UNDERSTANDING EMPLOYEE BENEFIT LAWS

by

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Table of Contents

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I. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 § 510

A. Coverage

Section 510 of The Employee Retirement Income Security Act, or "ERISA," of 1974 (29 U.S.C. § 1140) was passed into law in order to protect employees and their dependents with statutory protection regarding their accrual and use of benefits governed by ERISA. (ERISA basically governs pension or retirement plans and welfare benefit plans, such as health insurance, dental and so on.) Specifically, § 510 makes it unlawful:

> "... for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, [or] this title ... or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan, [or] this title ..."

Section 510 of ERISA therefore contains two separate types of protections:

An Anti-Retaliation Provision and an Employment Protection Provision.

B. Anti-Retaliation Provision

The Anti-Retaliation Provision of § 510 of ERISA is very straightforward: it prohibits employers from taking any type of retaliatory actions against an employee or the employee's dependents or beneficiaries for exercising their rights to secure benefits under an employer sponsored plan regulated by ERISA.

For instance, consider the example of an employee who is denied benefits under his employer's health insurance plan and then sues the employer to recover those denied benefits. If the employer takes any type of retaliatory action against the employee at all for pursuing this claim, such as by transferring the employee to an undesirable job or possibly even terminating the employee, then the employee

would have a cause of action against the employer under the Anti-Retaliation Provision of § 510 of ERISA.

C. Employment Protection Provision

The Employment Protection Provision of § 510 of ERISA prohibits employers from discriminating against their employees for the purpose of interfering with the attainment of their rights under any ERISA governed plan. (i.e., health plans, pension plans, etc.) The primary purpose of this provision of § 510 was to protect those employees who have given many years of faithful service to their employers from being terminated in order to prevent them from earning, or becoming "vested," in any benefit plan regulated under ERISA.

Further, this provision also prohibits employers from taking any adverse actions against those employees who have already vested in an ERISA governed benefit plan for the purpose of preventing that employee's benefits from accruing even further.

For instance, if an employee is about to fully vest in the employer's pension or retiree health plan, and the employer terminates the employee in order to prevent that individual from obtaining this benefit, then the employer has violated the Employment Protection Provision of § 510 of ERISA. The same would be true if the employee had already become vested in these plans and the employer terminates the employee in order to prevent him from accruing even more benefits.

D. Damages

ERISA permits aggrieved employees to file civil actions against an employer who has violated its provisions. Employees are entitled to recover their lost benefits and any "other appropriate equitable relief," which may include reinstatement, lost wages and so on.

II. MENTAL HEALTH PARITY ACT Of 1996 (29 U.S.C. § 1185a)

The Mental Health Parity Act of 1996, or the “MHPA,” was passed in an effort to amend HIPAA. The MHPA became effective as of January 1, 1998.

The MHPA basically requires plan sponsors of more than 50 plan participants that choose to offer mental health benefits as part of their health plans to provide the same level of coverage in their aggregate and annual limits for mental health benefits as are provided for physical conditions. However, if adding such benefits raises the cost of a plan at least one percent, then the plan would be exempt from having to comply.

Also, the provisions of the MHPA do not apply to benefits relating to chemical dependency or substance abuse.

III. NEWBORNS' AND MOTHERS' HEALTH PROTECTIONS ACT

If a group health plan, insurance company or HMO chooses to provide insurance coverage for a hospital stay in connection with childbirth, the plan must provide for at least 48 hours of hospital care for mothers after have a normal childbirth and a minimum of 96 hours after giving birth by cesarean section.

IV. HEALTH INSURANCE UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

A. Purpose

The Health Insurance Portability and Accountability Act of 1996, or "HIPAA," (H.R. 3103) was passed primarily for the purpose of allowing employees who have preexisting medical conditions, and their dependents, (from hereon referred to as plan "participants") to change jobs and to be able to secure health insurance coverage from their next employer without restrictions and to prohibit discrimination based on an individual's health status.

Therefore, HIPAA directly governs the issue of the portability of health insurance and health insurance eligibility. HIPAA also addresses such issues as long-term care, the deductibility of medical expenses for the self-employed, Medical Savings Accounts, and so on.

B. Portability And Pre-Existing Medical Conditions

HIPAA prohibits group health insurers and employers (from hereon referred to as "plan sponsors") from placing any preexisting medical condition limitations or exclusions on plan participants that exceed 12 months in duration if these participants enroll in their employer's health insurance plan when they first become eligible. Such preexisting conditions may only be imposed where the plan participant has received medical advice, a diagnosis, care or treatment for a condition within the six-month period before the individual's enrollment date. If a preexisting condition is imposed in addition to a waiting period, the two time periods will run concurrently.

Plan sponsors are permitted to place up to an 18-month pre-existing medical condition restriction on those plan participants who do not enroll in their employer's health plan when they are first eligible. Such individuals are referred to as "late enrollees."

On the other hand, preexisting condition limitation periods may not be imposed against newborns, an adopted child under the age of 18, or a child under the age of 18 who is placed for adoption, as long as the individual enrolls in the health plan within 30 days of the birth, adoption or placement for adoption, and provided the child has not incurred a subsequent break in coverage of 63 days or more. Preexisting conditions also may not be applied to pregnancies, regardless of

whether or not the woman had prior coverage.

However, if plan participants enroll in their employer's health plan when they are first eligible to receive coverage, the plan sponsor is required to reduce any preexisting medical condition exclusions that would have been placed upon these individuals by one month for every month of continuous coverage these participants can show that they previously carried under another creditable health insurance plan. This is customarily accomplished by the plan participant presenting a certificate a creditable coverage to the employer, which shows the number of months of creditable coverage the participants have accumulated.

Consequently, if a person has had at least 12 months of prior continuous coverage under a creditable plan, then no pre-existing conditions may be imposed on the plan participant or on any of his eligible dependents.

Under the "standard" method of crediting past coverage, a plan participant's prior health insurance coverage will not be viewed as having been "continuous" if the he has had a break in coverage of 63 days or more. If a plan participant has had such a lapse in coverage, then the health insurance coverage the plan participant had in place before this lapse occurred need not be credited against HIPAA's 12-month pre-existing coverage exclusion cap. Waiting periods for health insurance coverage are not considered breaks in coverage.

A plan sponsor may also elect to use the "alternative" method for crediting prior coverage to its plan participants. Under the alternative method, the plan sponsor first determines the number of months of creditable coverage plan participants have accumulated for any of the five following categories of benefits:

1. Mental health,

2. Substance abuse treatment,

3. Prescription drugs,

4. Dental care and

5. Vision care.

The plan sponsor then looks to each of these five categories of benefit coverage to determine if the plan participants have accumulated the 12 months of previous creditable coverage required to eliminate any preexisting condition exclusion. The standard method of granting creditable coverage is then used for all other benefits not included in these five categories.

For instance, if a plan participant has 12 months of creditable coverage, but only 6 months of previous coverage for vision care, then the plan sponsor may impose a six-month preexisting condition limitation for up to 6 months.

Within a reasonable period of time after being presented with a proper certificate or other information relating to an individual's creditable coverage, a plan sponsor must determine how many months of creditable coverage the plan participants have accumulated under another qualified plan.

The plan sponsor must then give notice to the participants within a "reasonable" period of time as to whether or not any preexisting condition exclusion period will apply to the plan participants, and if so, the length of this period. This notice must also tell the plan participants the basis upon which the plan sponsor made its determination, as well as any appeals procedure that may be available.

