Summer, 2003 **Volume 8.1**

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The PBG "Benefits Corner"

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LEGISLATIVE UPDATE . .

THE HIPAA PRIVACY REGULATIONS - A LOOK INSIDE

There has been much confusion on the issue of compliance with the April 14, 2003 deadline for the Health Insurance Portability and Accountability Act Privacy Regulations. Much of this can be attributed to the misinformation or lack of information circulated by both the insurance carrier and brokerage community. Many competitive brokers are using "non compliance" scare tactics as a means of a door opener with employers. In an effort to try to clear up some confusion, following is an overview of the regulations for your review.

Effective April 14, 2003, the HIPAA Privacy Regulations were established for several reasons:

- Give patients control over how their personal health information is used.
- Establish limits on the use and release of health records and information.
- Set safeguards that healthcare providers, health plans and other entities must implement to protect the privacy of that information.
- Hold violators accountable with civil and criminal penalties.

WHO IS A COVERED ENTITY?

- Health Plans
- Health Clearinghouses
- Healthcare providers who conduct certain financial and administrative transactions electronically.

WHAT MUST A COVERED ENTITY DO?

- Notify patients of their privacy rights and how their private health information may be used.
- Adopt and implement privacy procedures for its operation.
- Train employees to understand the privacy procedures
- Designate individuals to oversee privacy procedures.
- Secure patient records containing private health information so that such records are not readily available to those persons who do not need access to them.

The intent of the regulation was to ease the burden of compliance with the new privacy rules by allowing flexibility for each covered entity to establish privacy procedures tailored to fit their particular size and needs. This law is not applicable to employer groups with less than 50 participants and compliance with the law is not mandatory until April 14, 2004 for groups with less than 5 million dollars in total premiums. Most carriers have it in place already. The "HIPAA" does not pertain to life or disability policies but does include dental, vision, long term care and medical health programs.

The following information was provided to Preferred Benefits Group, Inc. by Kevin O'Connor, ESQ of Lum, Danzis, Drasco, Positan, LLC. You can feel free to contact him directly at 973-228-6760 with any additional questions you might have on the HIPAA law and how it affects your company.

HIPAA Q & A - Where to look?

HIPAAdvisory.com – offers a variety of HIPAA related news articles, industry surveys, etc. You may also register to participate in various HIPAA forums.

HIPAAcomply.com – provides a variety of HIPAA security and privacy compliance information. You may also participate in forums to share and gather information among peers.

SAMPLE OF A "HIPAA"

⇒ AUTHORIZATION FORM ⇐

ALL INSURANCE CARRIERS ARE NOW REQUIRING ALL EMPLOYEES AND/OR DEPENDENTS TO COMPLETE THEIR AUTHORIZATION FORM WHEN SOMEONE OTHER THEN THEMSELVES ARE CALLING ON A QUESTION OR CLAIM ISSUE. INSIDE THIS NEWSLETTER IS A SAMPLE ONLY. EACH CARRIER HAS THEIR OWN FORM WHICH MUST BE COMPLETED BEFORE ANY CALLS ARE MADE. PLEASE FEEL FREE TO CALL OUR OFFICE WITH ANY QUESTIONS.

HIGHLIGHTS

"Accuracy builds credibility"

- jim rohn

DID YOU KNOW...

. . . 40% of US retirees state that their only source of retirement income is social security – according to a study by Employee Benefits Research Institute.

. . . According to Forrester Research 1 in 4 large employer plans to introduce a consumer driven health plan in 2004.

. . . According to the 2002 Drug Trend Report from Medco Health Solutions spending on prescription drugs for children through age 19 increased 28% last year. By comparison, spending rose 23% for those between 35 and 49 and increased less than 10% for individuals over age 65.

INVITRO COVERAGE MANDATED IN THE STATE OF NEW YORK

On September 1, 2002, New York State enacted a law that mandates carriers to provide coverage pertaining to the diagnosis and medical/surgical treatment of infertility on all group sizes renewing on or after 9/1/02. Carriers are also obligated to provide coverage for infertility prescription drugs as long as the group has purchased outpatient prescription drug as part of their plan.

The PBG Benefits Corner is a publication intended for the clients of Preferred Benefits Group, Inc. and other interested persons. It is designed to keep its readers generally informed about developments in the company and its areas of practice and should not be construed as legal, financial, or medical advice concerning any specific factual situation.

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LOOMING LEGISLATION

Two bills are currently in the proposal state in the NJ legislature but are worth watching. The first bill sponsored by John O. Bennett would extend NJ State Continuation (currently 12 month maximum for a qualifying event) to the same time frames as the Federal Cobra Law that is 18 months for an employee who has a qualifying event. This would also match the Cobra provision of qualified dependents having their own set of rights and time frames, which is not the case with the current NJ State Continuation law.

