



BENEFIT *Advisor*

In This Issue

In this final issue of our Benefit Advisor for 2005, we review the important developments that affected employee benefit programs this year. We also review year-end housekeeping issues organizations should address.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth web site at www.mcgrawwentworth.com.

“2005 Year-End Review”

This year was not overwhelming when it came to new legislative compliance issues; however, several issues should have appeared on your compliance radar. This Advisor reviews the major compliance activity for 2005 and summarizes the key initiatives your organization should have addressed:

- Large group health plans had to comply with the Security Rule by April 21, 2005. Small groups have until April 21, 2006.
- Changes to USERRA were released in February.
- The IRS issued additional guidelines on key issues related to Health Savings Accounts (HSAs).
- Final and new proposed HIPAA portability regulations were released.
- Medicare Part D notice requirements affected any group health plan that covers a Medicare eligible individual.



This issue first discusses these key legislative initiatives and their potential impact on your organization; then it reviews housekeeping issues for 2005. These housekeeping issues should be revisited annually in every organization.

The Security Rule

The Security Rule is the final part of HIPAA's Administrative Simplification Provisions to affect group health plans. The rule requires covered entities to safeguard electronically transmitted or maintained health information. Large group health plans must comply by April 21, 2005. Small group health plans must comply by April 21, 2006.

A large group health plan is one that exceeds \$5 million in annual receipts in the most recent plan year. A small group health plan is one with less than \$5 million in annual receipts. Annual receipts are premiums paid for fully insured plans or claims paid for self-funded plans.

The Security Rule affects the same covered entities as the Privacy Rule. The intent is to protect the integrity, confidentiality and availability of Electronic Protected Health Information (EPHI) whether it is in transit or at rest.

EPHI is defined as health information relating to an individual's past, present, or future physical or mental condition or information relating to the payment for care of that condition *that is sent or stored electronically*. What forms of PHI are consid-

ered electronic? A key to determining whether PHI is considered electronic is the original format of the data. For example, paper faxes are not considered EPHI, but if the same information is faxed from a desktop computer, it is considered electronic.

In general, the rule requires covered entities to do the following:

- Ensure the confidentiality, integrity and availability of EPHI that a covered entity creates, receives, maintains or transmits.
- Protect EPHI against any threats to security.
- Protect against any not permitted use or disclosure.
- Ensure your workforce complies with your procedures.

The rule presents a series of standards a covered entity must use to evaluate the security of its present systems and improve any areas that may not be adequate.

IT and HR share responsibility for complying with this rule. To determine how to meet the security rule's requirements, your organization can consider size, capabilities, complexity, technical infrastructure, cost of proposed measures and the probability of potential risk to EPHI in determining action steps. The Department of Health and Human Services recognizes that, for the rule to remain timeless and to meet the wide range of entities subject to the rule, it should be flexible, scalable and technologically neutral.

A detailed discussion of the standards and implementation specifications can be found on our website at http://www.mcwent.com/Benefit_Advisor/2003/Issue%20Six.pdf.

com/Benefit_Advisor/2003/Issue%20Six.pdf.

However, compliance steps can be summed up in ten key action steps:

1. **Appoint a Security Officer:**

The Security Officer will be responsible for implementing the Security Rule at your organization.



2. **Map your Plan's EPHI:**

The Security Rule does not apply to all the information you maintain electronically. It applies only to EPHI. This critical step identifies the location, usage and access requirements for your plan's EPHI.

3. **Conduct a Risk Analysis:**

Analyze current security measures. During this process, identify potential weaknesses in your current set-up.

4. **Strengthen your Position:**

Review all the Security Rule standards. During this review process, design policies, procedures or implement new technology to improve security in your weak areas.

5. **Implementation Specifications:** Examine all the implementation specifications.

Focus on improving the security of your EPHI.

6. **Security Awareness Training:** Once your organization has established policies and procedures, train your workforce members on the security provisions and how they will affect their jobs.

Issue periodic reminders to

workforce members so they are aware of any new threats to EPHI security.

