EBIA

EBIA Weekly
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Announcement

EBIA Keeps You Informed About COBRA and Group Health Plan Mandates

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Visit the Health Care Reform Community on Checkpoint to join the discussion on this development (for Checkpoint subscribers to EBIA's Health Care Reform manual).

Health Care Reform

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HIPAA Portability, Privacy & Security

Theft of Unencrypted Laptops Leads to HIPAA Privacy and Security Settlements Totaling Nearly $2 Million

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Concentra Resolution Agreement

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Question of the Week

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- **COBRA: The Developing Law.** Recent updates examine the impact of COBRA on Exchange eligibility and consider when a qualified beneficiary may be eligible for a special enrollment period. We also analyze the COBRA rights of a dependent dropped from coverage in connection with a triggering event that would not otherwise have caused a loss of coverage-e.g., a spouse dropped by an employee who becomes entitled to Medicare or a child dropped due to divorce. In addition, we have added new examples and tables to our discussion of the unique COBRA issues facing HRA administrators. We also note recent informal remarks by an IRS official that shed light on the COBRA issues raised by the $500 health FSA carryover. For more information and to order, visit http://www.ebia.com/Manuals/COBRA.
- **Group Health Plan Mandates.** We've added more depth to our mental health parity discussion, including new coverage of how the rules affect the scope of services offered and what issues are associated with categorically excluding all coverage in nonhospital settings. We've also added new analysis of whether you can avoid the parity requirements altogether and expanded the discussion of disclosures required by the mental health parity rules. Plus we have updated and expanded our sample administration procedures for group health plan mandates, including updates related to clarifications in the mental health parity final regulations. For more information and to order, visit http://www.ebia.com/Manuals/GHPM.

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Topic(s): HIPAA Portability, Privacy & Security

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QCA Resolution Agreement

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HHS has announced resolution agreements to settle potential HIPAA privacy and security violations with two covered entities: a multi-state health care provider organization, and an Arkansas health insurer. In both instances, HHS investigations were prompted by breach notifications reporting the theft of unencrypted laptop computers containing electronic protected health information (ePHI). The agreements require a payment in excess of $1.7 million from the provider organization, and a $250,000 payment from the insurer. Each entity must comply with a two-year corrective action plan (CAP), as described below.

HHS's investigation of the provider organization began after the entity submitted a breach notification in December 2011, following the theft of an unencrypted laptop from its Missouri physical therapy center. The investigation revealed that the organization had previously indentified (in multiple risk analyses) the lack of encryption on laptops and other devices as a critical risk-but had not fully implemented encryption, documented why encryption was not reasonable and appropriate, or implemented a reasonable and appropriate alternative. The CAP requires the entity to undertake and document to HHS (1) a security risk analysis, a risk management plan, and specific remedial measures; (2) annual updates on its encryption status (including the percentage of all devices and equipment that are encrypted, an explanation of those not encrypted, and evidence that all new devices have been encrypted); and (3) security awareness training for all workforce members.

Similarly, HHS's investigation of the insurer followed the insurer's breach notification in February 2012 that an unencrypted laptop containing the ePHI of 148 individuals was stolen from a workforce member's car. The investigation indicated that the insurer had failed to conduct an accurate and thorough risk assessment or implement policies and procedures to prevent, detect, contain, and correct security violations, including a failure to implement physical safeguards for all workstations that access ePHI to restrict access to authorized users. Under the CAP, the insurer must submit for HHS review and approval (1) an updated risk analysis and risk management plan that includes specific security measures; and (2) training materials established to reduce risk and vulnerabilities to ePHI. Following approval, the insurer must submit documentation of workforce training and report any instances of noncompliance with its privacy and security policies and procedures.

EBIA Comment: Breach notifications are very likely to trigger HHS investigations. Once an investigation is launched, HHS can scrutinize all aspects of a covered entity's or business associate's privacy and security compliance. Encryption remains a critical issue for covered entities and business associates, and an apparent enforcement priority for HHS. While failure to encrypt ePHI is not a per se violation of the security rule, the HHS news release notes that it is an entity's "best defense" against security incidents. The news release also touts HHS's educational programs (geared toward health care providers) on compliance with various aspects of the privacy and security rules, including a module focusing on mobile device security. For more information, see EBIA's HIPAA Portability, Privacy & Security manual at Sections XX.D ("Resolution Agreements"), XXV ("Breach Notification for Unsecured PHI"), and XXX ("Core Security Requirements"). You also may be interested in our intermediate-level in-person HIPAA privacy and security seminar (live in Minneapolis on May 23 and Cleveland on June 6); a recorded version will be available May 12 to June 20. Or, for a beginner-level introduction, you may be interested in our recorded web seminar, "HIPAA Privacy and Security Training."

