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# Benefits Perspectives

Current Issues in Employee Benefits

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• A Guide to Managing Absence Costs

• Beyond the Health Plan SPDs

## Battling Obesity: Employers Managing an Emerging Issue

by Kate Fitch, Bruce Pyenson, Steven Abbs, and Margaret Liang

Obesity in the US poses a significant and growing health risk. The prevalence of obesity has doubled since 1980 and, with nearly one out of every four Americans now considered obese, obesity is viewed by the Centers for Disease Control as one of nation's top health threats. Treatments for obesity raise numerous cost and effectiveness challenges for patients, clinicians, employers, and insurers.

This article examines the prevalence and medical treatment of obesity, with a focus on the impact on employers that sponsor health plans. Disability, absenteeism, wellness costs, and life insurance costs are certainly increased by obesity, but are outside the scope of this article.

### Obesity Defined

The most common, accepted measure of obesity is body mass index (BMI), which uses a formula that takes into account a person's height and weight (see Table 1). Although BMI has limitations as a measure of body fat (e.g., BMI overestimates body fat in persons who are muscular), it is easy to calculate and provides a more accurate measure of total body fat than relying on weight alone.

For adults, overweight is defined as a BMI of 25.0 to 29.9. Obesity is defined as a BMI of 30 or greater. Extreme obesity (often referred to as morbid obesity) is defined as a BMI of 40 or greater.

### Prevalence and Health Risks

According to the National Health and Nutrition Examination Survey (NHANES) 1999-2000, the age-adjusted prevalence of obesity was 30.5%—an increase from the 22.9% reported in

NHANES 1988-1994. The prevalence of overweight also increased during this period from 55.9% to 64.5%, and extreme obesity increased from 2.9% to 4.7%. The prevalence of obesity was highest among women aged 40 to 59 years (37.8%) and women aged 60 to 74 years (39.6%).

Obesity significantly worsens health and quality of life and shortens life expectancy. The National Institutes of Health (NIH) reports the following health risks of overweight and obesity:

- Hypertension
- High total cholesterol
- Diabetes
- Coronary heart disease
- Congestive heart failure
- Stroke
- Osteoarthritis
- Gallstones
- Sleep apnea
- Cancer

TABLE 1

		BODY MASS INDEX (BMI) FOR ADULTS																					
		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
Height (Inches)	58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191
	59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198
	60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204
	61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211
	62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218
	63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225
	64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232
	65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240
	66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247
	67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255
	68	125	131	138	144	151	158	164	171	177	184	190	197	204	210	216	223	230	236	243	249	256	262
	69	128	135	142	149	155	162	169	176	182	189	196	203	210	216	223	230	236	243	250	257	263	270
	70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278
	71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286
	72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294
	73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302
	74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	
		Weight (Pounds)																					

### Treatments for Obesity

According to the NIH in 2003, there are three major components to the most successful therapy for weight loss and weight maintenance: dietary therapy, increased physical activity, and behavior therapy. In addition, treatment with drugs should be considered as an adjunct to these lifestyle therapies in patients with a BMI that is greater than or equal to 30 or with a BMI that is greater than 27 and concomitant obesity-related risk factors or disease. Certain patients may be candidates for weight-loss surgery. Weight-loss and weight-maintenance therapies that are provided over the long term and allow for a high frequency of contacts between the patient and the practitioner generally lead to more successful weight loss and weight maintenance.

Experience reveals that lost weight usually will be regained unless a weight-maintenance program combining dietary therapy, physical activity, and behavior therapy is continued indefinitely. This is why an accurate assessment and confirmation of patient motivation is critical to the success of a weight-loss program.

### Surgical Treatment for Severe Obesity

Surgery for severe obesity, referred to as bariatric surgery, began in the early 1950s. The techniques and clinical outcomes from bariatric surgery have improved dramatically over the years. The NIH reports that surgical intervention in adults with a BMI greater than or equal to 40 (or a BMI greater than or equal to 35 with comorbid conditions) can result in substantial weight loss. The NIH recommends that, when less invasive methods of weight loss have failed, surgical intervention is an option for carefully selected patients with clinically severe obesity who are at high risk for obesity-associated morbidity and mortality. Compared with other available interventions, surgery has produced the longest period of sustained weight loss in severely obese individuals.