Health insurance coverage that is considered “creditable” includes coverage under:

1. A group health plan,
2. Individual health coverage,
3. Medicare,
4. Medicaid,
5. Military-sponsored health coverage,
6. Coverage through the Indian Health Service,
7. A state health benefits risk pool,
8. The Federal Participant Health Benefits Program,
9. A public health plan (as defined in the regulations), and
10. Any health benefit plan under § 5(e) of the Peace Corps Act.

An "affiliation period," or waiting period, which is defined as being a period of time in which an individual must wait to become a participant and receive benefits under the plan, irrespective of that person's health status, and is not charged premiums throughout this period, may be imposed upon enrollees.

However, an “affiliation period” may only be imposed if:

1. No preexisting conditions are imposed,
2. If the affiliation period is applied in a uniform manner regardless of an individual’s health status, and
3. If the affiliation period is no longer than two months for individuals who enroll when they are first eligible and no longer than three months for individuals who enroll subsequent to their initial eligibility.

C. Eligibility For Coverage And Premiums

A group health insurance plan may not base an individual's eligibility for coverage on the individual's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. The insurer may impose a preexisting condition exclusion of up to 12 months if the other requisite conditions of this Act are met.

Although HIPAA does not regulate the amount of the premiums, which may be charged to plan participants, plan sponsors are prohibited from charging their participants higher premiums based on their health condition.

D. Certificates Of Prior Coverage

Plan sponsors are required to provide their members with certificates that document their period of creditable health care coverage, their coverage rights under COBRA, and any waiting or affiliation periods under the health care plan, if applicable. Such certificates must be provided upon request, automatically when an individual either loses coverage, when the individual becomes entitled to receive COBRA coverage or otherwise becomes eligible for COBRA. A certificate of creditable coverage must also be provided upon request before an individual loses coverage or within 24 months of losing coverage.

Plan sponsors are therefore required to track plan participants' coverage for the purpose of providing such certificates.

(See sample "Notice of HIPAA and Request for Certificate" and "Certificate of Group Health Plan Coverage" forms at the end of this section.)

E. Medical Privacy Requirements

Penalties under HIPAA may be imposed against those employers who:

1. Require the use of a unique identifier for those with health conditions or

2. Disclose a person's health information to someone else in violation of the law.

(See sample "Permission By Employee To Release Medical Information" and "Acknowledgment of Confidential Information" forms at the end of this section.)

F. Special Enrollment Provisions

Plan Sponsors must make special health insurance enrollment periods available to their employees and dependents, as opposed to waiting until the next regular enrollment season, if:

1. An employee had other health insurance but lost this coverage or

2. If an individual becomes an eligible dependent through marriage, birth, adoption or placement for adoption.

The person requesting enrollment in the employer's plan must do so no later than 30 days after the employee or dependent's qualifying event. Further, special enrollees are not to be treated as late enrollees. Therefore, the maximum preexisting condition exclusion period that may be imposed is 12 months, which is then in turn reduced by the enrollee's previous creditable months of coverage. (Of course, no preexisting condition exclusions may be placed upon a newborn, an adopted child or a child placed for adoption if the child is enrolled within 30 days of birth, adoption or placement for adoption.)

Also, a plan is required to provide a description of its special enrollment rights under HIPAA to anyone who declines coverage.

(See sample "Notice of Rights Under HIPAA Regarding Declination of Coverage Upon Initial Eligibility" form at the end of this section.)

G. Guaranteed Availability And Renewability Of Coverage

If a health insurance issuer offers health insurance coverage to individuals or to small employers, the insurance carrier must accept every small employer who applies for coverage in a timely manner within the state where such coverage is offered. (A "small employer" is defined as employing between 2 and 50 employees in a health plan.)

Further, the issuer of health insurance coverage must renew or continue in force an employer's coverage at its current level at the employer's option. However, an employer's group health insurance coverage may not be renewed or may be discontinued because of nonpayment of premiums, fraud, a violation of participation or contribution rules occurs, the issuer ceases to offer that particular type of coverage, the employer moves outside of the issuer's service area or the employer's membership in an association offering the coverage ends.

H. Disclosure Requirements

HIPAA and other legislation have increased the responsibility placed upon plan sponsors regarding the disclosure requirements for group health plans. Under the new disclosure rules, group health plan sponsors must improve their Summary Plan Descriptions (SPDs) and their Summaries of Material Modifications (SMMs) in four important ways. Group health plan sponsors must now make sure that they:

1. Notify their participants and beneficiaries of any "material reductions in covered services or benefits" within 60 days of making such a change. Such a change would include reducing benefits by increasing the participants' deductibles and co-payments under the plan. In the alternative, plan participants may be provided with a description of the plan at regular intervals of no more than 90 days apart. Previously, group health plan

sponsors could disclose such changes as late as 210 days after the end of the plan year in which the change was adopted.

2. Disclose to participants and beneficiaries information regarding the role the insurer, such as insurance companies and HMOs, plays in their group health plan. Specifically, the participants must be provided with the name and address of the insurer, whether or not and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the insurer, and the nature of any administrative services provided by the issuer, such as the payment of claims.

3. Inform participants and beneficiaries which Department of Labor office they can contact for assistance or information regarding their rights under ERISA and HIPAA.

4. Inform participants and beneficiaries that federal law generally prohibits plan sponsors from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections.

A "material reduction in covered services or benefits" is defined as being any modification to a group health plan or any change in the information that must be included in the Summary Plan Description that, either independently or in conjunction with other modifications or changes, would be considered by the average plan participant to be an important reduction in covered services or benefits under the group health plan. Examples of "material reductions in covered services or benefits" include any modification or change in the plan that:

1. Eliminates or reduces the benefits that are payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for determining the payment of benefits,

2. Increases deductibles, co-payments or any other amounts that are to be paid by a plan participant or beneficiary,

3. Reduces the size of the service area covered by a health maintenance organization, or

4. Places any new conditions or requirements upon participants in order for them to obtain services or benefits under the plan, such as preauthorization requirements.

In satisfying its disclosure obligations, the interim rules provide a "safe harbor" to plan providers who wish to use an electronic medium, such as e-mail, to provide group health plan SPDs, summaries of any "material reductions in covered services or benefits," and any other SMMs. In order to use this "safe harbor" and facilitate such communication by way of an electronic medium, one of the requirements that must be met is that employees must be able to effectively access these documents at their worksites. Plan participants must also have the right to receive such disclosures in writing upon request and free of charge. Currently,

this electronic media "safe harbor" rule is limited only to group health plans.

I. Other Provisions

1. Medical Savings Accounts, or MSAs

A Medical Savings Account, or "MSA," is a trust or custodial account created to pay the qualified medical expenses of employees under a high-deductible health plan. Qualified health expenses of employees may then be paid from this plan. Unlike pre-tax medical expense accounts under § 125C of the IRS Tax Code, the employee does not lose the money placed into an MSA Account if it is not used by the end of the plan year.

