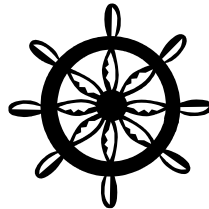


# **Successfully Navigating Mandatory Benefits Laws**



**William R. Watkins  
Lindabury, McCormick & Estabrook, P.A.**

**Council on Education in Management  
February 5, 2003**

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# Successfully Navigating Mandatory Benefits Laws

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## Outline

- I. HIPAA (Medical Privacy Rules)
- II. COBRA
- III. COBRA CASE LAW
- IV. Unemployment Insurance
- V. HIPAA (Portability & Continuity of Health Insurance Coverage)
- VI. ERISA
- VII. OWBPA

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## HIPAA (Medical Privacy Rules)

- 1. What is HIPAA?
  - a. HIPAA is an acronym for the Health Insurance Portability Act of 1996.
  - b. It was enacted into law in 1996.

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**HIPAA (Medical Privacy Rules) (cont'd)**

- 2. If HIPAA was enacted into law in 1996, why have we been hearing so much about it over the last two or so years?
  - a. HIPAA covers a wide range of topics having different effective dates, some of which were just reached in 2003 or will be reached in 2004.
  - b. There are 2 major components of the HIPAA legislation:
    - i. the component which relates to the portability and continuation of health insurance coverage (which became effective in 1997 and will be addressed in a subsequent section of this presentation.)
    - ii. the component(s) which relate to medical privacy issues (which became effective, for the most part, in and subsequent to 2000).

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**HIPAA (Medical Privacy Rules) (cont'd)**

- 3. HIPAA's medical privacy provisions have 3 major aspects, which are:
  - a. the Privacy Rule;
  - b. the Electronics Transaction and Code Set Standards; and
  - c. the Security Rule.

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**HIPAA (Medical Privacy Rules) (cont'd)**

- 4. There is a misconception by some that the Privacy Rule only pertains to providers in the medical industry (such as doctors and hospitals) and has no applicability to employers outside the health industry. HIPAA may have limited applicability to other employers and each employer needs to assess its applicability to their business and respond accordingly.

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**HIPAA (Medical Privacy Rules) (cont'd)**

5. In determining the applicability of HIPAA, start with the definition of the "covered entities" under the HIPAA's Privacy Rule. Covered Entities include:
- a. health care providers (e.g. M.D., hospital)
  - b. health care clearing houses (e.g. a billing company engaged by a provider)
  - c. health plans

Note that Employers generally are not per se a Covered Entity.

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**HIPAA (Medical Privacy Rules) (cont'd)**

6. If an employer (outside the health care industry) gets "roped-in" to being covered under HIPAA, it will generally be because it is the sponsor of a health plan. A health plan is generally defined as a plan that either provides for medical care or pays for the cost of medical care.

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**HIPAA (Medical Privacy Rules) (cont'd)**

7. Numerous employers sponsor health plans. The health plans often have no employees as such, and are dependent upon personnel provided by the employer. Consequently, any concerns the health plan (as a Covered Entity) has with respect to HIPAA compliance can, indirectly, become the employer's concern.

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**HIPAA (Medical Privacy Rules) (cont'd)**

8. Does this mean all employers that sponsor a health plan must be concerned with complying with the requirements of HIPAA's privacy provisions? The answer is "No" for the following reasons:
- a. Employers sponsoring group health plans are not Covered Entities if they have fewer than 50 participants.
  - b. As for the rest, how HIPAA impacts them depends largely upon:
    - i. whether their health plans are fully insured or self-funded; and
    - ii. on the nature of Protected Health Information (or "PHI") that the group health plan (including employees of the sponsoring employer) receives.

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**HIPAA (Medical Privacy Rules) (cont'd)**

9. As a general proposition, if the health plan does not receive PHI from plan participants, it doesn't need to worry about HIPAA compliance. Thus, many employers with fully insured group health plans which shift all of the financial and administrative responsibility to the insurance carrier are not required to implement measures to comply with the Privacy Rule (although the insurance carrier is obliged to comply).

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**HIPAA (Medical Privacy Rules) (cont'd)**

10. What is PHI?
- a. PHI is "individually identifiable health information" (i.e. it must contain information which identifies the individual, provides information that can reasonably be used to identify the individual; and
  - b. PHI relates to either the past, present or future health or condition of the individual, the provisions of health care to an individual, or to the payment for health care.
  - c. PHI can be in oral, written or electronic form.

