



## **KENTUCKY LATE INJURY REPORTING PENALTIES**

The State of Kentucky, Office of Workers' Claims, is assessing financial penalties to employers and insurers for not complying with Kentucky's Workers' Compensation Statute injury reporting requirements.

### **Employer/Insurer Reporting Requirements:**

- ◆ Employers/insurers are required to report all injuries causing an absence from work for more than one day, within one week after the date of occurrence and date the employer received knowledge of the work-related injury.
- ◆ The employer is required to report the injury to the workers' compensation carrier/TPA within three working days of receiving notice from the employee of the work-related injury.
- ◆ The carrier, or third party administrator (TPA), is required to file the injury report with the Office of Workers' Claims ([www.labor.ky.gov/workersclaims](http://www.labor.ky.gov/workersclaims)) within one week of receiving the injury report from the employer.
- ◆ Per KY Statute 342.038, subd. 1 through 5.

### **Employee Reporting Requirements:**

- ◆ The employee is required to give notice of an injury to the employer "as soon as practicable after the happening thereof", or within two (2) years after the date of injury, or within two (2) years after date of death, in the case of a fatality.
- ◆ Per KY Statute 342.185, subd. 1.

Kentucky's waiting period is seven days, with a two week retroactive period. The reporting requirement of more than one day absence from work will likely impact many medical only claim situations. An injury doesn't become an indemnity claim until eight days of time loss from work, or more. Employers/insurers will be required to report all medical only claims with more than one day of time loss from work, as well as indemnity claims.

The actual amount of the penalty assessment has not been confirmed by the Office of Workers' Claims.

The Office of Workers' Claims is scheduling hearings

to address the issue of late injury reporting. Kentucky employers are receiving notice of a hearing via a Service of Process Transmittal document. The nature of action noted on the hearing notice is "Order to show cause - failure to file reports when due". An Employer Timeliness Report, outlining the specific claims to be heard and various dates that apply; date of injury, received date, date of disability and number of days late, is attached to the hearing notice. Hearings appear to be scheduled within 30 days of when the hearing notice is sent, via certified mail, to the employer. The carrier/TPA does not appear to be copied on the hearing notice.

Employers are encouraged to report all work-related injuries to their carrier/TPA within 24 hours of receiving notice from the employee, especially those employers located in the State of Kentucky. In order to adhere to the Kentucky Office of Workers' Claims reporting requirements, it is critical to document, and report, the date the injured employee gives notice of when the injury/accident occurred.

Employers who receive a hearing notice to address the issue of late injury reporting should:

- ◆ Immediately provide a copy of the hearing notice to their carrier/TPA.
- ◆ Document the pertinent dates of the claim(s) listed on the Employer Timeliness Report; date of injury, date the employee gave notice of the injury and date the employer reported the injury to the carrier/TPA.
- ◆ Call the carrier/TPA to coordinate follow up with the Office of Workers' Claims and attendance/representation at the hearing, if appropriate. Some



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cases may be able to be resolved prior to hearing.

Please don't hesitate to contact your Hays Companies' representative with any questions about the State of Kentucky reporting requirements, the information contained in this article, your company's internal claim reporting process or if you receive a hearing notice. We are always available and happy to assist you with any workers' compensation claim or program issue.

*Julia Uehling, Vice President, Hays Companies*

## HIPAA AND THE PREMIUM PRE-TAX PLAN

Some of the most frequently asked questions concern how and when employees can make changes in their health (medical, dental, vision) plans. There are two federal laws that provide guidance in this area:

- ◆ The Health Insurance Portability and Accountability Act (HIPAA) under the auspices of the Department of Labor (DOL), and
- ◆ Cafeteria Plan Rules, specifically those governing pre-tax applications as controlled by the Treasury Department and the Internal Revenue Service (IRS).

