

Quarterly Review

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From the Desk of the Editor

How will health care be delivered in the coming years? With so many variables to consider, the savvy plan sponsor and administrator must keep abreast of industry and political currents that are shaping the future design and taxability of benefits, as well as federal and/or states' mandates that are addressing access, quality and price. And lets not forget regulatory and statutory changes that are often the by product of politics.

This issue is slim on regulatory discussion and analysis related to health and welfare plans. With certain branches of government at loggerheads and an election year focused on economic and **health care proposals**** for the future, it's not surprising for there to be little to report this issue on regulatory or statutory changes. However, our Guest Articles discuss the new Medicare reporting requirements effective 1/2009 so that you can begin planning ahead; and we also discuss briefly new FMLA requirements based upon the first expansion of this Act since its passage.

Primarily this issue focuses on health care trends and providing you with information to keep you in compliance and in the know.

Much success and prosperity for 2008,

Trish Neely

**** By the way, if you are interested in comparing 2008 Presidential candidate health care proposals, Kaiser Family Foundation has an excellent analysis at www.health08.org.**

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Health Care Trends

Thailand: Day One Visit a Temple, Day two Hip Replacement

Bob Dunn, CLU

Medical tourism refers to a rapidly growing practice in which individuals are increasingly leaving this county to find offshore locations to obtain medical care.

In this latest health care trend, patients who normally would undergo medical treatment in the United States, such as a costly surgical procedure, instead fly to Thailand, the Philippines or elsewhere to have the surgical procedure done there.

Factors that have led to the recent increase in popularity of medical travel include the high cost of health care or wait times for procedures in industrialized nations, the ease and affordability of international travel, and improvements in technology and standards of care in many countries of the world. As a result, patients save an enormous amount of money. Offshore medical procedures can be preformed for as little as one-tenth the cost of what would normally be charged here in the US. Many facilities offshore are state of the art. These are modern hospitals that often are newer and have much better technology and equipment than hospitals in the US. They are typically staffed by Western doctors and surgeons trained in Western medicine, and they provide equal or greater quality surgical care then US hospitals. These surgical procedures are performed with the same technology and expertise, but cost a fraction of the price.

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Popular medical travel destinations include Thailand, South Africa, The Philippines, Singapore, India, Israel among others.

However, perceptions of medical tourism are not always positive. In the US, where most individuals have insurance and access to quality health care, medical tourism is viewed as risky. Medical tourism carries some risks that local medical procedures do not. Risks include the following:

- No insurance if complications arise or unable to seek compensation via malpractice lawsuits.
- Threat of different infectious diseases in foreign countries and/or a different prevalence of the same diseases compared to the US. Exposure to disease without having built up natural immunity can be a hazard for weakened individuals.
- Travel soon after surgery can increase the risk of complications. Long flights can be hazardous for those with heart or breathing problems.

Individuals should carefully consider all of the facts with their family and local doctors when considering traveling to another county for medical care.

But did she retire with a long-term care plan?

Robert E. Parr, CLU, RHU, HIA, REBC

A few months ago, Kathleen Casey-Kirschling, retired at age 62. You may have missed this in the news, but this event made history. Casey-Kirschling is generally recognized as the nation's very first Baby Boomer. Born at 12:00:01 on January 1, 1946, she is leading the charge as the first wave of 3.2 million Boomers crashes into retirement. That equates to about 365 per hour.

By 2020, nearly 1 in 6 Americans will be 65 or older and over 40% of those 65 year olds will live to age 90. That's the good news. The bad news is that we will have more health problems to deal with as we age. Couple this with the generally poor job we have done saving for retirement, the care many of us have provided for elderly loved ones and the expense of trying to get our kids through college and what do you have? A perfect storm of financial disaster if we aren't prepared.

In the words of famed baseball pundit, Yogi Berra, "The future ain't what it used to be."

There are really three things that can happen to us. We can live too long, die too soon or become disabled. Effective retirement planning can help us to have the

funds we need in our retirement years. Life insurance can help our families when we die. Disability and medical insurance take care of our expenses when we are sick or injured, right? Not necessarily.

