

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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THE FUTURE MAY BE NOW FOR LONG TERM CARE

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Employers are attempting to determine which benefits are most important to employees now and in the future. One plan offering that is quickly gaining interest is Long Term Care (LTC) insurance. Long Term Care insurance offers coverage for nursing home care, assisted living facility care, home care (both formal and informal), adult day care, hospice care, respite services, bed reservations and caregiver training.

Several societal and economic factors have increased the need for Long Term Care insurance.

Aging of the Population

Approximately 12% of the U.S. population is over age 65. By 2040 those over 65 will make up nearly a quarter of the population. As the population ages and the cost of health care increases, the demands on elder-care dollars and facilities will increase. Current public programs are not structured to offer the coverage required on a long-term basis.

Limitations of Government Programs

When the government originally developed the Social Security program, the average mortality age was the early 50's. With improved technology and healthcare, the average mortality age is now well

into the 70's. Social Security is not in a position to support the increased number of individuals living through retirement years.

Medicare and Medicaid are greatly limited in a situation requiring long term care. Medicare, for instance, only covers Skilled Nursing Facility Care for the first 100 days and one must meet the stringent income requirements to qualify for Medicaid.

Effect on Business Production

Just over 14 million full- or part-time workers are involved in balancing work with care-giving roles. As a result, according to the National Alliance for Caregiving (NAC), employers are losing up \$29 billion a year due to lost time, lost employees and lost productivity.

With the aging population and effects on business production, individuals and employers continue to search for solutions to the problems of long-term healthcare coverage and cost.

Many people are just becoming aware of the cost for long-term care. *Business and Health* reports that 70% of single individuals and 50% of couples with one partner in a nursing home are impoverished within a year. In the state of Washington, the

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Insurers Monitor Social Security Numbers

What do you mean I can't enroll on the medical plan?

Yes, that's right, if one of your employees attempts to use someone else's Social Security Number, a carrier may deny coverage for that person. Forever.

Although not common, individuals have provided fraudulent Social Security Numbers when completing enrollment applications for insurance coverage. Most carriers will investigate the situation by contacting the employer to make certain numbers were not inadvertently transposed. The carriers will usually request a copy of the Social Security card and contact the Social Security Administration to verify the legitimacy of the SSN.

If it is determined that the SSN is being used fraudulently, the consequences can vary. Some carriers simply investigate the matter and allow the group to determine the consequences for the individual. One local carrier will take things a step further. Once it is determined that an individual has used an SSN fraudulently, that individual's name is flagged in the system. If you are flagged, you will never again be able to obtain coverage through this carrier.

Within the next two to three years some carriers have committed to using alternative means of identifying individual enrollees. For now, carriers are keeping a watchful eye on the information that passes through their systems.

HRA Revisited

In the past year, the IRS issued a significant amount of guidance regarding the tax-favored status of Health Reimbursement Arrangements (HRA). A qualified HRA must be funded entirely by the employer to reimburse employees for out-of-pocket medical expenses. An HRA differs significantly from Section 125 Health Flexible Spending Arrangements (FSA) in that an HRA can also reimburse premiums paid for health coverage by active employees, retirees and COBRA qualified beneficiaries. While the regulations permit an HRA to reimburse insurance premium payments for health coverage, other factors need to be evaluated prior to implementing this feature.

If an HRA allows for reimbursement of premiums paid for individual policies, the individual policies can be considered a group health plan subject to HIPAA and ERISA requirements. The HIPAA

nondiscrimination rules prohibit a group health plan from charging different rates or contributions based upon health status. This is a concern because the rates for individual policies often vary based on the individual's health history.

An optional feature of an HRA allows former employees to spend-down their HRA balances after termination of employment. A former employee may be more likely to elect COBRA coverage under the employer's plan if COBRA premiums are an eligible expense for reimbursement under the HRA. This could cause adverse selection and additional risk to the employer's medical plan.

Until further IRS guidance is issued, an employer should consult with legal counsel and benefit advisors before allowing for the reimbursement of insurance premiums through an HRA.

Clarification from IRS on COBRA in Divorce Situations

On December 30, 2002, the IRS issued guidance in Revenue Ruling 2002-88 clarifying when COBRA must be offered when employees drop their spouses' health coverage in anticipation of divorce. The group health plan is required to make COBRA continuation coverage available to the spouse, as of the date of the divorce, for a period of up to 36 months.

A divorce is typically only considered a COBRA qualifying event if the spouse is covered by the plan on the day prior to the divorce and the divorce causes the spouse to lose coverage under the group health plan. The regulations make an exception to this rule if coverage for the spouse was dropped in anticipation of divorce. In this case, the original termination of coverage is disregarded and the spouse must be offered COBRA as of the date of the divorce. This ruling also assumes that the spouse's coverage would not have otherwise been lost before the divorce. There is no requirement in the regulations for the plan to make COBRA coverage available prior to the actual qualifying event date, potentially resulting in a gap of coverage.

