HR-E ALERT
July 20, 2005

New and Impending Regulatory Changes Likely Require Health and/or 125 Plan Document, Administration Form, Communication and Procedure Updates Currently By Year End Act Quickly To Timely Make Needed Changes Before Upcoming Enrollment Period [i]

Time is getting short for employers and plan administrators to update their health plans and health care flexible spending plan documents, administrative forms, communications and practices to comply with changes to Federal regulations affecting most programs taking or that have already taken effect this year. Since many of these changes impact on eligibility and enrollment, most employers and plan administrators will want or be required to ensure the required updates are completed before their upcoming annual enrollment periods. Highlights of some of these changes include changes to the rules applicable to flexible spending accounts in cafeteria plans under Internal Revenue Code Section 125, new guidance regarding the special enrollment and creditable coverage mandates of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), newly mandated required notifications regarding employer-provided prescription drug coverage due in November, and new COBRA regulations that took recently.

Notice About Medicare Part-D Creditable Coverage Required By November 15, 2005

By November 15, 2005, group health plans offering prescription drug coverage to Medicare-entitled retirees and active employees generally must notify the Medicare eligible individuals as well as the Centers for Medicare and Medicaid Services ("CMS") whether the health plan's prescription drug coverage is "creditable coverage" for purposes of the new "Medicare Part D" prescription drug coverage program created under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MPA"). The new Medicare "Part D" coverage will provide voluntary prescription drug coverage as part of the federal Medicare program to eligible persons that timely enroll as of January 1, 2006. The notification requirement generally applies to all group health plans not otherwise specifically excluded from coverage. For instance, current regulations presently reflect that notification is not required for a health flexible spending plan offered as part of a cafeteria plan because the current regulations exempt benefits offered under those arrangements from the definition of "creditable coverage" under current Medicare Part D regulations.

The MPA generally mandates that group health plan sponsors provide notification about whether their prescription drug coverage qualifies as "creditable" for purposes of the MPA because Medicare eligible individuals need to know this information to decide whether they should enroll in Part D during the Initial Enrollment Period which will run from November 15, 2005, through May 15, 2006. Individuals eligible for Medicare Part D enrollment during the Initial Enrollment Period who do not have "creditable coverage" under another health plan generally must enroll in Part D during the Initial Enrollment Period will be required to pay higher premiums if and when they seek to later enroll in Part D coverage if they don't enroll during the initial enrollment period.

Prescription drug coverage generally is "creditable" for purposes of the MPA only if the actuarial value of the coverage equals or exceeds the actuarial value of the Part D prescription drug coverage. Under the safe harbor provisions in recently released regulations, a health plan's prescription drug coverage also automatically qualifies as creditable if it:

- Covers both brand name and generic prescription drugs;
- Provides reasonable access to retail providers, and alternatively mail-order coverage;
- Is designed to pay at least 60 percent of the participants' prescription drug expenses (on average); and
- Its maximum annual benefits and actuarial expectations either:
  - For plans with separate prescription drug and medical coverage the plan either has no annual benefit maximum or an annual benefit maximum of at least $25,000; or
  - The plan expects to pay benefits equal to at least $2,000 per Part D-eligible participant; or
  - For integrated prescription drug and medical coverage designed plans, the annual deductible is not higher than $250, and the plan does not have an annual benefit maximum or has at least a $1 million combined maximum lifetime benefit limit.

If the group health plan does not satisfy the safe harbor, the prescription drug coverage may still be creditable if the group health plan obtains an actuarial determination that the group health plan's prescription drug coverage equals or exceeds the coverage under Part D.

The MPA generally mandates that covered group health plans provide the MPA-required notice to all Part D eligible individuals covered under, or who apply for, enrollment in a group health plan providing prescription drug coverage. This includes both active and retired employees and their dependents who are Medicare Part D eligible. Group health plans generally are required to provide the notification to Medicare eligible active and retired employees whether their prescription drug coverage is primary or secondary to Medicare. Furthermore, the notification is in addition to already existing responsibilities to notify and provide an opportunity to active employees and their dependent spouses to elect for Medicare to be primary to group health plan coverage by electing to disenroll in group health plan coverage when they become eligible for enrollment in Medicare.

Group health plan sponsors generally are required to provide the required notice at the following times:

- Before the Medicare Part D annual coordinated election period (November 15 - December 31) each year;
- Within the 12 months before an individual's Initial Enrollment Period for Medicare;
- Before the effective date of coverage for a Medicare eligible individual beginning participation in the group health plan;
- When the plan's prescription drug coverage ends or is no longer creditable; and
- Upon a beneficiary's request

The group health plan must also provide this notice to CMS on an annually and when the prescription drug coverage is no longer creditable.