Unfortunately, having disability and medical insurance coverage without long-term care insurance is like a two legged stool – impossible to stand on. Consider the following:

- For a couple turning 65, there is a 70% chance that one of them will need long-term care.
- Singles are at risk because they're usually not with someone who can properly care for them. The same is true for wives, who tend to outlast their husbands by an average of 7 years.
- Over 50% of all people entering a long-term care situation are penniless within one year.
- The average stay in a nursing home in 2006 was 388 days. In Miami, the average cost is \$225/day or \$82,125 annually. In New York City that jumps to \$140,525 a year. And, if you'd rather convalesce in your own home, the average cost for a Home Health Aide is nearly \$20 per hour.
- Nursing homes don't just provide care for older people. Visit any nursing home and you'll be surprised to see young people there as well.
- Medicare only provides for a brief stay in a nursing home which must follow a hospital stay.
- Medicaid does provide for nursing home care but you must have used up virtually all your own assets before you qualify.

The independently wealthy won't need to fret, but for the rest of us, proper planning is essential. Long-Term Care Insurance in an excellent planning tool, along with promoting healthy life styles through wellness programs.

Consider this statement by the American Council of Life Insurers, "Despite the fact that the overwhelming majority of financial planners believe that long-term care plays an important role in a well-rounded financial plan, most Americans have given little or no thought to how they will pay for their own long-term care in years to come."

Today, Long-Term Care insurance is available through employer group plans, Voluntary payroll deduction plans and individual plans. It can also be added to certain life insurance and annuity contracts. Additionally, there is a plethora of information available on the Internet. You may wish to visit www.aarp.org or www.wikipedia.org and search for Long Term Care Insurance. Because of its availability, it is becoming a popular addition to employer benefit plans.

If you would like more information about adding long-term care to your benefit plan offerings, please speak

with your FBMC Account Manager or call Bob Parr, VP-Sales and Marketing at (800) 872-0345, Extension 2608.

Massachusetts Health Care Reform Reporting Requirements Due

Trish Neely, CFCI

If you have employees living in

Massachusetts, you are required to distribute statements and file certain reports by Jan. 31, 2008.

Employers are required to provide a statement to all health plan participants who reside in Massachusetts using Form MA 1099-HC, and also submit a report to the Commission of the Department of Revenue verifying that Forms MA 1099-HC were sent to all participants who reside in Massachusetts. Sponsors of self-funded plans must also file a report with the DOR Commissioner that electronically files the information on multiple forms MA 1099-HC regarding their health plan.

Any employee enrolled in your health plans as of Dec. 31, 2007 and that have a mailing address in Massachusetts should receive the statement from you. This applies to active participants, COBRA beneficiaries and retired participants who are not enrolled in Medicare. This is their proof of insurance under the new law. Plan participants who are Massachusetts residents who do not receive a 1099-HC may be subject to Massachusetts state income tax penalties as a result. (MA mandates health coverage.)

The statement must indicate the coverage the participants received during the 2007 calendar year, the plan participants, covered individuals and dependents, the policy or similar numbers and the dates of coverage during the year.

A model Form MA 1099-HC, issued by the Department of Revenue is available at DOR's website including the record layout and files specifications

Plan sponsors that fail to provide a Form MA 1099-HC to Massachusetts residents or to file a DOR Commissioner's Report are subject to a penalty of \$50 per individual (a maximum of \$50,000).

Plan sponsors should consult with legal counsel prior to preparing the Forms and filing disclosure reports with DOR.

Benefit Design Benchmarking Tools

Gingy Sampson

I have been helping our clients with benefit design in some way shape or form for most of my career

at FBMC. Surveying employees to identify the coverages they value and then working with plan sponsors to create benefit options that meet employee needs AND meet the employers long and short term objectives has been an exciting challenge.

While employees' needs are situational and generally based upon family circumstances and cost, employers are looking at competitive hiring goals, retention, and controlling cost. Remaining competitive in the job market has much to do with your physical location, type of business, the demographics of your local population, your local unemployment rate and how you benchmark against your peers. But, as we all know, benchmarking is not easy to do.