The following provisions also apply to MSAs:

a) Contributions to an MSA by individuals are tax deductible, while contributions made by employers are excludable, within limits.

b) The maximum contribution that can be made to an MSA is 65% of the deductible under a "high-deductible plan" for individual coverage and 75% of the deductible for family coverage.

c) A "high-deductible" health plan is defined as having an annual deductible of at least $1,500 but no more than $2,250 for individual coverage and at least $3,000 but no more than $4,500 for family coverage. The maximum out-of-pocket expenses under the plan cannot exceed $3,000 for individuals or $5,500 for family coverage.

d) The use of MSAs is a four-year pilot project beginning for the taxable years after December 31, 1996. Enrollment is limited to the first 750,000 enrollees.

e) MSAs are also limited to employers with fewer than 50 employees.

2. Long-Term Care Insurance Benefits

Benefits received under qualified long-term care insurance plans are nontaxable, up to $175 per day. Benefits are taxable if an employer-sponsored plan is provided through a cafeteria or flexible spending plan. Also, if long-term care insurance premiums do not exceed the following limits, based on the employee's age, they will be treated as medical expenses for the purpose of itemizing deductions:

Age	Limitation on Premiums Paid
40 or less	$ 200
More than 40 but less than 50	$ 375
More than 50, but less than 60	$ 750
More than 60, but less than 70	$2,000
More than 70	$2,500

3. **Penalty-Free Withdrawals From IRAs For Medical Expenses**

Ordinarily, whenever an individual withdraws money from an IRA before reaching the age of 59-1/2, the individual is not only taxed on this withdrawal but a 10% excise tax is also assessed. An exemption to this 10% excise tax exists if the withdrawal is made due to death, disability or if the withdrawal is made in the form of purchasing an annuity.

Previously, no excise tax exemption existed for withdrawals from IRAs if the withdrawal was needed to pay medical expenses, even though such an exemption did exist for tax-qualified employer-sponsored plans. Under HIPAA, this "medical expense" exemption now applies to IRAs the same as it does to employer plans. In order to qualify for this 10% excise tax exemption, the individual's medical expenses must be greater than 7-1/2% of the person's adjusted gross income.

Also, this 10% excise tax does not apply to withdrawals made for medical expenses if the individual has been receiving either federal or state unemployment compensation payments for a minimum of 12 weeks. This withdrawal must also be made in the same year or in the year after these unemployment compensation payments were received.

4. **No Interest Deduction is Allowed for Employer-Owned Life Insurance Policy Loans**

Previously, any interest earned by the policyholder under a life insurance policy owned by the employer were not taxed, nor were any benefits the beneficiaries received upon the policyholder's death. The policyholder could also borrow against the equity accumulated in the life insurance policy without affecting the tax-exempt status of this interest or these benefits.

Under HIPAA, any interest paid or accrued under an employer-owned life insurance policy is now taxable income. However, an exception exists for

such policies that cover up to 20 "key" employees.

HIPAA defines a "key" employee as being either an officer or a 20% owner. Any interest that is either paid or accrued by a key employee on a debt under such a life insurance policy is only deductible up to the interest rate established by Moody's Corporate Bond Yield Average.

V. HIPAA's PRIVACY REGULATIONS

A. Coverage

As of April 14, 2003, the "Privacy Requirements" of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) became effective for many employers. (HIPAA's various standards appear at 45 CFR parts 160 and 164.) While it is true that HIPAA's Privacy Rule does not directly cover employers, an employer who sponsors a group health plan or who has such privacy information regarding its employees in its possession will be affected nonetheless.

B. Which Plans Are Covered And When Are They Covered?

Almost all group health plans are covered. (The only plans that are exempt are those self-insured plans with fewer than 50 participants and are administered **exclusively** by the employer. **ALL** fully insured plans with $5,000,000.00 or more in receipts each year are covered.)

HIPAA's definition of a health plan is broad enough to encompass not only medical plans, but also other benefit plans such as dental, vision, prescription drug plans, employee assistance plans (EAPs) and flexible spending accounts. Unless the plan sponsor chooses to designate them collectively as an "**Organized Health Care Arrangement**," each plan must stand on its own with respect to meeting its HIPAA obligations.

A small plan is one that has annual receipts of $5 million or less. However, small plans should not wait too long before starting their "trek" to compliance. As anyone can see form these materials, complying with HIPAA's Privacy Requirements is not small task … which is why the extension was given.

C. Personal Health Information Defined

Personal Health Information ("PHI") includes medical or mental records or other data that contains any type of health information that identifies the individual that is either stored or transmitted by the organization in any form, such as electrical, paper or oral transmission. Therefore, in order to be classified as PHI, the individual's name need not be included in the information. If a person's Social Security Number or birth date is included with the health information, then the information qualifies as PHI information under HIPAA.

D. Who and What Is Covered By HIPAA?

There are basically three categories of HIPAA coverage:

1. Health Care Providers

2. Health Care Plans

3. Health Care Billing Providers

Therefore, in a **VERY** technical sense, employers are not really covered by HIPAA … their health plans are covered. However, since many employers offer health care coverage to their employees, the employer **may** be required to comply with HIPAA if the employer receives "Personal Health Information" ("PHI") regarding their employees under this plan.

If an employer **NEVER** receives **ANY** claim information that identifies any of the participants' identities in any way, then the employer is not covered under HIPAA.

However, if the employer receives information that identifies the participants in **ANY WAY**, such as by birth date, then this will be classified as PHI under HIPAA. This often happens at renewal. Employers often receive information regarding its most expensive claims for the year and the claimant is identified by birth date.

Therefore, if an employer receives **ANY** PHI information, then the employer must comply with HIPAA.

Additionally, if an employer has on-site medical services, such as with a company nurse, the company is covered by HIPAA as a provider.

E. Where Does HIPAA Hide?

HIPAA tends to "hide" in a few different areas for human resource professionals.

1. **Health Insurance Renewal**

HIPAA usually bites employers at renewal time. At renewal, in order to obtain other quotes, employers will receive large claims experience information. This information usually identifies employees, or their dependents, by their social security number, birthday, or by some other code. The person's medical claim information is included. As a result, the employer has just received PHI. The employer could easily be covered by HIPAA.

Further, once an employer receives this PHI information for renewal, the employer will more than likely distribute this PHI information to other carriers. **THAT** distribution is covered by HIPAA. This means Business Associate Agreements must be secured before this information is distributed.

2. **Section 125 Unreimbursed Medical Information**

Many employers have Section 125C Unreimbursed Medical Accounts for their employees … and many employers administer these plans themselves. (A Section 125C Unreimbursed Medical Account is a welfare benefit plan that allows employees to pay for their unreimbursed medical, dental and vision expenses with pre-tax dollars.) Since the IRS classifies these plans as health plans, if an employer receives this information, that employer is covered by HIPAA. (It is also important for employers to realize that in many instances, their Section 125C Unreimbursed Medical Accounts are covered by COBRA as well.)

F. What About Substance Abuse Testing and Fit-For-Duty Examinations?

Even if an employer does not receive PHI in relation to its health plan, many employers have adopted Substance Abuse Testing Programs (i.e., Drug and alcohol tests). The substance testing performed under these programs is also covered by HIPAA <u>if the testing is paid through the company's insurance provider</u>, so the employer must have certain forms in place ready to use in order to comply. (i.e., Business Associate Agreements, Authorization and Release Agreements, etc.)

Also, when an employer questions the ability of an employee to perform his/her essential functions, the employer may want to have the employee undergo a medical examination. These medical examinations are covered by HIPAA as well <u>if the testing is paid through the company's insurance provider</u>, so HIPAA requirements must be met. Therefore, again, the employer must have certain forms in place ready to use in order to comply. (i.e., Business Associate Agreements, Authorization and Release Agreements, etc.)