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**HIPAA (Medical Privacy Rules) (cont'd)**

- 11. The “bottom line” is that if the employer is in receipt (either directly or indirectly as the plan sponsor) of PHI, it must be concerned with HIPAA compliance.
  - a. A employer with a fully-insured plan does not become subject to HIPAA compliance by virtue of receiving “summary health information” (i.e. general data on enrollment, costs of care, etc. that does not contain PHI).
  - b. HIPAA obligations are not triggered when an employer has access to employment-related health information (although other laws, such as the ADA and FMLA regulate the privacy of such records).
  - c. Many employers have stopped practices which cause them to receive PHI to avoid HIPAA compliance issues.

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**HIPAA (Medical Privacy Rules) (cont'd)**

- 12. What about self-insured plans?
  - a. Generally speaking, self-insured plans must be concerned with HIPAA compliance, even if they use a Third Party Administrator or “TPA,” since they acquire PHI.
  - b. A TPA is technically a “business associate” of the self-insured plan, which has contractually assumed responsibility to administer the plan. An employer could arguably be liable for the improper disclosure of PHI by the TPA.

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**HIPAA (Medical Privacy Rules) (cont'd)**

- 13. What are some of the actions that an employer must taken if subject to HIPAA. Among other things, it must
  - a. provide individuals with Notice of Privacy Practices (in a prescribed format)
  - b. establish policies and procedures to safeguard PHI
  - c. train staff to ensure compliance with the policies and procedures
  - d. designate a Privacy Officer (to implement privacy policies) and a Contact Person (to address complaints or questions).

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**HIPAA (Medical Privacy Rules) (cont'd)**

14. What are some of the key deadlines for achieving HIPAA compliance?
- a. The Privacy Rule requires compliance before April 14, 2003 for all Covered Entities other than "small health plans."
  - b. Small health plans (plans that pay less than \$5 million annually in premiums or in self-insurance costs) have until April 14, 2004 to comply.
  - c. Other HIPAA deadlines include:
    - i. compliance with the Electronic Transaction and Code Set standards must be achieved by October, 2002 (or October, 2003 for those entities that applied for extensions).
    - ii. compliance with the Security Rule (pertaining exclusively to electronic transactions) must be achieved by April, 2005.

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**HIPAA (Medical Privacy Rules) (cont'd)**

15. It is impossible in the time available to discuss HIPAA in great detail. Suffice it to say, if you conclude that your company is or may be subject to HIPAA, there should (already) be someone in your organization that is fully conversant with the law, who will spear-head your company's compliance.

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**HIPAA (Medical Privacy Rules) (cont'd)**

16. Although beyond the scope of this presentation, HIPAA is something employers will need to deal with in some fashion, regardless of whether you sponsor a health plan which is a Covered Entity. For example,
- a. HIPAA may be implicated when Employee records are subpoenaed.
  - b. HIPAA may be implicated in personnel matters.

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## COBRA

1. What is COBRA?
  - a. COBRA is an acronym for the Consolidated Omnibus Reconciliation Act of 1985.
  - b. COBRA requires group health plans maintained by employers to offer covered individuals the opportunity to continue their health insurance coverage, at the employee's cost, if they are about to lose their coverage.
  - c. Generally, the continuation coverage must be identical to the coverage previously enjoyed.
  - d. COBRA applies to medical, dental and prescriptions plans, health FSA's, etc.

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## COBRA (cont'd)

2. Applicability of COBRA
  - a. COBRA does not apply to a small-employer plan, defined as a plan maintained by an employer which employed less than 20 employees during at least 50% of the prior year.
  - b. Both full-time and part-time employees count in determining the applicability of COBRA. Each full-time employee counts as one employee, and each part-time employee counts as a fraction of one employee (based upon the fraction of hours worked by that part-time employee compared with the number of hours worked by full-time employees.)

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## COBRA (cont'd)

3. COBRA Does Not Apply To:
  - a. Federal Government – it has its own rules.
  - b. Church plans as defined in IRC §414(e).

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**COBRA (cont'd)**

**4. Qualified Beneficiaries**

- a. Qualified beneficiaries include:
  - i. Covered employee
  - ii. Covered spouse
  - iii. Covered dependent children, both natural and adopted
- b. Each qualified beneficiary has the same rights under the plan as the active employee

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**COBRA (cont'd)**

**5. Qualifying Events**

- a. The right to continue health coverage arises only when coverage is lost as a result of certain qualified events.
- b. These qualifying events include:
  - termination of employment of a covered employee (except where term. is for gross misconduct)
  - reduction of hours of employment
  - strike, layoff, leave of absence
  - divorce of a covered employee
  - death of a covered employee
  - loss of dependent status by the child of a covered employee
  - Medicare eligibility attained
  - Bankruptcy of employer

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**COBRA (cont'd)**

**5. Qualifying Events (cont'd)**

**FMLA leave is not a COBRA qualifying event.**

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**COBRA (cont'd)**

**6. Duration of Coverage**

- a. The duration of coverage depends upon the type of qualifying event.
- b. Duration is 18 months for termination of employment or reduction in hours (plus an additional 11 months where a qualified beneficiary is disabled).
- c. Duration is 36 months for other qualifying events.

