

K&P Benefits Insider

Timely information for the dynamic world of employee benefits

A newsletter presented by the
Employee Benefits Division of
Kibble & Prentice

Spring 2004; Volume 7, Issue 2

HIPAA PRIVACY REGULATIONS

As part of our continued efforts to keep readers up-to-date on the most recent HIPAA developments, the following is a summary of the recently enacted Privacy Regulations.

Employer health plans with annual receipts of less than \$5 million must have been in compliance with HIPAA privacy rules as of April 14, 2004. Employer health plans with \$5 million or more in annual receipts were required to be in compliance as of April 14, 2003. HIPAA privacy regulations impose use and disclosure rules on "covered entities, business associates and plan sponsors." Employers are considered the plan sponsor of group health plans including medical, dental, vision, Section 125/flexible spending accounts and many employee assistance programs. In the case of Section 125 plans, the employer is considered the plan sponsor and the covered entity.

The HIPAA privacy regulations create protective rights for individuals with respect to their health information. Plan sponsors, business associates and covered entities must follow these new administrative procedures.

Compliance for most employers consists of the following actions: (1) appointing a privacy officer and contact person, (2) amending plan documents (in most cases, carrier amended plan documents reflect required privacy provisions prior to the April 14, 2003 deadline for large group plans), (3) developing privacy policies and procedures, (4) preparing and distributing the notice of privacy practices to all employees, regardless of participation within the health plan.

Some health plans may be exempt from the covered entity rules under HIPAA. For example, some self-funded health plans with fewer than 50 participants which are administered solely by the employer are not covered entities and thus do

not have to comply with this portion of the HIPAA privacy rules.

A self-administered or third-party administered (TPA) health flexible spending account program or medical reimbursement arrangement does not fall within this exclusion even if the employer's other group health plans do meet the exclusion. An employer should adopt the HIPAA privacy regulations within their normal course of business practices as it relates to the health plans, as well as interaction with its employees.

A broker or TPA is considered a business associate under the privacy regulations and may perform HIPAA compliance services

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Medicare Update

Prescription Drug Plan

Under the Medicare prescription drug law signed by President Bush on December 8, 2003, prescription drug benefits will be available to individuals covered by Medicare in 2006. Members will pay a premium of approximately \$35 a month for the new coverage. A basic outline of the plan is as follows:

- \$250 deductible
- After the deductible is satisfied Medicare will then pay 75% of prescription costs between \$250 and \$2,250
- Drug costs between \$2,250 and \$3,600 will be the responsibility of the member
- After \$3,600, Medicare will cover 95% of prescription drug costs

Medicare will offer assistance to low-income individuals. Any participant with an income below a certain level

(income limits to be set in 2005) will not be required to pay the premiums or deductible for prescriptions. Qualifying individuals will only pay a small co-payment for each prescription.

Premera to Exit the Medicare Part A Market

Premera Blue Cross has decided to exit the Medicare Part A market effective September 30, 2004.

Premera has served as a Medicare Part A fiscal intermediary for Washington and Alaska since 1966, providing claims processing and other related services for Medicare's Part A. Premera will work with the Centers for Medicare & Medicaid Services (CMS) and the Blue Cross Blue Shield Association (BCBSA) to ensure a smooth transition to another Medicare Part A fiscal intermediary.



Contact the Kibble & Prentice Employee Benefits Tech Team

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HIPAA Privacy Regulations

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through a Business Associate Agreement. However, there remains a legal obligation for "the plan" (owned by the plan sponsor/ employer) to comply with HIPAA, and any penalties imposed for a failure to comply will be imposed on the plan and not the broker or TPA. Note that group health plans are covered by the HIPAA privacy

regulations whether they use and disclose information electronically or in any other form.

For any questions concerning the HIPAA Privacy Regulations, please contact Kibble & Prentice's HIPAA Compliance Technician, Michelle Hokama, at 206-676-7438 or by email at michellehok@kpc.com.