The aim of bariatric surgery (often referred to as gastric restrictive or gastric bypass procedures) is to modify the gastrointestinal tract to reduce net food intake. Bariatric procedures fall into two major designs, each with varying approaches:

- Malabsorptive procedures involve rearrangement of the small intestine to decrease the functional length or efficiency of the intestinal mucosa for nutrient absorption. Malabsorptive procedures restrict both food intake and the amount of calories and nutrients the body absorbs.
- Restrictive operations do not bypass the stomach but reduce the size of the upper portion of the stomach.

Demand for bariatric surgery is rising. The estimated number of surgical procedures performed in 2003 is about 100,000—an increase from 60,000 procedures performed in 2002.

### Employer Plans and Obesity Treatment

Health plans or employers trying to determine the medical costs of obesity through claims data will likely grossly underestimate aggregate costs. Currently, few obese patients will have any claims coded with an obesity diagnosis, although the more recent attention to obesity may lead to improved coding by healthcare practitioners. Milliman examined a large 2001 claims database from group employer-employee coverage. Claims databases have diagnosis codes but do not contain details such as height, weight, or BMI. For purposes of claim analysis, we defined obesity as the appearance of at least two physician outpatient claims or one hospital inpatient claim with specific codes for “obesity, unspecified” or “morbid obesity.”

The prevalence of obesity in the claims data demonstrates gross undercoding. Only 0.3% of the insured population had these codes, in sharp contrast to population estimates of about 30% for obesity or 5% for morbid obesity. These differences are too large to be explained by demographic variation or the likelihood that some obese people would not have any physician or hospital claims in a year.

Because of undercoding, the results of this database search cannot be used to characterize total costs. Nonetheless, for individuals with an obesity code, our study uncovered the following, which merely hints at the broader cost picture:

- Per-person claim costs for those identified as obese were about triple those for the average health plan member.
- Hospital admission rates averaged about 350 per 1,000—comparable to that of rates for a Medicare population—in contrast with an admission rate of about 50 per 1,000 for an average commercial population.
- Cesarean section/total delivery rates were almost 50% of deliveries, more than double that of a typical commercial population.
- About 25% of the admissions (corresponding to about 8% of individuals identified) were for operating room procedures for obesity, confirming that practitioners code obesity much more often when the medical treatment is immediately connected with obesity.
- Although those coded for obesity accounted for 0.3% of the population, they accounted for a high portion of plausibly obesity-related admissions.

### Benefit Plan Design Considerations

Employers bear a sizable portion of costs associated with obesity-related conditions, primarily in terms of lost productivity, paid sick leave, and the increased cost of health, life, and disability insurance. Thus, benefit design considerations for obesity treatment coverage become paramount.

Employers with self-insured health plans are not subject to state mandates. But many plan sponsors, when designing obesity benefits, often consider state mandates along with cost, the quality of life for employees and spouses, and the potential reduction in absenteeism or future medical costs.

Health benefits that are provided under an insured arrangement are subject to state regulation. Several states have mandated coverage of treatments for morbid obesity, and the increasing prominence of the issue suggests more states will follow. States also often look to Medicare rules, and Medicare does cover bariatric surgery for individuals who meet specific clinical criteria. As with other mandates, state mandates for obesity will vary in their application and scope. A state may require health plans to cover morbid obesity treatment, or the state may simply require health plans to offer coverage of the treatment—the buyer can choose whether to purchase it. The mandate may apply to individual or group insurance, or to health maintenance organizations.