HIPAA provides guidance on what is required for individuals to enter health plans under what are called "Special Enrollment Events." These events are generally those already allowed by most health plans:

- ◆ Addition of new spouse and stepchildren upon marriage.
- ◆ Addition of newborn children or children placed for adoption

In addition, HIPAA provides that individuals who first waived coverage because they were covered under another health plan can enroll if they meet the following conditions:

- ◆ Employee must have been covered by the other plan at the time they were first eligible for coverage under the employer health plan; and
- ◆ Employees must have completed a written waiver form stating that the reason they were declining coverage was that they had other health insurance; and

- ◆ Employees must produce information that the other health coverage is terminating and provide the reason for the termination; these could include divorce, death of the other covered person, COBRA continuation being exhausted; other covered person's termination of employment; etc.: and
- ◆ Employees must enroll within 30 days after the termination of the other coverage.

HIPAA additionally allows employees to elect the level of coverage they wish to add. **Example:** Susan waived her employer coverage since she was covered by her husband. Susan has a baby and tells her employer she wants to add medical coverage for herself alone. Under HIPAA this is acceptable.

Cafeteria pre-tax rules are somewhat similar but are not identical. Those that crossover include: marriage, birth/adoption of a new child, loss of other coverage due to divorce or other spouse losing coverage due to termination or reduction in hours. However, there are some changes allowable for pre-tax application that would not trigger a HIPAA Special Enrollment Right. These include but are not limited to:

- ◆ Change in either the employer's or other employer plan that qualifies as a "significant" change either in cost or benefits available; or
- ◆ Spouse's Open Enrollment period occurs during the premium pre-tax year, as long as the employer plan has been amended to allow this as a qualifying change.

Cafeteria plan rules always require that the change the individual is requesting must be consistent with the event precipitating the request.

When the two sets of laws agree, there is no problem. When they do not agree, the difficulty is determining which takes precedence. HIPAA only provides guidance for individuals seeking to enter the plan; cafeteria plan rules govern both entry and leaving the plans. In addition, HIPAA rules must be stated in the health plan documents; cafeteria plan rules are normally set out in the separate cafeteria plan document. Because the health plan document sets out the actual eligibility rules, it is the primary source for coverage; the cafeteria plan is the secondary. This means that if the health plan document has no language that would allow the individual entry, then the cafeteria plan rules have no impact.

**Example:** Spouse's employer increases the contribution the spouse makes for family coverage. Our

employer's contribution level is less and the employee wants to make a change. The other employer has no open enrollment option. Under HIPAA there is no event which would trigger a Special Enrollment opportunity. The spouse is not losing his job or his coverage, the cost is merely changing. The cafeteria plan rules, however, might consider the cost of coverage increase a "significant" change and allow a pre-tax application.

In the example above, if our employer's plan has late entrant language, the individual could enroll subject to the plan's limitations on pre-existing conditions. Since the cafeteria plan may recognize the precipitating cause as a "significant" increase, the pre-tax application could be applied. If the cafeteria plan did not recognize the change, then premium contributions could be taken post tax until the next open enrollment, if any.

Since HIPAA only affects events for entering the plan, it does not address someone who wants to drop coverage. Indeed, most plans contain some standard provisions that dictate that active coverage will cease: termination of employment, dependent no longer meeting eligibility requirements. Cafeteria pre-tax rules however will apply for those events that are not Qualifying Events (QE) under the law; for instance, dropping an ex-spouse upon divorce. Cafeteria premium pre-tax elections are for the entire cafeteria plan year and can only be changed if a QE occurs. So a person who wants to make a change that is not a QE, can under the health plan itself, drop coverage. But the cafeteria plan may require that that employee continue to make contributions for the coverage even though the coverage is no longer in effect.

**Example:** Employee wants to drop her coverage since she is also covered under her husband's plan and wants to save the money she is now paying for her coverage. There has been no change in her employment status and there is no change in her husband's employment status – therefore, there is no cafeteria premium pre-tax event. Again, she can drop the health coverage but she is unable to stop her cafeteria premium pre-tax deductions.

In summary, HIPAA and the cafeteria premium pre-tax rules establish a hierarchy which determines which rules are primary in any given instance. Basically:

- ◆ HIPAA determines if there has been a Special Enrollment Event first. If there is no Special Enrollment Event, then determine if the health plan has Late Entrant wording.
- ◆ Then cafeteria premium pre-tax rules should be

checked to see if a Qualifying Event has occurred. If so, premium contributions can be taken pre-tax. If not, then, if coverage is available under Late Entrant wording, premium contributions may be taken post-tax.