7. **Amend your Business Associate Contracts:**

Make sure your business associate privacy contracts contain language verifying compliance with the Security Rule. These contracts need only be amended if a business associate uses EPHI when

performing a function on behalf of your group health plan.

8. **Amend Plan Documents:**

Your plan document should state your organization will use EPHI and that your plan has taken measures to comply with Security Rule provisions.

9. **Establish a Discipline Policy:**

Discipline workforce members who don't follow your security measures.

10. **Schedule a Compliance Review:**

Review your compliance plan periodically to make sure EPHI is secure. It also makes tremendous sense to review your plan any time technology changes to make sure your compliance steps are still adequate.

It will take time to work through all the standards and implementation specifications. If you haven't started Security Rule compliance yet, it should be on your work plan for 2006.

USERRA Changes

USERRA prohibits discrimination in reemployment, retention, or any other employment based benefit for employees in the United States military. USERRA also protects employment privileges and benefits for employees called to "active duty in the uniform services." The Veterans Benefits Improvement Act of 2004 instituted the following two changes under USERRA in 2005:

- The health plan benefit continuation period now extends to 24 months.
- Employers must now notify employees of their rights and obligations.

The Veterans Benefits Improvement Act extends the maximum continuation period for group health plan benefits from 18 to 24 months. Until now, USERRA coverage continuation rights were not a well-known aspect of this legislation. The continuation period matched COBRA requirements and most employees called to active duty had the right to elect COBRA. The other reason the continuation requirements were not common knowledge was that the Department of Defense was responsible for informing employees called to active duty of the USERRA continuation provisions. Now employees called to active duty may elect continuation under USERRA for an additional 6 months of coverage. The USERRA continuation rights and the COBRA continuation rights are not the same. It is important employees called to active duty understand the differences if they are considering continuation coverage options.



The revisions now require *employers* to notify employees of their USERRA rights and obligations. To meet this requirement, employers can simply post a notice in the same areas they generally post other required notices. The notice was required to be posted by March 10, 2005. A copy of the notice poster can be found at <http://www.dol.gov/vets/programs/userra/poster.pdf>.

While the revisions imply employers must notify each affected employee individually of his or her USERRA rights, the act also states employers can post a general notice to meet this requirement. If employers choose to notify each employee called to active service individually, they may want to provide the USERRA continuation rights information along with a COBRA notice to ensure the employee is aware of both options.

HSA Guidance

The IRS released additional guidance on Health Savings Accounts (HSAs). The Medicare Act established HSAs that allows individuals who meet the requirements outlined in the law (one requirement is coverage under a High Deductible Health Plan) to establish tax-free accounts to cover medical expenses. The interest accrued on these accounts is tax-free. Payments for qualified medical expenses are also tax-free.

The initial legislation broadly outlined the parameters of HSAs. Over the last two years, new information on properly administering these accounts has been issued. This year

new guidance clarified two key areas:

- **Contribution maximums based on self-only or family coverage:** This guidance explained how to determine the annual HSA contribution maximum in various circumstances. Maximum contributions to the HSA are the lesser of the plan deductible or an annually adjusted government set limit. At the end of the day, the employee's coverage choice determines the maximum contribution amount, providing the employee is not covered by another comprehensive health plan. Let's look at an example, your employee elects family coverage for himself and his wife and his wife already has comprehensive coverage with her employer that does not cover your employee. In this case, your employee's maximum contribution to the HSA would be the lesser of the family plan deductible or the government set family limit. The spouse's comprehensive health coverage is not a factor in determining the maximum contribution amount.
- **Comparability Requirements for Employers:** The Medicare Modernization Act requires employers making contributions to one employee's HSA to make a comparable contribution for any other employees covered by a high deductible health plan (HDHP) and an HSA. The additional guidance on the comparability requirements provides much more detail on differentiating contributions for individuals with HSAs and HDHPs. You can find all the details of this additional guidance at <http://>

www.mcwent.com/Special_Alert/2005/Special_Alert_Issue_4.pdf.