The second bill is in response to the physician malpractice insurance issue in New Jersey. Part of the compromise suggested includes $300,000 cap on jury awards for medical malpractice, with jury awards exceeding cap to be paid through a fund. The fund would be financed by a $2 to $3 surtax on all health insurance policies. All annual license renewal fees will increase $15 for healthcare professionals, lawyers and accountants. This fund is expected to raise an estimated $17 to $25 million per year.

Preferred Benefits Group Inc. will continue to keep you abreast of upcoming decisions on these new bills.

• • SPOTLIGHT ON • •
Defined Contribution (DC) Plans

A term that has been frequently mentioned as a new way of controlling health care costs is the Defined Contribution Plans. These plans are currently being offered by several carriers including Aetna, Cigna, United Healthcare, Lumenos, Destiny and Health markets. These plans include employer funded cash accounts, ranging from a few hundred dollars to several thousand dollars, from which participants make withdrawals to pay for medical care. After depleting the account, the employee pays out of pocket until a deductible is reached. Here are some important questions to consider in deciding if a plan is right for you.

1. What is the gap between the cash account and the deductible?
2. How can you use the cash account? (i.e. acupuncture, glasses, etc.)
3. Find out if your company caps the amount you can have in your cash account after carrying over balances from year to year.
4. How much do you expect to spend on healthcare including prescription drugs?
5. What is the worst case out of pocket if hit with a major illness?
6. Are you willing to be aggressive about reducing health care costs?
7. What happens to the cash account if you leave your job?
8. What happens to the cash account if you retire? The IRS permits the use of accounts for healthcare during retirement.

UP CLOSE... ...AND PERSONAL

Congratulations to:

New Parents Club

Ward Sanders on the birth of his son.

Christine Berringer-Jones on the birth of her son.

Thomas Fletcher on the birth of his son.

Richard Picardo on the birth of his daughter.

Rhrett Thurman on the birth of his son.

Theresa Tonis on the birth of her twins!

There is only one boss. The client. He/she can fire everyone in the company from the chairman on down, simply by spending his/her money elsewhere . . . . Sam Walton

COME VISIT US AT WWW.PBGROUP.COM

AUTHORIZATION FOR USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION (PHI)
This form will allow CARRIER, its agents or subsidiaries to release the private health information specified below to the persons or entities specified on this form.

SAMPLE ONLY

Description of Private Health Information to be released:

CLAIM INFORMATION

VERIFICATION

Identification of person authorizing release: (the following information is needed for verification. Please complete all sections)

Name of Member/Participant:	**JANE DOE**
Date of Birth	**7/1/56**
Social Security Number:	**123-45-6789**
Address: (including zip/code)	**123 ROCKY ROAD** **ANYWAY, NJ 12345**

Member ID number (if applicable)	**N/A**	Group or Account No:	**450294**
Subscriber Name (if different from member)		**JOHN DOE**	
Subscriber's relationship to member		HUSBAND	
Subscriber's Employer Name:		ABC COMPANY	
Subscriber's social security Number		987-65-4321	
Subscriber's date of birth		8/5/54	

Check if disclosure shall include information relating to:

( ) Acquired Immunodeficieny Syndrome (AIDS)
( ) Behavioral Health Services/Psychiatric Care
( ) Treatment of alcohol and/or drug abuse

If boxes are not checked, no such information shall be released.

This information is to be disclosed to **SUSAN PHELAN AND DIANE RAFFONI of PREFERRED BENEFITS GROUP** for the purpose of **CHECK ON CLAIM ISSUE FOR DR. SMITH ON MY HUSBAND JOHN DOE FOR DATE OF SERVICE 5/21/03 IN THE AMOUNT OF $2,500.**

Unless otherwise revoked, this authorization shall become effective immediately and shall remain in effect until **JANUARY 1, 2004.**

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance to this authorization.

Additional Copy. I understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: Yes ___ No ____ Member initials ___

CARRIER, their employees and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent and authorized herein.

Signed: _____

Member		Date
Or legal representative	Relationship to Member	Date
Signature of Witness	Relationship to Member	Date

ADVANCED RENEWAL NOTICE NEW JERSEY LEGISLATION

Enactment of P.L.2003, Ch. 27 Requiring Notification by Insurers to Employers With Regard to Health Benefit Plans passed March 10, 2003

The State of New Jersey recently passed legislation, which requires medical insurance carriers to provide a minimum of sixty(60) days notice to an employer of a rate action. Employers will be required to notify their employees (and continuation employees) at least 30 days in advance of any termination of benefits. In case of a change in their benefits plan, the employer shall immediately notify its employee in writing of the change upon receipt of the employer notification from the health insurer that its employees will be covered by the new plan.

This will be effect for plans renewing on or after 7/8/03. You can find out more information on this through the website www.njleg.state.nj.us or your Benefit Consultant at Preferred Benefits Group.

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