MetLife, one of our business partners and preferred providers, has a web-based Benefits Benchmarking Tool that can help increase or maintain an employer's competitive edge without the frustration of having to gather and compile hard to find data. You can compare your benefits against other companies in your industry of similar size and location or you can compare yourself to all industries in the northeast or south, etc. The tool is very flexible and based upon the variables you select. You can access the site at www.whymetlife.com/benchmark.

For additional information or assistance with benefit design, please contact the author.

HRA-VEBA

The Funding Mechanism Whose Time Has Come!

Patrick Peters

A rapidly growing trend is emerging for employers in the public and private sectors alike. VEBAs are irrevocable trust where employers make contributions to a trust without the requirement of a high deductible health plan (HDHP). The account can contain investment – mutual funds, stocks, bonds, etc. The health reimbursement arrangement (HRA) attaches to the VEBA to enable distributions through the HRA tax free to participants, who can withdraw funds to only pay for qualified medical expenses. The impact of this model is that employers can estimate and cap their healthcare liability and expense it. This model can potentially replace traditional retiree health care benefits.

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HRAs are favored by employer because they offer greater flexibility in plan design with respect to qualifications, vesting schedules, payout options. Public employers may use this vehicle to meet the GASB requirements for other post employment benefits.

FBMC is expending considerable energy on this solution for release in the second quarter 2008.

FMLA Expanded

Trish Neely, CFCI

Military families will benefit from the first ever amendment to the Family Medical Leave Act of 1993.

President Bush signed into law the National Defense Authorization Act (NDAA) on January 28, 2008. Section 585 of the Act adds two new FMLA-qualifying events, expanding FMLA to include employees caring for an injured service member as well as family members who have a family member called to active duty. The amendments' provisions are effective immediately.

More specifically and straight from the DOL website: *The Act permits a "spouse, son, daughter, parent, or next of kin" to take up to 26 workweeks of leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness."* [AND]

The Act permits an employee to take FMLA leave for "any qualifying exigency (as the Secretary [of Labor] shall, by regulation, determine) arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation." By its express terms, this provision of the NDAA is not effective until the Secretary of Labor issues final regulations defining "any qualifying exigency."

To view the amended Title I of the Family and Medical Leave Act in its entirety, log on to www.dol.gov/esa

The Department of Labor is quickly working to prepare comprehensive guidance for employers to use when offering this type of leave to qualifying employees.

I hear you asking, effective immediately, no guidance, what procedures do we use? Given that the Act amends existing law, it is recommended that current FMLA-type procedures be used as appropriate. The

important rule is to act in good faith and follow the spirit of the law.

More to come in this newsletter . . .

Keeping PHI Safe in a World of Changing Technology

Muriel Etienne

The good news: technology is capable of providing unbridled access to medical information making it easily attainable and transportable. The bad news: technology is capable of providing unbridled access to medical information . . .

Data storage is no longer limited to a central database or a company PC. Accessing HIPPA protected information (PHI) has become easier then ever for both those who have valid privileges to secure data and to those that do not.

The Centers for Medicare & Medicaid Services (CMS) have prepared an excellent guidance document which provides plan sponsors and covered entities with general information on the risks and strategies for remote use of, and access to, Electronic Protected Health Information (EPHI).

Per CMS, *The guidance document "does not seek to provide a comprehensive list of risks and mitigation strategies but rather a general list of suggestions for organizations that require remote use of sensitive health information"*.

The document does provide strategies that may be reasonable and appropriate for organizations when conducting business through

(1) the use of portable media/devices (such as USB flash drives) that store EPHI and

(2) offsite access or transport of EPHI via laptops, personal digital assistants (PDAs), home computers or other non corporate equipment.

Through the years we have adopted the majority of their suggestions, some do not apply to our business.

