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BENEFIT ADMINISTRATION

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In...



The Working Families Tax Relief Act of 2004 will make several changes affecting benefit plans.

These include extending the sunset date of the Archer Medical Savings Account (MSA) program from December 31, 2003 to December 31, 2005 and extending through December 31, 2005 ERISA mental health parity requirements. The Mental Health Parity Act prohibits group health plans from providing lower annual or lifetime limits for mental health benefits than for medical or surgical benefits. The Act was originally scheduled to expire on December 31, 2004.



The House passed a bill that would extend employer-provided health insurance eligibility for reservists covered by the Uniformed Services Employment and Re-employment Rights Act (USERRA).

If the bill becomes law, reservists covered by USERRA would remain eligible for employer-provided health coverage for 24 months, up from 18 months. The bill, HR 4658, awaited Senate action at press time. Currently, USERRA requires health plans to allow eligible servicepeople the option to continue coverage for 18 months or the period of service, whichever is less. If the leave is 30 days or fewer, the employer must pay premiums, but employers can require employees to pay up to 102 percent of the premium for leaves lasting more than 30 days.

## COBRA Notice Changes

In June, the U.S. Department of Labor (DOL) published final regulations that outlined the requirements for health plans to send COBRA notices to health plan participants and qualified beneficiaries. The new notice regulations apply to plan years beginning on or after November 26, 2004.

### What do the regulations mean for employers?

COBRA, the Consolidated Omnibus Budget Reconciliation Act, contains "continuation coverage" provisions. These require group health plans to offer participants and their qualified dependents the opportunity to continue coverage under the plan at group rates for a limited time if they lose coverage due to certain "qualifying events." (COBRA generally does not apply to employers with fewer than 20 employees.)

Health plans must provide beneficiaries and their spouses notice of their COBRA rights at two times: when coverage under the plan begins and whenever an employee, spouse or dependent loses coverage due to a "qualifying event."

Initial notices: The new regulations require plans to provide this initial notice within 90 days after coverage begins. Employers can include this notice within the health plan's summary plan description (SPD), which all covered employees receive. But this might not be adequate notice for spouses, since most employers do not mail the SPD, but rather provide it to the employee at the work site. To protect themselves, employers should mail this notice to the employee's last known address.

This notice must also contain certain information describing COBRA benefits and the beneficiary's responsibilities; for a model notice, please see [www.dol.gov/ebsa/modelgeneral-notice.doc](http://www.dol.gov/ebsa/modelgeneral-notice.doc)



EMPLOYEE  
BENEFITS  
REPORT

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# Cut Costs by Cracking Down on Fraud

Industry experts estimate that health care fraud costs Americans more than \$100 million—per day. And employers like you, who pay for health insurance, are footing most of this bill. Now that we have your attention, this article will provide some information about what health care fraud looks like and some tips on what you, as an employer, can do about it.

Fraud can occur at any point in the health care system, but fraudulent claims have the most direct effect on employers. Health claim fraud can take the form of provider fraud or claimant fraud. Provider fraud and patient fraud are the two types of fraud easiest for employers to detect.

## Types of provider fraud

Sometimes, doctors commit fraud with good intentions—according to a report in *Business Insurance* magazine, “more than 70 percent of doctors admit to lying for their patients to obtain coverage.” For example, if a doctor provides a treatment that isn’t covered by the patient’s insurance, he or she might submit a claim for a similar, but covered, treatment. Although the doctor isn’t directly profiting from this type of fraud (if you assume the patient would obtain treatment anyway), it still hurts employers by driving up insurance costs. Some doctors also waive copayments and deductibles for their insured patients—which defeats the purpose of these cost-control features.