Again, even if the employer is not covered by HIPAA, the **PROVIDER** is covered (i.e., Testing facility, physician's office, etc.). Therefore, employers should at a minimum have their HIPAA Authorization and Release Forms in place. If not, then the testing facility or physician's office cannot legally release this information.

G. What Are "Receipts"?

Fully insured plans should use the **total premiums paid for health insurance benefits during the plan's last fiscal year**.

Self-insured plans should use the **total amount paid for health care claims by the employer, plan sponsor or benefit fund on behalf of the plan during the last full fiscal year.**

Plans that provide benefits through a mix of insurance and self-insurance should combine these measures to determine their total annual receipts.

If the plan's annual receipts are $5 million or less, then the plan automatically qualifies for one-year extensions of both deadlines described above.

H. Complying With The Privacy Rule By Identifying Data

Regardless of which category a plan fits into, HIPAA's Privacy Rule requirements should be considered.

The Privacy Rule imposes numerous requirements that safeguard **individually identifiable health information and provides employees with notices of their privacy rights and access to their records**. It also requires establishment of additional physical and procedural safeguards. Many of these requirements vary, depending upon the kind of information employers receive, who receives it, how it is used and whether your plan is insured or self-insured.

To begin preparing to meet these requirements, human resource professionals should conduct an assessment of exactly what areas of their organization handle **any type of** individually identifiable health information. If the organization operates an on-site medical clinic, the organization's obligations will be greater than those imposed upon employers who do not operate such services, at least for that portion of the organization.

Human resource professionals should determine:

1. What types of individually identifiable health information you currently receive;

2. Who sees it; How they use it;

3. Where it is retained; and

4. Whether such access and use is necessary to accomplish the organization's purposes.

This assessment is where human resources should begin establishing its HIPAA compliance plan.

I. Authorization and Disclosure Agreement for Specific Instances *(Used By Employers Covered By HIPAA And NOT Covered By HIPAA)*

Other areas of the law affect the HIPAA Privacy Requirements. Specifically, in order to obtain information from health care providers so the organization might determine an employee's ability to return to work, what accommodations he/she may need to return to work under the ADA, his/her coverage under the ADA or FMLA, an Authorization and Disclosure form will be needed. This form should be made part of your FMLA/ADA documentation packet.

Also, since either an employer's "Substance Abuse Testing Program" and "Fit-To-Return-To-Work" medical examinations may be covered under HIPAA, if the employer's insurance plan pays for the test, or since the testing facility may be

covered as a provider, this release should be endorsed by employees **BEFORE** these examinations and testing occurs. This way, there will not be any "snags" when the employer wants to receive the results of the test. Too many times, testing facilities have refused to release the results of the tests to the employer since no Authorization and Disclosure Agreement exists. Again, even if the employer is not covered by HIPAA, the testing facility may be covered.

(Also, if the employer does use its insurance provider to pay for pre-employment medical examinations, "Fit-To-Return-To-Work" medical examinations, or substance abuse testing, then the employer is covered by HIPAA. The job applicant or employee should also be given a copy of the company's "Notice of Privacy Rights" and the "Notice of Confidentiality of Alcohol and Drug Abuse Testing Rights.")

These forms should therefore be loaded into your computer system and used when needed.

J. Confidentiality Agreement *(Used By Employers Covered By HIPAA And NOT Covered By HIPAA)*

Anyone who has access to Personal Health Information should endorse a Confidentiality Agreement. This document should then be filed in their personnel file.

It is also a good idea to have anyone who has access to medical or other types of confidential information to endorse a Confidentiality Agreement.

K. "Business Associate Agreements"

Human resources should also begin to identify all of the organization's "business associates" who receive protected health information ("PHI") from or on behalf of the plan. The organization's TPA, broker or an attorney could be business associates. Once these business associates are identified, the organization must have them execute a "business associate contract" before it discloses any PHI to them. Typically, these Business Associate Privacy Agreements should include many items, such as:

1. Identify the Business Associate and his/her role,

2. State his/her obligations under HIPAA regarding protected health information,

3. State that the Business Associate agrees to use appropriate safeguards to protect the PHI, and

4. Identify the proper uses of PHI by the Business Associates.

L. Privacy Policy

Covered organizations must draft and adopt a "Privacy Policy" and disseminate this information to anyone on whom it maintains PHI records. This Privacy Notice should at a minimum:

1. Identify the privacy safeguards that have been taken by the organization in order to put forth a "good faith effort" to ensure that the individual's protected health information will be secured,

2. Specify how an individual's protected health information will be stored, transmitted, and used or disclosed, which includes electronic, written and oral transmissions, and what safeguards have been adopted to ensure confidentiality,

3. Ensure that all "Business Associates" that receive this information will be subject to the same "Confidentiality and Privacy Requirements" as internal staff,

4. Ensure that all staff members that have access to this information will endorse a "Confidentiality Agreement,"

5. Ensure that PHI records will not be used in connection with any employment-related action or decisions, or in connection with any other benefit or benefits plan, except where allowed by law,

6. Ensure that any misuses of PHI records or any disclosures that are inconsistent with the purpose for which it was provided will be reported to the organization's Privacy Officer and/or the plan sponsor, which either is appropriate,

7. Review what rights individuals have under the HIPAA regulations,

8. Identify the penalties for violating the Privacy Policy,

9. Identify the organization's Privacy Officer and what role this person plays in ensuring maintaining the confidentiality of PHI records and HIPAA compliance,

10. The complaint procedure individuals should follow if they feel their rights have been violated and

11. Ensure that all employees will have access to their PHI records upon request and the procedure employees should follow in order to request such information.

The Privacy Policy statement should be signed by the organization's chief executive officer.

This Privacy Notice must then be communicated to anyone on whom the organization maintains PHI records. Employers should also obtain a written acknowledgment from its patients, consumers or employees that they have received a copy of its Privacy Notice.

Certain areas of compliance that should be included in the organization's Privacy Policy that deserves specific mention in more detail are as follows:

1. **PHI Records Release**

   Disclosures of health information should be limited to the minimum amount necessary for specified purposes. Disclosures for public health or law enforcement purposes are permitted when required or permitted by law.

   This rule requires that anyone maintaining PHI records must obtain special written authorization from patients before using any "protected health information" for anything besides treatment, payment or health care operations. It is important to note that healthcare providers, such as physicians and other medical providers generally must obtain an individual's written consent before making any uses or disclosures of the information.

   Therefore, employers must have "Authorization to Release Medical/Mental Information" forms ready to send to health care providers in order to receive leave information regarding FMLA, ADA, pregnancy, etc. Otherwise, healthcare providers may not be able to provide the necessary information to the employer.

   Patients, which may also be employees, must be given a clear written explanation of how their health information will be used or disclosed, with such use or disclosure generally occurring only upon the patients' written consent. Prior consents that provide equal or better protection may be relied upon.

   It is also important to note that employers are not permitted to force employees to sign these releases. Forcing employees to release such information for such purposes is a violation of HIPAA.

2. **Patients' Right Of Access**

   Patients must be given the right to have access to their own medical information and may request an amendment to records and restrictions in use. A complaint procedure must be provided to resolve privacy violations.

