

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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In this edition of the K&P Benefits Insider, we focus on the upcoming HIPAA security requirements and update you on recent legislative and carrier changes. We also introduce you to a new HR tool available to help you ensure compliance with the numerous HR regulations.

HIPAA Security Rules

As we have communicated in previous *Technical Bulletins*, the final HIPAA Security Regulations go into effect on April 20, 2005, for health plans with \$5 million or more in receipts. Small plans, defined as less than \$5 million in receipts, need to be in compliance by April 20, 2006.

This portion of HIPAA is specifically focused on the HIPAA Security Rules that are intended to create national safeguards to protect the confidentiality, integrity and availability of an individual's health information, which is maintained, stored, sent or received in an electronic format.

To clearly understand the HIPAA Security Regulations it is important to know a few key definitions: "Covered Entity" is defined as all employer-sponsored health plans with 50 or more eligible participants. Health plans with less than 50 eligible participants and those that are self-administered are exempt.

"Protected Health Information (PHI)" is defined as "individually identifiable health information created or received by a covered entity which is transmitted or maintained in any form or medium, including electronic, written and oral". PHI may be "de-identified" by removing, coding, encrypting, or otherwise eliminating or concealing all individually identifiable information, including names, social security numbers, addresses, phone numbers or other identifying numbers, identifiable photographs or other unique identifiers.

"Electronic Media" is broadly defined to include storage devices, such as computer hard disks and magnetic tapes, and transmitting devices, including the Internet, extranets, dial-up lines and private networks. When information is physically moved, it is subject to HIPAA security regulations.

The HIPAA Security Rule:

Covered entities must (1) ensure the confidentiality, integrity and availability of all electronic protected health information the covered entity creates, receives, maintains or transmits, (2) protect against any reasonably anticipated threats or hazards to the security or integrity of such information, (3) protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required, and (4) ensure compliance with this subpart by its workforce.

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HIPAA Security Rules

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The regulations set out a number of generic standards that are intended to be general enough to be effectively implemented by covered entities of all types and sizes, and broad enough to anticipate security concerns that might arise with future technologies. Some examples of areas where standards were established would be Administrative, Technical Safeguards and Compliance.

Under the standards, the regulations are either designated as “required” or “addressable”. “Required” specifications must be incorporated into the procedures of covered entities. If the specification is designated as “addressable”, the covered entity must decide if the specification is reasonable and appropriate, and either implement it, if reasonable, or document why it is not deemed reasonable and appropriate and adopt another procedure.

Overview of the areas where standards were established:

Administrative Standards

- Security Management Process
- Security Official
- Workforce Security
- Information Access Management
- Security Awareness and Training
- Security Incident Procedures
- Contingency Plan
- Evaluation

Physical Standards

- Facility Access Control
- Workstation Use
- Workstation Security
- Device and Media Controls

Technical Safeguards

- Access Control
- Audit Control
- Integrity Control

- Person or Data Authentication
- Transmission Security

Policies and Procedures

- To the extent appropriate, health plans are required to adopt, implement and document policies and procedures to comply with the security regulations.

Business Associate

- Covered entities must enter into a Business Associate Agreement with any person or organization that performs or assists in performing a function of the covered entity, or that provides services to the covered entity, which involves the use of PHI. This includes TPAs, brokers, accountants, attorneys, etc. The Business Associate Agreement specifies that the business associate will reasonably and appropriately protect any PHI that it receives, implement safeguards, report any security incident of which it becomes aware, and adopt its own policies and procedures.

Compliance Plan

- Covered Entity Analysis
- Appoint a Security Official
- Identify Relationships
- Information Flow Assessment
- Establish and Prioritize Compliance Steps
- Plan Amendment and Contract Revision
- Review the Security Standards and Develop Policies and Procedures

At Kibble & Prentice, we have tools available to help you with your HIPAA compliance. For more information, or to order a HIPAA Toolkit, contact Kellie Stone in the HR Support Unit at kellies@kpc.com.

