K&P Benefits Insider

Timely information for the dynamic world of employee benefits

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IMPORTANT CHANGES TO DEPENDENT CARE TAX CREDIT FOR 2003!

For the tax year beginning after December 31, 2002, there will be an increase in the allowable amount of a tax credit available under the Dependent Care Credit. Currently a taxpayer can take a tax credit on charges of up to $2,400 of qualified dependent care expenses for one qualified individual and up to $4,800 for two or more qualified individuals. Effective January 1, 2003, these limits will increase to $3,000 and $6,000 respectively. The credit that can be taken is a percentage of the qualified expenses based on the taxpayer's adjusted gross income. The maximum percentage also will be increasing from 30% to 35%. This percentage decreases as the taxpayer's income increases.

Many employers sponsor Section 125 Plans with a Dependent Care Assistance Plan (DCAP) option. This is an alternative to the Dependent Care Credit. Through pre-tax payroll deductions, a DCAP allows employees to set aside up to $5,000 annually for qualified dependent care expense. The $5,000 maximum applies regardless of the number of qualified individuals.

With the current Dependent Care Credit limits and applicable percentages, most employees with mid-range to higher incomes realize greater tax savings by using the DCAP as opposed to the Dependent Care Credit. This is still the case if an employee has over $5,000 in dependent care expenses for only one qualified individual. Employees with mid-range incomes and dependent care expenses for two or more qualified individuals will be most affected. With the new limits and percentages for 2003, some of these employees will realize greater tax savings by using the Dependent Care Credit. Most employees with high incomes (in high tax brackets) will continue to receive a greater benefit under a DCAP.

Employees having over $6,000 in eligible expenses for two or more qualified individuals can choose to use the full $5,000 benefit under the DCAP and then take the Dependent Care Credit for the additional $1,000.

If employees with low to mid-range incomes choose to take the Dependent Care Credit and employees with high incomes use the employer sponsored DCAP, it could cause problems for the employer-sponsored plan. The DCAP may not pass some of the required nondiscrimination tests that relate to the total percentage of DCAP benefit paid to highly compensated employees. In these cases, highly compensated employees may need to reduce or discontinue their DCAP elections.

For the tax year beginning January 1, 2003, it will be important for each employee to carefully evaluate their dependent care options and determine whether the Dependent Care Credit or an employer-sponsored DCAP will provide them with the greatest tax benefit. If you would like additional information about this topic, please visit www.irs.ustreas.gov/faqs.

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Legislative and Judicial Update

Generic Drug Bill

The Senate passed bill regarding generic drug competition has stalled in the House of Representatives. The bill would close a loophole of the 1984 Hatch-Waxman Act that pharmaceutical companies use to delay generic drug competition. The proposed bill will also prevent brand-name pharmaceutical companies from paying to keep generic drugs off the market and allow generic drug manufacturers to challenge patents regarding a drug's color or physical design.

This bill would bring generic versions of brand-name drugs to the market in a more timely fashion. In a recent national survey of pharmacy benefit managers, the trend or cost inflation for prescription drugs was 17%-18% for 2002. However, generic drug costs are usually significantly lower than their brand-name counterparts.

The Congressional Budget Office is projecting savings of $60 billion over the next ten years from passage of this bill. [1]

Medicare Prescription Drugs Bill

The Senate turned down legislation to include prescription drug coverage under Medicare. Drug coverage for all 40 million Medicare participants would cost an estimated $594 million over the next 10 years. However, in a related announcement, President Bush announced a new private drug card program targeted at senior citizens. The program is expected to save Medicare participants 10%-13% off drug expenditures. If card sponsors meet defined criteria regarding manufacturer rebates and discounts, they can market their cards with the Medicare imprint. The government will begin soliciting proposals from card sponsors this fall. [2]

Health Benefits for Trade-Displaced Workers Bill

This bill was signed into law on August 6, 2002. The law provides uninsured trade-displaced workers with a refundable tax credit to cover 65% of their health insurance premiums. The tax credits can be applied to COBRA payments. Under COBRA, terminated employees may continue health coverage under their former employer's benefit plan for 18 months. [3]

