

K&P Benefits Insider

Timely information for the dynamic world of employee benefits

A newsletter presented by the
Employee Benefits Division of

Kibble & Prentice

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STATE LEGISLATURE DEBATES CHANGES FOR SMALL BUSINESS HEALTH INSURANCE

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The Washington State Legislature is debating two measures that could significantly impact health plans available to small businesses. Republican-sponsored Senate Bill 5521 and Democratic-sponsored House Bill 2015 would both exempt small businesses from some state-mandated medical benefits. Both bills also call for looser limitations on premiums, potentially allowing for greater differences in rates for insurers' oldest and youngest members.

The goal of both bills is to allow companies with 50 or fewer employees to offer workers "bare bones" health plans. The stripped-down plans would exempt small businesses from mandated services including mental health, home health, hospice, chiropractic and chemical dependency care. Mammograms, mastectomies and reconstructive breast surgery are also being considered for exemption. Other proposed features include:

- ◆ Allowing insurers to charge more for their oldest enrollees. Current law allows carriers to charge their oldest members as much as 3.75

times the rate for their youngest members.

The Republican measure eliminates that limit entirely. The Democrats propose the ceiling to be raised to five times the cheaper plan.

- ◆ Exempt small businesses from the law requiring carriers to cover all people within a group.

Opponents, including officials with the Washington State Insurance Commissioner's Office, contend the proposals would negate the consumer protection battle that has led to the mandated benefits being put in place.

Michael Arnis, the health policy adviser for the Washington State Insurance Commissioner's Office, warned the legislature that such changes would likely lead to more uninsured people and, therefore, cost all Washingtonians more in the end. Arnis also feels the changes put older people at risk for being uninsured or not considered for employment because of higher premiums.



Section 125 Cafeteria Plan Updates

If your company permits health insurance coverage for domestic partners, there are several issues to keep in mind regarding the taxation of the premiums for that coverage.

According to the IRS, domestic partners are not considered spouses for tax purposes. In order to receive pre-tax benefits under a Section 125 cafeteria plan, a domestic partner must be considered a dependent as defined in Code Section 152.

To qualify as the employee's dependent under Section 152, the domestic partner must:

- ◆ receive over 50% of his or her support from the employee for the calendar year
- ◆ have his or her principal abode the employee's home for the entire calendar year
- ◆ be a member of the employee's household. (If the relationship between the employee and the domestic partner violates local laws then the domestic partner is not considered to be a member of the employee's household.)

If the employer pays for the domestic partner coverage and the employee's domestic partner is not

considered a Code Section 152 dependent, the value of that health coverage is considered taxable income to the employee.

If the employee is paying for the cost of the domestic partner's coverage through payroll deduction and the domestic partner is not considered a Code Section 152 dependent, the deduction should be taken on an after-tax basis.

If the employer also offers a Health Flexible Spending Arrangement (FSA) under the cafeteria plan, the out-of-pocket medical expenses for a non-dependent domestic partner are not eligible for reimbursement through the employee's Health FSA.

A cafeteria plan could be disqualified if it provides coverage on a pre-tax basis for a person that is neither the spouse of the employee nor a Code Section 152 dependent.

- ◆ Special fees paid to doctors for preferential treatment, such as first in line for appointments, physician telephone access, and special waiting rooms, are considered insurance premiums and are therefore not eligible for

reimbursement through a Section 125 Health FSA. Some doctors also charge a fixed monthly or annual fee regardless of whether or not the patient has office visits or receives treatment. These fees are also considered insurance premiums and are not eligible for reimbursement through a Health FSA.

- ◆ Lodging and transportation may be eligible for reimbursement through a Health FSA if the expenses are primarily for and essential to receiving medical care. Lodging expenses can be reimbursed up to \$50 per night. If a parent were traveling with a sick child, up to \$100 per night would be eligible for reimbursement (\$50 per person). Eligible travel and transportation expenses include expenses for bus, taxi, train, plane, ferry and ambulance services. For 2003, transportation by car to obtain medical care is eligible for reimbursement at a rate of 12 cents per mile. Parking fees and tolls incurred to obtain medical care are also eligible expenses for reimbursement through a Health FSA.

Privacy Rules May Limit Clergy Hospital Visits

Due to the new federal hospital privacy regulations, clergy may not be able to visit patients unless requested. The new HIPAA (Health Insurance Portability and Accountability Act) privacy regulations took effect April 14, 2003.

In response to the regulations, hospitals are limiting access to patient information, in some cases not divulging information to clergy or family members unless the patient gives the hospital permission to do so.

Hospitals are no longer using directories, which previously listed

patients' names, room numbers, conditions and religious affiliations. In most cases, the directories were clergy's only source of patient information.

