

In This Issue

- Medicare Prescription Drug Notice
- WHCRA Notice Reminder
- Women's Pension Bill Introduced
- Wal-Mart Prescribes Price Cut for Generics
- We're From the Federal Government and We're Here to Help
- California 'Fair Share' Legislation Vetoed
- CEOs in the Dark on Employees' Benefit Preferences
- To Blog or Not to Blog
- Are Language Barriers Compromising Health Care?
- Ready for Open Enrollment?
- HIPAA Update: Medical Privacy Law Nets No Fines
- Issue Spotlight: Summary Annual Reports

Medicare Prescription Drug Notice

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* made notice distribution an annual requirement. The notice must inform Part D eligible individuals about the creditable or non-creditable status of the sponsor's prescription drug coverage. *All* plan sponsors — not just those sponsoring retiree plans — must comply with this requirement.

The disclosure notices must be distributed within the twelve months before November 15th. This allows non-calendar year plans to distribute notices with their open enrollment cycle and not be tied to a November 15th schedule.

Those sending disclosure notices should take the following steps:

- Determine creditable status.
- Update the disclosure notices as appropriate.
- Distribute the notices.
- Report the status to the Center for Medicare and Medicaid Services (CMS) within 60 days after the first day of the plan year (the renewal or contract year).

Accurate and meaningful information must be communicated to Part D eligible individuals to enable informed decisions. This information often goes beyond the creditable/non-creditable status of the plan. Sponsors should pay particular attention to explain eligibility implications if the individual decides to enroll in Medicare's prescription drug benefit. Of course, wording should be carefully reviewed to ensure the notice remains accurate.

Model notices and guidance are available on the CMS website at www.cms.hhs.gov/creditablecoverage/ along with new guidance and disclosure notices for comment. *Until these materials are finalized, plan sponsors may use either set of guidance and notices.* Given the few changes and the fact that the materials are not finalized, plan sponsors may wish to continue using the earlier (May 2006) format.

WHCRA Notice Reminder

The *Women's Health and Cancer Right Act* (WHCRA) requires health plans to cover certain items for individuals who have had a mastectomy and to provide notice of this coverage at enrollment and annually. Notices may be included in any of the following materials:

- Union or benefits newsletters;
- Open enrollment materials; or
- Any other written communications about the plan.

In particular, a plan must offer mastectomy patients benefits for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Below is a sample of a WHCRA enrollment notice. Such a notice also can be used to satisfy the annual notice requirement.

*[Sample enrollment notice]
Women's Health and Cancer Rights Act (WHCRA)*

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact the plan administrator at [telephone number].

The DOL has approved a more brief notice to fulfill only the annual requirement. This short form annual notice is as follows:

*[Sample annual notice]
Women's Health and Cancer Rights Act (WHCRA)*

Do you know that your plan, as required by the *Women's Health and Cancer Right Act of 1998*, provides benefits for mastectomy-related services? This includes all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call your plan administrator at [phone number] for more information.

Women's Pension Bill Introduced

Congress appears determined to further unsettle the private pension system by destabilizing the voluntary nature of employee benefits. The American Benefits Council reports that a bill to force employers to offer more generous benefits in their 401(k) plans was introduced in the Senate. Although it is not expected to be acted upon this session, the Council does expect the bill to resurface next year.

Touted as a way to help women save more for retirement, the bill adds some additional incentives and opportunities for employer-provided retirement plans. As proposed, the bill would:

- Permit the rollover of up to \$500 of unused benefits under medical FSAs to qualified retirement

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plans or Section 457(b) plans (in the current version of the bill this looks to be a voluntary provision that employers can add to their Section 125 plans);

- Permit employees to elect to have qualified retirement planning services under Code Section 132(m) in lieu of compensation; and
- Provide tax incentives and simplification of plan requirements intended to encourage small employers to maintain retirement plans.

However, the bill would add new mandates for employers as well. Among other things the bill would:

- Require 401(k) plans to permit certain part-time employees (those who meet the service requirements and who work between 500 and 1000 hours in a year) to participate in the employer's 401(k) plan; and
- If employers decline to offer any retirement plan, they will be forced to allow employees to contribute to an IRA through payroll deduction.