Less honest doctors and providers will charge insured patients more than uninsured patients for the same treatment—and say that the higher fee is their “usual and customary” fee. Others will sometimes provide “phantom treatments” and bill your insurer for treatments, tests or equipment the patient never received or double-bill for the same treatment, in the hope that the insurer won’t discover the duplication. Other shady practices include “upcoding,” or charging for a more complicated procedure than the one performed (for example, charging for a comprehensive exam instead of a brief office visit) or billing for a doctor’s services when the patient saw a lower-paid provider, such as a nurse or physician’s assistant. And some doctors receive kickbacks for referring their patients to other providers, such as to laboratories or other providers.

## Patients not off the hook, either

Patients can sometimes have a hand in fraud. Some knowingly participate in providers’ shady schemes. Others defraud the health insur-



Although the Health Insurance Portability and Accountability Act made health care fraud a federal crime, some experts say that two of the law’s titles might make fraud easier. The patient privacy protections might make it more difficult to detect fraud. The administrative simplification provisions, which require covered providers and payers to use a “standard form” when conducting electronic transactions between themselves, might make it easier for hackers and other unauthorized persons to obtain information.

ance systems in other ways—by sharing their health insurance cards and prescription benefit cards or by adding non-family members to a policy. Employers can spot this type of fraud by conducting an “eligibility audit,” where they review their benefit rolls for ineligible spouses, dependents and retirees. Only about 17 percent of employers conducted eligibility audits in 2003, according to a poll by the National Business Group on Health.

However, larger employers that have conducted audits find that they cut benefit rolls by 10 percent or more, according to an article in *Business Insurance* magazine. For example, Ford Motor Company has removed 50,000 ineligible dependents from its benefit rolls since January 2000, which amounts to nearly 10 percent of its 560,000 plan members.

Things to look for in an eligibility audit include divorced spouses, children who have left full-time education or children who have reached the plan’s dependent cut-off age.

Although mounting a large-scale fraud detection effort is beyond the abilities of any but the largest employers, there are things you can do to help prevent and detect health insurance fraud. They include:

1 Verify that information provided by employees is correct, including dependent status and birth dates.

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# Enhance Executive Pensions with Nonqualified Retirement Plans

Employers who want to reward key executives often use nonqualified retirement plans to supplement their pension packages. This has become an increasingly desirable way of rewarding highly paid employees since the Omnibus Budget Reconciliation Act of 1993 (OBRA) imposed a \$150,000 compensation cap for calculating allowable contributions to employees' qualified retirement plans, even if their salary levels are higher than \$150,000. (Today, that cap is \$200,000.)

When OBRA took effect on January 1, 1994, analysts estimated that the cap figure (reduced from \$235,840), could cause as much as a 40 percent retirement income loss for highly paid employees. Since the average plan targets replacing 35 percent to 55 percent of an executive's income level, depending on the age and length of service at retirement, more than 70 percent of employers have adopted nonqualified plans to make up differences in lost employee retirement income caused by OBRA.

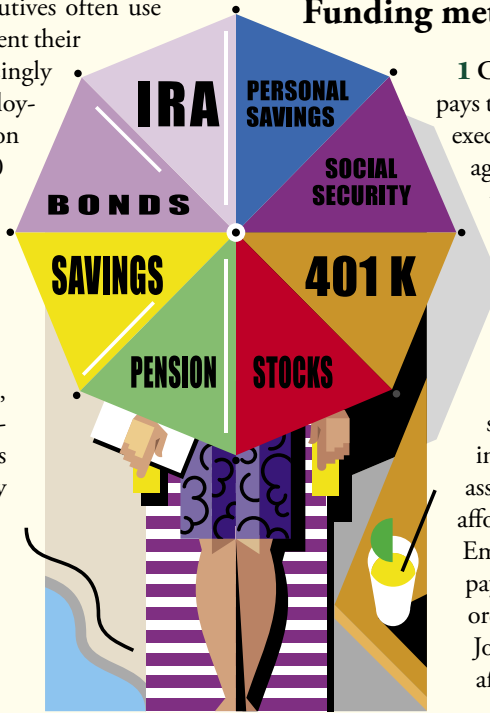
## Employers gain from nonqualified benefit plans, too

Nonqualified plans are much less regulated than qualified plans, although they must meet ERISA's definition of "unfunded," which limits how employers can fund or secure them.