When considering plan design to address obesity, employers should not overlook health and wellness programs. These programs can be relatively inexpensive, such as improving healthy food choices in the employee cafeteria or encouraging employees to walk more. It costs very little for the chief executive officer to champion a healthy lifestyle. Some programs can be expensive, such as the construction and maintenance of on-site health clubs or subsidies for health club memberships. In addition, programs can raise tax-deductibility issues; and charging obese people higher premiums (as is sometimes done with smokers) raises discrimination issues.

Employers that sponsor health flexible spending accounts (FSAs) also could consider reimbursing physician-diagnosed obese employees for uncompensated medical expenses incurred in a weight-loss program. The IRS's guidance in 2002 concluded that obesity is medically accepted as a disease and, therefore, certain amounts paid by an individual for treatment of the disease—such as initial enrollment and periodic meeting fees that are not paid for by insurance—are deductible, and thus could be reimbursed by a health FSA.

Other issues employers should consider include:

- *Coverage decisions*—Plan sponsors should address: medical appropriateness (e.g., should the plan cover aggressive surgical

treatment for adolescents?); the potential for adverse selection (e.g., should the plan require waiting periods and preexisting condition limitations for bariatric surgery?); and coverage restrictions for retirees (e.g., should the plan limit coverage to active employees?).

- *Medical management decisions*—Using evidence-based medical criteria to make medical necessity determinations can improve the quality of care and avoid inappropriate care. Will the plan require precertification? What criteria, if any, will be used to determine if an employee is a candidate for aggressive surgical treatment? Which treatments and follow-up care should be covered or encouraged? Will the plan restrict services to “Centers of Excellence” on quality grounds?
- *Benefit decisions*—Health plans typically have dollar limits, cost-sharing features, and network limitations, all of which should tie to medical management processes and which must be reflected in the plan document and the summary plan description. How do plan maximums, cost-sharing, and other features apply to obesity treatment? Will bariatric surgery be subject to its own limits? Will the plan cover the cost of less aggressive weight-loss programs that may be a prerequisite to surgery? Will food and nutritional supplements be covered following the surgery? Will abdominoplasty (removal of excess skin and skin folds following excessive weight loss) be covered following surgery? How will initial evaluations, psychological testing, and follow-up monitoring be covered? Will treatment be restricted to “Centers of Excellence” or network providers? Will stop-loss carriers impose limitations or rate changes if the health plan adds obesity benefits?

### Conclusion

Obesity is becoming a major public health issue of the 21st century and increased public awareness will fuel employee demand for medical and surgical obesity treatments. The costs will be borne by the private sector, and the private sector will be part of the solution. Employers that sponsor health benefit programs will have to evaluate obesity benefit coverage options in light of legal, financial, and employee satisfaction implications.

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# A Guide to Managing Absence Costs

by Daniel D. Skwire

The rapidly rising cost of employee benefits is familiar and troubling news to employers. With most of the discussion focused on healthcare trends as the primary culprit, however, many employers fail to recognize how much of their total benefits cost pertains to absence-related programs—and how much ability they have to manage these costs.

## Quantifying Absence Costs

Measuring absence-related costs is not an easy task. First, there are many different types of employee absences: vacations, sick days, family medical leave, workers' compensation claims, short-

term disabilities (STD), long-term disabilities (LTD), among others. Second, there are both direct and indirect costs associated with employee absences. Direct costs consist of dollars paid in the form of salary continuation, disability benefits, or insurance premiums, on behalf of the absent employees. Indirect costs include expenses incurred by the employer to keep the business operating at less than full staff. Examples include paying overtime to other employees, hiring temporary help, or accepting a reduction in sales or profits due to lost productivity.

TABLE 1

DISTRIBUTION OF TOTAL COMPENSATION COSTS*	
Category	Cost as % Total Compensation
Workers' Compensation, Unemployment Compensation, Social Security Taxes	8.7%
Medical and Life Insurance (Excluding Disability)	14.8%
Time Not Worked (Including Disability)	12.0%
Retirement and Savings	6.2%
Miscellaneous Benefits	0.6%
<b>Total</b>	<b>42.3%</b>

\*Source: US Chamber of Commerce's 2003 Employee Benefits Study, reprinted with permission.

