to the participant. The statutory maximum allowable under a DCAP plan during any calendar year is $5,000 if single or married filing jointly, or $2,500 if married filing

Continued on page 2

Modification to the "Use It or Lose It" Rule

Continued from page 1

separately. It is possible that any carry-over amount could cause a participant to exceed this plan maximum. A portion of the following year's deductions may have to be converted back into taxable income or the maximum allowable election for the following plan year decreased by the amount carried over into the grace period. At this time, a plan sponsor may not want to implement the grace period under DCAP.

Health Savings Account (HSA) eligibility may be affected by the implementation of a grace period. In order to be eligible for an HSA, an individual must have no disqualifying coverage (which would include a general-purpose health FSA). Because the grace period extends the coverage period for all participants from 12 months to a maximum of 14 months and 15 days, all participants would have overlapping coverage for the length of the grace period. This would cause the participant to be disqualified from participating in the HSA, regardless if funds are available to be carried over into the grace period. Employees are not allowed to waive the grace period to retain eligibility. A plan sponsor considering implementing an HSA alongside a Health FSA with a grace period should consider implementing a limited-purpose FSA grace period. A limited-purpose FSA reimburses only vision, dental and preventive care expenses.

The IRS is expected to further comment on the implications that the grace period will have regarding both DCAPs and HSAs. Currently, it appears that it may be beneficial to consider limiting the grace period to the Health FSA, at least until these concerns are addressed.

Run Out Period

The Run Out Period (period of time, usually 90 days, where the participant may submit expenses incurred during the previous plan year) will also be affected by this change. Plan sponsors adopting a grace period may want to review their run out timeline in relation to the grace period, especially if adopting the grace period for one benefit and not another. Following are two scenarios that offer options on how to coordinate the run out period with the new grace period ruling (examples assume a calendar year plan and assume that the Health Care plan includes the grace period and the Dependent Care plan does not):

1. An employer may choose to have the same run out period apply to all accounts, whether or not they have a grace period (for example, 90 days after 3/15 for Health Care and 90 days after 12/31 for Dependent Care), or
2. An employer may choose a single date that will be the end of the run out period for all accounts, regardless of grace period availability (for example 3/31 for Health Care with the grace period and also for Dependent Care without the grace period). Please note, if choosing this option the run out end date can be no earlier than the grace period end date.

Action Items

1. As an employer, you will need to determine whether or not to implement the grace period under your cafeteria plan prior to the expiration of the plan year.
2. Should you choose to implement a grace period, then you will need to determine the following:

a. When to adopt the grace period (mid-year or at renewal).

b. How long of a grace period you would like to implement (cannot exceed 2 months and 15 days).

c. How long of a run out period you would like to implement.

3. Amend the current plan document to reflect the adoption of a grace period under the cafeteria plan.
4. Communicate to participants the additional amount of time under the grace period to incur and submit expenses for their flexible spending accounts.

Kibble & Prentice will assist you in determining whether or not to implement a grace period, the steps involved in the implementation and communication to current and future participants. For clients with Section 125/Flexible Spending Accounts through Kibble & Prentice, we are working with our software vendors to update our system capabilities with this new option for administration. As the process unfolds, we will keep you up-to-date with relevant changes.

The following website provides additional information on this issue: www.treasury.gov/press/releases/js2456.htm

Contact the Kibble & Prentice Employee Benefits Tech Team

Would you like to obtain future copies of this newsletter by e-mail? If so, send us your name, phone number and e-mail address and we will add you to our e-mail list in time for the next mailing!

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New HIPAA Portability Regulations

The Internal Revenue Service, Department of the Treasury (IRS); the Employee Benefits Security Administration, Department of Labor (DOL); and the Centers for Medicare & Medicaid Services, Department of Health and Human Services (HHS) issued final regulations to clarify the portability requirements for group health plans under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These final regulations were effective February 28, 2005 and apply to plan years beginning on or after July 1, 2005.