There are no IRS approval or vesting requirements and employers have no fiduciary responsibility. There are few reporting requirements, which reduces administrative burden. Employers can also vary benefits for different employees, suspend or discontinue contributions and choose plan participants. Many investment vehicles benefit the employer throughout the life of covered employees, building tax-free assets and generating fresh cash flow that can be used to fund other employee benefit plans or finance other risk management objectives.

Nonqualified retirement funding options carry more employee risk than qualified plans do. Although there is no limit on employer contributions, they are not insured by the Pension Benefit Guaranty Corp. If a company fails or is taken over in a merger or hostile buyout, executives could find themselves among unsecured creditors, or see their plan contributions discontinued. However, there are several funding vehicles that provide some security for employees' pension assets.

## Funding methods that enhance plan security



**1 Corporate-owned life insurance (COLI):** The company pays tax-deductible premiums on life insurance policies for executives, is usually named beneficiary and can borrow against the cash value of the policy (which builds up tax-free during the employee's life). Companies can use proceeds to pay out death and other retirement benefits, or to fund other programs. Death benefits are received by the company tax free.

**2 Rabbi trusts:** Rabbi trusts are a type of grantor trust that holds assets for a nonqualified executive benefit plan. Executives can defer compensation into these trusts, using corporate-owned life insurance as the funding vehicle. A rabbi trust protects assets from hostile acquiring companies, although they afford no protection from creditors in case of bankruptcy. Employers take tax deductions only at time of benefits payout and pay taxes on earnings. The executive pays ordinary income taxes after distribution. The American Jobs Creation Act of 2004, recently signed into law, affirms the legality of these plans.

**3 Executive-owned life insurance:** The executive

*“When OBRA took effect on January 1, 1994, analysts estimated that the cap figure...could cause as much as a 40 percent retirement income loss for highly paid employees.”*

purchases a policy on his or her own life. The employer pays premiums, which are tax deductible to the employer as compensation. The executive pays taxes on the premiums, but these are generally offset by increases in the policy's cash value. After the executive retires, he or she can borrow against or withdraw the policy's cash value or use it as tax-free retirement income. The beneficiary receives death benefits tax-free if the executive dies.

**4 Secular trusts:** Assets are invested in a trust, which provides complete security to the employee. The tradeoff is that the executive must pay taxes on both employer contributions and investment income. The employer can take deductions for its contributions. These plans are subject to ERISA reporting, disclosure and fiduciary requirements.

**5 Annuities:** Purchased by the employer and owned by the executive, these assets are protected in case of bankruptcy. The employer can deduct payments, but the executive pays tax on the employer's contribution. Earnings are not taxed until distribution.

For more information on nonqualified retirement plans, please call us. ☐



### Consumers are interested in health savings accounts (HSAs) but not sure about high-deductible health plans (HDHPs).

In a survey by health insurer CIGNA, more than two-thirds (67 percent) of respondents said they were “at least somewhat” interested in an HSA. Features that appealed to a large majority (79 percent or more) included portability, the ability to invest the money in the account, and the ability to use the account for post-retirement health care. However, nearly half (48 percent) of respondents expressed doubts about enrolling in the HDHPs that are required for HSA participation, saying they’d prefer a more expensive health plan with lower deductibles, paid for by payroll deduction.



### Expect double-digit rate increases for benefit plans in 2005—however, increases will be lower than in 2004, according to a recent study by Segal, a consulting firm.

For medical plans, the study projects the highest rate of increase for indemnity

plans, at 14.4 percent, and the lowest for health maintenance organizations (HMOs), at 11.8 percent. Standalone prescription drug coverage will increase 15.2 percent for retail plans; 15.5 percent for mail order plans. This compares to cost increases of 18.1 percent and 17.4 percent, respectively, for drug coverage in 2004. Please note that these figures are nationwide averages; premiums for a specific group can vary greatly by region, size of group and other factors.