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The articles presented herein are for information purposes and should not be construed as legal opinions.

Washington State Passes Small Group Health Insurance Legislation

Governor Gary Locke has signed the long-debated small group health reform bill into law. House Bill 2460 was passed on March 11 just prior to end of the State Legislature's 2004 session. Governor Locke signed the bill on March 31, with the effective date of the bill expected to be June 10, 2004.

The key features of the legislation include:

- The definition of "small employer" will change from 1-50 to 2-50 employees.
- Carriers will now be allowed to cancel products if appropriate notice is provided to policyholders. The carrier must offer a transfer to any other products they currently sell in the applicable market.
- Eliminates the requirement to offer a small group product with the same benefits as the state's Basic Health Plan.
- Allows carriers to offer small employers plans featuring "a limited schedule of covered health care services" that is exempt from specified coverage mandates.

- Allows carriers more flexibility in adjusting community rates based on deductible leverage, benefit design, or provider network characteristics.
- Deletes the current 20% limitation on rate discounts for wellness activities.
- Allows portability to the individual market without requiring the health screening for people coming from groups of fewer than 20 employees with 24 months of uninterrupted group coverage.

The Governor vetoed the portion of the legislation that would eliminate the requirement of insurance carriers to offer conversion plans. With HIPAA requiring the issuing of conversion health plans, there were concerns over the state's ability to certify that it has a functioning alternative that would comply with HIPAA.

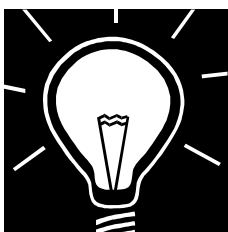
The state's insurance carriers are evaluating the various components of the legislation. We anticipate additional information from the carriers regarding the impact to their product offerings in the near future.

California Domestic Partner Rights and Responsibilities Act

The State of California recently passed legislation addressing domestic partners. Under the prior law, benefits paid by an employer-sponsored health or accident plan were not subject to California income tax for employees and their dependents. Domestic partners were excluded from this exemption. Under the new law, benefits received by domestic partners are not subject to California income tax. These

benefits will continue to be subject to federal income tax.

The same law extended the right of continuation of benefits in the event of the employee's death to domestic partners and their children. Insurance carriers may require a copy of a valid Declaration of Domestic Partnership and Notification of Termination of Domestic Partnership.



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.

CARRIER UPDATES

Aetna

- Our Lady of Lourdes – PGA, a physician group affiliated with Our Lady of Lourdes Hospital at Pasco, has joined the Aetna Eastern Washington network.
- Valley Internal Medicine’s physicians and outpatient surgery centers, located in Renton, Kent and Covington, WA have terminated from the Aetna network.
- Aetna Dental plans no longer require periodontic surgery in order to cover periodontic cleanings for PPO or Participating Dental plans. There is no change to how periodontic services are covered under DMO plans, which still require periodontic surgery in order to cover periodontic cleanings.
- Aetna Global Benefits (AGB) announced the rollout of a new webinar program (combination teleconference and web-based presentation) designed to help both employers and their employees learn more about the online resources available on the AGB Member Website.

CIGNA

- CIGNA Healthy Rewards made additions to the list of offerings: Weight Watchers Online, Weight Watchers At Home; QuitNet and Tobacco Solutions (two online smoking cessation services); subscription rates for popular health and wellness magazines; additional vision discounts.

Group Health

- Group Health is now offering The Welcome Plan rider to large groups of 51 or more eligible employees on deductible plans. Under this rider, the first four office visits are covered with just a copayment; deductibles and coinsurance are not applicable until the fifth visit. Preventive care and prescription drug coverage are not subject to deductibles.
- Group Health began issuing new look ID cards effective December 1, 2003. Old cards will be replaced as groups renew.

Jefferson Pilot

- Jefferson Pilot Corporation is in the process of acquiring the U.S group life, disability and dental business of The Canada Life Assurance Company. The reinsurance transaction closed during the first quarter of 2004.