While these final regulations do not significantly change the interim rules that were established in April 1997, they do include clarifications which fall into several broad categories that impact employers offering group coverage:

- Preexisting Condition Limitations
- Special Enrollment Rights
- Creditable Coverage

Pre-existing Condition Limitations

The Change

Under the interim rules established in 1997, plan provisions could limit benefits for certain conditions present before "first day of coverage." The final rules now use the term "effective date of coverage under a group health plan or health insurance coverage." The interim rules sometimes excluded coverage for participants when a plan changed insurers because of a condition that existed before the "first day of coverage" under the new insurer's policy. The "effective date of coverage under a group health plan or health insurance coverage" applies to coverage either under a plan or health insurance coverage.

How to Comply with the Change

A notice of a preexisting condition exclusion should be included with written enrollment and application materials. Participants should be notified of the preexisting condition limitations before their effective date of coverage.

Pre-existing information is typically supplied in the benefit summary information provided during open enrollment and benefit booklets/ Summary Plan Description (SPD).

Special Enrollment Rights

The Changes

A special enrollment right can arise if:

1. A person with other health coverage loses eligibility for that coverage,
2. An employer ceases to contribute toward other coverage, or
3. A person becomes a dependent through:
   a) marriage,
   b) birth,
   c) adoption, or
   d) placement for adoption.

The final regulations clarify that participants and their dependents already enrolled in a benefit package under a plan may enroll in another benefit option available under the same plan if they experience a special enrollment right because a dependent lost eligibility for other coverage.

The final regulations also clarify that where an individual has a claim denied due to the operation of a lifetime limit on a plan, there is a loss of eligibility for coverage for special enrollment purposes. This allows the participant to select another benefit package offered by the employer/plan sponsor mid-year.

How to Comply with the Changes

A notice of special enrollment rights should be included with written enrollment and application materials. Participants should be notified of the special enrollment rights before their effective date of coverage and at every opportunity to enroll.

Information on special enrollment rights is typically supplied in the Annual Legal Notices provided during open enrollment and benefit booklets/ Summary Plan Description (SPD).

Certificates of Creditable Coverage

The Change

The Departments now require an educational statement about HIPAA portability rights on HIPAA Certificates of Creditable Coverage.

How to Comply with the Change

It is recommended that SPDs be updated as may be appropriate to reflect the new HIPAA rules.

More information on the new HIPAA Portability Rules is available online at: www.dol.gov/ebsa/regs/fedreg/final/2004028112.pdf

Our Mission

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

Carrier Updates

Regence BlueShield

Regence BlueShield announces the RegenceRx Generic Incentive Program. Regence BlueShield is offering its members a voluntary opportunity to get a one-month supply of a generic alternative medication at no cost to members. A list of common brand-name medications is available at: www.regencerx.com/docs/genericincentiveprogrammeds.pdf. For more information regarding generics or the RegenceRx Generic Incentive Program, please visit www.regencerx.com/programs/genericincentive/index.html.

PacifiCare

PacifiCare has announced several new product offerings in the Northwest. New SignatureOptions℠ (HSA-Compatible) and PacifiCare SignatureFreedom℠ plans are now available in Washington and Oregon for large groups and small groups in Oregon (Washington small group plans are scheduled for release later in 2005).

In addition, changes are being made to the Self Directed Account (SDA) on the SignatureFreedom℠ plans*. The following services will no longer be eligible for payment under the SDA, but will continue to be covered benefits subject to deductible and coinsurance:

- Radiology services (other than standard x-rays)
- Specialized scanning, imaging, and laboratory procedures including: CT, SPECT, PET, MRA, MRI, EKG, Nuclear Medicine Studies
- Ultrasounds

* Effective for new and existing groups at renewal beginning May 1, 2005 for Oregon. Effective for new and existing groups at renewal beginning June 1, 2005 for Washington (pending Washington OIC approval).

LifeWise

Seattle Emergency Physicians' contract with LifeWise Health Plan of Washington expired March 31, 2005. Seattle Emergency Physicians provides emergency room services for Swedish First Hill campus in Seattle. LifeWise members may continue to seek emergency care at this facility; however their out-of-pocket costs may be higher.

