

K&P Benefits Insider

Timely information for the dynamic world of employee benefits

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SUPREME COURT HEARS CASE INVOLVING PATIENT RIGHTS

In the wake of the stalled Patient Bill of Rights Legislation, the Supreme Court is pondering whether recent Patient Rights Laws passed by about 40 states should take the place of federal legislation. The issue at hand is whether these state laws are pre-empted, or overridden, by ERISA (Employment Retirement Income Security Act of 1974). ERISA was passed by the Federal Government to regulate pension plans and employee benefit plans. According to court rulings over the years, ERISA prohibits employees from suing their medical plan for damages. State-passed Patient Rights Laws allowing independent physician reviews of insurance company medical decisions appear to contradict the premise of ERISA preempting state law.

In January, the Supreme Court heard arguments for *Rush Prudential HMO Inc. v. Moran*, No 00-1021 (S. Ct., Jan. 16, 2002). The complete version of this argument can be seen using the link: http://a257.g.akamaitech.net/7/257/2422/30jan20021630/www.supremecourtus.gov/oral_arguments/argument_transcripts/00-1021.pdf

This case involved an Illinois woman, Debra Moran, suing her HMO for not paying a bill for services of \$94,841.27. A non-network specialist completed services recommended by the

woman's primary care provider. The HMO first refused to pay on the grounds that the surgery was unnecessary. However, the state of Illinois recently passed a law allowing independent physician review if an insurance company refuses to pay for services. The independent review board felt the surgery was necessary. Now the HMO is refusing to pay because it feels the state law requiring independent review is preempted by ERISA.

The Supreme Court is trying to decide if the Patient Rights Laws passed by the individual states are in fact preempted by ERISA or simply complement them. In the past, lower courts have issued both in favor and against state-sponsored laws dealing with ERISA-governed plans. The Supreme Court expects to make a ruling by mid-June 2002.

Last year, both the House and Senate passed different versions of a Patient Bill of Rights (see the Fall 2001 edition of the Technical Advisory) in order to address the issue of independent reviews among other things. Congress has been unable to agree on a finalized version of Patients Bill of Rights, leaving the States to pass their own versions of patient protection laws.

If the Supreme Court rules in favor of Debra Moran, opponents of the state-passed Patient Rights Laws foresee claims decisions taking years

due to lengthy state-imposed review procedures. Proponents of a decision in favor of Moran see this as the most viable alternative to the stalled Federal Patient Bill of Rights.

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Supreme Court Rules on FMLA Leave Notice

The Supreme Court handed down a decision on March 19, 2002 regarding FMLA Leave notices. The Court ruled employers are not required to provide FMLA leave in addition to the company's normal period of leave.

The case spurring the decision is *Ragsdale ET AL. v. Wolverine World Wide Inc.*, No. 00-6029 (S. Ct. March 19, 2002). The complete version of this decision can be seen using the link: <http://a257.g.akamaitech.net/7/257/2422/19mar20021115/www.supremecourtus.gov/opinions/01pdf/00-6029.pdf>

Tracy Ragsdale was a worker in an Arkansas shoe factory. She sued her employer claiming she was denied 12 weeks of leave under FMLA (Family Medical Leave Act of 1993). Under FMLA, companies with 50 or more

employees must offer 12 weeks of unpaid leave to employees to attend to serious family illnesses, childbirth and adoption without losing their job. Ragsdale had been working at Wolverine for less than a year when she was diagnosed with cancer in 1996. The company contended it fired Ragsdale after she could not find work during the company's maximum leave period of seven months. The Court found in favor of the employer.

In its decision, the Supreme Court eliminates the potential for companies being sued for not explaining how maternity or medical leaves satisfy FMLA. The ruling eliminates the Department of Labor regulation requiring a company to offer FMLA in addition to the regular company leave if the employer did designate the leave as satisfying FMLA requirements.

IRS Ruling Approves Obesity as a Medical Condition

On April 2, 2002 the IRS issued a ruling that approved obesity as an acceptable medical condition. This will allow weight-loss programs to qualify as a medical deduction for tax purposes. Prior to this ruling, expenses for weight-loss programs were only deductible if the program was prescribed to treat a medical condition such as hypertension or diabetes. This ruling will also allow the expenses relating to the weight-loss program to be run through a Section 125 Health Flexible Spending Account.

Eligible expenses include the fees to join the program and attend periodic meetings. The cost of special diet foods is not eligible. Weight-loss programs to improve general health or appearance and health clubs and spas are not eligible.

A physician's diagnosis of obesity and prescription for the weight-loss program are necessary in order for the expenses to qualify.