Contributing Editors: EBIA Staff.

CMS Releases New Tools for SHOP: Small Business Health Care Tax Credit Estimator and FTE Employee Calculator

Topic(s): Health Care Reform for Employers and Advisors

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SHOP FTE Employee Calculator

CMS has announced the availability of two new tools for employers using SHOP Exchanges: A small business health care tax credit estimator and a full-time equivalent (FTE) employee calculator. Certain small employers that offer health insurance to their employees and pay at least 50% of the premiums have been eligible for a tax credit since 2010, but some important changes went into effect in 2014, including an increase in the maximum credit amount from 35% to 50% of employer-paid premiums (from 25% to 35% for eligible small tax-exempt employers). Also starting in 2014, the coverage generally must be offered through a SHOP Exchange (unless transitional relief is available) and the credit can be claimed for only two consecutive years. The announcement reminds employers of these changes and that SHOP is available to them year-round if they had 50 or fewer FTE employees (using 30 hours per week to calculate the equivalency) during the preceding calendar year, although the tax credit is only available if

they have fewer than 25 FTE employees (using 40 hours per week to calculate the equivalency) and average wages of less than $50,000 (adjusted for inflation). (For more on the changes in the tax credit for 2014 and calculating FTE employees for purposes of the tax credit, see our article.)

The interactive tax credit estimator assesses an employer's eligibility for the tax credit and estimates the amount of the credit based on information about tax-exempt status, number of full-time employees, part-time employee hours, total employee wages, total premiums, and employer contributions to premiums. The SHOP FTE employee calculator assesses whether an employer qualifies for the SHOP Exchange by counting the number of FTE employees based on the number of full-time employees and the hours worked by part-time employees.

EBIA Comment: Employers are cautioned that the results derived from these tools are only estimates. This is good advice considering, for instance, an apparent discrepancy between the SHOP FTE employee calculator-which allows the user to estimate the number of FTE employees based on part-time employee hours worked per week, month, or year-and the regulations, which follow the employer shared responsibility rules for calculating FTE employees (i.e., monthly determinations, with 120 hours equating to one FTE employee, that are summed and then divided by 12 to obtain the average for the year). The calculator also cautions that some state-based SHOP Exchanges count SHOP FTE employees differently. For more information, see EBIA's Health Care Reform manual at Sections XXI.D ("Small Business Health Option Program (SHOP)"), XXVI ("Small Business Health Care Tax Credit"), and XXVIII.B ("Large Employers Are Potentially Subject to an Assessable Payment (Penalty Tax)").

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CMS has posted an FAQ clarifying how an individual's COBRA coverage affects his or her eligibility to enroll in an Exchange and receive premium tax credits. As background, an Exchange generally must offer individuals an opportunity to enroll during an annual open enrollment period and during special enrollment

periods triggered by certain specified events. For example, an individual has a special enrollment period if he or she loses minimum essential coverage; acquires a new dependent through marriage, birth, adoption, or placement for adoption; or experiences a change in eligibility for premium tax credits.

The FAQ confirms that, during an Exchange's open enrollment period, an individual can voluntarily drop COBRA coverage in favor of coverage through the Exchange, even if the COBRA coverage has not expired. In this case, an individual also may be determined eligible for premium tax credits. Outside of open enrollment, an individual whose COBRA coverage expires will qualify for a special enrollment period and may also be eligible for a credit. But an individual who voluntarily drops coverage outside of the Exchange's open enrollment period will not qualify for a special enrollment period.