TABLE 2

ABSENCE-RELATED COSTS AS A % OF TOTAL COMPENSATION*	
Category	Cost as % Total Compensation
Payments for Holidays	3.2%
Paid Breaks, etc.	0.6%
Sick Leave Pay	2.0%
Payments for Vacations	4.0%
Paid Time Off	1.6%
Family and Medical Leave Pay	0.1%
Short Term Disability or Accident Insurance	0.2%
Long Term Disability or Wage Continuation	0.2%
Other Time Not Worked	0.2%
<b>Total</b>	<b>12.0%</b>

\*Source: US Chamber of Commerce's 2003 Employee Benefits Study, reprinted with permission.

The distribution of total compensation costs (wages and benefits) for various benefit programs is shown in Table 1. The table reveals that the cost of absence-related benefits, including STD and LTD, is the second largest component of benefit costs, behind only medical benefits.

Table 2 provides further detail on the source of these absence-related costs, showing the wide variety of benefits that contribute to total absence-related costs. At first glance, many of these programs appear to have low overall costs. But this is misleading for two reasons:

- Many of the programs are closely related to each other and to other types of benefits. For example, sick leave claims often transition to STD claims and then to LTD claims, and disability claimants account for a large share of an employer's healthcare costs.
- Tables 1 and 2 illustrate only the direct cost of absence-related benefits. They do not include the difficult-to-measure indirect costs. For example, there is very minimal direct cost associated with family and medical leave pay, since the leave is generally unpaid (although California recently launched a program of paid leaves). Employers, however, incur significant indirect costs associated with family and medical leave because the resulting staff shortages lead to either temporary staffing and retraining costs or reduced productivity. Studies have estimated that indirect costs of absences may equal or exceed the direct costs.

## Methods for Managing Absence-Related Costs

Employers can use a variety of methods to manage absence-related costs. They range from simple to more complex strategies and target direct or indirect costs. Some focus on a single program while others consider the interaction of several programs.

### *Review of Plan Design*

Employers should periodically review the design of their absence-related benefit plans to ensure that the plans coordinate well with each other, are consistent with those offered by other companies in their industry, and have the legal language necessary to support appropriate claim management. Employers that have not reviewed their plans in many years may find they have fallen out of line with their industry. For example, many years ago, LTD plans commonly replaced 66 2/3% or 70% of salary; most modern plans replace 60% of salary. The additional cost of a plan that replaces 70% of salary plan can be significant, particularly if such a level of benefits is not necessary to attract and retain employees.

Modern plan language can be helpful in managing employee absences. Many STD and LTD plans now include specific rehabilitation and workplace accommodation benefits that help employers and employees work together to shorten the period of disabilities. Small differences in the wording of plan definitions and provisions also can affect benefits. For example, defining disability in an LTD plan to include a requirement that the claimant be receiving appropriate medical care from a licensed physician can ensure that the employee takes necessary steps to recover and return to work.

### *Contributory and Voluntary Plans*

Contributory and voluntary plans, in which employees pay some or all of the cost of benefits, can take many forms. One common structure is a “core-buy-up” plan, in which the employer pays for a basic benefit (e.g., an LTD plan covering the first \$2,500 of monthly income) and employees have the option to buy additional coverage through payroll deductions. In addition to reducing the employer’s share of benefit costs, contributory and voluntary benefit plans permit employers to offer a wide spectrum of benefits they would not otherwise be able to afford, such as accident and critical illness coverage.

### *Self-Insured Benefits*

For benefits such as LTD and STD, which employers often purchase through insurance, the use of self-insurance may offer an opportunity to reduce costs, because the premiums paid for these benefits must cover the insurers’ sales costs and profit requirements. Self-insured plans also carry significant risks for employers. Instead of being responsible only for the payment of insurance premiums, employers that self-insure these benefits bear the full risk of benefit payments that are higher than expected levels. Therefore, it is important for employers with self-insured plans to obtain experienced professional assistance in administering their plans and managing their claims.