Adoption Assistance Plans

There have been some significant changes to the Adoption Assistance Tax Credit and employer-sponsored Adoption Assistance Plans for tax years beginning after December 31, 2001. Effective January 1, 2002, the tax credit and maximum reimbursement under an employer-sponsored program is increasing from \$5,000 to \$10,000. The limit for special needs adoptions is also increasing to \$10,000. The income level at which the benefit begins to phase out is increasing from \$75,000 to \$150,000. For tax years beginning after December 31, 2002, the \$10,000 tax credit and maximum reimbursement for special needs adoptions will be regardless of the actual amount of qualified adoption expenses.

Since 1997, adoptive parents have been able to take a tax credit for qualified expenses paid toward the adoption of a child. Employers have been able to sponsor Section 137 Adoption Assistance Plans to provide employees with an income tax free reimbursement of adoption expenses (still subject to Social Security, Medicare and unemployment taxes). The employer-sponsored plans can either be funded by the employer or

through employee salary reductions. Employer sponsored Adoption Assistance Plans must have a written plan document in place and certain non-discrimination rules apply. Adoption assistance benefits can also be offered under a Section 125 cafeteria plan. The limits mentioned above would still apply. These dollar limits apply on a per child, not a per parent basis.

Qualified expenses include adoption fees, court costs, attorney fees, travel expenses and other expenses directly related to the legal adoption of a child. Eligible children must be under 18 years old, or physically or mentally incapable of caring for themselves. Non-qualified expenses include those paid to a surrogate parent or expenses for adopting your spouse's child.

Adoptive parents can take both the Adoption Assistance Tax Credit and receive benefits under an employer-sponsored plan up to the maximum limits but not for the same expenses.

As an employer, an adoption assistance plan can be a low cost addition to your employee benefits package.

Communication is Key for Continuing Coverage

One of the first questions that comes to mind when an individual ends their employment with a company is, “can I continue on the company health plan when I leave?” In most cases, the answer is yes.

What has to happen in order for an individual to continue their coverage? The answer to that question lies in the number of employees the company has or had.

If a company had 20 or more employees (including part-time) for more than half of the previous calendar year, then that group is considered COBRA eligible. COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) requires employers of 20 or more employees, who sponsor group health plans (including medical, dental, and vision) must allow qualified beneficiaries (employees and/or covered dependents) to continue their coverage under certain circumstances. Those circumstances include:

- (a) Termination of employee’s employment (for any reason other than gross misconduct).
- (b) Reduction of work hours.
- (c) Death of the employee.
- (d) Divorce or legal separation.
- (e) Employee’s eligibility for Medicare, if loss of dependent coverage results.
- (f) A dependent child ceases to qualify as a covered dependent under the terms of the plan.

When any one of the above qualifying events occur, the employer has 30 days to directly notify all qualified beneficiaries of their continuation rights. If a Plan Administrator is used, the employer has 30 days to notify the Plan Administrator of the qualifying event, who will in turn have 14 days within which to notify the beneficiary. Such notice should be mailed to the

beneficiary’s last known address.

The beneficiary has 60 days from the later of (a) the date the notice is received, or (b) the date the group coverage would end, to elect continuation of coverage. In the event of divorce, legal separation or dependents becoming ineligible, the **employee** is responsible for notifying the employer (or plan administrator) within 60 days of the qualifying event.

Once an individual chooses to continue coverage, they become responsible for paying the monthly premium for the coverage. Qualified beneficiaries have an additional 45 days to remit the first payment, which must include premium retroactive to the date coverage was terminated. Future payments must be made within 30 days after the first day of that period. An employer can request an additional 2% on top of the contractual premium rate as an administration charge.

It is very important to follow these processes and timelines if a company is COBRA eligible. There are penalties for a company that does not comply with law, including possible excise taxes and lawsuits. Plan administrators may be liable for a \$110/day penalty under ERISA for failure to comply with continuation coverage requirements.

For companies employing fewer than 20 employees, there are also ways for employees to continue coverage if an employee leaves a company. Many medical and dental carriers offer continuation of coverage for 3 to 6 months. Under these circumstances the process is not as involved as COBRA notification. Premium payments will be the responsibility of the former employee, just as they would be for COBRA eligible individuals. Unlike under COBRA, companies cannot add an additional 2% for

administration.

Each carrier has its own process to continue coverage. Some carriers will require a new enrollment form for the employee, denoting that the employee is not active but will continue on the benefit plan. Other carriers do not need to be contacted. The employee simply stays on the bill until the period of continued covered has expired (or when the premium payment is not made by the former employee). The group administrator can request the former employee be removed from the billing statement and terminated from the plan.

It is important for both companies and individual employees to understand their options when it comes to providing health benefits. Communication of accurate information is the key to a smooth transition. Contact your carrier or account manager for more details on the process for continuing coverage.