EBIA Comment: Based on this FAQ, it would appear that a qualified beneficiary who elects COBRA will generally be able to enroll in an Exchange only during the Exchange's annual open enrollment period or upon expiration of the COBRA maximum period of coverage. This seems consistent with final Exchange regulations, which provide that an individual who chooses to drop COBRA coverage during the year (e.g., by not paying COBRA premiums) would not be eligible to enroll in Exchange coverage based on a special enrollment period resulting from a loss of minimum essential coverage. We wonder, however, if certain qualified beneficiaries might still be eligible for a special enrollment period on another basis. For instance, a special enrollment period is triggered if an individual becomes newly eligible for premium tax credits. Former employees who elect COBRA are not eligible for premium tax credits during the months in which they are enrolled in COBRA coverage. But a former employee who voluntarily drops COBRA will no longer be disqualified from eligibility on that basis, and-if otherwise eligible-might be entitled to special enrollment based on being newly eligible for a premium tax credit. For more information, see EBIA's COBRA manual at Sections III.G.12 ("Effect of COBRA Coverage on Eligibility for Premium Tax Credits on the Exchange") and III.G.13 ("Special Enrollment in an Exchange for Qualified Beneficiaries"). See also EBIA's Health Care Reform manual at Sections XXI.A.4 ("Initial, Annual, and Special Enrollment Periods Required for Exchanges") and XXIX.F ("Premium Tax Credits for Lower-Income Individuals").

Contributing Editors: EBIA Staff.

How Do We Prepare a Plan Document for Our Self-Insured Health Plan?

Topic(s): Self-Insured Health Plans; ERISA Compliance for Health & Welfare Plans

QUESTION: We are changing our company's group health plan from insured to self-insured. Do we need to create a plan document, or can we use a document that our TPA gives us?

ANSWER: Your company, as the plan sponsor, is responsible for the content and formal adoption of the ERISA-required written plan document. While this is true whether the plan is insured or self-insured, these

responsibilities often take on more significance with a self-insured health plan because the employer is financially responsible for paying benefits and generally has a greater role in plan administration. As indicated by your question, there are two general approaches to plan documentation for a self-insured health plan: drafting a single document that comprehensively sets forth the plan's provisions; or using a document prepared by the plan's TPA, perhaps in combination with a customized supplement that sets forth important elements not covered by the TPA's document. (The customized portion could also incorporate other health and welfare benefits-insured or self-insured-that your company offers.) In either case, it is important to work closely with the plan's TPA to understand the TPA's procedures and ensure that the plan's provisions will be administered as intended.

Deciding which approach to take involves many considerations, including the following:

- *Design flexibility.* The company may wish to take advantage of the significant discretion in plan design that is afforded to self-insured group health plans subject to ERISA. Because ERISA preempts (supersedes) state law, the plan (unlike insured plans) is not required to comply with state laws requiring certain benefit coverage. For example, you may want to exclude some services that were covered when the plan was insured, or narrow the definition of eligible beneficiaries (keeping in mind, of course, that the plan must comply with federal law). Alternatively, you may decide for employee-relations reasons to keep the prior provisions in place.
- *Administrative and financial considerations.* A plan design that adheres to one of the TPA's standard offerings may result in lower administrative fees than a design that requires specialized administration (in addition to saving the expense of drafting an entirely customized document). Presumably, the TPA's plan document accurately reflects the TPA's administrative practices. But you should adopt the TPA's document only after independently reviewing and understanding all of its provisions. And, as noted above, if the TPA's document does not address all aspects of the plan-for example, eligibility criteria-you will need to supplement it. Also, if the company purchases stop-loss insurance, you will want to align the plan document provisions as closely as possible with the stop-loss policy, since any gaps create potential financial exposure for the company.

Under either approach, experienced benefits counsel-internal or external-should be engaged as part of the plan document process. It is the plan sponsor, rather than the TPA, that will be legally responsible if the plan does not comply with legal requirements. In addition, there are instances where having particular language in your plan document, although not legally required, can make a crucial difference when enforcing plan provisions in court-for example, when defending a claim denial or enforcing the plan's subrogation and reimbursement rights. The new document also needs to be formally adopted in accordance with your current plan document's amendment provisions, including any applicable procedures or delegations of authority. Be sure that the plan's procedures are followed-faulty adoption could diminish the plan's ability to enforce plan provisions in court.

For more information, see EBIA's Self-Insured Health Plans manual at Sections III.F ("The Self-Insured Health Plan Team: Roles and Responsibilities"), VIII.F ("Plan Governance for Self-Insured Health Plans")

and IX ("Written Plan Document"); see also EBIA's ERISA Compliance manual at Section VIII ("Plan Design and the Written Document Requirement").

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