Under recent guidance, plan sponsors may fulfill their notification obligations by drafting their own notices or chose to use model disclosure notices recently published by CMS to help plan sponsors fulfill their obligation to provide the notice before November 15, 2005.

The regulations recognize various means by which plan sponsors may distribute the MPA-required notices. Because CMS has announced that it will treat the first two required notices satisfied if the group health plan provides notification to all health plan participants regardless of Medicare Part D entitlement, after the Initial Enrollment Period that begins November 15, 2005, most plan sponsors will want to incorporate the required notice into their annual open enrollment materials to minimize the burden of administering these notification requirements. The current regulations specify that notices may be included with the general plan enrollment and renewal materials if the disclosures are "prominent and conspicuous" in 14-point type in a separate box, bolded or offset on the first page of the enrollment materials. Electronic delivery of the notification also is permitted under certain conditions. Except for affected dependents that the plan sponsor knows reside at a different address than the participant, the regulations permit plan sponsors to mail a single notice to all multiple family members residing at the same address as the participant. Plan sponsors may distribute the required notifications themselves or arrange for a third party to disseminate the notices to the affected individuals on behalf of the plan sponsor. Plan sponsors that intend to rely upon their parties to prepare and distribute notices should ensure that they obtain adequate written contractual commitments to provide for proper preparation and delivery of required notices before delegating this responsibility, however.

Sponsors Can Amend Flexible Spending Account Plans To Delay Forfeitures

Employers and other cafeteria plan sponsors now can amend their cafeteria plans to allow participants an extra 2-1/2 months after the close of the cafeteria plan year to use amounts the participant contributed to the cafeteria plan during the plan year before the "use-it-or-lose-it rule applicable to cafeteria plan flexible spending accounts under Internal Revenue Code (Code) § 125 will require the participant to forfeit the balance of any unused amounts contributed to the cafeteria plan. Plan sponsors desiring to make this new "grace period" available to participants under their cafeteria plan will need to appropriately amend their cafeteria plan documents and procedures to take advantage of this new opportunity. Absent a timely amendment, Code § 125 will continue to require forfeiture of the unused amount on the last day of the plan year. In order for participants eligible to use the grace period allowed by Notice 2005-42 during this plan year, your cafeteria plan documents must be amended before the end of current plan year and timely communicates this change in writing to participants.

IRS Notice 2005-42 published on May 18, 2005 modifies the "use-it-or-lose-it" requirements traditionally applicable to cafeteria plans under Code § 125 to include a new 2-1/2 month grace period exception. Under the modified rules, Code § 125 generally continues to prohibit cafeteria plans that allow participants to defer compensation beyond the close of the plan year. Under IRS Notice 2005-42, however, now allows a sponsoring employee to amend it to permit participants to use a cafeteria plan document unused contributions or benefits remaining in a participant's cafeteria plan account at the close of the plan year to pay for or

reimburse expenses for qualified benefits incurred by the participant during the 2 ½ month period immediately following the close of the play year. If an employer timely amends its cafeteria plan to take advantage of this new grace period exception, the cafeteria plan may pay or reimburse a participant who has unused benefits or contributions remaining in his account relating to a particular qualified benefit from the immediately preceding plan year for expenses that the participant incurs for that same qualified benefit during the grace period from the unused benefits or contributions as if the expenses had been incurred in the immediately preceding plan year. The effect of the grace period is that the participant may have as long as 14 months and 15 days (the 12 months in the current cafeteria plan year plus the grace period) to use the benefits or contributions for a plan year before the plan must forfeit those amounts under the "use- it-or-lose-it" rule. To the extent any unused benefits or contributions from the immediately preceding plan year exceed the expenses for the qualified benefit incurred during the applicable plan year including its immediately following grace period, however, the "use-it-or-lose-it" requirements of Code § 125 continue to prohibit the carry over of any of those remaining unused benefits or contributions to any subsequent period (including any subsequent plan year). The unused amounts remaining at the close of the grace period still must be "forfeited" under the "use-it-or-lose-it" rule.

Notice 2005-42 is only one of a series of legislative and regulatory changes impacting the design of cafeteria plans. In recent years, many employers also have found it necessary or desirable to update their cafeteria plan documents and procedures in response to various other regulatory changes. For instance, many employers offering health flexible spending accounts under their cafeteria plans have amended their plans to take advantage of the opportunity for health flexible spending accounts to reimburse over-the-counter drugs now permitted under Code § 125, and have updated their election procedures in response to regulations relating to the impact of federal family and military leave, health plan special enrollment, and health plan coverage continuation requirements. Many employers also have considered other modifications to the design and use of their health flexible spending plans as they consider updating their current programs to incorporate limited benefit and high deductible health plan, health savings account options now available under Code § 223, or other defined contribution health plan options.