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**COBRA (cont'd)**

**7. Earlier termination of COBRA coverage may result if any of the following events occur:**

- a. the employer no longer offers group health insurance to any of its employees;
- b. the qualified beneficiary fails to make a timely premium payment
- c. the qualified beneficiary becomes covered under another group health plan (that does not impose an exclusion on the beneficiary)
- d. the qualified beneficiary becomes Medicare eligible

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**COBRA (cont'd)**

**8. Responsibility to Pay for Coverage**

- a. Employers are not required to pay for COBRA coverage
- b. the qualified beneficiary may be required to pay up to 102% of the applicable premium
- c. the first payment cannot be required until 45 days after the COBRA election is made

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## COBRA (cont'd)

### 9. Notification Requirements

- a. An Initial COBRA notice must be sent to employees and their spouses within 90 days after they are first covered under the plan.
- b. Qualifying Event COBRA notice must be provided by the Employer to the COBRA administrator within 30 days after the qualifying event. The COBRA administrator has 14 days to send notice to qualified beneficiaries.
- c. The DOL has promulgated regulations addressing which parties must receive notice, how and when they should be served and the content of such notices.
- d. There are also notice requirements pertaining to disability determinations and second qualifying events, and with respect to COBRA termination.
- e. An employer can face significant penalties for failing to provide COBRA notices as required.

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## COBRA (cont'd)

### 10. Employee Election

- a. Once a qualifying event has occurred, a covered employee and other qualified beneficiary has at least 60 days during which to elect continuation of coverage.
- b. Any election of continuation of coverage by any one covered employee or beneficiary is treated as an election of continued coverage for all other qualified beneficiaries who will lose benefits as a result of the same qualifying event.

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## COBRA Case Law Interpreting Notice Requirements

1. Neither the statute nor the DOL regulations prescribe the absolute deadline for notification where the Employer acts as the plan administrator.
  - a. DOL has taken the position that the notice period is 44 days (the 30 day period which the employer has to notify the administrator, plus the 14 day period which the administrator has to notify the qualified beneficiary). The Third Circuit has generally followed their approach. DiSabatino v. DiSabatino, 894 F. Supp. 810 (D. Del. 1995).
  - b. At least one Court (the Southern District of Georgia) has rejected DOL's recommendation and ruled that the Employer, when acting as the Plan Administrator, must notify qualified beneficiaries within 14 days Hamilton v. Mecca, 930 F. Supp. 1540 (S.D. Ga. 1996).

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**COBRA Case Law**  
**Interpreting Notice Requirements (cont'd)**

2. When a third party acts as the COBRA administrator issues have arisen as to whether the Employer (i.e. plan sponsor) may be liable for the failure of the Plan Administrator to give appropriate COBRA notices?
  - a. In Scott v. Suncoast Bev Sales, Ltd., 295 F.3d 1223, the 11<sup>th</sup> Circuit recently held the employer liable (it fined the Company in excess of \$10,000) as a result of the administrator's failure to provide a terminated employee with COBRA notice, even absent any harm to the former employee or evidence of bad faith on the part of the employer.
  - b. Here, it appears that the Administrator failed to properly perform its functions, and the Employer likely has a claim for indemnification against the Administrator.

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**COBRA Case Law**  
**Interpreting Notice Requirements (cont'd)**

3. Another issue recently addressed by the Courts is whether administrators have an obligation to ensure that the notice is actually received by the qualified beneficiary? (as distinct from merely the obligation to send notification in an appropriate manner).
  - a. In Degruise v. Sprint, 279 F.3d 333 (5<sup>th</sup> Cir. 2002), the Fifth Circuit (consistent with the ruling of various other courts that have addressed the issue) determined that the Administrator (Employer) is not obligated to ensure that notice is actually received. (Here, the beneficiary was out of town on the two occasions the Post Office attempted to deliver the notice by certified mail, and it was returned to send marked "undelivered.")
  - b. The Court ruled that the employer was in compliance with the COBRA notice rules if it makes a good faith attempt to provide notice and generally has no duty to verify actual receipt.