The HIPAA regulations therefore any removes any previous mandatory consent requirements that prevent the patient's access to their own health care records.

3. **Complaint Procedure**

HIPAA's "Privacy Standard" requires that covered organizations draft, implement and communicate a complaint procedure for responding to any complaints lodged by patients, consumers or employees regarding the safeguarding of their protected health information.

M. Corporate Privacy Officer

Any organization that has access to any protected health information ("PHI") must appoint a company "Privacy Officer." The duties of the Privacy Officer should be outlined in a job description, which includes such duties as:

1. Maintaining compliance with federal and state privacy laws,

2. Develops policies and procedures that provide safeguards for PHI,

3. Develops policies and procedures for reporting violations,

4. Establishes internal audit procedures to ensure compliance and

5. Trains employees who handle PHI regarding the proper procedures to follow in order to ensure its privacy.

N. Required Training

Training the organization's staff on its "Privacy Policy" and its procedures is a specific requirement of the Privacy Rule. Organizations are required to provide a detailed training session to all staff members who have access to protected health information addressing at least the following areas:

1. HIPAA's Privacy Rule,

2. HIPAA's penalties for non-compliance,

3. A review of the organization's privacy procedures,

4. The forms and disclosures used by the organization for compliance and

5. The system the organization has adopted for documenting compliance.

It is also important to document all of the training staff members receive regarding HIPAA by stating the topics covered and individuals who participated.

Employees who do not have access to PHI records should be trained regarding the organization's Privacy Policy and their rights under the law.

O. HIPAA's Electronic Data Interchange ("EDI") Rule

As of October 16, 2002, any organization transferring or storing PHI electronically were required to ensure that the proper firewalls were in place to protect this sensitive information.

P. HIPAA'S Security and Electronic Signatures Rule

Organizations are also required to:

1. Establish and maintain personnel security policies,

2. Establish and enforce physical security requirements, which may include access controls,

3. Audit controls and procedures,

4. Authorization controls and

5. Data and entity authentication controls.

Q. Checklist For Compliance

Covered organizations should examine the following checklist in order to begin complying with HIPAA:

1. Develop a Privacy Policy, along with the necessary procedures, including implementation deadlines.

2. Develop a budget for HIPAA compliance expenses, which would include attorney assistance, training, administrative assistance, copying, etc.

3. Review and revise group health plan documents in order to ensure that the necessary HIPAA privacy language is in place.

4. Appoint a HIPAA Privacy Officer.

5. Obtain "Business Associate" agreements wherever appropriate.

6. Train key managers regarding the organization's Privacy Policy, its procedures, the scope of HIPAA's rules and the consequences of noncompliance.

7. Conduct in-depth training for all staff members who will have access to PHI records, which at a minimum includes the organization's Privacy Policy, the organization's security procedures, its documentation procedures, the scope of the HIPAA rules and the consequences of noncompliance.

8. Train all employees regarding the organization's Privacy Policy and its procedures in accordance with HIPAA's regulations.

9. State in the employer's "Disciplinary Policy" clear sanctions for anyone who violates the organization's Privacy Policy or its procedures.

10. Ensure that appropriate security safeguards have been put into place, such as firewalls, access codes, Confidentiality Agreements endorsed, Business Associate Agreements endorsed, etc.

R. Penalties Under HIPAA

HIPAA prohibits retaliation against employees who refuse to sign authorizations that allow additional, specific uses of health information beyond treatment, payment and health care operations. Employers should remember that they are prohibited from using any protected health information in relation making personnel decisions.

Although the Privacy Rule includes no authority for private lawsuits, significant penalties may be imposed for violations, including criminal sanctions. HIPAA violators face penalties of $100.00 for each violation from the Health and Human Services Office of Civil Rights up to a maximum of $25,000.00.

The maximum criminal penalties under HIPAA are:

1. $50,000 and one year in prison for obtaining or disclosing protected health information.

2. $100,000 and five years for obtaining protected health information under "false pretenses."

3. $250,000 and 10 years for obtaining or disclosing protected health information with the intent to sell, transfer or use it for commercial advantage, personal gain or malicious harm.

WHAT DOES THIS MEAN TO HUMAN RESOURCES?

Human Resources have the necessary forms needed to comply with HIPAA. Those forms are listed below.

The nice aspect of HIPAA is that it is "form driven." Once an employer has these forms in place, compliance is relatively simple.

One way to avoid being covered by HIPAA is to outsource many of these various functions to an insurance broker. (i.e., Cafeteria Plan Claims, Insurance Renewals, etc.)

However, even if an employer is able to avoid HIPAA coverage, Human Resource professionals must still have the following forms in their arsenal:

1. **Confidentiality Agreement**

2. **Authorization and Disclosure**

Even if the employer is not covered by HIPAA, medical professionals are covered. Too many HR people these days are not getting their "Leave Certification Requests" completed by physicians since no proper release exists. The idea is to keep the system moving smoothly. HR people should put the Authorization and Disclosure Release Form with their "Medical Certification" forms under the ADA and FMLA.

Further, it is just a good idea to have all supervisors and managers sign "Confidentiality Agreements." Too many times, management inadvertently says something about a person's vasectomy, miscarriage, etc. This agreement helps to remind managers that such information is confidential.

REMEMBER: HIPAA is not the only privacy issue out there. ADA has privacy restrictions, as do most states under "common law privacy" rights.

DOCUMENTS EMPLOYERS WILL NEED TO COMPLY WITH HIPAA

(Used By Employers Covered By HIPAA And <u>NOT</u> Covered By HIPAA)

1. **Confidentiality Agreement**
2. **Authorization and Disclosure Privacy Policy**

(Used By Employers Covered By HIPAA)

3. **Job Requirements for Privacy Officer and Employees**
4. **Business Associate Agreement**
5. **Notice of Privacy Rights**

S. HIPAA Sample Forms

(Used By Employers Covered By HIPAA)

Notice of Rights Under HIPAA
Regarding Declination of Coverage Upon Initial Eligibility

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you somehow no longer become eligible to participate in the plan, provided that you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Notice of HIPAA and Request for Certificate

IMPORTANT NOTICE OF YOUR RIGHT TO DOCUMENTATION OF HEALTH COVERAGE

Recent changes in federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for preexisting medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for preexisting medical conditions. Under the law, a preexisting condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to receive a certificate that will show evidence of your prior health coverage. Even if you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a preexisting condition exclusion. Contact your state insurance department for further information.

You have the right to receive a certificate of your prior health coverage dating back as far as 18 months of uninterrupted creditable coverage. Check with your new plan administrator to see if your new plan excludes coverage for preexisting conditions and if you need to provide a certificate or other documentation of your previous coverage.

To get a certificate, complete the attached form and return it to:

_____
_____
_____
_____

The certificate must be provided to you promptly. Keep a copy of this completed form. You may also request certificates for yourself and any of your dependents (including your spouse) who were enrolled under your health coverage.