No matter the intent, the more mandates that are added the more the plans cost and the more costly they are to administer.

Wal-Mart Prescribes Price Cut for Generics

As reported recently by the *Wall Street Journal*, Wal-Mart is cutting prices on some of its generic drugs to \$4 for a 30-day supply. Since publication of that *Wall Street Journal* article, CNN.Money.com reports that overwhelming customer demand has accelerated Wal-Mart's statewide rollout by four months from its originally planned January 2007 timeline.

Further enhancements include an expanded list of the program's generic prescriptions to more than 300 commonly prescribed, 30-day dosages. A list of the drugs can be found at the following link: http://money.cnn.com/2006/10/05/news/companies/walmart/florida_drug_list.pdf In addition, the over 90,000 employees of Wal-Mart in Florida will also be able to use their ten percent associate discount for cash sales of the prescriptions (not purchased through their medical plan). The article further states that Target is planning to match Wal-Mart's generic drug prices in all Florida Target pharmacies.

Although savings on some drugs is considerable, on others Wal-Mart's new price still does not beat the competition. The announcement drew praise from doctors, health-care experts and politicians; it was seen as a publicity move by rivals and critics. One retail analyst sees price competition likely having the greatest impact on supermarket chains with pharmacy services. Pharmacy Benefit Managers (PBMs) could also feel the pinch because, like retail pharmacies, much of their profit comes from the big margins on mail order generic drugs.

As Wal-Mart's pricing plan goes nationwide, some industry observers predict an influx of Canadian drug purchasers to the U.S. to buy comparatively lower-priced prescriptions.

We're From the Federal Government and We're Here to Help

President Ronald Reagan stated that those ten words were the most terrifying in the English language. Yet, it now appears that the DOL is attempting to be both helpful and non-threatening by introducing a Web site tool to help promote ERISA compliance. To use the tool, an employer selects the law that it wants to check. The laws included are:

- The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)



- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- The Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act)
- The Mental Health Parity Act of 1996 (MHPA)
- The Women's Health and Cancer Rights Act of 1998 (WHCRA)

For each law, successive screens provide several paragraphs describing an aspect of the law. At the bottom of each screen a question asks the employer to indicate whether it follows requirements described. At the end, the tool generates a report stating whether the responses indicate compliance or non-compliance. Perhaps most conveniently, the tool then provides a listing of on-line DOL resources on the topic.

This new tool also has a section for employees that helps them determine their rights under various federal health benefit laws. The employee section is organized by life event and reviews various options that may be available to an employee at the time of each event. The events reviewed are:

- Marriage
- First Job/Re-Entering Workforce
- Legal Separation or Divorce
- Death of a Covered Employee
- Child's Loss of Dependent Child Status
- Eligibility for Medicare
- Childbirth or Adoption
- Reduction in Hours
- Job Loss
- Changing Jobs
- Retirement
- Disability

Although this resource does not appear to shed light on any of the many lingering open questions associated with some of the laws covered — it does seem to indicate that the DOL is trying to provide meaningful support.

California 'Fair Share' Legislation Vetoed

California Governor Arnold Schwarzenegger (R) has vetoed Senate Bill 1414. This bill, if enacted, would have required employers with 10,000 or more employees in the state to spend an amount equal to at least eight percent of total wages on employee health insurance costs. Those not complying would have to pay the difference between what it contributes to the health insurance costs of its employees and eight percent of payroll into a state fund created to provide coverage to the uninsured.

In his veto message, the Governor stated that "Singling out large employers and requiring them to spend an arbitrary amount on health care does nothing to lower costs or guarantee that even one more person has health care coverage. In fact, SB 1414 will do little more than lead to expensive legal challenges. A Maryland law similar to SB 1414 was recently struck down by the courts as preempted by federal law."

CEOs in the Dark on Employees' Benefit Preferences

Employee Benefit News recently published an article describing the prevalent disconnect between em-



employer leadership and workforce benefit expectations. The article cites a survey from *McKinsey Quarterly* indicating that executives are at a loss to understand what *type* of benefits would do the most to attract top employees and provide the best return on the company's investment in these benefits.