### *Paid Time-Off Plans*

Many employers have begun offering paid time-off (PTO) plans as a way of combining sick pay, vacation, holiday, and other time-off

programs. In a PTO plan, each employee receives a certain number of days of paid time off, which may be used at his or her discretion for any reason. Once the days have been used up, any additional time off is taken without pay or, in some cases, may qualify as a short-term disability claim.

There are pros and cons to PTO plans. The use of a single program can help an employer track absences and receive detailed information on the causes of absences. The impact that PTO plans have on absence costs, however, varies significantly for different employers. For instance, in a company where most employees use all of their sick time each year, a PTO plan may reduce costs if the number of PTO days awarded is less than the sum of sick days, vacation days, and personal days available under separate plans. (This is particularly true if the employer adopts a PTO plan to replace a sick leave policy that permitted unused sick days to be carried over each year.) Where a small portion of available sick time is used, however, PTO plans may increase the number of days that employees take in the form of vacations.

### *Data Collection and Benchmarking*

Employers have much to gain from improving their data collection and management. In many cases, self-administered plans suffer from under-reporting of sick time during periods of salary continuation. When data is not collected or is incomplete, employers will have difficulty understanding their absence costs and, consequently, to take actions that may help reduce those costs. For instance, if an employer is unaware that an employee’s absence is due to a medical rather than a vacation reason, it cannot begin discussions about workplace accommodations or returning to work until that absence evolves into a disability or workers’ compensation claim. Employers that are able to capture complete and accurate data on their absence plans and to benchmark their experience against other employers in their industry have a head start in controlling their absence costs.

### *Integration of Claim Management*

One advantage of capturing improved data on absence plans is the opportunity for an employer to coordinate the management of different types of absences. Consider an employee who initially takes a personal day for a doctor’s appointment, then sick time for a worsening condition, and eventually short-term and long-term disability. If an employer does not collect absence data in an organized fashion and integrate the management of its various absence programs, then the claim may be reported to an LTD claim administrator with no prior warning. At that point, the employee might have been out of work for 180 days with little chance of returning to work. For an employer with more effective absence management data, however, the first personal day with its corresponding health insurance claim would alert the employer to begin making proactive efforts to reach out to the employee and become involved with disease management, workplace

accommodation, rehabilitation, or other techniques to manage the potential loss of time.

When making any changes to data collection or claim management procedures, employers should carefully consider employee privacy issues.

### Conclusion

The total costs, both direct and indirect, of absence-related programs are a significant component of total employee benefit costs, equaling or exceeding the cost of healthcare benefits. Employers

have a wide range of options for controlling these costs, including plan design, improved data management, and the integration of claims processes for a wide range of employee benefits. The advantages of improved absence management include lower total employee benefit costs and a more productive workforce.

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## Beyond the Health Plan SPDs

by Vincent P. Reynolds

Health benefit plan sponsors face ongoing challenges in complying with the Department of Labor's (DOL) participant notice requirements. Numerous laws have amended the Employee Retirement Income Security Act (ERISA)—the federal law that governs employee benefits—and regulations from the DOL provide guidance to plan sponsors about their responsibilities to keep health plan participants informed about the health plan benefits. In some cases, regulations are still under development, forcing plan sponsors to attempt good-faith compliance.

Although health plan sponsors rely on summary plan descriptions (SPDs) for much of the required information disclosures, there are some notices beyond the SPDs that must be given to participants. A failure to do so can lead to significant penalties for the plan sponsor.

This article discusses health plan notices that all health plan sponsors must supply separately from information included in the SPD, with a focus on three laws—HIPAA, WHCRA, and COBRA—that amended ERISA's notice requirements. Some plan sponsors have overlooked these requirements, mistakenly believing that the SPD satisfied the disclosure obligation.

### Application of the Requirements

The notice requirements discussed in this article apply to self-insured and insured group health plans. A plan that purchases insurance typically relies on the insurer to provide the appropriate notices to plan participants, but ultimately retains the responsibility for compliance.