****

REQUEST FOR CERTIFICATE OF HEALTH COVERAGE

Name of Participant: _____ Date: _____

Address: _____

_____

_____

Telephone number: (_____) _____

Name and relationship of any dependents for who certificates are requested (and their address if different from above):

Name Address

_____

_____

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

IMPORTANT - This certificate provides evidence of your prior health coverage, as well as for your covered dependents. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for preexisting medical conditions. You may therefore need to provide this certificate to your employer or insurer if medical advice, diagnosis, care, or treatment was either recommended or received for a condition within 6-months before you and/or your dependents enrolled in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate:_____

2. Name of group health plan:_____

3. Name of other plans:_____
   _____
   _____

4. Name/SS # of participant:_____

5. Identification number of participant:_____

6. Dependent(s) to whom this certificate applies:
   Name Social Security Number
   _____
   _____
   _____
   _____

7. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:
   _____
   _____
   _____

8. For further information, call: (_____)_____

Note: Separate certificates may be furnished if information is not identical for the participant and each dependent.

INFORMATION ON CATEGORIES OF BENEFITS

The following information applies to the individual(s) identified below:

a. HEALTH INSURANCE:

Participant(s)	Date Coverage Began	Date Coverage Ended	Date Waiting Period Began?

b. MENTAL HEALTH:

Participant(s)	Date Coverage Began	Date Coverage Ended	Date Waiting Period Began?

c. SUBSTANCE ABUSE TREATMENT:

Participant(s)	Date Coverage Began	Date Coverage Ended	Date Waiting Period Began?

d. PRESCRIPTION DRUGS:

Participant(s)	Date Coverage Began	Date Coverage Ended	Date Waiting Period Began?

e. DENTAL CARE:

Participant(s)	Date Coverage Began	Date Coverage Ended	Date Waiting Period Began?

f. VISION CARE:

Participant(s)	Date Coverage Began	Date Coverage Ended	Date Waiting Period Began?

For each category above, enter, "N/A" if the individual had no coverage within the category.

PERMISSION BY EMPLOYEE TO RELEASE MEDICAL INFORMATION

I _____, understand that HIPAA protects my medical records from being divulged to anyone who does not have a business reason to know and view them. By signing this disclaimer, I agree to authorize the release of my medical information to _____ (Indicate by name.)

_____ _____

Signature Date

_____ _____

Witness Date

ACKNOWLEDGEMENT OF CONFIDENTIAL INFORMATION

I, _____, understand that the nature of my job requires me to work with and personnel records containing highly sensitive medical information. I further understand that I am not permitted to reveal this information without specific written authorization. I am also not permitted to discuss this information with other employees, friends or with members of my family. I acknowledge that I have been made aware of the requirements of the Health Insurance Portability and Accountability Act of 1996, or "HIPAA," which allows for possible prison sentences for violating this policy.

_____ _____

Signature Date

_____ _____

Witness Date

VI. HIPAA PRIVACY REGULATIONS

A. In General

As of April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) became effective. While it is true that HIPAA's Privacy Rule does not directly cover employers, an employer who sponsors a group health plan or who have such privacy information regarding its employees in its possession will be affected nonetheless.

B. Which Plans Are Covered, And When Are They Covered?

Almost all group health plans are covered. (The only plans that are exempt are those with fewer than 50 participants and are administered **exclusively** by the employer.) HIPAA's definition of a health plan is broad enough to encompass not only medical plans, but also other benefit plans such as dental, vision, prescription drug plans, employee assistance plans (EAPs) and flexible spending accounts. Unless the plan sponsor chooses to designate them collectively as an "Organized Health Care Arrangement," each plan must stand on its own with respect to meeting its HIPAA obligations.

"Small plans" automatically have an extra year to comply with the April 14, 2003 Privacy Rule deadline. A small plan is one that has annual receipts of $5 million or less.

C. What Are "Receipts"?

Fully insured plans should use the amount of **total premiums paid for health insurance benefits during the plan's last fiscal year**.

Self-insured plans should use the **total amount paid for health care claims by the employer, plan sponsor or benefit fund on behalf of the plan during the last full fiscal year.**

Plans that provide benefits through a mix of insurance and self-insurance should combine these measures to determine their total annual receipts.

If the plan's annual receipts are $5 million or less, then the plan automatically qualifies for one-year extensions of both deadlines described above.

D. Complying With The Privacy Rule

Regardless of which category a plan fits into, HIPAA's Privacy Rule requirements should be considered.

The Privacy Rule will affect employers who sponsor group health plans, as well as those who operate on-site medical clinics and/or EAPs. The Privacy Rule imposes numerous requirements that safeguard **individually identifiable health information and provides employees with notices of their privacy rights and**

access to their records. It also requires establishment of additional physical and procedural safeguards. Many of these requirements vary, depending upon the kind of information employers receive, who receives it, how it is used and whether the organization's plan is fully insured or self-insured.

To begin preparing to meet these requirements, human resource professionals should conduct an assessment of exactly what areas of their organization handle **any type of** individually identifiable health information. If the organization operates an on-site medical clinic, the organization's obligations will be greater than those imposed upon employers who do not operate such services, at least for that portion of the organization.

Human resource professionals should determine:

1. What types of individually identifiable health information the organization currently receives and retains;

2. Who sees it;

3. How they use it;

4. Where it is retained; and

5. Whether such access and use is necessary to accomplish the organization's purposes.

This assessment is where human resources should begin establishing their HIPAA compliance plan.

E. "Business Associate Agreements"

Human resources should also begin to identify all of the organization's "business associates" who receive protected health information ("PHI") from or on behalf of the plan. The organization's TPA, broker or an attorney could be business associates. Once these business associates are identified, the organization must have them execute a "business associate contract" before it discloses any PHI to them. Although written business associate contracts in effect before October 15, 2002 can extend the compliance deadline for this specific requirement, it is important to identify the organization's business associates soon.

Although the Privacy Rule includes no authority for private lawsuits, significant penalties may be imposed for violations, including criminal sanctions. Rule violations may also be used against Plan Sponsors in ERISA lawsuits or in state law invasion of privacy actions.

Since the plan amendments and/or policy changes that human resources makes vary depending upon the organization's particular circumstances, human resource professionals should realize that a "one-size-fits-all solution" is unlikely to meet HIPAA's needs.

VII. OLDER WORKERS BENEFIT PROTECTION ACT OF 1990 ("OWBPA")

A. Bona Fide Employee Benefit Plans And The Older Workers Benefit Protection Act of 1990, Or The "OWBPA"

In short, the EEOC divides benefit plans into two categories:

Retirement Plans and "All Other Plans."

As for "all other plans" under the Older Workers Benefit Protection Act of 1990, Pub. L. No. 101-521, 104 Stat. 978 (1990), which was signed into law by President Bush in October of 1990, ("OWBPA"), employers are allowed to "cost justify" either each plan individually or a "package" of benefits collectively, which is referred to as the "equal costs" principle. After the OWBPA adopted this "equal costs" principle in relation to all nonretirement benefit plans, the EEOC drafted its regulations outlining how such evaluations of employee benefit plans would work (29 C.F.R. § 1625.10).

Under the EEOC's regulations, cost justification works in the following manner: Employers are permitted to define the average cost of the benefits of workers in age brackets of no more than five-year increments which can then be compared to the average cost of benefits of workers in the next younger age bracket.

For example, if the average cost of a benefit for 55 to 59-year-old individuals is in parity with the average cost for workers between the ages of 50 to 54, the benefit is cost justified between these groups, even if the older group receives less of a benefit for this cost. Of course, the burden of proving that the benefit plan does not discriminate rests squarely with the employer.