Final and New HIPAA Portability Regulations

At the very end of 2004, the federal government released final HIPAA portability regulations. At the same time, it also released newly proposed regulations to clarify some administrative portability issues. The final regulations became effective on the first day of your first plan year on or after July 1, 2005. For many organizations, these final regulations will be effective January 1, 2006. The good news is the final regulations are not very different from the initial proposed regulations released in 1996.

The bad news is these regulations are complicated and have many small details that should not be overlooked. You can find a complete discussion of the final regulations and the

new proposed regulations in our Benefit Advisor at http://www.mcwent.com/Benefit_Advisor/2005/BA_Issue3.pdf.

The key clarifications of the final regulations include:

- More detail on the information you must include in the required written notice to plan participants before they enroll.
- More detail on pre-existing condition limitations. Some plan provisions are not expressly defined as pre-existing condition limitations,

but they, in fact, operate as pre-existing condition limitations. These provisions are subject to the portability requirements. A common example would be a plan that covers prosthetic limbs but only if the limb was lost while the individual was covered by the plan.

- Confirmation that a participant's enrollment date does not change even if the health plan vendor is changed.
- Affirmation that if an individual changes plans during open enrollment, any time spent under the former plan option applies to any new pre-existing condition limitation.
- The rules reiterate when Section 125 Medical Reimbursement Accounts are

considered "excepted benefits" and not subject to the portability requirements of the rule. The final regulations add one

additional requirement. In order for a medical reimbursement account to be considered "excepted," the employer must have an annual open enrollment for the employer-sponsored group health plan.

- Finally, additional detail was added to the discussion of special enrollment rights that allow an eligible employee or dependent who previously waived coverage to enroll in the plan. One key clarification is that employees reaching the lifetime benefit limits under a health plan should be treated as if experiencing a loss of coverage.

The proposed regulations discuss administrative issues, including:

- Tallying the days for a 63-day break in creditable coverage.
- Tallying days for special enrollment.
- Interacting with the FMLA.

Medicare Part D Notice Requirements

The Medicare Part D legislation required most group health plans to send all Medicare eligible covered participants a coverage notice before November 15. This requirement applies to any plan you offer to retirees or active employees. However, you will need to evaluate your plan coverage to determine which notice you must send. If your plan benefits are at least as good as the Medicare standard benefit option, you will need to send a Notice of Creditable Coverage. If your coverage is not as good as the Medicare standard benefit, you will need to send a Notice of Non-Creditable coverage

The good news is many carriers have determined what drug card options should be considered creditable and what drug card options should be considered not creditable. Many employers were struggling through the creditable coverage determination and carriers stepped in to assist. However, employers must still officially notify Medicare eligible plan participants. More details about the notice requirements can be found at http://www.mcwent.com/Benefit_Advisor/2005/BA_Issue7.pdf.

The government has required health plans to notify Medicare eligible plan participants every year. Additional guidance on this annual notice requirement will be released in the future.

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Annual Reminders and Updates

• **2006 Medicare Information**

The Department of Health and Human Services released the Medicare information for 2006 (see table below).

January 1, 2006, is the launch date for two major changes in the Medicare program:

- Medicare Part D plans across the country will begin to offer Medicare eligible individuals outpatient prescription drug coverage delivered by private organizations. The initial enrollment period runs from November 15, 2005 to May 15, 2006.
- Medicare Advantage plans will be introduced to the market on January 1, 2006. These new plans will replace Medicare Choice plans or Medicare Risk HMOs. Medicare Advantage plans offer more expansive plan designs; expect to see HMO, PPO and traditional plans introduced in the market place. The government funding for these plans has also changed. Stipends will be adjusted for geography and also utilization factors. These new plans will offer an

HEALTH SAVINGS ACCOUNTS LIMITS		
Health Savings Account Limits	2005	2006
HDHP Minimum Deductible		
Self Only Coverage	\$1,000	\$1,050
Family Coverage	\$2,000	\$2,100
HDHP Maximum Out-of-Pocket		
Self Only Coverage	\$5,100	\$5,250
Family Coverage	\$10,200	\$10,500
HSA Statutory Contribution Maximum		
Self Only Coverage	\$2,650	\$2,700
Family Coverage	\$5,250	\$5,450
Catch-Up Contribution (55 and older)	\$600	\$700

affordable and comprehensive coverage alternative to Medicare Parts A, B and D.