- ◆ HIPAA is not concerned with individuals wishing to drop coverage. In this instance, determine if there is a cafeteria premium pre-tax QE, if so then premium contributions can be ceased. If not, the individual can drop coverage, but will have to continue the pre-tax contributions until the next open enrollment.
- ◆ The cafeteria plan election rules for health care spending accounts are even more restrictive than the premium election rules and must be consulted prior to allowing a mid-year health FSA contribution election change.

*Barbara Heinonen, Director of Research & Compliance, Hays Companies Benefits*

## **NEW JERSEY LAW PROVIDING PAID FAMILY LEAVE SIGNED INTO LAW**

On May 2, 2008, New Jersey Governor, Jon Corzine, signed into law a paid family leave insurance program. This program will provide up to six weeks of paid leave for employees who request time off to care for seriously ill family members or to care for a newborn/newly adopted child.

The leave will be funded by a payroll tax of 0.09% (rising to 0.12% in 2010) on employee earnings up to the TDI limit currently at \$27,700. Deductions will begin on January 1, 2009; employees will not be able to claim benefits, however, until July 1, 2009.

Employees will receive 2/3s of their current wages up to a maximum of \$524 per week. There is a one week waiting period before benefits will be paid. If the leave extends for three or more weeks, the first week will become payable. Employees must submit a notice and claim for benefits within 30 days after the leave commences. The law does not appear to apply to leaves in less than full day increments.

Employers can require employees to take up to two weeks of available sick or vacation pay or other leave programs provided by the employer before receiving benefits under the new law. In this case, the one week waiting period may be offset by any such leave.

Although employers do not have to directly pay for this

## **NEW JERSEY LAW PROVIDING PAID FAMILY LEAVE SIGNED INTO LAW, cont.**

leave benefit, there are certain notice requirements. The New Jersey Commissioner of Labor will provide a Notice of Benefit Rights which must be posted and distributed to all New Jersey employees within 30 days of its being issued. In addition, the employer must provide employees with a written copy of this notice (1) upon hiring a new employer after the initial distribution; (2) when an employee notifies the employer that he/she is taking time off for situations covered by the Law; and (3) when requested by the employee.

When a claim is recognized, the employer will need to submit a printed notice to the Division of Temporary Disability Insurance containing the name, address, Social Security Number, and wage information for the employee as well as information that pertains to the employer itself. This notice must be issued by the ninth day of the leave, regardless of whether there is an unpaid leave or if the employee is being paid during the leave.

While other laws in New Jersey have minimum size limits for applicability, this law has no such provision. Therefore, even small employers are subject to this new law. Nor are there any provisions similar to the federal Family Medical Leave Law which define eligible employers and employees. Also unlike FMLA, the paid leave does not require an employer to return the employee to the same or equivalent position at the end of the leave. However, if the leave also qualifies under FMLA or the New Jersey Family Leave Act, this provision of the new law may not be applicable.

It is anticipated that New Jersey will issue more specific details on this new law as the first contribution period on January 1, 2009 approaches.

## **WHO, WHAT, WHEN... What is an SAR and what are we supposed to do with it?**

An SAR is a Summary Annual Report. Under ERISA pension and welfare plans are required to distribute the SAR to participants and beneficiaries under the plan. It will provide them information about the plan's financial status and is a brief version of the information that the plan reports on its annual 5500 reports filed with the government. There is no requirement to file a copy with the government. SARs need to be distributed within 60 days of the date the 5500 is required to be filed. For example, a plan with a plan year ending date of December 31<sup>st</sup> must file its 5500 forms by July 31<sup>st</sup> of the next calendar year. The SAR, in this case, must be issued by September 30<sup>th</sup>.

SARs can be distributed in a number of ways:

- ◆ By hand;
- ◆ Using a special insert in a periodical distributed to employees if the distribution list is comprehensive and up-to-date and a notice on the front page alerts the readers to the insert.
- ◆ Through the US Postal Services using the most current address for the participant.
- ◆ Electronically IF a) appropriate measures are taken to ensure that the system used for distribution results in actual receipt by participants; b) each participant is provided a notice, through electronic means or in writing, telling the participant that the SAR is being furnished electronically, the importance of the SAR, and the participant's right to request and receive, free of charge, a paper copy of the SAR.



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