Updated HIPAA Portability Regulations Impact Health Plan Special Enrollment and Pre-Existing Condition

Health plans and health plan issuers also generally must update their program documents and practices to comply with final HIPAA portability regulations for all plan years beginning after June 30, 2004. The newly restated HIPAA Portability Regulations implementing the portability mandates of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) were published on December 30, 2004.

While substantially preserving many of the rules contained in the previously issued interim regulations, the new HIPAA portability regulations dictate changes to the content and form of certificates of creditable coverage and other required notifications relating to these rules, as well as modify the rules governing the interpretation and administration of these HIPAA dictated plan requirements in several other minor respects. Furthermore, the updated regulations update the definition of the types of coverage that must be treated as creditable coverage to reflect changes in federally provided health care programs such as the new Medicare Part D coverage.

The final portability regulations issued last December generally require that health plan sponsors and administrators update their health plan practices, notifications and procedures to comply with updated interpretations about the health plan eligibility, special enrollment, preexisting condition, creditable coverage, and notice mandates imposed under the HIPAA portability requirements. Conforming changes to cafeteria plan election and enrollment, and health care flexible spending account programs also are likely to be required in most instances.

Updated COBRA Regulations Effective For All Post February 26, 2005 Health Plan Years

The rollout of the new HIPAA portability regulations comes only months after the Department of Labor's implementation of its recently restated and expanded federal medical coverage continuation rules interpreting the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). These new COBRA rules generally apply to all group health plans of employers with more than 20 employees that re regulated by the Employee Retirement Income Security act ("ERISA") for plan years that begin after November 26, 2004.

Among other things, the new regulations generally require plan administrators to update the content of the initial notice of rights and the notices sent to qualified beneficiaries following the occurrence of a qualifying event triggering COBRA rights. In addition, the new regulations dictate that plan administrators adopt and provide a host of newly required notices relating to COBRA rights under the circumstances and having the

content mandated by the regulations, as well as provide updated guidance about procedures for delivering required notifications and a host of other administrative matters. Virtually all ERISA-covered health plan administrators are required to tweak their existing COBRA administration forms and practices in response to these new requirements.

Proposed Military Leave Regulations

Final regulations interpreting the health plan rights of employees taking military leave to health coverage and reinstatement to health coverage following return to employment under federal law are expected to be released shortly. Meanwhile proposed regulations published September 24, 2204 provide helpful insights about the interpretations that the Department of Labor is likely to apply when considering the adequacy of a health plan's compliance with the health coverage continuation and reinstatement mandates of USERRA. The proposed rules, when finalized, are in addition to guidance issued over the past few months about the application of USERRA's employment protections for employees taking military leave by the Labor Department and Treasury Department guidance about the coordination of USERRA's military leave protections with the Code's tax qualification rules.

Protecting Health Information Under HIPAA Privacy and Security Regulations

Since April 20, 2005, health plans (other than small heath plans) and health plan issuers generally have been required to comply with the requirements for the protection of "electronic protected health information" imposed under the "Security Standards for the Protection of Electronic Protected Health Information" (the "Security Standards). The deadline for small health plans to comply with these new Security Standards, which were imposed pursuant to HIPAA, is April 20, 2006. The new Security Standards mandates are in addition to tough new privacy mandates about the use, access and disclosure of "protected health information" that generally have applied to most health plans, health plan issuers and other covered entities under the "Standards for Privacy of Individually Identifiable Health Information" (the "Privacy Standards") since April 14, 2005. Noncompliance with the Privacy or Security Standards exposes the group health plan, and under certain circumstances, potentially even fiduciaries and other persons bearing key responsibilities for compliance with these requirements, to potential civil or even criminal liability.

The Security Standards mandate that covered health plans protect the confidentiality, integrity, and availability of all electronic protected health information created, received, maintained or transmitted by or on behalf of the covered health plan in accordance with the Security Standards. Under the Security Standards, health plans generally must adhere to certain administrative, physical and technical safeguards defined by the Security Standards and to ensure that members of the health plan's workforce also comply with these requirements. These safeguards are designed to protect against any reasonably anticipated threats or hazards to the security or integrity of electronic protected health information and reasonably anticipated uses or disclosures of electronic protected health information other than as allowed by the Security Standards.

The Security Standards are an extension and expansion of the protections for protected health information dictated by the Privacy Standards, previously implemented as part of HIPAA. The Privacy Standards generally prohibit a covered health plan or other covered entity from using or disclosing protected health information except as specifically permitted by the Privacy Standards. The Privacy Standards specify with often complex detail the specific circumstances under which the Privacy Standards permit uses and disclosures of protected health information. Except for "authorized" uses and disclosures and or uses and disclosures made for "treatment, payment or operations purposes" within the meaning of the Privacy Standards, the Privacy Standards also generally only allow otherwise allowable uses or disclosures if the covered health plan disclosed its policy of allowing that use or disclosure in its notice of privacy practices, limits the use or disclosure the "minimum necessary" use or disclosure for the purpose allowed by the Privacy Standards and otherwise complies with the applicable requirements of the Privacy Standards.