• **Group Term Life Insurance: Section 79**

Each year employers need to review their employer-provided life coverage to assess employees' tax liability. Employers have to impute income for the value of the life insurance plan only in the following instances:

- If the employer provides employer-paid life insurance that exceeds \$50,000.
- If the life plan discriminates in favor of key employees.

- If the employee-paid optional life plan rate tables straddle Table 1 rates.

The most recent Benefit Advisor (http://www.mcwent.com/Benefit_Advisor/2005/BA_Issue11.pdf) explains when an employer must impute income and how to calculate imputed income.

• **W-2 Forms for STD Benefits**

At year-end many employers forget to account for any disability benefits or earnings paid to disabled employees during the year. Remember to issue W-2s for all employees who received short term disability benefits under your short-term disability (STD) plan in 2005. Reporting for this income is generally handled in one of two ways:

- Disability carriers and/or third party administrators may issue W-2s directly to participants who received benefits during the year.
- Carriers and/or administrators may send the employer a quarterly or annual report, including

Medicare Information

Medicare Part A Annual Deductible	\$952.00
Hospital Per Day Copay	
60 to 90 day stays	\$238.00
90+ day stays	\$476.00
Skilled Nursing Facility Per Day Copay (after 20 days)	\$119.00
Medicare Part B Monthly Premiums	\$88.50
Medicare Part B Annual Deductible	\$124.00

the information necessary to issue each claimant's W-2.

Ask your STD insurer or administrator if they will issue W-2s for your claimants. If the insurer issues the W-2 separately, it is wise to let your 2005 claimants know that they will receive a separate W-2 from the disability vendor. It is more common for disability vendors to tell employers how much they paid in disability benefits and then have the income added to the employees W-2.

If your organization self-funds STD benefits, you will need to include those benefit amounts in the employee's 2005 W-2. If you use a payroll service to issue W-2s, make sure your payroll vendor is aware that each STD plan participant who received benefits during 2005 will have additional compensation that needs to be included on their W-2.

Conclusion

You may have already considered many of these year-end compliance issues. However, day-to-day pressures may have pushed some of them off the plate. If you overlooked any of these issues this year, make sure your action plan for next year includes the necessary compliance projects. Although the housekeeping issues arise only once a year, they cannot be ignored.

Good luck with the year-end compliance issues that affect your organization's benefit plans.

The staff of McGraw Wentworth wishes you and your family, a happy, healthy and prosperous 2006! **MW**

INDEXED PLAN LIMITS		
Plan Limits	2005	2006
Section 401(k) or SAR-SEP	\$14,000	\$15,000
Section 402(g) maximum pre-tax contribution by employees for elective deferrals	\$14,000	\$15,000
Age 50+ Catch-Up Contributions	\$4,000	\$5,000
Section 403(b) Plan	\$14,000	\$15,000
Section 408(p)(2)(A) SIMPLE Plan Contributions	\$10,000	\$10,000
Section 457(b)(2) Limit	\$14,000	\$15,000
Section 415 Limit for: Defined Contribution Plans (calendar year) Defined Benefit Plans	\$42,000 \$170,000	\$44,000 \$175,000
Highly Compensated Employees Section 414(g)	\$95,000	\$100,000
Includible Compensation - Section 401(a)(17)	\$210,000	\$220,000
FICA Taxable Wage Base: Social Security (Tax Rates 6.2%) Medicare (Tax Rate 1.45%)	\$90,000 No Limit	\$94,200 No Limit

Our technical bulletins are written and produced by McGraw Wentworth staff and are intended to inform our clients and friends on general information relating to employee benefit plans. They are not intended to provide either legal or tax advice. Before implementing any welfare or pension benefit program, employers are urged to consult with their benefits advisor and/or legal counsel for advice that is appropriate to their specific circumstances.

McGraw Wentworth
3331 West Big Beaver Road, Suite 200
Troy, MI 48084
Telephone: 248-822-8000 Fax: 248-822-4131
www.mcgrawwentworth.com