Update on proposed changes to HIPAA regulations:

In December 2004, information was released on possible changes to the HIPAA regulations that would take effect for plan years starting on or after July 1, 2005. These changes primarily focus on portability. The new regulations require additional educational tools, procedural documentation and updated enrollment rules.

These are proposed changes to the final rules published in 1999 and are subject to a commentary period, which ends on March 30, 2005. Final changes will be announced following the commentary period and Kibble & Prentice will provide you with all of the latest information once the final rules are available for publication.

Listed below is a link to the proposed regulations in detail: <http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/pdf/04-28113.pdf>

For additional information contact Kellie Stone at kellies@kpc.com.

Contact the Kibble & Prentice Employee Benefits Tech Team

Would you like to obtain future copies of this newsletter by e-mail? If so, send us your name, phone number and e-mail address and we will add you to our e-mail list in time for the next mailing!

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California Seeks Parity for Domestic Partners

A new law (AB 2208) passed in September called The California Insurance Equality Act is meant to create parity between spouses and registered domestic partners. Effective January 2, registered domestic partners will receive group health care the same as married spouses.

What this means to employers:

If health benefit contracts originate in California - companies must comply.

If health benefits originate elsewhere, i.e. Washington, companies may need to comply. If the majority of employees are located outside of California, it is not necessary to comply. If more than 50% reside in California, the organization must comply and offer health plan coverage to registered domestic partners if they also offer coverage to spouses. If no coverage is offered to spouses, then coverage need not be offered to domestic partners.

If an employer requests documentation to verify that the domestic partnership is registered with the state, then parity must be met by also requesting marriage certificates.

Self-Insured plans do not need to comply.

If you have further questions, please review the documents below, call Kibble & Prentice, or consult your attorney.

Support documents:

1. If you are a member of SHRM (Society of Human Resource Management), here is a link to an article about the new law.
http://www.shrm.org/hrnews_published/archives/P-11_0

2. Here is the exact wording of the law:

AB 2208 This bill enacts the California Insurance Equity for All Families Act. The bill conforms to the requirements of AB 205, the existing law extending health care benefits to domestic partners. According to current law, group health care service plans and insurance companies are required to offer health coverage for a registered domestic partner that is equal to the coverage offered to the “dependent” of the employee or subscriber. Current law is revised to require group health care service plans and insurance policies to provide a registered domestic partner of an employee or subscriber with health benefits on the same terms and conditions as a “spouse,” instead of a “dependent,” upon application of the employer. AB 2208 applies to group health care service plans or group health insurance policies issued, amended, delivered, or renewed in California on or after January 2, 2005.

In short, if an employer’s medical plan offers benefits to employees’ spouses and the medical plan is not self-funded, then it is expected the health care service plan or insurance company will offer such benefits to registered domestic partners on the same terms and conditions as offered to spouses. This new law also may apply to employers’ life insurance programs for their employees and employees’ spouses and domestic partners. It is therefore important to review your health plans, life insurance programs, and domestic partner policies in light of this new legislation.

There’s No Losing the “Use it or Lose it” Rule

Recently, a lot of attention has been drawn to the possibility of eradicating the “Use it or Lose it” rule governing health Flexible Spending Accounts (FSA). Currently, health FSA participants forfeit the unused money remaining in their health spending account at the end of the plan year. Recent media attention was brought to this issue when Senator Charles Grassley, (R-Iowa) requested the treasury department do away with the “Use it or Lose it” language. On Wednesday January 5, 2005, the Treasury Department, in a letter sent to the Senator, rejected his request. The reasoning for the rejection was twofold: (1) the Treasury Department “lacks the authority to administratively change this long standing rule”, and (2) eliminating this rule could impact the “health care priorities of Congress and the administration”.

One concern of the Treasury Department was the impact this change would have on Health Savings Accounts (HSA). The Treasury estimated that the number of HSAs established could be reduced by upwards of 10% if the rule was eliminated. The FSA, without the forfeiture language, potentially makes the HSA less desirable to the individual because the HSA requires coordination with a high deductible medical plan. The FSA has no such requirement.

The debate surrounding the future of the “Use it or Lose it” rule continues and will likely remain a focus in the development of new mechanisms of consumer driven health care. For the time being, however, the “Use it or Lose it” rule is here to stay.

