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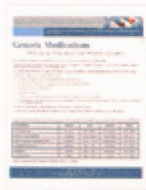

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Legislative Brief

COBRA Regulations: Handy Reference Guide

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that employers provide former employees and dependents who lose group health benefits with an opportunity to continue group health insurance coverage. Since originally enacted in 1985, the Internal Revenue Service has released two sets of final regulations and three sets of proposed regulations. Most recently, the IRS released final regulations in January, 2001 that finalized the 1999 proposed regulations and made some changes to the final regulations released in 1999[1]. This Hylant Group, Inc. - Toledo Legislative Brief is intended to provide you with a *consolidated* look at the guidance provided in the final regulations released in 1999 and 2001.

Small Employer Exception[2]

- Group health plans maintained by an employer that had fewer than 20 employees on at least 50% of its typical business days in the previous calendar year are not subject to COBRA. (1999 final regulations)[3]
- Only common law employees are taken into account for purposes of the small employer plan exception. Self-employed individuals, independent contractors, and directors are not counted. *(1999 final regulations)*[4]
- Both part-time and full-time employees must be counted, whether they are eligible for health insurance or not. *(1999 final regulations)*
- Part-time employees must be counted on a pro-rata basis. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee works for the employer divided by the number of hours that an employee must work in order to be considered full-time. This method of calculation is intended to produce the same result regardless of how the hours are scheduled. *(1999 Proposed Regulations; 2001 Final Regulations)*
- Employers may count part-time employees either on an individual basis or on an aggregate basis because both methods produce the same results. Therefore, an employer can determine the number of part-time employees for COBRA purposes by looking at each employee's hours for the year or by adding up all hours worked by part-time employees and dividing it by the number of hours required for one worker to be considered working full-time. *(2001 Final Regulations)*

Payment of Premium

- Where the COBRA premium remitted is short by an amount that is not significant, the plan must either a) treat the payment as satisfying the plan's payment obligation, or b) notify the qualified beneficiary of the deficiency and allow a "reasonable period" (which is generally 30 days) for the deficiency to be paid. *(1999 final regulations)*
- An amount is considered insignificant if it is not more than the lesser of $50 or 10% of the required premium amount. *(2001 final regulations)*
- Payment is made on the date it is sent. *(1999 final regulations)*
- A third party may pay COBRA premiums on behalf of a qualified beneficiary. *(1999 final regulations)*

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[1] The 1999 final regulations apply to qualifying events occurring in plan years beginning on or after January 1, 2000. Generally, the 2001 final regulations apply to qualifying events occurring on or after January 1, 2002.

[2] The 2001 final regulations adopted the 1999 proposed regulations without change, but clarified the ability to use individual or aggregate calculations.

[3] The 1987 regulations used the term "working days."

[4] The 1987 regulations required the inclusion of self-employed individuals, independent contractors, and directors.

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HIPAA

Are you ready to comply with the **new final** HIPAA Portability Regulations effective for health plan renewing on or after July 1, 2005? If not, our HIPAA Legislative Guide is here to help!

Our HIPAA Legislative Guide has been completely rewritten to reflect the new guidance and also contains all four notices plans are required to provide.

This Guide covers the following provisions within HIPAA:

- Portability of Coverage
- Special Enrollment Rights
- Nondiscrimination Rules
- Guarantee Issue and Renewal

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HIPAA Regulations: Final & Proposed Portability Regulations

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Legislative Brief

HIPAA Regulations: Final & Proposed Portability Regulations

In August 1996, President Clinton signed into law the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA initially went into effect for plan years beginning on or after July 1, 1997. On December 30, 2004, the Department of Treasury, the Department of Labor, and the Department of Health and Human Services jointly released both **final** and **proposed** regulations governing the portability requirements for group health plans and health insurance coverage issuers. The final regulations do not significantly modify the April 1997 interim final regulations, but are intended to add several clarifications to the general framework currently in place.

This issue of the Hylant Group Legislative Brief will provide you with an overview of the guidance within the final and proposed regulations.

FINAL HIPAA PORTABILITY REGULATIONS

In summary, the **final** regulations provide further guidance in the following areas:

- Requirements related to content and time frames for delivering notices required by HIPAA,
- Special Enrollment Rights,
- Pre-Existing Condition Exclusions,
- Creditable Coverage,
- HIPAA's application to flexible spending accounts,
- HIPAA's application to health savings accounts, and
- Clarifies the definitions of: limited-scope dental plan, limited-scope vision plan, and dependent.