Some hospitals have chosen to adhere tightly to the regulations; others have chosen to be more liberal when divulging information to clergy. Larger hospitals with a chaplain have taken to calling the clergy if a patient makes a request. Unfortunately, most hospitals have either part-time chaplains or none at all.

Carrier Updates

Aetna

Aetna has introduced "Simple Steps to a Healthier Life," a web-based wellness product. Simple Steps is a combination of online and offline wellness products and services designed to work with any health benefits plan. Employers can customize the website with their company logo and additional links. An integrated assessment tool helps employers track employee health trends on an aggregate basis. Employers can use this information to further develop and refine their wellness programs.

CIGNA

CIGNA Life and Accidental coverage provides new survivor support services for no additional cost. Financial, bereavement and legal services are provided as part of the benefit.

CIGNA's Manager's Disability Toolkit gives supervisors instant access to information on how to manage disabled employees, their co-workers and FMLA.

CIGNA now offers a suite of online information and decision support tools through their Web portal, www.myCIGNA.com. Employers can access PharmaAdvisor, an interactive tool that helps members research drug treatment options; CareSteps Health Risk Assessment, a questionnaire that helps members identify and monitor health status; Select Quality Care, a hospital comparison guide; and HealthWise, online member access to general medical information.

Group Health Cooperative

Group Health closed three medical centers (West Olympia, Monroe and West Seattle) effective April 4, 2003 to improve productivity and reposition resources to provide better member service. Members receiving care at these facilities have been notified of the closings.

Effective April 1, 2003 Fexofenadine (Allegra) is no longer covered under the prescription drug benefit unless it meets Pharmacy & Therapeutics' approved medical exception criteria.

Employers now have access to health plan descriptions, downloadable forms, service area maps, pharmacy information, and quality achievements through portals at www.ghc.org.

Premera Blue Cross and Premera Blue Cross Blue Shield of Alaska

Premera began sending specific correspondence directly to members age 13 and older as of January 1, 2003. The change was made to comply with the state Patient's Bill of Rights. Previously, the subscriber received all

correspondence. Examples of materials include explanations of benefits, checks and any individual-related correspondence. General information, ID cards and correspondence for children under age 13 will still go to the subscriber.

Northwest Hospital and Outpatient Medical Center in Seattle terminated its HealthPlus contract effective March 1, 2003.

LifeWise of Oregon will begin offering Medical Savings Account qualified health plans to employers with 2-50 employees effective June 1, 2003.

Regence BlueShield

Due to a contracting impasse, Regence will end its relationship with Harrison Memorial Hospital in Bremerton effective April 30, 2003. Regence recently issued the following guidelines to members affected by the change.

- ◆ If emergency care is received at Harrison, Regence BlueShield will reimburse the member directly for the amount Harrison charges for these services (less any personal deductible, copayment or coinsurance amounts owed by the member).
- ◆ Those receiving recurring care at Harrison for a condition, such as pregnancy or cancer, will be covered for a defined period of time. Regence will send a follow-up letter and the member will be contacted by a Regence nurse case manager.
- ◆ If care is received for elective or non-emergency services at Harrison after April 30, 2003, Regence BlueShield will deny charges for those services if the member's benefit package does not include reimbursement for non-network hospitals. Plans that do include reimbursement for non-network hospitals will be paid at the amount allowed by Regence BlueShield, less any deductible, copayment or coinsurance amounts owed by the member. Members will be paid directly for these services. The difference between what Harrison charges for these services and Regence BlueShield's reimbursement amount will be the member's responsibility.

Regence is discontinuing the RegenceCare HMO plan. The termination for current RegenceCare groups will be effective at renewal beginning November 1, 2003.

Regence will notify all groups and members who are currently enrolled on RegenceCare, and will be doing so as follows:

- ◆ Notification letters were mailed to group administrators on April 24, 2003.
- ◆ Notification letters will be mailed to subscribers on May 6, 2003.

For more information call Regence BlueShield at 1-877-258-3782 or contact your Kibble & Prentice representative.

In the past few months, we've seen considerable national media coverage about the rising cost of medical malpractice insurance for physicians. Malpractice insurance provides financial protection against court-ordered awards due to a physician's catastrophic medical mistake. Malpractice awards are comprised of three components: economic damages (for lost income and medical care), non-economic damages (for pain and suffering) and exemplary damages (punitive).

In an effort to remedy the rising cost of malpractice insurance, state and federal lawmakers have been considering legislation that would place limits on malpractice awards. The first national malpractice laws were enacted by California in 1975. This legislation capped "pain and suffering" damages, placed a statute of limitations on filing lawsuits and allowed defendants to make award payments over time. Currently, California has the lowest malpractice premiums in the nation.