Tax Deductions for Long-Term Care Insurance Costs

The House of Representatives passed a bill on July 25, 2002 permitting tax deductions for the cost of long-term care insurance. Long-term care insurance provides health and custodial care to support people who have chronic long-term physical or mental conditions that prohibit them from taking care of themselves. Under the current law, individuals may deduct the cost of long-term care insurance if the cost, combined with medical expenses, exceeds 7.5% of their income. The bill applies to middle-income individuals with earnings between $20,000 and $40,000 and couples with earnings between $40,000 and $80,000. In order to be eligible for the deduction, 50% of cost of the insurance must be paid by the individual. The new legislation also includes a tax exemption of $3,000 for individuals who act as long-term caregivers for a family member. The bill is expected to save taxpayers $5.3 billion over the next 10 years. [4]

Colon Cancer Screening Bill

The Senate is considering a bill that would require health insurers to cover colon cancer screenings for high-risk individuals. According the American Cancer Society, 56,600 Americans will die from colon cancer this year. Opponents of the bill say this will only increase already spiraling health care costs by adding to the growing list of federal mandates. Federal mandates are services that must be covered by all ERISA health plans. [5]

Health Care for Local Government Retirees Bill (WA State)

The State of Washington passed a law on April 2, 2002 that provides access to health care benefits for retirees of local governments. The benefit structure is left to the discretion of the governments and enables them to charge the retirees for the full cost of the coverage including administration. In order to be eligible to participate, retirees must meet certain eligibility requirements set forth by the public employees' retirement system. If a retiree is eligible for coverage with another former employer, that health coverage is primary to the coverage offered through the local government. This new legislation takes affect January 1, 2003. [6]

"Usual & Customary Charges" Court Ruling

In a class action suit, Hickman v. Gem Ins. Co., plaintiffs attempted to recover additional payments for certain charges not covered by policies issued by the defendant, an insurance company. The Tenth Circuit court ruled in favor of the defendant insurance company. When paying claims, the insurance company relied on the policy provision limiting payments to "Usual & Customary". "Usual & Customary" is defined as "currently prevailing charge made for a medical service or charge by a majority of providers within the same geographical area as determined by the insurance company". The court agreed to the use of the "Usual & Customary" as the standard for the payment of claims. [7]

[1] *Kaiser Network*, Sept. 18 and 20, 2002

[2] *NY Times*, Aug. 1, 2002; Reuters Medical News, Aug. 30, 2002

[3] *Kaiser Network*, August 7, 2002

[4] *Kaiser Network*, July 26, 2002

[5] *Associated Press*, July 15, 2002

[6] *WA State Certificate of Enrollment*, Senate Bill 5777, April 2, 2002

[7] *EBIA Weekly*, Sept. 22, 2002

DOL Issues Guidance for New ERISA Claims Procedure Regulations

The Department of Labor (DOL) has issued guidance regarding the new claims procedures required under ERISA. For group health and disability benefit claims, the regulation substantially changes the procedures for benefit determinations. Among other things, it creates new procedural standards for initial and appeal-level decisions, new time frames for decision-making, and new disclosure rights for claimants. The new ERISA rules were effective January 1, 2002 for disability and other ERISA claims; the rules are effective no later than January 1, 2003 for health, dental and prescription drug claims.

The following information is a summary of the guidance that can be found at http://www.dol.gov/pwba/faqs/faq_claims_proc_reg.html.

