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Perspectives on health care legal issues

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New law creates sweeping changes in NQDCP regulation

Many health care providers supplement their employee compensation and benefit packages with nonqualified deferred compensation plans (NQDCPs) that allow employees to defer income tax on plan contributions until they receive the money from the plans. In the wake of improprieties with executive compensation, Congress enacted a new law last year that brought sweeping changes to how NQDCPs are regulated. These changes, which are spelled out in Section 409A of the Internal Revenue Code, will generally be effective for deferrals occurring after Dec. 31, 2004.

Broad definition, major change

Sec. 409A defines an NQDCP as any deferred compensation arrangement that is neither a qualified employer plan nor a bona fide vacation leave, sick leave, compensatory time, disability pay or death benefit plan.

Amounts deferred under an NQDCP must be reported on an employee's W-2 or on an independent contractor's Form 1099.

The term "NQDCP" includes both elective and nonelective plans, including traditional deferred compensation plans, severance pay, long-term incentives, stock appreciation rights, discounted stock options, supplemental executive retirement plans, equity compensation awards, bonus deferral plans, phantom stock awards, and ineligible 457(f)



deferred compensation plans. The new definition may encompass simple letter agreements and employment contracts that were not originally intended as NQDCPs, and even a one-person arrangement may be considered a "plan."

The NQDCP definition specifically excludes payments of annual compensation made within 2½ months into the next year, vacation, sick leave, disability pay, death benefits, IRC Section 401(a) qualified plans, IRC Section 403(b) tax-deferred annuities, Savings Incentive Match Plans for Employees (SIMPLEs), Simplified Employee Pension (SEP) plans, and eligible IRC Section 457(b) plans.

To defer income taxes on NQDCP benefits until they are actually or constructively received by plan participants, the plan must satisfy:

- > Requirements pertaining to the initial deferral election,
- > Restrictions on the type of permissible events for which a distribution is allowed and on the acceleration of distributions, and
- > Limitations on the participant's ability to further extend the deferral or alter the form of the distribution.

Otherwise, the participant will pay income tax on plan benefits generally at the time they become vested. Plan distributions that don't conform to these requirements will face penalties and interest charges.

Time all elections

Under Sec. 409A, NQDCP participants must make initial deferral elections as to both the time and form of distributions before the taxable year in which services will be performed. In the case of performance-based compensation such as bonuses, the participant may make an election within the first six months of the taxable year.

Distributions are generally permitted:

- > At fixed dates or on fixed schedules,
- > Upon separation from service, death or disability,
- > Upon change in ownership or effective control of a corporation, or
- > In case of unforeseeable emergency.

Payments upon separation from service by a key employee of a publicly traded corporation must be delayed at least six months following the separation from service.

Participants who wish to change the timing and form of distributions must make such elections at least 12 months after the initial election and 12 months before the date of the first scheduled distribution. The new election must provide for account balances to be paid out at least five years later than the original distribution date.

Termination rights

An NQDCP may be terminated provided all other arrangements of the same type are terminated for all participants and the plan sponsor does not adopt a new NQDCP arrangement within five years. A plan sponsor also may terminate a plan upon a change in control of the corporation, corporate dissolution or bankruptcy.

Sec. 409A also regulates the funding options for NQDCPs. Assets may no longer be held in offshore trusts, or in trusts with financial health

triggers (wherein trust assets become restricted if the plan sponsor meets certain financial conditions).

Finally, Sec. 409A includes new reporting and withholding requirements. Amounts deferred under an NQDCP must be reported on an employee's W-2 or on an independent contractor's Form 1099, even if the amount is not included in the participant's income for that year. Nonqualified deferred compensation included in income will be subject to federal income tax withholding.



The penalties for violating the new section are severe. If an NQDCP does not meet Sec. 409A requirements, all current and prior years' amounts deferred must generally be counted as income. Amounts included in income because of a violation of Sec. 409A are also subject to a 20% penalty tax plus interest — which are paid by the plan participant, not the employer.

Identify and verify

Sec. 409A brings significant changes to NQDCPs. Although there may be additional changes in the future, NQDCP sponsors now face a substantial burden to identify arrangements which may be subject to Sec. 409A and to ensure that the NQDCPs meet the requirements of Sec. 409A.

Providers should review all written agreements with employees, partners and independent contractors to see whether they defer compensation and, thus, must meet the new Sec. 409A requirements. The potential for missteps by plan sponsors and the significance of penalties for participants make NQDCPs worthy of careful scrutiny. <

Consumer-directed health care means change for providers

Consumer-directed health care promises to reshape the face of health care in America, with significant implications for those who provide that care. From a push for more information sharing to direct-to-consumer advertising and the logistics of payment collections, providers will see changes in the way they work.

Health Savings Accounts

The Medicare Prescription Drug Improvement and Modernization Act of 2003 established Health Savings Accounts (HSAs) for individuals covered by high-deductible health plans. Participants may make tax-deductible contributions to the accounts to use for health care expenses.