Proposed federal legislation is modeled after the California legislation. Recently, the U.S. Senate approved a bill that would limit non-economic damages to \$500,000 and allow awards of at least \$2,000,000 for cases of disfigurement or physical disability. Lawsuits against managed care plans and drug companies would not be limited and state laws mandating a lower award ceiling would not be affected.

The U.S. House of Representatives is proposing a version of the Senate bill (HR 5). This bill would impose limits on state and federal malpractice awards and attorney's fees, modify the statute of limitations and eliminate joint and severe liability. Non-economic damages would be limited to the higher of \$250,000 or twice the economic damages with no limit set for economic awards, which include medical costs and lost wages. The proposed legislation would apply to lawsuits against physicians, HMOs, pharmaceutical companies and medical device companies and would allow evidence from group health plans to be introduced at trial. However, group health plans would not be allowed to recover benefit payments from malpractice awards through third parties. State governments would be allowed to increase or decrease the cap on malpractice awards at their own discretion.

On the state level, at least 30 states are expected

to introduce legislation to address the rising costs of malpractice insurance within the next year.

Proponents applaud the legislation because they feel high jury awards are the cause of rising malpractice premiums that, in some cases, have jumped as much as 80% in one year. These rising costs have caused some clinics and lawsuit-prone hospital departments, such as trauma centers and maternity wards, to eliminate services. In addition, twenty percent of hospitals nationwide have had to curtail services and six percent have had to close completely or discontinue some services. Rural areas have been hit the hardest, due to the historical shortage of physicians in these areas.

Some opponents feel caps would be unfair to patients, especially children and elderly victims that are likely to suffer economic damages. Others feel insurance companies are charging higher premiums to make up for the rising cost of healthcare and investment losses, so capping malpractice awards would not reduce insurance costs. One survey shows malpractice awards have increased an average 6.2% per year between 1990 and 2001, close to the medical inflation rate of 6.7% for that period and far below the current medical inflation rate of 14%.

Still others opposed to the legislation feel there are no safeguards built into the legislation to discipline doctors found guilty of malpractice. A recent study found 5% of all doctors were responsible for 54% of malpractice payouts. State medical boards disciplined only 16% of those doctors. Each year 44,000 deaths are attributable to preventable medical errors, with only one in eight of those preventable deaths resulting in a malpractice claim.

Lastly, opponents feel insurance companies have no incentive to settle lawsuits and victims will not be able to find an attorney due to costs and time consumption. The average attorney spends \$100,000 on experts and the median time for a malpractice case is 2½ years. Not to mention the fact that malpractice plaintiffs lose 77% of trials.

Some remedies offered include adding provisions to the legislation that would require discipline of malpractice repeat offenders through a state medical review board, along with increased public disclosure of information about doctors' errors.

Malpractice insurance carriers can help to reduce premiums by experience-rating physicians and offering discounts to good doctors.

Continued on page 5

Legislative/Judicial Updates

Family Medical Leave Act (FMLA)

In a recent case, a Louisiana court ruled that an employee's need to stay home to baby-sit a healthy child, in order for the spouse to care for a sick child at the hospital, might be an FMLA qualifying event. According to the law, an eligible employee is entitled to family or medical leave under the following circumstances:

- ◆ the birth and care of a newborn child of the employee
- ◆ the placement of a child for adoption or foster care
- ◆ a serious health condition of a spouse, child, or parent requiring the employee to care for that person
- ◆ a serious health condition of the employee that prevents the employee from performing his or her job functions.

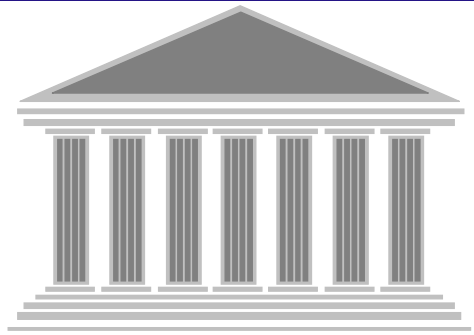
While the situation in the Louisiana case does not specifically fall into one of the above categories, the court indicated that a literal reading of the FMLA makes it clear that Congress passed the law to aid families in crisis such as in this situation.

This case only directly impacts Eastern Louisiana, but it raises important questions regarding the scope of FMLA.

Failure to Provide Employee With an SPD Can Be Costly!

In the case *Leyda v. AlliedSignal, Inc.* the plaintiff, Mrs. Leyda, sued her husband's employer, AlliedSignal, Inc., for failing to provide the employee, Charles L. Leyda, with a summary plan description (SPD) for a new life insurance plan.