To review the guidance document in it's entirety visit: <http://www.cms.hhs.gov/SecurityStandard/Downloads/SecurityGuidanceforRemoteUseFinal.pdf>

GUEST ARTICLES

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NEW MSP REPORTING REQUIREMENT FOR GROUP HEALTH PLAN INSURERS, TPAs, PLAN ADMINISTRATORS, AND FIDUCIARIES

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[Medicare, Medicaid, and SCHIP Extension Act of 2007, S. 2499 (Dec. 29, 2007)] For a copy:

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:s2499.enr.txt.pdf

Congress has enacted a new Medicare secondary payer (MSP) reporting law, effective January 1, 2009, as part of the multi-faceted Medicare, Medicaid, and SCHIP Extension Act of 2007 ("Act"). This new reporting requirement, found in section 111 of the Act, requires insurers and TPAs of group health plans to gather information from plan sponsors and plan participants to identify situations in which the group health plans are or have been primary to Medicare and to submit the information to HHS. For plans that are self-insured and self-administered, a plan administrator or fiduciary must gather the required information and submit it to HHS. The Act allows the Secretary of HHS to specify both (1) the exact information that must be submitted; and (2) the form and manner of the required reports, including how often the reports must be provided. The Act authorizes a substantial fine on non-complying entities: a civil monetary penalty of \$1,000 for each day of noncompliance for each individual for which information should have been submitted. This fine is in addition to any other penalties prescribed by law and any potential claims under the MSP regulations (e.g., a claim by Medicare that the group health plan should have paid primary to Medicare).

Notwithstanding any other law that might restrict such actions, the Act also (1) requires HHS to share information on Medicare Part A entitlement and Part B enrollment with group health plan insurers, TPAs, plan administrators, and fiduciaries; (2) authorizes (but doesn't require) HHS to share Medicare Part A entitlement and Part B enrollment information with others; and (3) authorizes HHS to share the information it gathers

under the new reporting system as necessary for proper coordination of benefits.

EBIA Comment: Group health plans and their insurers, TPAs, plan administrators and fiduciaries likely won't be overjoyed about this new MSP reporting mandate, especially with the specter of large fines if reports aren't filed or are filed incorrectly or late. However, the requirement won't be in effect until January 2009. And it is too early to know how onerous the new reporting requirements will be until HHS announces what information it will require in the reports and how often reports must be submitted. For more information on the MSP rules, see EBIA's Group Health Plan Mandates manual at Section XXIV ("Medicare Secondary Payer (MSP) Requirements"); also see EBIA's COBRA manual at Section XXX.D ("Medicare Secondary Payer (MSP) Rules") and EBIA's Cafeteria Plans manual at Section XXII.J.7 ("Health FSAs: Medicare Secondary Payer (MSP) and Medicare Part D Requirements").

Contributing Editors: EBIA Staff.

AT LAST! EEOC ISSUES FINAL REGULATIONS ALLOWING EMPLOYERS TO COORDINATE RETIREE HEALTH BENEFITS WITH MEDICARE ELIGIBILITY

(This copyrighted article originally appeared in the 1/3/2008 EBIA Weekly and is reproduced with the permission of EBIA.)

[29 CFR Part 1625, 72 Fed. Reg. 72938 (Dec. 26, 2007)]

For a copy:

<http://a257.g.akamaitech.net/7/257/2422/01jan2007180/0/edocket.access.gpo.gov/2007/pdf/E7-24867.pdf>

The EEOC has published final regulations that permit employers to coordinate retiree health benefits with Medicare (or comparable state health programs) without violating the federal Age Discrimination in Employment Act (ADEA). (The ADEA prohibits covered employers from age discrimination against employees or job applicants who are at least 40 years of age, and it is the EEOC's view that the ADEA also prohibits age discrimination against retirees.) Under these regulations, created under the EEOC's statutory authority to issue ADEA exemptions, it is permissible for employee benefit plans to provide health benefits for retired participants that are altered, reduced, or even eliminated when the retired participant is eligible for Medicare health benefits or for health benefits under a comparable state health program (whether or not the retiree actually enrolls in Medicare or the state health program). In addition, the exemption allows employers to alter, reduce, or eliminate health benefits for spouses or other dependents of retirees when the dependents are eligible for health benefits under Medicare or a comparable state program, whether or not the retirees'