Many executives reported poor understanding of employees' benefit preferences. According to *Employee Benefit News*, human resources managers need to communicate that benefits are an investment in the company's future, similar to research-and-development or similar expenses. Measuring the performance of benefits against company objectives may help foster better understanding of this fact. Deciding precisely what benefits to offer — particularly in companies with cafeteria-style plans — may yield helpful and often overlooked dividends.

To Blog or Not to Blog

Growing in popularity, blogs provide an easy means of communication, but have the potential to range from irksome to illegal for employers.

Some companies may be obligated to save and store blog posts and comments permanently; thereby, creating a wealth of information that can be used as evidence should a workplace lawsuit be filed. A unique feature of blogs is the use of permanent linking. These perma-linked posts can last forever. Blogs also have the potential to create challenges under applicable HIPAA and ERISA rules.

Under ERISA, electronic records related to employee benefit plans must be kept indefinitely. Benefits-related statements posted to a company's internal blog would have to be permanently stored because privacy requirements under HIPAA require healthcare organizations to safeguard electronic documents containing protected health information.

A written policy that addresses content, language, online etiquette and confidentiality for blogs is one way to minimize risk. Developing rules that meet the company's legal, regulatory and security needs is advisable. Commercially available blog software (unlike most free software) allows for greater editorial control and may be worth consideration.

Are Language Barriers Compromising Health Care?

According to the *New England Journal of Medicine*, language differences sometimes cause tragic situations while also contributing to the high cost of healthcare. The author notes that there are an estimated 50 million (19 percent) U.S. residents who do not speak English at home and another approximately 22 million (eight percent) with limited English proficiency. The article also cites several frightening, documented cases of miscommunication between the physician and medical interpreters for patients with limited English proficiency:

- The misinterpretation of a single word led to a patient's delayed care, preventable quadriplegia and a \$71 million malpractice settlement. The patient was wrongfully treated for drug abuse when he actually was complaining that he felt sick to his stomach. The delay in treatment resulted in rupture of a brain aneurysm.
- An informal interpreter told the mother of a seven-year old girl to put an oral antibiotic in the girl's ear to treat her middle ear infection.
- A resident physician who interpreted a Spanish speaking mother's explanation that her daughter had "hit herself" when she fell off her tricycle assumed the fracture had resulted from abuse, and called the social services department who had the confused and distraught mother sign over custody of her two children.

Language problems seem to be exacerbated because many patients who need medical interpreters

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have no access to them. According to one study, there was no interpreter used in 46 percent of emergency-department cases involving patients with limited English proficiency. Most at risk are young children who are unlikely to have full command of either language and may have trouble discussing sensitive issues in any language.

On the other hand, the provision of adequate language services results in optimal communication, enhanced patient satisfaction, outcomes, resource utilization, and safety. The article calls for the federal government to require insurance carriers and privately sponsored health plans to reimburse providers for interpreter services in healthcare.

Ready for Open Enrollment?

With the annual open-enrollment season upon us, results of a new MetLife Study suggest employers may want to evaluate their enrollment strategy to assure it is responsive to benefit plan participants.

In its second year, the *MetLife Study of Open Enrollment Benefits Trends for 2006*, measured the benefits concerns of employees to provide insight to employers. This year they found workers more engaged, showing greater awareness, and looking forward to their company's benefit offerings.

Regardless of age or gender, MetLife found that there is growing interest in having access to benefits choices. Changes, such as online enrollment, could go a long way toward making enrollment more responsive to the changing needs and desires of employee populations. Customized communication materials are recommended to reflect various life-stage differences including marriage, the birth of a child, homeownership, college tuition, job change and retirement.

Since electing the right benefits coverage can be challenging to many employees, MetLife has provided a benefits checklist on their Web site that includes tips on purchasing health care, dental, disability, life insurance and other coverages. The checklist, *Rules of Thumb for Employee Benefits Enrollment*, can be found at the Metlife site, www.whymetlife.com.

HIPAA Update: Medical Privacy Law Nets No Fines

The *Washington Post* notes that nearly 20,000 complaints have poured into the Department of Health and Human Services' Office of Civil Rights regarding medical privacy violations, but the department has only prosecuted two criminal cases and has not issued any fines at all. Almost three-fourths of the complaints have been closed by the agency, thereby allowing physicians, hospitals, and health plans to simply correct the problems that led to wrongly revealed patient data.