Effective Date

The final HIPAA Portability Regulations apply to plans and health insurance coverage issuers on the first day of the plan year beginning on or after July 1, 2005. In the meantime, each plan and issuer must continue to comply with the requirements contained within the April 1997 interim rules until these regulations become applicable to the plan or issuer.

Notice Requirements

The final HIPAA Portability Regulations require the addition of "educational statements" to notices already required by HIPAA. In some cases, the regulations also provide further guidance as to the amount of time a plan or health insurance coverage issuer has to provide notices required by HIPAA. The regulations also provide a model Certificate of Creditable Coverage, Notice of Special Enrollment Rights, and an Initial Pre-Existing Condition Notice.

Special Enrollment Rights – Qualifying Events

HIPAA requires that individuals who do not initially enroll in the health plan be provided with rights to enroll at a later date, in the event the individual experiences a qualifying event. The final HIPAA regulations expand the list of events that constitute a qualifying event that provide an individual with a special enrollment right.

Legislative Brief

HIPAA Security Regulations

On February 20, 2003, the Department of Health and Human Services (HHS) released final HIPAA Security Regulations which establish a minimum standard for security of electronic Protected Health Information (ePHI). The standards require that basic safeguards be implemented to protect ePHI from unauthorized access, alteration, deletion, or transmission. With the exception of small health plans, Covered Entities are required to comply by April 20, 2005. Small health plans* have an additional year to comply.

The **HIPAA Privacy Regulations** govern a) who may access Protected Health Information (PHI) and b) how PHI may be used and disclosed. The HIPAA Privacy Regulations govern PHI that is oral, electronic, or written.

In contrast, the **HIPAA Security Regulations** set forth administrative, physical, or technical security standards that are intended to ensure that only those individuals who should have access to ePHI have access. The HIPAA Security Regulations only govern ePHI and require that security measures be in place to protect ePHI.

This issue of the Hylant Legislative Brief will provide an overview of the standards and implementation specifications contained within the HIPAA Security Regulations.

What entities are regulated by the HIPAA Security Regulations?

The HIPAA Security Regulations directly regulate the following Covered Entities:

- Health plans,
- Health care clearinghouses,
- Health care providers that conduct certain transactions electronically, and
- Endorsed sponsors of the Medicare prescription drug discount card.

The HIPAA Security Regulations indirectly regulate plan sponsors and other third parties that receive ePHI by providing that a Covered Entity require an otherwise non-regulated entity to agree to comply with the restrictions contained within the HIPAA Security Regulations.

What information is governed by the HIPAA Security Regulations?

The HIPAA Security Regulations govern ePHI. PHI is:

- Oral, written, or electronic,
- Individually identifiable health information,
- Created or received by a Covered Entity, and
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

EPHI is PHI which is in an electronic format. For example, this includes PHI that is stored on a CD, sent via email, or stored on a computer.

PHI that is transmitted via paper-to-paper fax, person-to-person telephone calls, video teleconferencing, or messages left on voice mail are not considered to be in an electronic form and, therefore, are not governed by the HIPAA Security Regulations. However, telephone voice response systems are governed by the regulations because they are used as input and output devices for computers.

* The HIPAA Privacy Regulations define a small health plan as a health plan with annual receipts of $5 million or less.

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Our HIPAA Legislative Guide also includes sample forms, legislative news, and quick reference.

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The HIPAA Privacy Rules:

Three Types of Information

	Protected Health Information (PHI)	Summary Health Information (SHI)	De-identified Information
Definition	Personally Identifiable + Health Information + Created or Received by a Covered Entity + Treatment or Payment of Health Care	May be individually identifiable health information + Summarizes claims history, claims expenses, or types of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan – 18 identifiers,[1] but may include 5 digit zip code	Statistical Method[2] Safe Harbor PHI – 18 identifiers – Covered Entity has no actual knowledge that the information could be used alone or in conjunction with other information to identify an individual who is a subject of the information
Example	Medical records in the possession of the physician	DMW Reports[3]	High cost claimant report that does not include employee names, dob, SS#, etc.
Purpose	May use PHI for treatment, payment, or health care operations, or other uses permitted by HIPAA. Must apply minimum necessary standard.	May use SHI for (1) obtaining premium bids for providing health insurance coverage under the group health plan or (2) modifying, amending, or terminating the group health plan.	De-identified is NOT regulated by the Privacy Rules.

05/03

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[1] (1)Name, (2) all geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of Census a) the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people, and b) the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000, (3) all elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, and date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older, (4) telephone numbers, (5) fax numbers, (6), electronic mail addresses, (7) social security numbers, (8) medical record numbers, (9) health plan beneficiary numbers, (10) account numbers, (11) certificate/license numbers, (12) vehicle identifiers and serial numbers, including license plate numbers, (13) device identifiers and serial numbers, (14) web universal resource locators (URLs), (15) internet protocol (IP) address numbers, (16) biometric identifiers, including finger and voice prints, (17) full face photographic images and any comparable images, (18) any other unique identifying number, characteristic, or code.