As for retirement plans, employers may "coordinate" an employee's benefits in order to reduce plan costs. The OWBPA specifically states that defined benefit plans under ERISA may be coordinated with the employee's Social Security benefits. This provision of the OWBPA therefore allows plans to take into account an employee's age insofar as it relates to Social Security benefits (29 U.S.C. § 623(l)(1)(B)).

Additionally, employers may reduce the severance amount paid to an existing employee by the amount the employee receives in retirement benefits as long as the severance amount is not tied to age (29 U.S.C. § 623(l)(2)(A)). Furthermore, employer may also reduce any long-term disability benefits paid to employees by the amount of pension benefits these employees voluntarily elect to receive or which they are eligible to receive either at age 62 or normal retirement age, which either is later (29 U.S.C. § 623(l)(3)).

Also, the OWBPA states that it is permissible for a retirement plan to provide for a minimum age as a condition of eligibility for normal or early retirement benefits (29 U.S.C. § 623(l)(1)(A)). However, the statute does not mention any "safe

harbor" for establishing a minimum retirement age. Instead, the OWBPA merely states that establishing an early retirement age is not a per se ("by itself") violation. As a result, there is still ambiguity in the law since the OWBPA conditions the legality of such provisions on being consistent with the purposes of the ADEA, which is an uncertain standard.

Still, the ADEA forbids any defined benefit or defined contribution retirement plan to allow for any age-based reduction in an employee's account. However, benefits can still be limited by years of service or of plan participation.

B. Early Retirement Or Exit Incentive Plans And The Use Of Settlement And Release Agreements Under The OWBPA

In the past, older employees who were offered early retirement or exit incentive plans claimed that they had agreed to accept such incentives because of the implied threat of discharge that accompanied such offers. On the other hand, other employees often sued their employers because they were not offered an opportunity to participate in such plans. The OWBPA addressed both of these issues.

Section 626(f) of the OWBPA lists several requirements that employers must fulfill in order for any exit incentive or early retirement plan to be considered nondiscriminatory when such plans are offered to employees over the age of 40 *and* the employer seeks to have its older workers sign an agreement waiving their rights to sue the employer under the ADEA. Such waivers are commonly referred to as Settlement and Release Agreements. If such waivers are to be effective, the following requirements must be met:

1. The employee must execute this agreement, or waiver in a "knowing and voluntary" manner,

2. The agreement, or waiver of liability, from the employer must:

    a) Be written in a manner that can be understood,

    b) Specifically refer to waiving all ADEA claims,

    c) Not relate to claims arising after its execution,

    d) Present true consideration to the employee, which means the employee must be paid a sum of money or some benefit that is not already owed to him,

    e) Advise the employee to consult legal counsel,

    f) Give the employee adequate time to decide whether or not to sign the agreement, which is a period of 21 days from the date it is presented to the employee, and

    g) The employer must provide the employee with a seven-day period

after executing the agreement in which to revoke the agreement.

3. If the plan if being offered to a group of employees, which may be defined as being few as two employees, then:

   a) The employer must give employees a 45-day period in which to consider the agreement, as opposed to the 21-day period previously mentioned,

   b) The employer must provide to each person covered by the program with a written notice listing everyone who is eligible to participate by class, unit, job titles and age, as well as the ages of everyone in the same unit or job classification not eligible to participate, and

   c) The affected employees must also receive in writing the eligibility factors for the program and any time limits that apply.

If these requirements are not met, then the Settlement and Release Agreement the employer received from the employee may not be valid should the employee decide to file a charge of ADEA discrimination.

Of course, the remaining portions of the Settlement and Release Agreement may still be enforceable, thus barring the employee from suing the employer for other potential claims, such as for race discrimination, sex discrimination and so on. However, the Settlement and Release Agreement would no longer act as a bar to any claims filed under the ADEA.

C. Other Issues Related To Settlement And Release Agreements And The OWBPA

1. Contradictory oral statements may invalidate a Settlement and Release Agreement.

In Wamsley v. Champlin Refining, 11 F.3d 534 (5th Cir. 1993), as part of a downsizing strategy, the employer, Champlin Refining, offered a sum of money to those employees who were being laid off. In return for this sum of money, or "legal consideration," Champlin Refining received a Settlement and Release Agreement from each of these exiting employees in which these employees relinquished their right to bring any private causes of action or lawsuits against the company for any illegal discrimination that may have occurred now or in the past.

As for those employees who were 40 years of age or older and were therefore protected by the ADEA, Champlin Refining was sure to comply fully with the OWBPA. One of the sections in the agreement clearly stated that these protected "older" workers each had 45 days in which to review the document and return it to the company.

After these "older" workers signed their agreements, returned their copies to the company, and then accepted a sum of money in return for endorsing

the waiver of claims, some of these "older" workers claimed that they had been told by management that they did not really have 45 days to review the document. Instead, these workers claimed they were told that really had less than the 45 days required under the OWBPA in which to review the document and return it to the company. These workers therefore claimed that the agreements they signed should be declared invalid, which would then allow them to pursue their private lawsuits under the ADEA against the company.

The court held that under the OWBPA, in order for such agreements to be valid in relation to the ADEA, the individual signing the document must do so in a "knowing and voluntary" manner, which means the individual must have adequate time to review the document and obtain advice regarding its contents and effects. The amount of time these employees had to review these agreements was clearly stated in the document itself.

However, the court also reasoned that if an employer orally contradicts what the Settlement and Release Agreement states, then the employer has violated this requirement under the OWBPA. As a result, the waiver may indeed be declared invalid by the court, which then allows these "older" former employees to bring their private lawsuits against the company under the ADEA.

It is important to understand that the Wamsley court did not say that employees could not voluntarily waive this 45 or 21-day waiting period guaranteed to them under the OWBPA when they decide to sign such agreements. Instead, the court held that if an employer orally contradicts what is written in the agreement, and these oral statements act to deprive employees of their rights under the OWBPA, then the employer's Settlement and Release Agreement may be declared invalid in relation to ADEA claims.

2. **No additional compensation is needed to waive ADEA claims.**

In DiBiase v. SmithKline Beecham Corporation, 48 F.3d 719 (3rd Cir. 1995), as part of a downsizing plan, employees were given the opportunity to receive additional compensation in return for signing a Settlement and Release Agreement which waived their right to pursue any claims against the company in the future.

However, some of the "older" employees who were being laid off claimed that their waivers were not based on sufficient consideration. These "older" workers reasoned that in addition to waiving all of the rights their younger co-workers were waiving, the "older" workers claimed they were also relinquishing their right to sue the employer over any potential ADEA claims. The "older" workers therefore contended that since they were signing away more rights than their younger counterparts, they should have received greater consideration for signing their agreements.

However, the court reasoned that an ADEA claim is but one claim being relinquished by these agreements. Women may be signing away valid sexual harassment claims. Other employees may be signing away valid claims based on race, national origin, and so on. On the other hand, these "older" workers may only be signing away the **right** to pursue an ADEA suit instead of a valid claim under the law.

The court therefore held that employers are not required to pay additional consideration to those employees who were protected by the ADEA as opposed to those who were not. In fact, the court reasoned that since the ADEA requires "older" workers to be treated the same as younger workers, paying "older" workers a greater sum in consideration for executing a waiver of rights and claims against their employer might actually raise the question of an ADEA violation.