Critics argue that by adopting this position, the agency has sent a message to providers that weak compliance will be tolerated. They are pushing for stricter enforcement of medical privacy laws to ensure that electronic databases do not exacerbate the compliance problems that currently exist.

Issue Spotlight: Summary Annual Reports

Many *FOCUS* readers have asked us for clarification of Summary Annual Reports (SARs). An SAR is an employee-friendly summary of the Form 5500 (also referred to as an annual report), and all ERISA plan sponsors are required to distribute SARs each year to plan participants.

Individuals who must receive SARs are employees or former employees who are (or may become) eligible to receive any benefit from an employer plan. SAR distribution rules contain no exception for COBRA coverage recipients. COBRA requires that qualified beneficiaries be treated the same as "similarly

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situated active” participants, so COBRA coverage recipients should also receive the SAR.

A plan sponsor may provide SARs to participants through the following means:

- In-hand delivery to employees
- First class mail
- Inclusion in a union or company publication, but only if the mailing list for the publication is complete and up-to-date, the cover includes a prominently-displayed notice that the information is contained in the issue, and steps are taken to ensure delivery to participants not on the mailing list.
- Electronic transmission (provided the plan sponsor has obtained required employee consent) along with notification of the electronic distribution in addition to making provision for hard copies of the SAR. (See *Willis EB Alert #45* for further details.)

Employers should retain some proof of SAR distribution in preparation for DOL audits and to also counteract employee claims that SARs were not distributed. As proof of delivery of the SAR, some employers require employees sign an acknowledgment of receipt.

The SAR must be distributed within nine months after the close of the plan year. However, if the Form 5500 annual report deadline has been extended, the SAR must be furnished within two months after the extension date.

U.S. Benefit Office Locations

Atlanta, GA (404) 224-5000	Austin, TX (800) 861-9851	Baltimore, MD (410) 527-1200	Birmingham, AL (205) 871-3871
Boise, ID (208) 340-0645	Boston, MA (617) 437-6900	Cary, NC (919) 459-3000	Charlotte, NC (704) 376-9161
Chicago, IL (312) 621-4700	Cincinnati, OH (513) 762-7661	Cleveland, OH (216) 861-9100	Columbus, OH (614) 766-8900
Dallas, TX (972) 385-9800	Denver, CO (303) 218-4020	Detroit, MI (248) 735-7580	Eugene, OR (541) 687-2222
Farmington, CT (860) 284-6137	Florham Park, NJ (973) 410-1022	Ft. Worth, TX (817) 335-2115	Grand Rapids, MI (616) 954-7829
Greenville, SC (864) 232-9999	Houston, TX (713) 625-1023	Jacksonville, FL (904) 355-4600	Knoxville, TN (865) 588-8101
Las Vegas, NV (702) 562-4335	Long Island, NY (516) 941-0260	Los Angeles, CA (213) 607-6300	Louisville, KY (502) 499-1891
Memphis, TN (901) 248-3100	Miami, FL (305) 373-8460	Milwaukee, WI (414) 271-9800	Minneapolis, MN (763) 302-7100
Mobile, AL (251) 433-0441	Mountain View, CA (650) 944-7000	Naples, FL (239) 514-2542	Nashville, TN (615) 872-3700
New Orleans, LA (504) 581-6151	New York, NY (212) 344-8888	Omaha, NE (402) 778-4851	Orlando, FL (407) 805-3005
Philadelphia, PA (610) 964-8700	Phoenix, AZ (602) 787-6000	Pittsburgh, PA (412) 586-1400	Portland, OR (503) 224-4155
Roswell, NM (505) 317-3397	St. Louis, MO (314) 721-8400	San Diego, CA (858) 678-2000	San Francisco, CA (415) 981-0600
San Juan, PR (787) 725-5880	Seattle, WA (206) 386-7400	Spokane, WA (206) 386-7400	Tampa, FL (813) 281-2095
Washington, DC (301) 530-5050	Wilmington, DE (302) 477-9640		

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