

BENEFIT

Plan Developments



A monthly report covering plan design and legislative changes

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Health Care Plan Costs Jump 15% For Employers

Health care plan costs increased by 15% for employers during 2003, which was five times greater than the rate of inflation over the same period, according to "Trends in Employer Sponsored Health Benefits 2003 Survey." The national survey was conducted by two Wells Fargo companies: Acordia, Inc., and Bryan, Pendleton, Swats & McAllister (BPS&M).

"Responses from 350 companies with more than a half million employees in all regions of the country have confirmed what we've been hearing, that health care benefit costs continue to rise at a pace that far exceeds the general levels of the U.S. economy," said Dennis Donahue, national benefits practice leader for Acordia. "Employers are now faced with future health care cost increases exceeding their ability to pay."

The latest survey found that 59% of employers had a cost increase of at least 13%. Of

these, 23% had a cost increase of more than 20% in the past year. According to the survey, the average cost per employee for single coverage within a **preferred provider organization (PPO)**, the most popular

health care plan offered by respondents, is \$3,750 per year. Full family coverage cost averaged about \$9,900 per year. Twenty-three percent of all employers said they continue to pay the full cost of employee-only health care for PPO plans, and 7% pay the entire cost of full family coverage. When the cost is shared, employees typically pay only 23% of the true cost for a health care plan.

Overall, a total of 80% of those responding offer a PPO as either their sole or primary plan. The survey found that only 7% of employers offered **consumer-driven health plans (CDHPs)**, and less than one-third offered multiple health plan options.

Meanwhile, **health maintenance organization (HMOs)** plans proved to be the second most popular health care program option, with 35% of employers offering them. Five percent of employers offered a fully insured health care plan.

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Services to Value, People to Trust

“Until we see significant change in the health care funding and delivery system in the U.S., employers and their advisors are adopting a variety of short-term strategies to cope with health care cost increases,” said David Shaub, health and welfare practice leader at BPS&M. “They continue to curb health care cost increases largely by strategic management of their health care plans and by somewhat limited attempts at making the participant a more informed consumer of health care benefit dollars.”

According to the survey, 86% of employers are considering some redesign of their health care plans, and 33% indicated they planned to increase the amount their employees pay for health care by at least 10%. In addition, employers say they are actively considering multiple strategies to combat rising prescription drug costs. Thirty-one percent expect to increase their prescription drug co-pay by at least 10% in the coming year.

The survey also found that 86% of the respondents said their employees do not have a realistic idea of the true cost of their health care benefits, yet 53% agreed that most employees have a good working knowledge of their health and other benefits choices.

FSA Mileage Reimbursement Now 14 Cents

The **flexible spending account (FSA)** reimbursement for mileage associated with medical costs will increase to 14 cents from 12 cents per mile as of January 1, 2004, according to Rev. Proc. 2003-76, which also states that parking fees and tolls attributable to the use of an

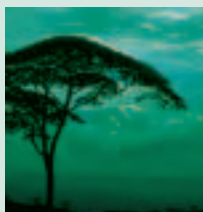
automobile for medical expense purposes may be deducted as separate items.

Those taking advantage of the reimbursement should also keep in mind that IRC Sec. 125 requires that a health FSA may reimburse a medical expense only if the participant provides a written statement from an independent third party stating that the medical expense has been incurred and has not been reimbursed or is not reimbursable under any other health plan coverage.

Act Mandates Health Care For Employees

The Health Care for Working Families Act of 2003 (H.R. 3100), which would guarantee health care benefits for workers and their families, has been introduced by Rep. Frank Pallone, Jr., D-NJ. The Act would add a new Title II to the Fair Labor Standards Act (FLSA) to require employers with 50 or more full-time employees to offer them the opportunity to enroll in a “qualifying health benefit plan” that provides coverage for the employee and his or her family.

A “qualifying health benefit plan” is defined in the bill as one that provides benefits for health care items and services that are actuarially equivalent or greater in value than the benefits offered as of January 1, 2004, under the Blue Cross/Blue Shield Standard Plan provided under the Federal Employees Health Benefit Program (FEHBP). Under the Act, the employer would be required to make a contribution to the qualifying health benefit plan in an amount at least equal to the portion of the total premium the federal government contributes to the Blue Cross/Blue Shield Standard Plan under FEHBP.



59% of employers had a health care plan increase of at least 13% in 2003.

The bill was referred to the Ways and Means, Education and the Workforce, Energy and Commerce, and Armed Services committees.

Senate Creates Act To Close HIPAA Loophole

A U.S. Senate Committee has approved a bill that would close what lawmakers say is a loophole in the Health Insurance Portability and Accountability Act (HIPAA) that could allow health insurance plans to deny coverage for injuries sustained in common recreational activities, including riding a motorcycle.

The Health Care Parity for Legal Transportation and Recreational Activities Act was approved by a voice vote of the Senate Health, Education, Labor, and Pensions Committee.