HSAs appear to have become the primary driver in consumer-directed health care because they allow consumers to manage their own health care dollars. Individuals covered by high-deductible health plans must shoulder more responsibility, and they become more frugal, more informed and more willing to change providers. As a result, providers may need to re-examine their approaches to attracting and retaining patients.

HSA participants have a financial interest in reducing their health care expenditures. Participants (and often their employers) contribute to HSAs for future medical needs. Those who use any HSA funds for nonmedical purposes face a 10% penalty and the amount will be subject to federal income taxes. Any unused HSA funds, however, roll over to future years, and participants may leave the accounts for their heirs.

Consumers weighing the financial advantages of leaving their HSA balances intact — and earning interest — against the cost of their health care services are more likely to scrutinize the costs of treatment and to consider changing providers.

Information required

To decide how best to spend their health care dollars, consumers require more information. Although most have not typically had access to health care pricing, some high-deductible health plan sponsors now are giving consumers the prices the plans have negotiated with providers. In the past, this information was available only after the consumer had received care.



That transparency means consumers now may compare the cost of one physician or treatment option against another. Many are experiencing “sticker shock” as, for the first time, they are encountering the true cost of the medical care they receive. Providers will see increased pressure not only to inform consumers of the cost of services but also to price their services competitively.

Of course, pricing is just one consideration in a truly informed decision. Any correlations between cost and quality of care also must be addressed. Some treatment options, while significantly more expensive, may be more effective for a particular consumer.

Also, cost differences may not reflect factors such as experience and success rates. Without information beyond the cost of a treatment, consumers may choose inefficient or ineffective modes of care that will not result in the best possible outcomes at the lowest possible prices. Consumers may also demand information on clinical experience and treatment success rates, comparative cost analyses among treatment options, and provider success rates — all of which they will look to the provider to supply.

Detailed, understandable billing is another way to facilitate information sharing. The explanation of benefits that insurers provide today is filled with unintelligible codes that don't identify or explain the significance of the procedure performed. More transparency and "plain English" explanations will be required of providers in billing for their services.

Profits of prevention

Some of the information providers supply should encourage consumers to adopt healthier behaviors that can help reduce the

need for costly treatments. Providers must devote more time to explaining the benefits of a healthy lifestyle and preventive care, as well as the financial advantages of well-care benefits (physical exams, mammograms, childhood immunizations, etc.) that may be covered outside high-deductible plans.

In addition, providers can expect to practice in an increasingly retail-driven marketplace. Advertising

How do HSAs work?

Forrester Research predicts that the number of Health Savings Accounts (HSAs) in America will grow to more than 6.3 million by 2008. But how, exactly, do they work?

HSAs are open to individuals under age 65 who are covered under high-deductible health plans (those with annual deductibles of at least \$1,000 for individual coverage and at least \$2,000 for family coverage). Participants use funds from their HSAs to pay for medical care up to the amount of their deductibles. At the end of the year, any money left in the HSA may be rolled over for the next year's health expenses. As with an IRA, funds in the HSA belong to the participant even if he or she changes employers.

Participants and their employers may make contributions to the participants' HSAs. Contributions are tax deductible up to the amount of the annual deductible, but cannot exceed \$2,650 for individuals with single coverage and \$5,250 for individuals with family coverage. These dollar limits are indexed for inflation.

and customer service will take on new importance in an ever-more-competitive business environment.

An increased emphasis on direct-to-consumer advertising is already apparent in the pharmaceutical industry. A similar increase in provider advertising and branding can be expected in efforts to appeal to increasingly sophisticated patients. Providers will need to focus their customer-service functions, fielding more questions before rendering services. Providers will also have to concentrate more resources on billing and collections as patients assume primary responsibility for paying bills.

Adapt to change

Providers will be key players in the cultural and mental shift that will take place as patients evolve into consumers. New communications and treatment strategies will be required to deliver timely information and cost-effective services. As health care becomes a commodity in the minds of consumers, the providers who are successful at making the change to a more retail-oriented business model will best adapt to the changing marketplace. <

Strategy for change

Report shapes steps for national health information technology

Two years ago, President Bush announced a national health care strategy in which every American would have an electronic health record by 2014, and the records would all be linked into the National Health Information Network (NHIN). The president named Dr. David Brailer national coordinator for health information technology (HIT). It's Brailer's task to further the president's goal of using technology to encourage development of a health care system that puts patients first while being more efficient and cost-effective.

The question facing Brailer is how to succeed. The answer, according to a recently released report from the Commission on Systemic Interoperability, involves 14 steps.

14-step program

The report divides the steps into three categories to facilitate understanding: adoption (encouraging acceptance); interoperability (technology); and connectivity (networking, security and confidentiality).

HHS has already awarded \$17.5 million in grants to spur the adoption of HIT technology.