- Casual benefit inquiries by plan participants do not trigger the ERISA rules, but plan sponsors should be careful whether the person making the inquiry is actually trying to file a claim.
- The final regulations apply to both disability plans and disability-based benefits in pension plans. If a benefit requires a claims adjuster to approve a claim, the plan's claim procedures would have to satisfy the rules regarding independent review, time limits for deciding claims, and consultations with outside professionals.
- ERISA plans must have administrative processes and safeguards that ensure each claim determination is made in accordance with the plan document and that the terms are applied consistently to each participant.
- Claimants are required to have access to documents used in an "adverse benefit determination" (ABD) or claim denial. Claim payments of less than 100% are considered an ABD, even if the plan is applying coinsurance, deductibles, etc.
- Plan sponsors must determine if a claim is considered "urgent care" based on information provided by the claimant. If a physician with knowledge of the condition would characterize it as urgent, then the plan must treat it as such. If there is no physician opinion available, then the administrator must make a decision using the judgment of a layperson.
- Claim determinations must be made within certain time limits of no later than 72 hours for urgent care and no later than 15 days for pre-service health claims. The plan must also notify the claimant of these deadlines.
- If a rule, protocol or guideline was used in making a claim denial or ABD, the plan must include a copy of the rule, protocol or guideline or state a copy will be provided upon request.
- Third party administrators and other service providers must disclose any guideline or protocol used in a claim denial or ABD even if they are considered proprietary information.
- Most health and disability plans use committees to review and make decisions regarding appeals to claim denials or ABDs. Committees can no longer take advantage of a special exception that allows them to make decisions at regularly scheduled meetings; decisions must be made within the new time limits.
- The person reviewing an appeal cannot be the person who made the initial denial or a subordinate of the person who made the initial determination.
- A second-level appeal reviewer cannot give any consideration to the decision of the first appeal. The reviewer cannot be the person who conducted the first appeal or a subordinate of the person who conducted the first appeal.
- The time period for reviewing claim denials or ABDs is one-half the time allowed for the first appeal level. Example: pre-service health claim determinations must be made within 30 days. The following two appeal levels must be completed within 30 days, 15 days for each level.
- A reviewer making a claim determination must consult an experienced and properly trained health care professional if the appeal involves any medical judgment.
- A claimant must be allowed access to the identity of any experts consulted in connection with a claim determination even if the advice was not relied on in making the decision.

Carrier Updates

First Choice Health Plan

The First Choice Health Plan (FCHP) will not be offering renewals to any groups effective January 1, 2003. First Choice will be sending non-renewal notifications to each group 90 days prior to the renewal date.

Group Health Cooperative

- Outpatient care for chemical dependency services will be referred to a network of Group Health contracted providers. A patient may complete scheduled treatments if they are currently receiving care from Group Health staff. This applies to Western Washington members only.
- Effective September 4, 2002 the maternity unit at Group Health's Eastside Hospital in Redmond will be closed. Maternity patients may choose to deliver their babies in Overlake Hospital in Bellevue or Group Health's hospital on Capitol Hill in Seattle.
- The Mercer Island Virginia Mason clinic will be closing in October and consolidated into the Bellevue clinic. Most of the Mercer Island physicians will be moving to the Bellevue clinic.

Aetna

- Effective October 21, 2002, Aetna will be changing their Direct Member Reimbursement policy for Full-Risk PPO members who do not present their ID cards when they have a prescription filled at a participating pharmacy. Currently, when a member submits a paper claim for a prescription purchased at a participating retail pharmacy, Aetna will reimburse the full price of the prescription minus the applicable copay. This method of reimbursement does not take into consideration the discount for drug costs that Aetna has negotiated with the participating pharmacies. Aetna is therefore paying more for prescription drugs by not being able to apply the discounted rate.

  Beginning October 21, Aetna will begin to factor in the negotiated discounts for drugs when processing paper claims. Members will be reimbursed the negotiated price, not the full price, of the drug minus the applicable copay. Any difference between the full price and the negotiated price will be the member's responsibility.
- Effective January 1, 2003, Seattle Orthopedic & Fracture is terminating from Aetna's network for the following products: HMO, QPOS, USAccess, Open Access HMO, Open Access POS, Open Access EPO, Open Choice PPO, Managed Choice POS and Elect Choice EPO.

  Seattle Orthopedic & Fracture is a group of 11 surgeons with office locations in King County. The group is affiliating with Proliance Surgeons, Inc. effective January 1, 2003. Proliance is a non-participating entity with Aetna. Following the termination, there will be a total of 121 participating orthopedic surgeons on PPO based products and 113 participating orthopedic surgeons on HMO based products. The terminating physicians are primarily affiliated with the Swedish Health System. However, Aetna will continue to include 28 orthopedic surgeons with admitting privileges to Swedish Hospital – First Hill and an additional 23 orthopedic surgeons with admitting privileges to Swedish Hospital – Providence Campus.

Regence Blue Shield

Regence Blue Shield is currently evaluating their options in order to comply with Senate Bill 168 (SB 168) that was recently passed by the California State Legislature. This bill restricts the use of the Social Security numbers (SSN) of California residents. Regence will be in compliance with these provisions by the required dates, but at this time will not be making changes regarding the use of SSNs for members in other states.