CARRIER UPDATES

Aetna

Aetna has implemented a new FSA debit card that will allow automated payments at point of care. The card will eliminate the need for participants to pay twice for care. The card can be used at any of the IRS-approved merchants, which includes more than 99% of health care providers and pharmacies nationally.

CIGNA

CIGNA announces the ending of their preferred relationship with DANA Diabecare USA, which manufactures insulin pumps. CIGNA also advises members or providers who wish to be reconsidered for a non-DANA pump to contact member services.

CIGNA announces a partnership with JP Morgan to market the CIGNA Choice Fund Health Savings Account effective January 1, 2005, which combines health care and financial management capabilities into one product.

CIGNA adds eligibility and enrollment capabilities to CIGNAaccess.com to allow administrators to instantly make changes to coverage.

EyeMed

Luxoticca Group, the parent company of EyeMed, announces the acquisition of Cole National Corporation.

EyeMed is launching the Xtra 10 Program, which allows providers more control and additional reimbursements over frames purchases.

EyeMed is also implementing a new customer relationship management tool and an Interactive Voice Response System to better serve its members.

Group Health Cooperative

Group Health selected Scott Armstrong as its new President & CEO.

HMA

HMA has recently launched FaxRecall and Secure Email technologies to better serve its clients. FaxRecall allows providers to verify benefits or check the status of claims 24/7. Secure Email prevents unauthorized access of email via improvements in software encryption.

HMA is expected to launch the new Consumer Directed product portfolio soon. It will hold seminars for the portfolio in February and March.

KPS

KPS is conducting a re-certification of all existing small groups with renewal dates beginning February 2005. Employers and brokers will receive a notice approximately 90 days before renewal date.

Premera Blue Cross

Albertsons has decided to rejoin the Premera Network effective December 1, 2004.

Premera is changing its members' ID cards to "BlueCard PPO" or "BlueCard Traditional" from "Heritage" or "Foundation" to help members or providers outside of Washington better identify the correct network of cardholders.

Premera is utilizing Eliza, a voice recognition software, to encourage and educate its members about the importance of receiving preventive tests and immunizations. Premera is also using Eliza to conduct a survey on its members' experience with the preferred drug list.

Premera will implement a new program called "Therapeutic Alternative Program" (TAP) to minimize prescription costs. TAP will waive the copay for a member prescribed with branded drugs such as type COX -II inhibitors for pain, statins for cholesterol, and Angiotensin Receptor Blockers for cardiovascular disease if the member and his/her doctor decide a generic drug is a better fit. TAP is available for two or three tier plans.

K&P Benefits Insider

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

COBRA Notice Regulations

As part of our ongoing education efforts we have been periodically communicating the new COBRA notice requirements since they were finalized in May 2004. We feel it important to include an additional reminder of the new COBRA notice requirements since they became effective on January 1, 2005.

On May 26, 2004, The Department of Labor (DOL) published final COBRA regulations imposing significant new obligations on the sponsors and administrators of COBRA eligible benefit plans. These regulations apply to employers with 20 or more employees. The new regulations are effective for non-calendar plan years beginning November 26, 2004 and for calendar plan years effective beginning January 1, 2005. The regulations are summarized below.

Initial COBRA Notices

The initial COBRA notice must be sent to employees and spouses within 90 days from date of enrollment on the benefit plan. The new regulations require information on how COBRA coordinates with Medicare.

Election Notice

This notice must be sent to the employee and family within 14 days of the administrator being notified of a COBRA qualifying event. As with the Initial COBRA Notice, language regarding Medicare's coordination with COBRA is required.

Qualified Beneficiary Notice

Plans must adopt "reasonable procedures" for the employee and qualified beneficiaries to notify the plan administrator of certain qualifying events, such as divorce, legal separation or disability. Reasonable procedure terminology also extends to notification of a second qualifying COBRA event, which will extend the duration of benefits and changes in disability status. The procedures must include the following:

- Recipient of the notice
- Acceptable methods of notice delivery
- Information that must be provided as part of the notice
- Any necessary accompanying documentation to the notice

Reasonable procedures must be outlined in the summary plan description. Plans failing to outline the procedures are still governed by the regulation, and are required to accept oral or written notification if such notification is given.