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own health benefits are similarly altered, reduced, or eliminated. The exemption applies to existing, as well as newly-created retiree health benefit plans. However, the EEOC notes that the exemption is very narrow: (1) no other aspects of ADEA coverage or employment benefits other than retiree health benefits are affected by the regulations (e.g., the exemption does not apply to health benefits for current employees); and (2) the exemption, which concerns only the ADEA, doesn't affect any non-ADEA obligation that employers may have under Medicare or any other law (such as an employer's obligation to observe the Medicare secondary payer rules).

The final regulations, effective December 26, 2007, are identical to the proposed final regulations issued in April 2004. The preamble, however, provides additional information regarding the EEOC's reasoning behind issuing the exemption, as well as a summary of the protracted litigation that delayed issuance of the final regulations for several years. (See our article on the 2004 proposed regulations at <http://www.ebia.com/WeeklyArchives/GHPM/Statutes/17685> and our most recent article on the litigation at <http://www.ebia.com/WeeklyArchives/GHPM/CourtCases/19042> (Premium Access subscription required).)

EBIA Comment: As the EEOC noted, most employers aren't legally obligated to provide retiree health benefits, and many don't offer them at all. However, employers who do offer such benefits (and their advisors) will likely welcome the final regulations, which are intended to help employers create, adopt, and maintain a wide range of retiree health plan designs, such as Medicare bridge plans and Medicare wrap-around plans. Employers are now free to supplement a retiree's Medicare coverage without having to demonstrate under the ADEA that the coverage is identical to the health coverage of non-Medicare eligible retirees or that the cost of the coverage was the same. Although the litigation isn't over (AARP has recently asked the U.S. Supreme Court to review the Third Circuit's decision), the EEOC regulations are now law and can be relied upon. Thus, employers offering retiree health benefits may wish to discuss their Medicare coordination options with their advisors. For more information, see EBIA's Group Health Plan Mandates manual at Sections XIX.D ("Retiree Health Benefits and the ADEA") and XXIV ("Medicare Secondary Payer (MSP) Requirements").

Contributing Editors: EBIA Staff.

QUESTION OF THE WEEK

(This copyrighted article originally appeared in the 12/6/2007 EBIA Weekly and is reproduced with the permission of EBIA.)

QUESTION: We know that we have to provide disclosure notices under Medicare Part D for our company's major medical plan. But do we have to provide disclosure notices for our HRA and health FSA?

ANSWER: The answer is generally yes for the HRA, and no for the health FSA. This assumes that your company's health FSA and HRA each provides prescription drug coverage, and that you have Part D-eligible individuals (individuals covered under Medicare Part A or Part B (including active and disabled employees, COBRA participants, retirees, and their covered spouses and dependents) who live in the service area of a Part D prescription drug plan (Part D plan)).

As background, plan sponsors that provide prescription drug coverage through a group health plan must disclose to Medicare Part D (Part D) eligible individuals and to the Centers for Medicare and Medicaid Services (CMS) whether the employer's coverage, when compared to the Part D prescription drug coverage, is "creditable" (i.e., whether the actuarial value of the employer-provided coverage equals or exceeds the actuarial value of defined standard Part D coverage) or "non-creditable" (i.e., whether the actuarial value of the employer-provided coverage is less than the actuarial value of defined standard Part D coverage). The disclosure notices are intended to help recipients compare their employer-provided prescription drug coverage with coverage under a Part D plan and make timely, informed decisions about whether to enroll in a Part D plan. Part D-eligible individuals who remain covered under an employer-provided prescription drug plan providing creditable coverage won't be assessed higher premiums if they enroll in Part D within certain timeframes at a later date. However, Part D-eligible individuals who are covered under an employer-provided prescription drug plan that isn't creditable coverage must enroll in a Part D plan during their initial enrollment period for Part D if they want to avoid higher premiums under the Part D plan.