Supreme Court Rules on ERISA Plan Recovery

On January 2, 2002 the Supreme Court ruled that ERISA plans could sue in federal court to recover medical costs from an insured that received a settlement from a third party. The case prompting this ruling is *Great-West Life v. Knudson*, 2002 WL 15399 (S. Ct., Jan. 8, 2002). The complete version of this ruling can be seen using the link: <http://a257.g.akamaitech.net/7/257/2422/08jan20021100/www.supremecourtus.gov/opinions/01pdf/99-1786.pdf>

In this case, Janette Knudson became a quadriplegic as a result of an auto accident in 1992. The medical costs from the accident

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ERISA Plan Recovery

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totalled \$411,000. At the time, Knudson was covered by her employer's self-insured medical plan with Great-West Life. The plan sponsor was responsible for the first \$75,000 of the medical expenses with Great-West covering the additional costs as part of the stop-loss agreement with the employer. The stop-loss contract between Great-West and employer stipulates that once Great-West begins paying for medical costs, they take assignment to pursue reimbursement through any third party settlements.

After the accident, Knudson sued Hyundai Motor Co. for medical costs. Hyundai and Knudson agreed to settle out of court for \$650,000. Under the settlement agreement, only \$13,828 is allocated to previous medical expenses, the remainder is placed directly in a trust to cover

future medical expenses and her attorney's fees. Great-West sued Knudson to recover the additional costs paid out to cover medical expenses resulting from the accident.

The Supreme Court ruled Great-West is not entitled to any additional reimbursement. The Court ruled against Great-West on procedural grounds that Knudson was never in possession of the settlement. The ruling affirms ERISA plans may seek reimbursement through the Federal Courts. Up to this point, the lower courts have not given a clear direction on whether ERISA plans could seek monetary recovery through the courts. This decision strengthens the clause of right to recovery from subrogation or third party settlements contained in insurance contracts.

Auditing Section 125 Plans

Many employers sponsor Section 125 cafeteria plans enabling employees to save significant tax dollars on insurance premiums, out of pocket medical expenses and dependent care expenses. One important factor to keep in mind if you are sponsoring a Section 125 plan is that certain individuals are not eligible to participate in the plan based on your company structure.

The following individuals are not eligible to participate in a Section 125 cafeteria plan:

- Self-employed individuals such as sole proprietors
- The partners in a Partnership
- More than 2% shareholders in a Subchapter S Corporation
- Members in Limited Liability Companies (LLC's), outside directors and limited partners

These companies can still sponsor a Section 125 plan for their common

law employees, including the spouses and other family members of the ineligible individuals. The spouse or family member must be considered an actual employee of the company and must not be deemed an owner by state law. However, in a Subchapter S Corporation, a spouse or other family member of a more than 2% shareholder is not eligible to participate in the cafeteria plan due to ownership attribution rules.

If your plan allows ineligible employees to participate, the minimum penalty would be taxation for the ineligible participants, or it could cause the plan to be disqualified. In this case, all participants would be taxed on their pre-tax benefits.

Make sure to do a regular audit of your Section 125 plan to ensure that the ineligible individuals are not participating in the plan.

Community Groups: Premium rates based on who they are, not how much they use

Healthcare insurers define 'Community' groups as companies with 50 or fewer employees. When determining monthly premium rates for community size groups, it is demographic information, not utilization, that ultimately determines the rate.

The demographic factors taken into account include: ages of the individual employees and dependents, location of the company, and the family size/make-up for those who will be on the plan. Rating factors are applied to each applicable demographic characteristic, which are then put into a formula that determines a rate for the group.

What won't be included is information about the health of individual employees or how many times employees sought treatment in the past. That information is only used when rating companies outside of the community pool. In the eyes of the health insurance carriers, 50 or fewer employees is not enough of a sample size to accurately predict how a group is going to use their benefits throughout the year.

The demographic information, however, can give the carrier an idea of who will be a higher risk. Using age as an example, one can assume older individuals will be more susceptible to health problems. Using that assumption, insurance carriers will apply a higher rate factor for the older employees. The inverse occurs for younger groups. The age factor also plays a role when the carrier analyses the make-up of families who will be on a plan. Groups with several young children receive higher rate factors because, just like the

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Community Groups

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older individuals, it is assumed young children will have to seek care more than the norm. Carriers have also determined that different geographic locations have a history of higher or lower utilization, leading the carriers to include location as a factor as well.

For insurance carriers, the process of determining a rate for 'Community' groups is more about who you are, not how many times you see your doctor.

Contact the Kibble & Prentice Employee Benefits Tech Team

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IRS Suspends 5500 Tax Filing Requirement for Section 125 Plans

Effective April 4, 2002, the Internal Revenue Service suspended the requirement to file Schedule F (Form 5500) "Fringe Benefit Plan Annual Information Return". This applies to cafeteria plans, education assistance programs and adoption assistance programs. The ruling does not affect the filing requirements for plans subject to ERISA, including health FSAs. Only employers with over 100 participants in a health flexible spending account need to file with the IRS, and only the Form 5500 needs to be sent, without attached schedules.

The IRS press release is available at www.irs.gov/pub/irs-news/ir-02-43.pdf.

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