### California employers must provide benefits to registered domestic partners, to the extent that they provide spousal benefits.

The bill, AB 2208, goes into effect on January 1, 2005 for health insurance policies, and January 2, 2005 for HMOs. It does not affect self-insured plans, which are exempted by the federal Employment Retirement Income Security Act (ERISA) or to COBRA benefits, nor does it expand COBRA continuation rights under federal law.

*FRAUD* – continued from Page 2

**2** Learn about the warning signs of fraudulent claims and train your in-house benefits administrator to recognize them. These include “clusters” of unusual or costly claims coming from the same provider, claims for untested or untried procedures, overutilization of drugs or services by patients, claims for dependents or spouses whose names you do not recognize. If you contract with an outside vendor for claims administration services, let them know how important cracking down on fraud is to you.

**3** Communicate with your employees about fraud. Tell them the company will not tolerate fraud.

**4** Promote employees’ awareness of fraudulent practices. Health claim fraud can have serious health consequences for your employees, particularly if unscrupulous physicians prescribe unnecessary treatments or surgeries. Your employees can serve as frontline fraud detectors. When obtaining medical services from a new provider, they should check the provider’s credentials and background—does he or she have a degree from an accredited institution and the appropriate licenses? Do the local Better Business Bureau, your state’s attorney general’s office or board of medical examiners have any complaints against the provider? Insureds should also check their copy of the bill to make sure it accurately reflects the services received.

**5** Find out where to report suspected fraud, and give that information to your employees. Most insurers have special investigative units (SIUs) to investigate suspected fraud. The FBI also has a Health Care Fraud Unit, which tends to focus on large-scale fraud with national impact. According to a recent article in *Employee Benefit News*, the unit “actually classified health care fraud as the No. 1 white-collar crime for many years until corporate fraud overtook it in 2002.”

**6** Encourage employees to report suspected fraud by creating a work atmosphere in which honesty and integrity are rewarded.

For more information on controlling health care claims costs, please contact us. □



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*COBRA* – continued from Page 2

Continuation notices: After a beneficiary experiences a “qualifying event,” the employer has 30 days to notify the plan administrator, which will send a continuation notice within 14 days. (The 30-day notice does not apply to multi-employer plans where the administrator determines whether a qualifying event has occurred.) This continuation notice informs the beneficiary of his or her right to continue group coverage under COBRA. Qualifying events include the employee’s death, termination, reduced hours of employment or entitlement to Medicare. In the case of a spouse or dependent, a qualifying event can also include divorce, legal separation or the child ceasing to be covered as a dependent under the plan’s rules. Like the initial notice, the continuation notice must contain certain information; the DOL provides a model notice at [www.dol.gov/ebsa/modelgeneralnotice.doc](http://www.dol.gov/ebsa/modelgeneralnotice.doc).

Your plan must also develop “reasonable procedures” for employees and their dependents to follow when notifying the plan administrator of certain qualifying events, such as divorce or legal separation, or when a dependent child loses eligibility for coverage. Your plan documents should describe how qualified beneficiaries must give notice, who should receive notices and what the notices should contain.

## Employee responsibilities

Employees also have responsibilities under the new regulations. Currently, employees and their family members must inform the plan administrator of a divorce, legal separation or a dependent child losing eligibility for coverage within 60 days after the event occurs. If you are enrolled in a multi-employer health plan, your insurer will likely provide compliance assistance and notices tailored to your company’s health plan.

For more information on COBRA, the Department of Labor offers a list of FAQs (frequently asked questions) at [www.dol.gov/ebsa/FAQs/faq\\_compliance\\_cobra.html](http://www.dol.gov/ebsa/FAQs/faq_compliance_cobra.html) □

Correction: Our June 2004 issue contained an error in the article “HSA Update.” It said, “HIPAA does not apply to group health plans with fewer than 50 participants.” Small health plans had to comply with the HIPAA privacy provisions as of April 14, 2004. We regret the error.