The five recommendations in the adoption category are the result of a combined effort of the Department of Health and Human Services (HHS) and the National Committee on Vital and Health Statistics, along with Congressional funding of the Health Care Quality Innovation Fund. They represent an attempt to engage the interest of the medical community and encourage prioritization of HIT needs through:

1. **Incentives.** Encourage financial and other enticements for participation in a standards-based health care information network. Incentives could include pay-for-performance approaches and grants for financially challenged participants.
2. **Regulatory reform.** Enhance health care entities' ability to work together while promoting competition and maintaining kickback protections. Recent rules proposed by HHS and Centers for Medicare and Medicaid Services would modify antikickback laws to allow certain donations of necessary equipment, technology and other resources.
3. **Reporting on adoption gaps.** Work to ensure the technology is available to all citizens equally, nationwide.
4. **Work force needs and impacts.** Identify deficiencies in the health care industry work force. Correcting deficiencies is seen as essential in strengthening the industry's ability to maximize technology benefits.
5. **Public awareness.** Mount a campaign to inform consumers, the health care industry and others on the benefits of HIT, and to encourage people to participate.

The interoperability category presents these challenges:

6. **Product certification.** The report demands that the purchasers of HIT have a reliable source of information concerning available technologies. Additionally, minimum standards must be established so that vendors will be able to differentiate their products and compete. In October 2005, HHS awarded a \$2.7 million grant for development of criteria and evaluation processes to certify technological resources.

7. Data standards. To ensure effective interaction of all technologies when they are synchronized into a single network, it's critical to establish a set of nonoverlapping, interoperable data standards. The standards will cover a variety of health care classifications, including clinical, billing, research, public health and administration. To advance the seamless integration, HHS has awarded \$3.3 million for a harmonization project to develop processes that support interoperability of a large variety of health care software and systems.

8. Standard product identifiers and vocabulary. Standardizing terms and product identifiers used in the industry will assist integration across the health information network.

9. Interoperability of drug records. Physicians and other caregivers need access to patients' medication records when necessary, while respecting privacy issues. A road map should be developed that can provide access to drug records and also serve as a model for future interoperable health care modules, such as laboratory records.

The connectivity category identifies these tasks:

10. Patient authentication standard. Without recommending a particular method, the report promotes a national standard for authenticating patient data and identity. The standard would allow providers to access vital patient medical information nationwide and assist with interconnection of networks.

11. Federal privacy standard. To ensure the security of health care information, the Commission has requested that Congress enact a national privacy standard for NHIN contributors and patients.

12. NHIN support. Financial support for NHIN is vital to its success, and the report suggests the federal government make sure the network has adequate funding from the Department of Homeland Security and other relevant agencies.

13. Criminal sanctions for privacy violations. To protect consumers, the report calls on Congress

to authorize criminal sanctions against those who intentionally access unauthorized data.

14. Consumer protections. The Commission asks Congress to protect consumers against discrimination and other consequences of unauthorized release of private information.

The largest HHS grant is for \$11.5 million, to be used for development of privacy and security solutions.

Signs of progress may be cited on at least one of the steps — the one encouraging federal financial support. HHS has already awarded \$17.5 million in grants to spur the adoption of HIT technology. The president has stated that the role of the federal government is not only to develop the process, but also to encourage the health care industry to become an active partner.



Broad funding support

Funding for increased use of HIT has enjoyed bipartisan political support, mainly due to expert analyses concluding that the technology could reduce health care costs by as much as \$120 billion a year by eliminating duplicate tests, shortening hospital stays and improving care for chronically ill patients. Many U.S. executives also have indicated their support, citing health care as the No. 1 cost issue for most businesses.

Still, the task is daunting. Brailer's goal is to have the groundwork laid for a comprehensive HIT system before President Bush leaves office, but even he acknowledges that its real effects may not be felt for 20 years. <

A message to our clients and friends:

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We understand the value of good information when making sound business decisions. *Practical Health Law* is written by Hall Render's health law attorneys, each with extensive experience handling the legal issues of health care providers. We trust the information in each issue will be a valuable resource. Our attorneys stand ready to respond promptly to your questions and needs; please contact us if there are specific topics you'd like to see addressed.

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IN Downtown Office: Suite 2000, Box 82064, One American Square, Indianapolis, IN 46282, Ph: 317-633-4884 Fax: 317-633-4878
IN North Office: Suite 820, 8402 Harcourt Road, Indianapolis, IN 46260 Ph: 317-871-6222 Fax: 317-338-3946
KY Office: 614 West Main Street, Suite 4000, Louisville, KY 40202 Ph: 502-568-1890 Fax: 502-568-4878
MI Office: Columbia Center, Suite 315, 201 W. Big Beaver Road, Troy, MI 48084 Ph: 248-740-7505 Fax: 248-740-7501
WI Office: 411 East Wisconsin Ave., Suite 900, Milwaukee, WI 53202 Ph: 414-721-0442 Fax: 414-721-0491