For purposes of the Part D disclosure requirements, an employer-sponsored "group health plan" is generally defined as an employee welfare benefit plan providing Code Section 213 medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. The term "group health plans" for disclosure purposes specifically includes "account-based medical plans," such as HRAs and health FSAs to the extent that they are ERISA employee welfare benefit plans providing medical care (or would be subject to ERISA but for ERISA's exclusion for governmental or church plans). As a practical matter, HRAs and health FSAs are usually treated as ERISA plans.

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Plan sponsors of HRAs that offer prescription drug coverage either on a stand-alone basis or combined with a major medical plan such as a high deductible health plan (HDHP) must provide disclosure notices to Part D-eligible individuals advising whether the prescription drug coverage provided through the HRA, either on a stand-alone or combined basis, is creditable or non-creditable. HDHPs are also subject to the Part D disclosure requirement, assuming they are group health plans that offer prescription drug coverage.

In contrast, plan sponsors of health FSAs offering prescription drug coverage don't have to provide disclosure notices to Part D-eligible individuals. Under a specific exception in CMS guidance, health FSAs aren't taken into account when determining whether employer-provided prescription drug coverage is creditable or non-creditable. That's because it's difficult to determine actuarially whether a health FSA is providing creditable coverage, given the participants' wide range of coverage levels and the lack of information about what portion of a health FSA will be spent on prescription drugs.

For more information, see EBIA's Group Health Plan Mandates manual at Section XXV.F.2 ("Account-Based Medical Plans and High-Deductible Health Plans (HDHPs) Offering Prescription Drug Coverage"); see also EBIA's Consumer-Driven Health Care manual at Section XXV.E.1 ("HRAs and Other Laws: Medicare Part D") and EBIA's Cafeteria Plans manual at Section XXII.J.7 ("Medicare Secondary Payer (MSP) and Medicare Part D Requirements").

Contributing Editors: EBIA Staff.

QUESTION OF THE WEEK

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QUESTION: An employee who participates in our company's major medical plan has just adopted a child with an ongoing medical issue. The plan covers dependent children, but our plan documents don't mention adopted children. Do we have to cover this adopted child?

ANSWER: Yes, your plan must cover adopted children to the extent that it covers dependent children. An ERISA group health plan that provides coverage for the dependent children of participants or beneficiaries must also cover dependent children who are placed with participants or beneficiaries for adoption. Coverage must be provided under the same terms and conditions that apply to dependent children who are the biological children of participants or beneficiaries. This rule applies regardless of whether the adoption has become final. For this purpose, "child" means an individual who

hasn't attained age 18 as of the date of the adoption or "placement for adoption." Placement for adoption, if applicable, occurs if your participant assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption. A DOL advisory opinion confirms that a plan must provide coverage for adopted children born with medical conditions requiring special care if the plan provides such coverage to natural children in like circumstances.

HIPAA provides that if a child who is adopted or placed for adoption is enrolled within the HIPAA special enrollment period (at least 30 days), the child's coverage (and the coverage of any others who can be added under the HIPAA regulations, such as the employee's spouse or the employee if he or she is not already enrolled) must be retroactive to the date of the adoption or placement. Under HIPAA, no preexisting condition exclusion (PCE) may be imposed on a new dependent enrolled within 30 days. Finally, ERISA prohibits a plan from restricting coverage for a child who is adopted or placed for adoption based on the child's preexisting condition.

Thus, your plan and SPD should include provisions that extend coverage to children who are adopted (or placed for adoption) under the same terms and conditions as biological children. The plan and SPD should also take into account the prohibition of PCEs and the special enrollment rights for adopted children discussed above.

For more information, see EBIA's Group Health Plan Mandates manual at Sections VI ("Required Coverage for Adopted Children") and XX.G ("ADA: Discrimination Based on Usage of Employee Benefits"); see also EBIA's HIPAA Portability, Privacy & Security manual at Sections VII.C.2.c ("Prohibition Against Applying PCEs to Newborns and Newly Adopted Children") and X.B ("Opportunity #2: Acquisition of a New Dependent").

Contributing Editors: EBIA Staff.

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