LifeWise has signed a new contract with Skagit Valley Medical Center. This new contract offers members preferred provider access to Skagit Valley Medical Center and its affiliated clinics:

- Stanwood Camano Medical Center
- Skagit Urgent Care
- North Cascade Internal Medicine
- Skagit Valley Occupational Medicine

LifeWise has announced that, beginning January 2005, the generic equivalents of Dilantin™ and Coumadin™ are now available. Effective May 1, 2005, when the member chooses the brand-name drug over the generic equivalent, they will be responsible for both the higher tier copay as well as the cost difference between the brand-name medication and its generic equivalent.

Beginning June 1, 2005, LifeWise Health Plan of Oregon began to transition all new and renewing employer groups to their new LifeWise Latitude™ program. New services include a 24-hour health information line, the Healthcare Advisor (online healthcare informational tool) and the "Dose Optimization" pharmacy program. New products are available under the medical, prescription drug, vision and dental plans. For more information, please contact Kibble & Prentice or visit LifeWise at www.lifewiseor.com.

Premera

Premera announces the resignation of Jeff Roe, Vice President and General Manager for Sales, Washington Market. After nine years with Premera, he is taking a new role at the Safeco Corporation. Effective immediately, Rick Grover, Vice President of Channel Management, will assume the position of Vice President and General Manager for Washington and Darryl Price, Vice President of Marketing, will take over as Vice President, General Manager of Consumer Sales and Product Development.

Medical

On June 3, 2005, Yakima Regional Medical and Cardiac Center entered into a new contract with EmCare, the emergency room physicians. While Premera continues to have a contract with Yakima Regional Medical and Cardiac Center, they do not yet have one with EmCare. Members may continue, however, to seek emergency care at the highest level of benefits, their out-of-pocket costs may be higher as EmCare are non-contracted providers and may bill a higher dollar amount.

Dental

Premera Alaska will begin offering new dental plans, called Dental Optima™, to both small and large groups effective July 1, 2005. These additional plans offer more choice with varying deductibles and annual maximums. For more information, please contact Kibble & Prentice.

Effective immediately, Premera dental members can access a nation-wide network of 52,000 dentists when traveling or residing outside of Alaska or Washington. To locate a dentist when outside of Alaska or Washington, members can log onto www.premera.com.

Great-West Healthcare

Beginning September 1, 2005, Great-West Healthcare will offer new disease management programs for members with End Stage Renal Disease and Pain Conditions. As with current programs, members may self-enroll, be referred by a physician or be identified by a claim associated with these conditions. Enrollment is purely voluntary for the member. Some of the benefits of these programs are:

- 24/7 access to a nurse specifically trained in the conditions,
- Prevention and care education to minimize health risks,
- Coordinated care with the participant's physician for optimal care and support.

In addition, Great-West's Great Beginnings℠ maternity program is being enhanced to broaden education and support offered to expectant mothers.

For more information, contact your Account Manager at Kibble & Prentice, or visit Great-West at www.greatwesthealthcare.com.

AGC Health Plan

AGC announces that copies of the life insurance certificates, a benefit through LifeWise Assurance, are now available to its members online at www.thincservice.com.

Medicare Part D – Certificates of Creditable Drug Coverage

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 created "Medicare Part D" which will offer subsidized coverage for prescription drugs beginning January 1, 2006.

Entities that provide prescription drug coverage to Medicare beneficiaries must provide a Disclosure Notice indicating whether or not the coverage is "creditable" or actuarially equal to or better than Medicare Part D. This disclosure is required regardless if the entity's coverage is primary or secondary to Medicare. As a result, it may affect employer-sponsored plans that have employees and dependents on Medicare.

Medicare beneficiaries who choose not to sign up for Part D when first eligible may be required to pay higher premiums if they wait to enter the program after the open enrollment period. Medicare beneficiaries who have other prescription drug coverage that is at least equal to or better than Medicare Part D must provide a certificate of creditable prescription drug coverage in order to waive penalties (in the form of higher premiums) if choosing to sign up for Part D at a later date.