[2] A person with appropriate knowledge and experience applying generally applicable statistical and scientific principles and methods for rendering information not individually identifiable makes a determination that the risk is very small that the information could be used, either by itself or in combination with other available information, by anticipated recipients to identify the subject of the information. The Covered Entity (link to 1) must also document the analysis and results that justify the determination.

[3] Summary health information may not constitute de-identified information because there may be a reasonable basis to believe that the information is identifiable to the plan sponsor especially for plans with few participants. Preamble to December 2000 Regulations 65 Fed. Reg. 82461; 82647

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Legislative Brief

Family and Medical Leave Act of 1993

On February 5, 1993, President Clinton signed into law the federal Family and Medical Leave Act of 1993 (FMLA). This law became effective on August 5, 1993. The Department of Labor (DOL) also issued final regulations on January 6, 1995. Those regulations became effective April 6, 1995. Generally, the Family and Medical Leave Act of 1993 provides that covered employers must: a) allow eligible employees to take 12 weeks of unpaid leave during any 12 month period, b) continue the employee's group health insurance benefits while on leave, c) restore the employee to the same or equivalent job upon return from leave, and d) not take any adverse action against an employee for taking FMLA leave.

What Employers Must Comply?

This federal law applies to all:

- public agencies, including state and federal employers;
- public and private elementary and secondary schools; and
- private-sector employers with 50 or more employees in 20 or more calendar workweeks in the current or preceding calendar year.

What Employees are Eligible for FMLA Leave?

An employee is eligible for FMLA if he or she:

- currently works for a covered employer;
- has worked for this employer for a total of 12 months;
- has worked at least 1,250 hours over the previous 12 months (must be consecutive);
- works in the United States, District of Columbia, or any Territory or possession of the United States; and
- works at a location where the employer has 50 employees within a 75-mile radius at the time the employee requests leave.

When is an Employee Entitled to Leave?

Covered employers must grant eligible employees up to 12 weeks of unpaid leave during any 12-month period. Eligible employees are entitled to leave for any of the following reasons:

- Birth and care of a newborn child of the employee;
- Placement of a child under the age of 18 for adoption or foster care with the employee;
- Care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- The employee is unable to work because of his or her own serious health condition.

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Our Section 125 Administrative Guide will provide answers to commonly asked questions. In addition, we have included useful forms and quick reference tools that will make administration of your Section 125 plan easier.

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Section 125 Plans:
Grace Periods Allowed

Internal Revenue Code Section 125 allows employees to make pre-tax contributions to a Flexible Spending Account (FSA). Employees may seek reimbursement from the FSA for expenses paid for child care and eligible medical expenses not otherwise covered under a health insurance plan. FSAs are subject to the "use-it-or-lose-it" rule. Thus, any money remaining in the FSA at the end of the Section 125 plan year must be forfeited. For several years, Congress has declined to pass proposed legislation that would allow employees to carry over unused funds within an FSA.

On May 18, 2005, the Treasury Department and the IRS released Notice 2005-42 (Notice). This notice allows Section 125 Plans, including FSAs, to allow a grace period during which plan participants may continue to incur eligible medical expenses.

When may employers permit grace periods within their Section 125 Plans?

At the employer's option, it may allow grace periods within its Section 125 Plan beginning with the current plan year, so long as the plan document is amended before the end of the current plan year.

How long is the grace period?

The Notice states that "the grace period must not extend beyond the fifteenth day of the third calendar month after the end of the immediately preceding plan year to which it relates." In other words, employers may add a 2 ½ month grace period to the end of their Section 125 Plan year.

For example, a plan with a plan year ending on December 31, 2005 may allow plan participants to continue to incur expenses through March 15, 2006.

The grace period must apply to all participants in the Section 125 Plan.

How does a grace period differ from a "run-out" period?

A grace period extends the amount of time in which participants may incur expenses.

A run-out period allows employees to submit eligible expenses after the close of the plan year. Unlike a grace period, expenses submitted during the run-out period must have been incurred prior to the end of the plan year.

Plans that choose to allow a grace period within its Section 125 Plan should also consider amending their plan to allow the run-out period to begin on the last day of the grace period.

Can a Section 125 Plan allow unused benefits or contributions to be cashed out or carried over?