Premera Blue Cross

- Effective July 1, 2002, Merck-Medco changed its name to Medco Health.
- On July 15, 2002, South Sound Radiology terminated its contract with Premera Blue Cross. Members in the area were directed to Olympia Radiology in order to receive the highest level of benefits.
- In August 2002, Premera added a disease management program for members with end-stage renal disease (ESRD) through Renaissance Health Care. All members identified as having ESRD have the opportunity to participate in the voluntary program and will be assigned a Renaissance nurse who is specially trained in the care of kidney disease.
- To ensure privacy of claims information, Premera has modified their automated Customer Service Interactive Voice Response (IVR) system. For information regarding the status of a claim, members will now be directed to a customer service representative. Eligibility information can still be accessed through the IVR system.
- Effective October 1, 2002, Tacoma Radiology contracted to participate in the Premera Blue Cross provider network. Members who receive care at Tacoma Radiology will receive the highest level of reimbursement.
- On October 1, 2002, the following HCA hospitals terminated their contract with Blue Cross of California:
  - Northern CA (Santa Clara County): Regional Medical Center of San Jose, Good Samaritan Hospital and San Jose Medical Center
  - Southern CA: Columbia Los Robles Hospital Medical Center, Columbia West Hills Medical Center and Riverside Community Hospital

HIPAA Privacy Regulations

The long awaited HIPAA privacy regulations have been finalized. In August of this year, the final rules designed to protect the confidentiality of medical data were put in place. Described as "HIPAA Administrative Simplification", the restrictions are less stringent than those proposed by the previous administration and some consumer advocates, but for the first time offer individuals certain federal rights over how their "protected health information" is used.

Protected health information, or PHI, is defined as individually identifiable health information that is transmitted or maintained electronically or in any other form or medium. Protected health information includes:

- Name
- Address
- Dates directly related to an individual (e.g. birth date, treatment date, discharge date)
- Social Security number
- Medical record number
- Health plan number
- Telephone or fax number
- Account number
- Vehicle I.D. or license number
- E-mail address
- Or any other individually identifying number, characteristic or code

The new regulations will address four main areas:

- Standards defining how patient's health information is exchanged electronically between health plans (including employers), providers, and vendors.
- Privacy rules defining who is authorized to access an individual's health information, how it can be used and disclosed, and an individual's rights concerning the access, amendment, and restriction of how that information is used.
- Security rules defining the administrative, technical and physical security standards for protection of health information.
- Identifiers that allow the industry to uniquely identify an employer, a payer, or a provider.

Covered entities are subject to the HIPAA privacy rules. Under the new policy, covered entities are defined as health plans, health care providers conducting certain electronic transactions and health care clearinghouses. While employers are technically not subject to the new HIPAA privacy rules, ERISA group health plans sponsored by employers are considered covered entities. Often the only evidence of an ERISA group health plan is the plan document, summary plan description or the group contract. Accordingly, the employer must act on behalf of the ERISA group health plan in fulfilling its compliance obligations under the HIPAA privacy rules.

The effective date of the new rules is dependent on the group size. April 14, 2003 is the first compliance date and applies to covered entities considered larger groups. Small group health plans (i.e., those with annual receipts of less than $5 million dollars) have until April 14, 2004 to comply. The Center for Medicare and Medicaid Services (CMS) has issued guidance on how to determine annual receipts for this purpose. Generally, for fully insured health plans, total premiums paid for health benefits should be used. For self-insured health plans, the total amount paid in health care claims should be used. Plans that are partially insured and partially self-insured can use a combination of premiums and claims.

In order to be considered in compliance, employers who receive protected health information must perform the following:

- Designate a privacy official
- Give plan subscribers a Privacy Practices notice by April 14, 2003 (April 14, 2004 for small groups) and to new employees thereafter
- Post a copy of the privacy notice on their website (if applicable)
- Develop barriers that separate their plan administration functions from employment related functions
- Amend their plan documents and certify that they have been amended before allowing disclosure of an individual's health information to the plan sponsor
- Implement HIPAA required confidentiality language into contracts with third parties, such as plan financial auditors, who may have access to member health information

If your plan is fully insured, you can choose not to receive PHI and then your only obligation is to not retaliate against or intimidate your employees seeking to exercise their rights under the privacy rules. Under these circumstances, employers cannot require employees to waive their rights under the regulations and must obtain an authorization from the individual if PHI needs to be obtained. If the plan is self-funded, in order to administer the plan, access to PHI will be necessary (e.g., to fund claims); therefore, the employer sponsor will need to comply with all of the requirements.