### HIPAA's Special Enrollment Rights

The 1996 Health Insurance Portability and Accountability Act (HIPAA) generally prohibits discrimination in group health plans on the basis of health status and limits the ability of plans to impose preexisting condition exclusions. It also requires plans to

give, under certain circumstances, special enrollment rights to employees, dependents, and COBRA-qualified beneficiaries without the individuals having to wait until the next annual open enrollment period or being subject to strict late-enrollment procedures. Special enrollments must be allowed for employees who:

- lose other group health or insurance coverage during the plan/coverage year; or
- marry or acquire a dependent by marriage, adoption, or birth, or who place a child for adoption.

The special enrollment notice—for which the DOL has model language—must be included in the SPD and also at or before the time an employee is initially offered the opportunity to enroll in the plan. The notice should be included as part of the plan's enrollment form or as a separate document.

### WHCRA's Notice Requirement

The 1998 Women's Health and Cancer Rights Act (WHCRA) includes protections for patients who elect breast reconstruction and related follow-up care in connection with a mastectomy. Under WHCRA, group health plans that provide benefits for mastectomies must provide coverage for all stages of reconstructive surgery and for physical complications arising from the mastectomy. The law requires such plans not only to provide information about the plan's benefits in an initial notice at the time of enrollment, but also in annual reminders.

The initial notice may be included as text within the enrollment materials given to employees or as a separate document, and the DOL's model language may be used. The information also should be included in the SPD. The annual notice may be part of the SPD or a separate document, including: a union newsletter; a

benefits newsletter; an open enrollment newsletter; or any other written communication by the plan as long as the notice is prominently displayed. Plan sponsors may use the DOL's sample abbreviated language to comply with the annual notice requirement.

### Notices under COBRA's Healthcare Continuation Coverage Requirements

The 1986 Consolidated Omnibus Budget Reconciliation Act (COBRA) includes provisions requiring certain employers that sponsor group health plans to offer employees and their dependents the ability to continue coverage at group rates when specific "qualifying events" occur. Plan sponsors may require electing individuals to pay the entire cost of the premiums for continuation coverage, plus 2% to cover administrative costs. In general, COBRA extends the period of group health coverage for 18 to 36 months, depending on the qualifying event that triggers the right to the extended coverage period.

The COBRA requirements apply to employers with 20 or more employees, but many states have COBRA-like laws that extend to other employers. Exceptions to the COBRA rules may apply to governmental and church plans.

In addition to providing guidance on other COBRA notice requirements (e.g., content of the election notice), the DOL includes guidance on COBRA's initial notice and on two new notices.

Key items that must be included in the *initial COBRA notice* given to plan participants are:

- The name of the plan and the name, address, and telephone number of the party responsible for COBRA benefits administration.
- A general description of the continuation coverage, including: identification of the classes of individuals who may become qualified beneficiaries; the types of qualifying events that give rise to COBRA coverage rights; the employer's notice obligation; the maximum COBRA coverage period; when and under what circumstances the maximum coverage period may be extended; and the plan's requirements concerning premium payments for continuation coverage.
- An explanation of the qualified beneficiary's notification obligations when qualifying events (e.g., divorce, legal separation, or a child's ceasing to be a dependent under the plan) occur and the plan's procedures for providing such notice.
- An explanation of the importance of participants keeping the administrator informed of their current addresses.

- An explanation of the plan's requirements for qualified beneficiaries who are receiving COBRA coverage to notify the administrator of a second qualifying event or a determination by the Social Security Administration that a qualified beneficiary is disabled, and the plan's procedures for receiving such notices.
- A statement that the notice does not fully describe continuation coverage or other rights under the plan, and that more complete information is available from the plan administrator and in the SPD.

The DOL's regulations provide model language that will satisfy the requirements for the initial COBRA notice.