COBRA continuation coverage must only be offered if notice of the event is provided to the plan administrator within 60 days of the divorce decree. It may be difficult to determine when coverage was lost in anticipation of divorce and if coverage would have otherwise been lost before the divorce. Plan administrators should take into consideration all of the facts and circumstances and consult with professional advisors when making this determination.

A copy of IRS Revenue Ruling 2002-88 can be found at www.irs.gov/pub/irs-irbs/irb02-52.pdf.

Aetna

- ◆ Beginning January 1, 2003, Aetna will more strictly and consistently enforce benefit exclusions under their pharmacy benefit. HMO and QPOS plans exclude drugs used for cosmetic purposes or to promote hair growth or for any drugs available over-the-counter.
- ◆ Aetna will not renew contracts with the current mail order prescription drug vendor, Express Scripts. Aetna's new mail-order pharmacy program, Aetna Rx Home Delivery, took effect February 1, 2003.

CIGNA

- ◆ CIGNA members may receive a discount on three types of wellness programs: weight management, smoking cessation and stress management. Members must utilize Health Rewards to receive a 10% discount on these programs.

Group Health Cooperative

- ◆ Group Health will close their West Olympia, Monroe and West Seattle facilities effective April 4, 2003.
- ◆ Kelsey Creek, a skilled nursing facility owned by Group Health, will be put up for sale, with the sale likely to occur by mid-2003.
- ◆ Group Health has settled a class action lawsuit filed in 2001 alleging Group Health was in violation of the 1996 "every category of provider" state law with regards to complementary and alternative care. The settlement requires Group Health to notify members who were enrolled between June 1, 1996 and December 31, 2002 that they may be eligible for reimbursement for services provided by massage therapists, acupuncturists and naturopaths.
- ◆ Members of Group Health now have a limited self-referral benefit for acupuncture and naturopathy under the complementary and alternative care medicine program.

Kaiser Permanente of California

- ◆ As part of a settlement for a lawsuit filed in 1999, Kaiser Permanente will post the clinical guidelines developed by its physicians on its website. The guidelines will cover consultations for conditions ranging from asthma to visual impairment. Along with the clinical guidelines, Kaiser will post its physician compensation structure. Kaiser of California's website address is: www.kaiserpermanente.org/locations/california/index.html.

Premera Blue Cross and Premera Blue Cross Blue Shield of Alaska

- ◆ A generic version of Tiazac, a blood pressure medication, will be available as a tier 1 drug. Tiazac will be changed from a tier 1 drug to a tier 3 drug.
- ◆ Premera's Extras! program provides discounts for health-related products including massage therapy, chiropractic services, eyeglasses, contact lenses, hearing aids and bicycle helmets.
- ◆ Sound South Radiology signed a contract with Premera to participate in their Preferred and Participating plans.
- ◆ Yakima Urology signed a contract with Premera to participate in their Preferred and Participating plans.

Prudential

- ◆ Prudential plans to discontinue their internet-based voluntary products platform called WorkingSolutions. Four products were offered under the program: property and casualty, financial planning, long-term care insurance and real estate services. Prudential expects to complete referrals to alternative providers by April 2003.

Regence BlueCross BlueShield of Oregon

- ◆ Regence introduced a complementary care product in July 2002. Under the new program, members can seek care from any chiropractor, acupuncturist or naturopath as part of their group medical coverage.
- ◆ Regence will begin converting their claims and membership computer systems in March 2003. The process is expected to take until summer 2003. The goal of the conversion is to provide better, faster service to clients by modernizing and consolidating membership and claims functions.

UNUMProvident

- ◆ A California jury has awarded \$31.7 million in damages to an eye surgeon who claimed UNUMProvident fraudulently and maliciously stopped paying disability benefits. The surgeon sued UNUMProvident after they terminated his \$12,000 monthly disability payment. The surgeon claims he developed anxiety symptoms, including shaky hands, which a psychiatrist diagnosed as phobia to performing surgery. UNUMProvident claims two of its staff doctors and nurses concluded the conditions were not supported and that he could return to work. UNUMProvident is appealing the decision.

California Extends COBRA and Cal-COBRA Health Care Continuation Rights

The California Legislature signed Assembly Bill 1401 (AB 1401) into law on September 22, 2002. This bill amends the California Continuation of Benefits Replacement Act (Cal-COBRA) by requiring healthcare service plans and health insurers to extend the continuation of coverage period for up to 36 months from the date the original COBRA coverage began. This applies to policies issued, amended or renewed in California and for individuals who begin receiving COBRA coverage on or after January 1, 2003. AB 1401 will require healthcare service plans and health insurers to allow individuals to continue on group insurance policies for an additional 18 months (or 7 months in the case of a disability extension) after their original 18 or 29 months of COBRA coverage expire. The extension will not apply to individuals who are initially offered 36 months of COBRA coverage due to divorce, loss of dependent status or death of a covered employee.