Employer Notice to Plan Administrators

Employers have 30 days from the time of the qualifying event to notify the COBRA administrator of the occurrence. If the employer is also the administrator, the deadline changes to 44 days.

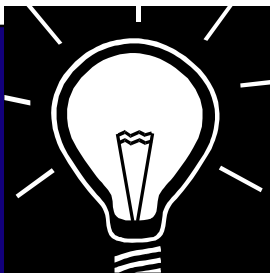
Notice of Early Termination of Coverage

This notice serves to inform the employee or qualified beneficiary that COBRA coverage has terminated prior to the expiration of the statutory period, either 18 or 36 months. Once the determination is made that COBRA coverage will expire, notification should be sent as soon as practicable.

Notice of Unavailability of Coverage

This notice serves to inform the employee and qualified beneficiary that COBRA coverage is denied because either (1) no qualifying event occurred or (2) notice of the event was not received in a timely manner. This notice should be sent within 14 days of receiving the notification.

Kibble & Prentice has a COBRA manual available with these updated documents. Please contact your Account Manager for a copy. Also, further information is available online. DOL has Initial and Election Notice samples available on their website at www.dol.gov/ebsa/compliance_assistance.html. These samples meet the requirements of the new COBRA regulations.



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.



Regence BlueShield: Update on Preferred/Formulary Medication List

On January 1, 2005, Regence BlueShield implemented their annual changes to their prescription formulary. This list is comprised of selected FDA-approved medications chosen for their medical effectiveness and value. Formulary/Preferred medications listed are covered at lower

co-payment levels than other brand medication not listed, according to the member's prescription benefit.

While many drugs are being added to the Regence Preferred Formulary, there are 13 medications being removed from the formulary, two of which are quite popular medications (Lipitor and Zoloft). For instance, if your prescription drug program through Regence includes a Non-Formulary level copay and you elect to purchase one or more of these 13 medications, the non-formulary copay will apply.

There is an exception for those individuals who were taking the removed medications prior to January 1. For example, if the individual was receiving either Lipitor and/or Zoloft through Regence BlueShield prior to January 1, 2005, the prescription will be "grandfathered". What this means, is that the individual will not be paying the higher cost for the prescription, if they were receiving this medication just prior to January 1, 2005. However, if that individual stops taking this medication after January 1, and their physician wants them to go back on Lipitor or Zoloft (for example), the individual will then be responsible for the new higher copay amount.

Included below is a list of the significant formulary changes. This list does not include all of the changes, simply those that have been deemed by Regence to be of significant impact to a large number of participants. Individuals with specific questions regarding the medications they are currently taking should contact the Customer Service Department at Regence BlueShield for assistance at (800) 472-2270 or visit their website at www.regencercx.com for a full listing of specific changes effective January 1, 2005.

Significant Additions to the Regence BlueShield Preferred/Formulary Medication List as of 1/1/2005:

Acular LS® ophthalmic solution	Diastat® rectal suppository	Ocupress® ophthalmic solution
Acular PF® ophthalmic solution	Ditropan XL® tablet	Orap® tablet
Acular® ophthalmic solution	Droxia® capsule	Ortho-Prefest® tablet
Acular® ophthalmic solution	Duoneb® ophthalmic solution	Ovide® lotion
Agrylin® capsule	Epitol® tablet	Pancrease® capsule
Albenza® tablet	Epzicom® tablet	Pancrecarb MS® capsule
Alinia® tablet	Eurax® cream, lotion	Plexion® cleansing cloths
Alinia® tablet, oral suspension	Fungizone® oral suspension	Prandin® tablet
Alocril® ophthalmic solution	Galzin® capsule	Precose® tablet
Alrex® ophthalmic solution	Glucagon® injection	Prevpac®
Apokyn® injection (added fall 2004)	Gynzaole-1® cream	Proglycem® capsule
Bactroban® nasal ointment	Hectoral® capsule	Proglycem® capsule
Buphenyl tablet, powder	Hectorol® tablet	Seromycin® pulvule
Carnitor® tablet, oral solution	Kemadrin® tablet	Spiriva® oral inhaler
Celontin® tablet, capsule	Kutrase® capsule	Stalevo® tablet (added fall 2004)
Chemet® capsule	Ku-zyme® capsule	Stimate® nasal spray
Cipro HC® otic suspension	Lamprene® capsule	Sular® tablet
Cloderm® cream	Lanoxicaps® capsule	Syprine® capsule
Cognex® capsule	Lescol® capsule	Thyrolar® tablet
Cordran SP® cream, ointment, tape, lotion	Lescol® XL tablet	Tikosyn capsule
Crestor® tablet	Loprox® cream, lotion, shampoo	TOBI® inhalation solution
Cutivate® ointment, cream	Lotemax® ophthalmic solution	Uroxatral® (added fall 2004)
Cystadane® powder	Mesnex® tablet	Visicol® tablet
Derma-Smoother/FS® oil	Myfortic® tablet	Vytorin® (added fall 2004)
Detrol LA® capsule	Nora-BE® tablet	Zyvox® tablet, oral suspension
	Nordette® tablet	

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Kibble & Prentice Introduces HR SWAT Tool

Assess and Address Your Company's Unique HR Strengths, Weaknesses and Tasks

Do you struggle to stay on top of the stack of HR paperwork waiting for your attention? When you think about the complex maze of HR regulations, do you ever get the uneasy feeling that you might be missing something?

Kibble & Prentice, in partnership with Agent 77, presents a new way to identify your unique **S**trengths, **W**eaknesses and **T**asks, enabling you to save valuable HR time and effectively manage HR issues and regulations.

In 3 easy steps, your HR frustrations are over!

Reveal – Through a series of simple questions you complete online, the HR SWAT Tool assessment leads you through over 100 critical HR topics to reveal your company's unique areas of risk.

Recommend – The HR SWAT Tool automatically combines your responses with information about your company, including number of employees, company location and other relevant factors. The result is a comprehensive, prioritized “to do” list with detailed recommendations that highlight your company's specific HR needs.

Resolve – Finally, the HR SWAT Tool helps you solve your unique HR issues with easy-to-use, low-cost solutions.

From staffing and hiring, to COBRA, FLSA and OSHA, the HR SWAT Tool helps you move beyond merely dealing with HR paperwork to building solid employment practices that effectively reduce your company's employment risks.

In less time – and with less money – than it's taking you today!

To start using the HR SWAT Tool, contact Kellie Stone in the HR Support Unit at kellies@kpc.com, or call 206.577.6850 for more information.

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Regence BlueShield

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Products No Longer on the Medication List/Formulary

Alomide® ophthalmic solution
Biaxin XL® tablet
Biaxin® tablet, suspension
Detrol® tablet
Estring® vaginal ring
Flarex® ophthalmic solution
Floxin® otic solution
Lamisol® tablet
Lipitor® tablet
Livostin® ophthalmic solution
Norvasc®
Xalatan® ophthalmic solution
Zolofit® tablet

Proposal to End FICA Tax Savings on 125 Plans

On January 28, 2005 the Joint Committee on Taxation delivered a proposal to the Senate Finance committee recommending changes to increase federal revenues. One recommendation of the committee is to eliminate the Federal Insurance Contributions Act (FICA) exemption from employer provided health coverage, dependent care assistance and qualified transportation benefits. This is a radical change from the current taxation of cafeteria plans.

The reason for this change is to align the treatment of tax-favored salary reductions. Currently, salary contributions for a tax-favored retirement plan and salary reductions under a Section 125 cafeteria plan or 132 qualified transportation accounts are treated differently for FICA tax purposes. Salary contributions to a tax-favored retirement plan are pre-tax for purposes of federal income tax. However, these contributions are considered wages and therefore subject to the FICA tax. Unlike tax-favored retirement plans, salary

contributions under a cafeteria plan (health FSAs, dependent care accounts, qualified transportation accounts) are exempt from both the FICA tax and federal income tax. The proposal seeks to remove the FICA tax exemption for cafeteria plans, thereby equalizing the treatment of all tax-favored salary reductions. Clearly, this proposed change might negatively impact the value of Section 125 plans for both the employer and employee.