Entities found to be not in compliance face significant penalties. While there is no private right of action, the Secretary of HHS may bring enforcement actions against covered entities. The civil penalty can be up to $100 per person per violation, with a maximum of $25,000 per person for the violation of a single standard in a calendar year. Criminal penalties for the knowing misuse of PHI are possible, subject to a maximum of $50,000 and/or not more than one year in prison. A penalty of up to $250,000 and/or 10 years in prison, may apply for the sale of PHI or the use of PHI under false pretenses.

HHS has stated that penalties will be based on the harm to the individual for noncompliance as well as the willingness of the group health plan to become compliant. Under the regulations, HHS is authorized to conduct compliance reviews of covered entities and to investigate complaints regarding the improper use and disclosure of PHI.

For more information on this subject, contact your ERISA legal counsel. Information can also be found on the Department of Health and Human Services (HHS) website at: www.aspe.hhs.gov/admnsimp/.

Use of Social Security Numbers

The California State Legislature has passed a bill to restrict the use of Social Security numbers (SSN). Senate Bill 168 (SB 168) was passed in response to the growing movement to protect the confidentiality of the Social Security numbers of California residents. SB 168 now makes it unlawful to:

1. Publicly post or display an individual's SSN
2. Print an individual's SSN on any card needed to access products or services
3. Require the transmission of an individual's SSN over the Internet, unless the connection is secure or the number is encrypted
4. Require the use of a SSN to access an Internet site, unless a password or unique personal identification number is also required
5. Print an individual's SSN on materials that are mailed to the individual, unless required by state or federal law

The time line for compliance is as follows:

- January 1, 2003: Compliance with all five provisions for existing policyholders, except for provisions relating to member identification cards
- January 1, 2004: Compliance with all five provisions for new individual policyholders and new employer groups effective on or after January 1, 2004
- July 1, 2004- July 1, 2005: Compliance with all five provisions for individual and employer group policyholders in existence prior to January 1, 2004 renewal date and then upon renewal, but no later than July 1, 2005.

Washington state currently does not have a law that restricts the use of Social Security numbers. Local carriers at this point have no plans to make any major changes in the identification process. Although Washington's carriers understand the goal of the new Californian law, many questions exist on how moving away from the use of Social Security numbers would effect the use of plans by current and future enrollees. There is concern that restricting the use of Social Security numbers on I.D. cards but not for other uses could cause confusion with service providers. Providers could have trouble cross referencing information that is identifiable with a Social Security number with the replacement number showing on a member I.D. card. Carriers are also concerned with the increased possibility of number duplication if replacement numbers are used in place of already unique Social Security numbers.

Though no immediate changes in the way of identifying enrollees are on the horizon, there are small steps being taken in that direction by one local carrier. Premera Blue Cross will be introducing a new product in 2003, where new enrollees will be assigned an identification number by the carrier. Carriers are also continuing to develop technologies that will allow for convenient, private and secure transactions of enrollee's private information.

Contact the Kibble & Prentice Employee Benefits Tech Team

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Recent State Legislation

California

On September 23, 2002, Governor Gray Davis signed a law enacting a paid family leave bill. California will become the first state to provide workers with paid family leave.

The law will allow workers to take six weeks of leave annually to care for a newborn, a newly adopted child, or a seriously ill family member. A worker on leave will be eligible to receive 55% of their pay with a weekly maximum of $728. The program will cost employees an average of $27 a year, which will be taken through payroll deductions. Employees will be able to take this leave beginning July 1, 2004.

Employers with less than 50 employees will not be required to hold a job for an employee that is out on paid family leave. Many other states have introduced similar legislation, including Washington.

Oregon

Oregon residents will vote on a universal health care initiative during the upcoming November elections. Oregon will be the only state to have this type of initiative on the ballot.

If Measure 23 is passed, the Oregon Comprehensive Health Care Finance Plan would cover "medically necessary health services" for all residents. Some of the covered services would include: preventive care, hospital and emergency services, prescription drugs, mental health services, long term care, dental services, eye care services, diagnostic testing, rehabilitation services, and durable medical equipment. Two new taxes would be created to help fund this plan.

A copy of Measure 23 can be found at www.healthcareforalloregon.org. Several other states are currently researching ways to provide a universal health care system.

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