KPS

- KPS has eliminated the preauthorization process currently required of all members that have a maximum number of mental health outpatient visits.
- A new Vision Rider has been introduced by KPS, which offers members a more flexible benefit design for reimbursement of vision hardware.

Premera

- Fourth Corner Neurosurgical Associates of Bellingham terminated all Premera Blue Cross networks March 18, 2004. Providers in this group are David E. Baker, MD, Barry J. Landau, MD, David L. Goldman, MD and Michael S. Lawrence, MD.
- Ballard Emergency Physicians are no longer contracted with any of the Premera Blue Cross networks. These physicians provide emergency room services for Swedish Medical Center in Ballard.
- Eastside Gastroenterology, Seattle Gastroenterology Associates and Northwest Gastroenterology Associates will no longer be under contract with the Premera Blue Cross Foundation network as of April 30, 2004.
- Providence Health Care (PHC) announced that it is re-opening contract negotiations between Premera Blue Cross and four of PHC’s Spokane-area hospitals: Sacred Heart Medical Center, Deer Park Hospital, St. Joseph’s Hospital in Chewelah and Mount Carmel Hospital in Colville. All of these facilities are under separate contracts with Premera Blue Cross. PHC re-opened negotiations for the four other hospitals by issuing a no-cause, six-month termination notice effective September 30, 2004. The termination clause is a formal means of

re-opening negotiations on existing contracts. It included terms PHC wishes to negotiate at contract renewal.

- Premera will make available 19 new small group (50 or less employees) Dimensions plans for effective dates beginning July 1, 2004. The new product portfolio offers a variety of new medical and pharmacy options, including three new plan designs qualified to work in conjunction with tax-deductible Health Savings Accounts.
- Premera added an intervention component to their End Stage Renal Disease (ESRD) Management Program. Through this unique program, Premera contacts members with an elevated risk of kidney failure and encourages them to ask their doctor

how to prevent the condition, delay it or prepare for life on dialysis.

Regence

- Regence BlueShield has a Health Reimbursement Arrangement (HRA) product available for groups with 51 or more employees.
- Regence BlueShield is offering diabetic members free nutritional education and a free blood glucose meter. Regence is also providing drug discount coupons for several over-the-counter medications not covered under the Regence prescription drug formulary, such as Prilosec and antihistamines, effective alternatives to more costly prescription medications.

Patient Bill of Rights Update

Legislation for a federal patient bill of rights continues to stall in Congress. Consensus is that legislation to address denials of doctor-recommended treatments by health insurance companies has become less important to the public in the last few years. The public has shifted focus to prescription drugs.

Currently, the only course of action for patients with a complaint against an HMO is to seek restitution through the state courts. In 2000, the Supreme Court ruled that federal employee benefit law prevents patients from suing HMO doctors in federal court in cases in which the doctor decided both whether or not a particular treatment was needed and whether or not it should be covered. The Supreme Court's ruling left open the possibility that such "mixed"

decisions can still be challenged under state malpractice law.

There have been a few cases brought against HMOs on the state level in the past few years, but none have swayed the opinion of the Supreme Court. Two cases (*Aetna Health v. Davila*, and *Cigna Healthcare of Texas v. Calad*) were recently presented before the Supreme Court in which both plaintiffs said they suffered physical harm when managed care firms denied coverage for treatments their physicians had recommended. A decision from the Supreme Court is expected by July 2004. Advocates for patients rights hope the Supreme Court will rule against the HMOs and open the door for relief on a federal level.

Spam Alert!

With the increased activity of viruses and spam, we have all been forced to install firewalls and virus software to protect the integrity of our internal computer systems. Consequently, recent e-mail messages sent from Kibble & Prentice may have been quarantined.

To ensure future receipt of important messages, technical bulletins or legislative updates, please consult with your internal Information Technology (IT) department to allow or release e-mail from Kibble & Prentice.