This recommended change is one of many included in the report for the Senate Finance Committee. There has been no action to implement these changes. However, many lobby groups are currently working to rally support against this change. As an employer, you may want to contact your state Senator to voice your opinion. As always Kibble & Prentice will keep you updated on the latest information with regards to these pertinent issues. You can find the full text of the report at www.house.gov/jct/s-2-05.pdf.

New Standard Definition of “Dependent” by IRS

The Working Families Tax Relief Act of 2004 (the “Act”) was signed into law this past October, and the changes become effective on tax years following December 31, 2004. On December 6, 2004, the IRS issued a notice that helps correct a technical issue raised in the initial Act, helping to clarify the definition of *dependent*. Those employee benefit plans which define *dependent* by reference to the Tax Code (Section 152) will be affected by this legislation. All Section 125 plans will be affected by this legislation because of the reliance on Section 152 for definition of dependent.

The tax benefits available under employer-provided health and welfare plans are available only to employees, their spouses and *dependents*. Subsequently, some individuals who previously qualified for tax advantages available to dependents may no longer qualify, while some individuals who previously failed to qualify as *dependents*, may now satisfy the definition under the new law.

The IRS Notice will allow some domestic partners and other non-children to continue to qualify as dependents for purposes of tax-free health plan coverage. Following is a direct link to the IRS notice: http://www.irs.gov/irb/2004-49_IRB/ar10.html.

What should employers do?

Many plans do not reference Section 152 when defining dependent status, and therefore those plans aren’t affected by this new wording. However, it should be noted that an employer offering Section 125 plans may inadvertently offer benefit plans with inconsistent definitions of *dependent*.

Kibble & Prentice will work with you to ensure you are aware of the eligibility definitions and any differences you may have between your plans.

The new definition of “dependent”

Effective for tax years beginning Jan. 1, 2005, Section 152 of the Tax Code defines a *dependent* as someone who is either a “*qualifying child*” or a “*qualifying relative*”. A taxpayer’s *qualifying child* for any taxable year is someone:

- Who is the taxpayer’s child, sibling or step-sibling, or a descendant of any such relative;
- Who has the same principal place of abode as the taxpayer for more than one-half of the taxable year;
- Who is younger than 19 as of the close of the year, or is a student younger than 24 as of the close of the year (no age limit for someone who is disabled); and
- Who has provided one-half or less of his or her own support for the year.

A taxpayer’s “*qualifying relative*” for a taxable year is someone:

- Who is the taxpayer’s child (or descendant of a child), sibling or step-sibling, parent (or ancestor of either parent), step-mother or step-father, niece, nephew, uncle, aunt, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law or any other individual who has the same principal place of abode as the taxpayer for the year and was a member of the taxpayer’s household;
- Who receives from the taxpayer more than one-half of his or her individual support for the year;
- Who is not a *qualifying child* of the taxpayer (or any other taxpayer) for the year; and
- Who has gross income for the year that is less than the dependent exemption amount listed in Tax Code § 151(d) (\$3,200 in 2005).

TIMELY INFORMATION FOR THE DYNAMIC WORLD OF EMPLOYEE BENEFITS

2004 COBRA Regulation Changes: The General Notice

The General Notice (formerly the Initial Notice) must be distributed to all employees as they become eligible for benefits. This notification has undergone a significant change both in name and content. In a proactive step, we are recommending all employers send this revised notification to all benefit-eligible employees. This will serve to ensure all employees are aware of their notification responsibilities should a COBRA qualifying event occur.

Kibble & Prentice has a COBRA Packet available to our clients that provides a sample copy of all the letters and changes. Further, if the administrative challenge of COBRA is no longer a function you want to serve in-house, Kibble & Prentice provides COBRA administration services for employer groups. Please contact Alicia Scalzo at 206-676-7474 or alicias@kpc.com for more information.

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