Regulations to implement HIPAA that were issued in 2001 said that while the law prevents individuals in group health plans from being excluded from coverage or charged more, “benefits for a particular injury can, in some cases, be excluded based on the source of the injury.” Sponsors of the new bill were concerned that those who participate in potentially dangerous activities—such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, and skiing—could have their coverage denied by insurers.

“If this rule is allowed to stand, millions of Americans will be forced to forgo recreational activities that they currently enjoy, lest they have an accident and find out that they are not covered,” said Sen. Susan Collins, R-Maine, who introduced the measure. Sen. Russell Feingold, a Democrat from Wisconsin—whose

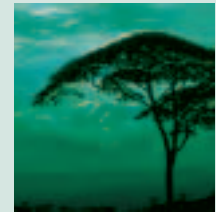
state is home to the motorcycle manufacturer, Harley Davidson—agreed. “Millions of Americans rely on motorcycles for their transportation to work. Individuals should not be singled out just because they choose a different mode of transportation.”

Bill Proposes Tax Exclusion For Domestic Partners

Stating that “every American should have access to affordable health insurance regardless of marital status,” Sen. Gordon Smith, R-Oregon, has introduced the Domestic Partner Health Benefits Equity Act. The Act (S. 1702) would amend the Tax Code to specify that, for purposes of the tax exclusion for amounts received under an accident and health plan, the term “dependents” would include “any individual who is an eligible beneficiary as defined in the employer’s accident or health insurance arrangement.”

Currently, the Tax Code states that the employer’s contribution of the premium for health insurance for an employee’s spouse is excluded from the employee’s taxable income. An employer’s contribution for domestic partner coverage, however, is included in an employee’s taxable income as a fringe benefit. In addition, the employer’s payroll tax liability is increased.

Under the proposed act, which has been referred to the Finance Committee, the tax exclusion for health care coverage of a plan’s defined dependents would be equal to 25% of the coverage in 2005, 2006, and 2007. It would increase to 50% in 2008, 2009, and 2010.



The Domestic Partner Health Benefits Equity Act would broaden affordable health insurance.

Company Pays For Not Providing Timely Notice

An award of \$82,052 has been upheld by the Eighth U.S. Court of Appeals for an employee who was not provided with a timely notice of **COBRA** rights or a copy of a company's **summary plan description (SPD)** for a benefit plan. In upholding a decision by the U.S. District Court for the Western District of Missouri (*Brown v. Aventis Pharmaceutical, Inc., et al.*), the Court of Appeals in Case Nos. 02-4063 and 03-2084 noted that Linda Sue Brown began working for one of the defendant's predecessor companies in 1986. In 2000, she received disability leave for a 180-day period, but was ultimately unable to return to work—and her employment was then terminated.

Ms. Brown's **termination letter** was sent on November 15, 2000 and notified her that her effective date of termination was October 29, 2000. The letter also indicated Ms. Brown would receive further information regarding her health, dental, and life insurance benefits. Employees had the right to *convert* their life insurance benefits to individual policies at their current level of coverage without having to provide additional evidence of insurability. To qualify, employees were required to fill out forms and pay a fee within 31 days of termination. The conversion right was of particular importance to Ms. Brown because she had health problems.

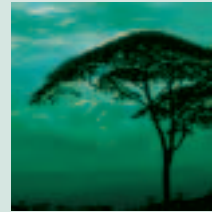
All conversion information was explained in the company's SPD and Employee Yearbook. Aventis provided Ms. Brown with a yearbook,

but she did not possess it when terminated. She had left it in her locker when she left on disability leave. And, while on leave, the maintenance staff cleaned out her locker, but did not return its contents.

When Ms. Brown did not receive the benefits information promised in her termination letter, she called the company's human resources department on two occasions. She was assured the information would be forthcoming. After two months, Ms. Brown hired an attorney who wrote two letters to the company requesting the benefits information. On February 23, 2001, about two weeks after the second letter was sent by her attorney, Ms. Brown finally received COBRA information and insurance conversion forms. However, she did not receive an SPD.

Ms. Brown's application to convert her life insurance was denied because it was not filed within the required 31-day period. Ms. Brown filed suit against the company and its plan administrator for failure to provide information in a timely manner. The district court awarded her \$8,030, the maximum in damages for failure to provide timely information; \$11,550 in civil penalties under ERISA Sec. 502(c)(1) for failure to provide an SPD upon written request; \$39,000 in a life insurance certificate (the amount of coverage she was unable to convert); and \$23,472 in attorney's fees.

On appeal, the company argued that maximum damages should not have been awarded because there was no evidence of bad faith and because Ms. Brown had been provided health benefits retroactively. The Court of Appeals rejected the argument and said the company's failure to provide the necessary information "was anything other than an administrative error."



The plaintiff filed suit for failure to provide information in a timely manner.