Kibble & Prentice is working with medical carriers to ascertain how they will be managing this.

For further information on Creditable Coverage for Prescription Drugs, visit the Medicare web site at: www.cms.hhs.gov/medicarereform/Credcovrg.asp. Guidance on the regulation, including model notices, can be found online at: www.cms.hhs.gov/medicarereform/CCGuidance.pdf

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Washington State Legislators Call It A Day for 2005

The Washington State 2005 legislative session came to a close on Sunday, April 24; just hours after the legislature gave final approval to a $26 billion state budget and an $8 billion transportation plan.

Although Governor Gregoire has taken action on a number of bills, most measures are awaiting review and recommendation by her staff. Pursuant to the state constitution, the Governor had twenty days (excluding Sundays) from the close of the session to take action on bills. There is no "pocket veto" in Washington State. If the Governor failed to take action on a measure, it went into effect without her signature.

Unless otherwise specified, bills become effective 90 days following the close of the legislative session in which they have been enacted.

This article concentrates on bills specific to health insurance that have a possible impact on your benefit offerings and future premiums:

Health Insurance Bills That Have Passed:

HB 1154 — Mental Health Parity

Group health insurance plans with over 50 employees must provide a level of coverage for mental health services that is equal to the coverage provided for medical and surgical services. The requirements are imposed in three increments between 2006 and 2010. Once the mental health parity requirements are fully implemented in 2010, limitations on mental health services may be imposed by an insurance plan only if the same limitations are imposed on medical and surgical services.

HB 1441 — Health Insurance for Children

The Legislature intends to provide health care coverage for all children by 2010. Within available funds, the children's health program will provide health services to poor children who are not eligible for medical assistance because of their legal status. An emergency clause is provided. On May 2005, Governor Gregiore exercised the partial veto by removing the July 1, 2005, effective date wording. This was done to avoid possible confusion or false expectations that the coverage would be available on that date.

SB 5957 — Deferring Taxes on Multiple Employer Welfare Arrangements

Beginning either upon the certification of the fourth Multiple Employer Welfare Arrangement by the OIC, or April 1, 2006, whichever is earlier, MEWAs must deposit state premium taxes and assessments into an interest bearing escrow account. Upon final determination that the taxes are not preempted by ERISA, the funds would be transferred to the State Treasurer.

SB 6043 — Security Breaches Compromising Personal Information

Any agency, person, or business that owns and licenses computerized data that includes personal information, is required to inform Washington consumers of any breach of their data security, following discovery or notification of the breach. The notification must be made without unreasonable delay, consistent with the needs of law enforcement. Notification may not impede a criminal investigation.

"Personal information" covered by the duty to notify includes: social security numbers, driver's license, or ID card numbers, and credit and debit card numbers in combination with access codes. Personal information does not include publicly-available information from federal, state, and local government records.

Notice of the security breach may be provided by written or electronic notice, or by a "substitute notice" by e-mail, conspicuous website posting, or major statewide media.

As a matter of public policy, consumers cannot waive their right to notice.

Remedies include a civil action to recover damages, or injunctive relief against a business that violates the notice requirements.

Health Insurance Bills That Failed:

SB 5637 and HB 1702 — Employer "Play or Pay" Requirements

SB 5628 — "Any Willing Pharmacy" Bill

SB 5888 — Health Insurance Pool and Individual Health Insurance Market

HB 1221 — Employer Coverage Offered Through the Health Care Authority

HB 2060 — Allowing the Basic Health Plan to Send High Risk Applicants to the Washington State Health Insurance Pool

HB 1336 and SB 5277 — Mandated Coverage for Hearing Aids

SB 5771 — Mandated Benefits for Neurodevelopmental Therapies

For additional information on any of the bills passed or failed as stated above, or any additional bills not referenced, please log onto www.leg.wa.gov and select "Bill Information."