3. **An employee does not ratify an invalidated Settlement and Release Agreement by not returning to the employer the consideration paid to him the employee.**

In Oubre v. Entergy Operations, Inc., No. 96-1291, 1998 U.S. Lexis 646, Delores Oubre, an employee with Entergy Operations, Inc., was given a poor performance review. As a result of this review, Entergy offered Oubre the option of either accepting a voluntary severance package or improving her poor performance. After consulting with her attorney, Oubre accepted the severance package. The installment payments made to Oubre from this severance package totaled $6,258.00.

In exchange for receiving this severance package, Oubre endorsed a Settlement and Release Agreement with Entergy. In this Settlement and Release Agreement, or the "Agreement," Oubre agreed to waive all of her rights to pursue any claims against the company.

However, after she received her last installment payment from Entergy, Oubre, who was over the age of 40, filed suit against Entergy Operations under the ADEA, alleging that she was constructively discharged because of her age. When Oubre refused to return the $6,258.00 to Entergy, Entergy argued that Oubre's suit must be dismissed.

Entergy reasoned that if Oubre refused to return the $6,258.00 in severance payments, she should still be bound by the terms of the Settlement and Release Agreement, which barred Oubre from bringing any suits against the company. Entergy therefore claimed that by keeping these severance payments, Oubre was in essence ratifying their Agreement and she should be bound by it.

The U.S. Supreme Court disagreed. The Court stated that whenever an employee who is protected by the ADEA is asked to sign a Settlement and Release Agreement in exchange for receiving a severance package, employers must strictly comply with the very stringent requirements of the

OWBPA. Otherwise, the Agreement between the employer and the employee will be invalidated as far as any ADEA claims are concerned since the waiver will no longer be viewed by the courts as having been endorsed by the employee in a "knowing and voluntary" manner.

In this instance, Entergy failed to comply with the requirements of the OWBPA. Specifically, the Court found that:

1. Entergy failed to give Oubre the statutory time required to review the Agreement and consider her options,

2. Entergy failed to give Oubre seven days after she endorsed the document to revoke, and

3. Entergy failed to specifically mention in the Agreement that Oubre was waiving her right to file and claims against the company under the ADEA.

The U.S. Supreme Court therefore held that "[s]ince Oubre's release did not comply with the OWBPA's stringent safeguards, it is unenforceable against her insofar as it purports to waive or release her ADEA claim. As a statutory matter, the release cannot bar her ADEA suit, irrespective of the validity of the contract to other claims."

Consequently, even though the Agreement Oubre signed was invalid as far as her ADEA claim was concerned, the Court made it clear that the Agreement was still effective in barring any other claims against Entergy.

4. **In order to be valid, an employee's revocation of the Settlement and Release Agreement must be very clear.**

In Ruth v. Woods, 45 F.3d 377 (10th Cir. 1995), an employee who had waived her right to sue her employer under the ADEA decided to revoke this waiver on the last day of her seven-day revocation period allowed under the OWBPA. However, when she called her employer's attorney to inform him of her decision to rescind, she got his answering machine. The employee left a message on his recorder stating that it was an emergency and that she needed to speak with him about the case as soon as possible.

However, the employee never stated that she wished to revoke her agreement. Neither the employer nor the employer's attorney spoke to the employee again until after the seven-day revocation period had lapsed. The employee claimed that this notice to the employer's attorney was a valid revocation. The court disagreed, holding that the employee's message on the recorder did not give the employer actual notice of her desire to revoke.

VIII. WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

A. Reconstructive Surgery And The WHCRA

The WHCRA basically requires group health plans, health insurance companies and health maintenance organizations (HMOs) that cover mastectomies to also pay for reconstructive surgery.

An important clarification to make is that the WHCRA does not require health plans to cover reconstructive surgeries. Instead, the WHCRA only requires health plans that cover mastectomies to cover reconstructive surgery as well. Therefore, if a health plan does not cover mastectomies, then the health plan is not required to pay for reconstructive surgeries.

In providing this coverage for reconstructive surgery, these benefits must include coverage for:

- The reconstruction of the breast where the mastectomy was performed,
- Reconstruction of the other breast to ensure a symmetrical appearance between the two, if necessary,
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Any coverage provided under the WHCRA may be subject to the same annual deductibles and coinsurance as any other treatments received under the plan.

Further, the WHCRA prohibits health plans from denying patients eligibility for coverage in order to avoid compliance with the Act.

Additionally, the Act forbids health plans from providing incentives to physicians for providing care that is not consistent with the WHCRA. Likewise, the Act prohibits health plans from imposing penalties against physicians who attempt to provide care consistent with the WHCRA.

B. Notice Requirements Of The WHCRA

In addition to placing coverage requirements upon group health plans, health insurance companies and health maintenance organizations (HMOs) that cover mastectomies, the WHCRA also requires these entities to provide covered individuals with two written notices of their rights under the Act. The only difference between these two notices is **when** they must be delivered.

1. **Upon the Adoption of the Health Plan: One Time Requirement**

The first notice that must be provided to plan participants is when a new health plan is adopted. All participants must receive a written description of their rights when such an event occurs.

2. **Upon Enrollment in the Plan…and Annually Thereafter**

A second written notice to plan participants must then be sent whenever someone new enrolls in the health plan. From then on, plan participants must receive another written description of their rights under the WHCRA on an annual basis.

C. What Must Be Included In This Written Summary Of Rights Under The WHCRA?

According to the Department of Labor, which is the administrative agencies charged with governing the WHCRA, these notices must state the following:

1. **What is Covered?**

The notice must inform the plan participant that if she has a mastectomy and elects for reconstructive surgery, coverage for the reconstruction will be provided based upon the professional opinion of the attending physician, in consultation with the patient, for:

- The reconstruction of the breast where the mastectomy was performed,
- Reconstruction of the other breast to ensure a symmetrical appearance between the two, if necessary,
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

2. **Deductibles and Coinsurance Coverage Amounts**

These notices must also state that the participant would be responsible for paying any applicable deductibles and coinsurance amounts as a result of having such procedures performed.

D. Sending The Notices

All notices under the WHCRA must be sent by the same means that have been approved by the Department of Labor for sending Summary Plan Descriptions. Of course, the most accepted manner used to send such notices is by first-class U.S. Mail.

The Department of Labor further requires that these notices be sent to the last known address for the plan participants and their beneficiaries. Therefore, if the last known address differs between the plan participant and his/her beneficiaries, separate notices must be sent to each address.

Notice: Legal Advice Disclaimer

The purpose of these materials is not to act as legal advice but is intended to provide human resource professionals and their managers with a general overview of some of the more important employment and labor laws affecting their departments. The facts of each instance vary to the point that such a brief overview could not possibly be used in place of the advice of legal counsel.

Also, every situation tends to be factually different depending on the circumstances involved, which requires a specific application of the law.

Additionally, employment and labor laws are in a constant state of change by way of either court decisions or the legislature.

Therefore, whenever such issues arise, the advice of an attorney should be sought.

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Scott has been named one of Business First's 20 People To Know In HR, CEO Magazine's 2008 Human Resources "Superstar," a Nationally Certified Emotional Intelligence Instructor and a SHRM National Diversity Conference Presenter in 2003, 2006, 2007, 2008 and 2012.

Scott has also received the Human Resource Association of Central Ohio's Linda Kerns Award for Outstanding Creativity in the Field of HR Management and the Ohio State Human Resource Council's David Prize for Creativity in HR Management.

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