Leyda was employed by Textron, Inc. from 1989 through 1994 and was eligible to participate in Textron's life insurance benefit plan. He was enrolled on the plan with a coverage level of \$120,000 - three times his annual salary of \$40,000. When AlliedSignal, Inc. purchased Textron's assets in 1994, the Textron benefit plan was replaced by AlliedSignal's benefit plan. AlliedSignal provided basic life insurance coverage equal to one and a half times an employee's salary. Leyda did not attend the benefit meetings that reviewed the differences between the Textron and AlliedSignal plans and he was never provided with an SPD for the new life insurance plan. Mr. Leyda therefore remained under the assumption that his base life insurance benefit was \$120,000. AlliedSignal also offered a voluntary group universal life (GUL) insurance program that provided additional



coverage of one-to-five times the employee's salary. Leyda enrolled in the GUL program for \$40,000 worth of coverage, which he expected to be in addition to the \$120,000.

Charles Leyda died in 1997. His wife was designated as the policy's beneficiary and she received benefits totaling approximately \$100,000. Of the total benefit, \$40,000 was from the GUL policy and \$60,000 was from AlliedSignal's basic life insurance policy. Mrs. Leyda was expecting a benefit of \$160,000. She sued AlliedSignal for the difference between the actual benefit and the expected benefit, claiming that AlliedSignal had violated ERISA by failing to provide her husband with an SPD that outlined the lower benefit.

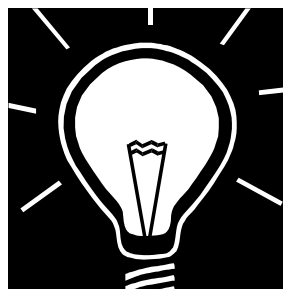
The district court awarded Mrs. Leyda \$62,250 in damages because the court found that AlliedSignal failed to disclose the SPD. AlliedSignal appealed the award of damages, but the Second Circuit upheld the district court's decision.

Medical Malpractice Awards

Continued from page 4

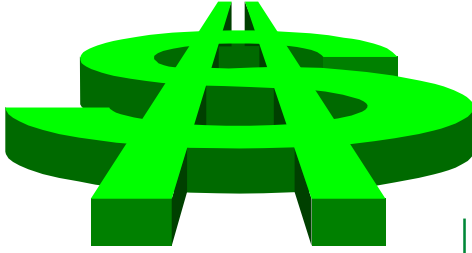
Government officials can control premiums by requiring state insurance departments to approve malpractice rate increases, allowing states to enter into multi-state agreements to create larger risk pools and possibly creating a no-fault system of victim compensation, modeled after worker compensation, funded by premiums from healthcare providers.

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.



Increased Prescription Cost Leading to Misuse of Drugs

According to a study published in *Health Care News*, the increase to out-of-pocket costs for prescription drugs is causing an increase in patient noncompliance with physician's instructions. The higher the out-of-pocket costs for the prescription, the greater the likelihood for noncompliance.

The study found patients use lower doses and take their medications less frequently than directed in order to cut costs. Survey results show that noncompliance is prevalent among those who are in fair or poor health.

Patients who do not take medications in proper doses and for the prescribed lengths of time could seriously jeopardize their health. On an individual level, the misuse of medications will lead to significantly higher levels of mortality and morbidity. In a larger picture, these patients will save a significant amount of money in the short term, but long term costs will be higher due to an increased number of hospitalizations and more expensive medical care.

In Washington, most carriers require the purchase of a prescription drug benefit when an employer purchases a group major medical plan. Often participants on these plans will have limited out of

pocket costs due to the low copayments that are a part of the plan. However, as health insurance premiums for group plans continue to increase, employers have begun to shift more costs to employees. More and more employees are looking for coverage on their own to avoid the increasing costs of continuing on the group plan. The increase in enrollment on individual plans could lead to more noncompliance in Washington as most individual plans available offer a prescription drug benefit with greater member out-of-pocket costs attached.

Complete survey results are available online at www.harrisinteractive.com/news/newletters_healthcare.asp.

NAME CHANGE!

The Labor Department has changed the name of its pension regulatory unit from the Pension and Welfare Benefits Administration (PWBA) to the **Employee Benefits Security Administration (EBSA)**.

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Contact the Kibble & Prentice Employee Benefits Tech Team

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TIMELY INFORMATION FOR THE DYNAMIC WORLD OF EMPLOYEE BENEFITS



Kibble & Prentice

www.kpc.com

Effective May 19, 2003, Kibble & Prentice will be moving to Two Union Square.

The new address is:

601 Union Street, Suite 1000
Seattle, WA 98101-4064

Our phone numbers will not change.