In order to receive the additional months of coverage, COBRA participants must submit written coverage continuation elections to insurance carriers no later than 30 calendar days prior to the end of the initial COBRA coverage period.

Employers will be responsible for notifying COBRA and Cal-COBRA beneficiaries of their rights under the new law. This information should be included in the required notice of termination of coverage sent to COBRA participants at least 120 days prior to the end of the original coverage period. AB 1401 does not apply to stand alone dental or vision plans.

The healthcare service plan or health insurer can charge up to 110% of the applicable premium during the

additional coverage period or up to 150% if the COBRA participant was deemed disabled by the Social Security Administration. The healthcare service plan or health insurer will be responsible for the collection of the required premium.

AB 1401 also requires group HMOs and health insurers to offer conversion coverage to individuals when their participation in a group health plan terminates, if similar group coverage does not replace the coverage within 15 days. A goal of this new law is to keep a significant portion of the COBRA and Cal-COBRA risk with the group carriers and away from the individual health plan market by requiring the conversion plans.

Ideas??

If you have questions or ideas for future issues of the [K&P Benefits Insider](#) we would like to hear from you! Please call or e-mail us at techteam@kpc.com.

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DOL Clarifies FMLA Rights for Military Reservists

According to a recent memorandum issued by the Department of Labor, military reservists called to active duty have protection of employment rights under FMLA (Family Medical Leave Act of 1993). FMLA entitles employees to 12 weeks of leave during the 12-month period following the birth of a child, adoption or foster care of a child or the serious health condition of the employee or certain family members. To be eligible for FMLA, an employee must have worked a minimum of 12 months and 1,250 hours during the 12-month period prior to the leave.

The memorandum cites the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) as the basis for reemployment rights. USERRA gives returning military veterans the same rights and benefits as if the veteran had been continuously employed throughout his or her military leave, including FMLA.

Questions and answers regarding USERRA and FMLA are on the Department of Labor website at: www.dol.gov/vets/media/fmlaqa.pdf.

Contact the Kibble & Prentice Employee Benefits Tech Team

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Long Term Care

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current cost of an assisted living facility is approximately \$54,000 a year. The costs of facilities that provide custodial care are growing at a compounded rate of 5% each year. A potential solution may be the combination of a retirement account and a Long Term Care policy.

As with any consumer purchases, there are risks. There are no guarantees that the Long Term Care Carrier will stay in business. If the Carrier ceases operation and no plan is in place to work with another carrier, the insured's premium dollars are lost. Another risk is the insured never using the services covered under a Long Term Care policy, resulting in lost premiums.

In looking toward the future, the theme of protecting one's assets may be prevalent for both employers and employees. The presence and productivity of employees are assets to employers. Money to take care of oneself and one's family members are assets to employees. Long Term Care insurance has the potential to become an important part of protecting those assets.

For more information on Long Term Care coverage, feel free to contact your Kibble & Prentice representative.



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Mental Health Parity Act Extended

The Mental Health Parity Act of 1996 was extended to the end of 2003 through the Mental Health Parity Reauthorization Act enacted on December 2, 2002.

Under the Mental Health Parity Act, a group health plan that provides mental health benefits may not impose annual or lifetime financial limits that are lower than any financial limits placed on the other

medical benefits covered by the plan. Employers with 50 or fewer employees are exempt from the Act if their total health plan costs would increase by more than 1% to comply with the law.

You can view a summary of the Mental Health Parity Act of 1996 at: <http://cms.hhs.gov/hipaa/hipaa1/content/mhpa.asp>.

NEW!

Kibble & Prentice introduces a newsletter for Retirement Plan Services

The Retirement Plan Services team at Kibble & Prentice is pleased to introduce a new plan sponsor newsletter, "**DC Solutions**". You can access "**DC Solutions**" at www.kp401k.com under the Retirement Planning Tools/Investment News and Education sections.

We hope you enjoy "**DC Solutions**" and look forward to your feedback.

Hospital Ratings

In an effort to give consumers the ability to evaluate health care services, hospitals will begin releasing ratings. These reports are seen as a way to improve hospital quality and reduce the number of medical errors that cost millions of dollars and thousands of lives each year.

Initially the reports will address how well hospitals cover three health conditions: heart attacks, heart failure and pneumonia. Other

medical conditions will be added once quality improvement priorities are identified. The reports are voluntary, however, the public will be told which hospitals are not reporting data.

The federal government will oversee the ratings program and scores will be published on the website of the Centers for Medicare & Medicaid Services at: www.cms.hhs.gov.

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