The Privacy Standards also require that a covered health plan or other covered entity disclose protected health information to an individual and to CMS under certain circumstances, honor certain individual rights of individuals relating to their protected health information defined by the Privacy Standards, and provide certain notifications to participants and beneficiaries.

Under both the Privacy and the Security Standards, each covered health plan generally must adopt detailed written policies setting forth their practices for complying with the requirements of the Privacy and Security Standards. Both sets of Standards dictate that these practices not only be adopted in form, but also operational compliance with the Standards and required policies in reality. To this end, both contemplate detailed documentation as to the process and decision-making underlying the design of a covered health plan's compliance strategy, as well as other documentation about both authorized and unauthorized uses and accesses to safeguarded information and systems. Both also dictate that covered health plans implement

written agreements, obligating service providers to adhere to applicable policies and meet certain other conditions as a condition to the health plan's ability to allow the service provider to access, use or disclose protected health information or protected electronic health information on behalf of the covered health plan or otherwise. Specific safeguards and procedures also generally are required to regulate the access and use that employers and plan sponsors may have to protected health information created, accessed or received by the health plan. While using different terminology, the Privacy and Security Standards also generally dictate that a covered health plan provide for accountability by appointing one or more persons oversee and enforce compliance with the applicable standards and investigate and address possible violations. Both the Privacy Standards and Security Standards dictate that covered health plans implement documented processes and procedures for monitoring and enforcing compliance with their privacy and security practices, and for providing notification and correction of privacy or security breaches.

Caution Needed When Relying Upon Vendors To Provide Solutions

As for many other legal mandates, many health plan sponsors assume that their health plan compliance responsibilities will be handled as a matter of course by their health plan consultants and service providers. Absent proper verification, these assumptions may prove perilous for health plans, their sponsors or fiduciaries. While service providers and consultants may provide substantial valuable assistance to plan sponsors in this and other respects, many service providers assign legal responsibility to plan sponsors or other fiduciaries for ensuring that the plan documents, administrative procedures and forms are legally compliant and properly administered. In many instances, service providers not only disclaim legal liability for ensuring the legal appropriateness of the plan designs, documents, administrative forms and practices that they contract to provide as part of their services agreement, their services agreement also may require the plan sponsor or fiduciary to indemnity the service provider for liabilities arising from the service provider's delivery of services. Furthermore, in many instances, legal rules may continue to impose liability upon plan sponsors or fiduciaries for noncompliance with these regulations despite the delegation of tasks to a service provider or engagement of a consultant, particularly if the delegation is not made based upon appropriate delegation documentation and due diligence. Furthermore, because communicating between a plan sponsor and its consultant or service provider about the legal adequacy or advisability of certain arraignments or practices generally are not protected by evidentiary privilege. Consequently discussing legally sensitive concerns with consultants or service providers may create evidence that a plan sponsor might prefer not to have introduced in the even of a lawsuit or governmental investigation. Finally, even with the best assistance of the highest quality consultants and service providers, plan sponsors and fiduciaries may face unanticipated liability unless they possess a proper understanding of their roles and responsibilities in enabling their appointed service providers to properly administer duties and responsibilities. Therefore, before relying upon consultant or vendor supplied plan documents, administrative forms or other procedures, plan sponsors and fiduciaries generally should carefully review both the legal appropriateness of vendor or consultant provided documents and materials as well as the contractual commitments provided by the applicable consultant or vendor. Likewise, before discussing the legal adequacy or advisability certain compliance or administrative actions with consultations or vendors, plan sponsors should weigh the potential difficulties that those discussions might have in the event of a lawsuit or government investigation and tailor the discussion accordingly.

If you wish assistance in understanding, reviewing or updating your existing health plan documents, administration forms, communications or procedures to comply with these or other new requirements, to receive additional information about these new regulations or other employee benefit, insurance or human resources matters, or to request information about upcoming programs or alerts, please contact: **Cynthia Marcotte Stamer, P.C.**, Member, Glast, Phillips & Murray, P.C., 2200 One Galleria Tower, 13355 Noel Road, LB 48, Dallas, Texas 75240. Telephone (972) 419-7188. E-mail cstamer@gpm-law.com. For additional information about Ms. Stamer and/or Glast, Phillips & Murray, P.C., see CynthiaStamer.com or gpm-law.com or contact Ms. Stamer. **If you would like to receive future Alerts or announcements about other programs or developments, please be sure that we have your current contact information – including your preferred e-mail – by providing that information to us via telephone, fax or e-mail using the contact information provided in the above paragraph.**

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