Under the final rules that the DOL published on May 26, 2004, the initial notice must be furnished to a covered employee and the employee's spouse (if covered under the plan) not later than the earlier of: (1) 90 days after the health plan coverage begins or, if later, 90 days after the date on which the plan first becomes subject to COBRA; or (2) the date on which the administrator is required to furnish an election notice to the employee or to his or her spouse or dependent. The notice requirement may be satisfied through the SPD.

The regulations require plan sponsors to establish reasonable procedures by which covered employees and qualified beneficiaries furnish the COBRA notices to the plan administrator and to describe those procedures in the SPDs. They also impose time limits for COBRA notifications for both the plan sponsor and the beneficiary.

The DOL's final regulations add two new notice requirements under COBRA:

- "Notice of unavailability of continuation coverage"—If, upon receiving notification of a qualifying event from an employee, the plan administrator determines that the individual is not entitled to COBRA, the administrator must provide written notice as to why the individual is not entitled to elect COBRA. The administrator must provide the individual this notice 14 days after receiving the individual's notice of a qualifying event.
- "Notice of termination of continuation coverage"—If the administrator determines that an individual's COBRA coverage will be terminating prior to the maximum period available (e.g., due to an individual's failure to pay the premiums), the plan administrator must provide written notice of the coverage termination to the individual. The notice must be provided as soon as possible after the determination of coverage termination has been made, and must include: the reason(s) for the early termination of COBRA coverage; the date COBRA coverage will terminate; and an expla-

nation of any rights that the qualified beneficiary may have under the plan, or applicable laws—such as individual insurance conversion rights—that allow the individual to elect alternative coverage.

**Penalties for Failure to Comply**

The DOL may impose penalties on plan administrators who fail to comply with the health plan notice requirements. The agency also has stepped up its enforcement efforts, auditing plans for compliance with the regulations that apply to health benefit plans. The DOL's report on its most recent compliance project notes that audits uncovered plans that are not providing HIPAA special enrollment or WHCRA notices in a timely fashion. Giving the notices with the SPD after an employee enrolls in the plan constitutes non-compliance, the penalties of which may be as much as \$100 per day from the IRS and separate from DOL-imposed penalties. A failure to comply with the COBRA notice requirements may result in penalties of \$110 per day (separate from IRS penalties).

**Communication of Notices**

The employer or the plan administrator generally is responsible for ensuring the plan participants receive the appropriate notices. The DOL's regulations require that notices be provided by the appropriate party using "measures reasonably calculated to ensure actual receipt of the material."

The regulations specifically discuss three means of delivering notices:

- *First-, second-, or third-class mail*—If using the regular mail system, first-class delivery is the preferred method to ensure actual receipt because the plan administrator may request return receipt guarantees and address corrections, which is difficult to achieve through second- or third-class mailings.
- *Hand delivery*—Although the plan administrator can ensure actual receipt of notices through hand deliveries to employees, the

same cannot be said to hold true for notices that must be provided to other individuals (such as a covered spouse or dependent children) or workers (such as telecommuters or traveling salespersons) who spend portions or most of their time off-site.

- *Electronic delivery*—Plan administrators might find delivering the required notices through electronic means more convenient and efficient than through mailings and hand deliveries, but there are numerous requirements that must be satisfied, including being able to prove receipt of documents and taking steps to preclude unauthorized receipts and to ensure protection of confidential information. In addition, plan administrators may have to address how to deliver notices to participants who do not have access to electronic media (e.g., email, kiosk site).

**Conclusion**

Complying with ERISA's notice requirements and related administrative procedures is no easy task. Fortunately, in many cases, the DOL has provided model language that plan sponsors will find helpful. Plan sponsors should explore the extent to which updated administrative systems and electronic dissemination of the required notices can facilitate compliance. Because the DOL has expanded its health plan compliance auditing with some of its focus directed at the notice requirements, plan sponsors should take steps to ensure that the plans can satisfy the various regulations or are able to demonstrate good-faith compliance where regulations do not exist.

The DOL's model notices are available on the agency's website: <http://www.dol.gov/>

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