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**COBRA Case Law**  
**Interpreting Notice Requirements (cont'd)**

4. Still another notice issue recently addressed by the Courts is whether a COBRA notice is required in circumstances where health care coverage is continued beyond the termination of employment?
  - a. In Williams v. Teamsters Local Union No. 727, 2003 WL22424726 (N.D. Ill. 2003), the Court, in a Slip Opinion, ruled in the negative, finding that a COBRA notice is required only where there is a qualifying event which causes a loss of coverage prior to the end of the maximum COBRA period.
  - b. Here, an individual's coverage was continued for four (4) years after his employment was terminated, well beyond the otherwise applicable 18 month COBRA coverage period.
  - c. The result would presumably have been different if the coverage continued after termination of employment, but for a period that was less than the applicable COBRA coverage period.

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## Unemployment Insurance

1. What is unemployment insurance?
  - a. It was created by the Social Security Act of 1935.
  - b. Unemployment Insurance is a program designed to provide benefits to individuals who are out of work – generally due to no fault of their own.
  - c. Today unemployment insurance is the subject of both state and federal laws. Federal law establishes broad coverage provisions and each state designs its own benefit program within the framework of the federal requirements.
  - d. The program is funded in NJ both by employer taxes and taxes paid by employees (NJ is in the minority in that it taxes employees to help fund the program.)

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## Unemployment Insurance (cont'd)

2. Employee Claims
  - a. Upon termination of his/her employment, an employee who is not working may elect to file an unemployment claim.
  - b. Unless the employer wants to challenge the employee's entitlement to benefits, the employer's responsibility is generally limited to providing pertinent information to the State.
  - c. An employer's premium for unemployment insurance is experienced rated; i.e. the more claims that have been filed against a particular employer, the higher its premiums.

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## HIPAA Portability And Continuity Of Health Insurance Coverage

1. HIPAA protects workers and their families by:
  - limiting exclusions for pre-existing medical conditions.
  - providing credit against maximum pre-existing exclusion periods for prior health coverage.
  - requiring plans to provide certificates of creditable coverage to individuals at certain specified times.
  - providing rights allowing individuals certain rights to enroll for health coverage when they lose other health coverage, get married or add a new dependent.
  - prohibiting a plan from discriminating in enrollment or premiums charged based on health status-related factors.

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## HIPAA: Portability And Continuity (cont'd)

2. **Effective Date and Applicability**
  - a. This aspect of HIPAA became effective in 1997.
  - b. HIPAA applies to all group health plans other than:
    - plans with less than two participant employees.
    - plans providing only excepted benefits (e.g., accident or disability benefits, workers compensation insurance) or other plans whose provision of medical care benefits is incidental to other insurance.
    - plans that provide limited scope dental or vision benefits, benefits for long term care or similar limited scope benefits through a separate contract not coordinated with a broader health care plan.
    - plans providing Medicare supplemental coverage or other similar coverage through a separate contract.

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## HIPAA: Portability And Continuity (cont'd)

3. **Pre-existing Conditions Exclusions**
  - a. A pre-existing condition is defined as a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to an individual's enrollment date (earlier of first day of coverage or first day of any waiting period).
  - b. HIPAA provides that a group health plan may not impose a pre-existing condition exclusion on an individual of more than 12 months (18 months for late enrollees) after an individual's enrollment date.
  - c. HIPAA further requires that a new employer's plan must give individuals credit for the length of time they had prior continuous health coverage (without a break of 63 days or more without coverage) or "creditable coverage," thereby reducing or eliminating the exclusion period.

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## HIPAA: Portability And Continuity (cont'd)

### 4. **Creditable Coverage**

Includes prior coverage under:

- another group health plan
- an individual health insurance policy
- COBRA
- Medicaid, Medicare, CHAMPUS and other governmental plans

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## HIPAA: Portability And Continuity (cont'd)

### 5. Certificate of Creditable Coverage

- a. Certificates of Creditable Coverage must be provided automatically and free of charge by the plan or issuer when an individual loses coverage under the Plan, becomes entitled to elect COBRA coverage or exhausts COBRA coverage.
- b. The Certificate should contain information about the length of time an employee or his/her dependents had coverage as well as any waiting period that applied to such coverage.

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## HIPAA: Portability And Continuity (cont'd)

### 6. Special Enrollment Rights

- a. HIPAA grants certain individuals the right to enroll in group health plans outside of the plan's regular enrollment period.
- b. Employees or their eligible dependents must be allowed to enroll in certain circumstances; such as employees who lose their coverage as a result of divorce, death of the employee, termination of employment, reduction in hours, or where a dependent is acquired through birth, marriage, or adoption.