No. Although Notice 2005-42 allows a Section 125 Plan to incorporate a grace period into its plan, unused benefits or funds within the plan or FSA at the end of the grace period continue to remain subject to the use-it-or-lose-it rule.

May a grace period be applied to both a health FSA and a dependent care spending account (DCAP)?

Yes. However, the Notice clarified that unused funds within a health FSA may not be used to pay or reimburse dependent care expenses incurred during the grace period.

Employers considering allowing a grace period for funds held in a DCAP should work with their plan administrator or legal counsel to amend their plan in a way that does not allow employees to violate statutory contribution limits and takes into consideration the DCAP's interaction with dependent care tax credits.

If an employer amends its Section 125 Plan during the current plan year to incorporate a grace period, may employees increase their contribution to their FSA?

No. Employees are only permitted to make mid-year FSA election changes following a change in status. A change in status includes marriage, birth, adoption, or change in employment status. An employee may also change his or her FSA elections at the beginning and end of a Family and Medical Leave Act leave.

If an employer amends its Section 125 Plan to incorporate a grace period, when will expenses be eligible for reimbursement from a health FSA?

The following example demonstrates how a grace period applies to a health FSA:

Example

Employer's Section 125 Plan year ends on December 31, 2005. The employer amended its plan document prior to the end of the plan year to allow a 2 ½ month grace period. The grace period ends on March 15, 2006.

Employee elects to contribute $1,000 to his health FSA for the plan year ending on December 31, 2005. As of December 31, 2005, Employee has $200 remaining in his health FSA. Employee also elects to contribute $1,000 to his health FSA for the plan year ending December 31, 2006.

On January 15, 2006, Employee incurs $250 in unreimbursed medical expenses when he purchases a pair of glasses. Employee submits this claim for reimbursement in a timely manner. Employee is reimbursed $200 from the unused funds within his health FSA for the plan year ending December 31, 2005. The remaining $50 of unreimbursed medical expenses is paid to Employee from funds within his health FSA for the plan year ending December 31, 2006.

The grace period within a health FSA not only provides employees with an additional 2 ½ months to incur claims, but it also provides employees with "overlapping coverage." In this example, Employee is covered under the two health FSA plan years during the 2 ½ month grace period.

Please contact your Hylant representative if you have any questions or wish to discuss your Section 125 Plan design.

To view a copy of the press release and Notice, visit www.treas.gov/press/releases/reports/n0542.pdf
This copy of Plan Designs is not meant to be provided or construed as legal advice. Readers seeking legal advice should contact an attorney.

Legislative Brief

Amended Definition of "Dependent"

The Working Families Tax Relief Act of 2004 ("WFTRA")[1] was signed into law by President Bush on October 4, 2004. Among numerous other things, the WFTRA includes a new definition of dependent under Section 152 of the Internal Revenue Code ("IRC") which may impact employee benefit plans.

On November 17, 2004, the IRS released Notice 2004-79 to provide guidance regarding the effect of WFTRA on employer-provided accident or health plans. This Hylant Legislative Brief summarizes the guidance regarding the new definition of dependent provided in WFTRA and in IRS Notice 2004-79.

New Definition of Dependent under WFTRA

Section 201 of WFTRA amended the definition of dependent in Section 152 of the IRC, effective for taxable years beginning January 1, 2005. Pursuant to amended Section 152, an individual must be either a "qualifying child" or a "qualifying relative" to be a dependent.

Qualifying Child

A Qualifying Child must meet all of the following:

- Is the employee's daughter, son, stepchild, stepsibling, or a descendant of any of these individuals;
- Has the same principal abode as the employee for over half the year;
- Is under age 19 at the end of the year, or if a full-time student, under age 24 at the end of the year, or disabled; and
- Does not provide more than half of his or her own support.

Qualifying Relative

A Qualifying Relative must meet all of the following:

- Is not a Qualifying Child;
- Is a relative of the employee, or has the same principal place of abode as the employee and is a member of the employee's household;
- Has gross income under $3,100 for 2004; and
- Receives more than half of his or her support from the employee.

As a result of the changes made by WFTRA, the definition of dependent in Section 105(b) (which allows employer provided health plans to reimburse the medical expenses of employees, their spouses, and their dependents on a tax free basis) differs from the definition in the regulations under Section 106(a) (which provides that the gross income of an employee does not include employer provided coverage under an accident or health plan). Accordingly, minus any modifications to these conflicting definitions, the value of employer provided coverage for an individual who is not a qualifying child and who does not meet the gross income limitation for a qualifying relative would have to be included in the employee's gross income.

[1] A copy of WFTRA can be found at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_bills&docid=f:h1308enr.txt.pdf