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## HIPAA: Portability And Continuity (cont'd)

### 7. Discrimination Prohibitions

- a. HIPAA provides that a group health plan may not impose eligibility rules based upon an individual's health status, medical condition, claim experience, medical history, evidence of insurability, or other health-status related factors.
- b. HIPAA precludes a plan from charging an individual his/her premiums based on any of these conditions.

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## ERISA

### 1. What is ERISA?

- a. An acronym for the Employee Retirement Income Security Act of 1974.
- b. ERISA is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to protect the interests of the participants (and their beneficiaries) in these plans.
- c. ERISA protects participants and their beneficiaries by establishing standards of conduct, responsibilities and obligations for fiduciaries of employee benefit plans.

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## ERISA (cont'd)

### 2. Applicability of ERISA

- a. ERISA applies to any "Employee benefit plan" established or maintained by:
  - i. an employer engaged in interstate commerce;
  - ii. a union or other employee organization that represents employees engaged in interstate commerce; or
  - iii. jointly by such an employer or union.
- b. ERISA does not cover plans established by governmental entities, by churches for their employees, or unfunded excess benefit plans.

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## ERISA (cont'd)

### 3. Employee Benefits Plans

- a. An "Employee benefit plan" includes both "welfare benefit plans" and "pension benefit plans."
- b. A "welfare benefit plan" is a plan that provides medical, surgical or hospital benefits or sickness, accident, disability, death, unemployment or vacation benefits.
- c. A "pension benefit plan" is a plan that provides retirement income to employees or enables employees to defer a portion of their income until retirement or beyond.

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## ERISA (cont'd)

### 4. ERISA Requirements

- a. ERISA imposes certain disclosure requirements upon plan sponsors, such as preparing a Summary Plan Description and furnishing participants with a copy of same.
- b. ERISA imposes certain reporting requirements, such as the filing of annual reports (Form 5500) with the IRS (who thereafter forwards copies to DOL for its review under ERISA).
- c. ERISA imposes certain fiduciary requirements, such as requiring an employee to administer its employee benefit plans in accordance with the terms of a written plan and solely in the interests of participants.

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## ERISA (cont'd)

### 5. Enforcement

- a. ERISA is enforced by the US Department of Labor, the Treasury Department and the Pension Benefit Guaranty Corporation. Civil penalties can be levied by DOL and the IRS.
- b. Additionally, plan participants and beneficiaries may bring a civil action to enforce their rights under ERISA.

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## OWBPA

### 1. What is OWBPA?

- a. An acronym for the Older Workers Benefit Protection Act.
- b. OWBPA amended the Age Discrimination in Employment Act ("ADEA") which was discussed at length by a previous speaker.
- c. OWBPA prohibits an employer from discriminating against an employee on the basis of age with respect to terms and conditions of employment, including benefit plans.
- d. OWBPA protects employees 40 years or older.

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**OWBPA (cont'd)**

**2. Benefits for Older Workers**

- a. OWBPA permits an employer to provide different or lesser benefits to older workers under a "bona fide" employee program upon demonstrating that the cost of providing benefits to the older workers equals or exceeds the cost of providing benefits to younger workers.
- b. OWBPA permits retirement plans to specify a minimum age for normal or early retirement.
- c. OWBPA does not prohibit offering incentives to induce the voluntary retirement of protected workers.

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**OWBPA (cont'd)**

**3. Waiver of Rights under ADEA**

- a. An employer who intends to offer incentives to protected workers to induce early retirement should obtain waivers of the protected employees' rights under ADEA.
- b. In addition to be knowing and voluntary, the following minimum procedural safeguards should be observed:
  - i. the waiver must be written and in plain language;
  - ii. the waiver instrument must specifically refer to relinquishment of rights or claims arising under ADEA;

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**OWBPA (cont'd)**

**3. Waiver of Rights under ADEA (cont'd)**

- iii. the waiver must be supported by the receipt of consideration beyond that which the employee is already entitled to receive;
- iv. the employee must be given a minimum of 21 days to consider the waiver (45 days if requested in connection with a severance program offered to a group of employees);
- v. the employee must be given at least 7 days to revoke his/her execution of the waiver;
- vi. certain additional information relating to the identity of the group must be provided if the waiver is requested as part of a program offered to a group.

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**William R. Watkins**

**Lindabury, McCormick & Estabrook, P.A.**

**53 Cardinal Drive**

**Westfield, NJ 07091**

**908-233-6800**

**[wwatkins@lindabury.com](mailto:wwatkins@lindabury.com)**