

Health and Welfare Plans: 2008 Year-End Review

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Although our nation's eyes will soon turn to Washington, D.C. and focus on the growing debate about how to deliver healthcare in our country, this debate will take months or years to conclude. In the interim, there are many recent developments that cannot be overlooked by health and welfare plan sponsors. The following summary provides a general overview of new guidance and legislation applicable to health and welfare plans. This summary is not intended to be an exhaustive list of all compliance requirements affecting health and welfare plans but is intended to provide a reminder of the general issues facing such plans.

Federal Developments

- **Cafeteria Plans:** In August 2007 the Internal Revenue Service (IRS) published proposed cafeteria plan regulations with a January 1, 2009 effective date. The IRS has informally indicated that because of the delay in issuing the final regulations, the regulations will instead apply to plan years beginning on or after January 1, 2010. Plan sponsors may rely on the proposed regulations until final regulations are issued or continue to use the prior proposed regulations. Absent any formal guidance from the IRS, plan sponsors should review their existing cafeteria plan design, administration, and documentation to ensure current compliance and identify those issues that will likely require attention when the final rule is in place. A copy of our recent LawFlash, offering suggested next steps for employers to take to position their cafeteria plans for the final cafeteria plan regulations, can be found at http://morganlewis.com/pubs/EB_LF_CafeteriaPlan_14oct08.pdf.
- **Medicare Part D Creditable Coverage Notice:** The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires group health plans that provide prescription drug coverage to notify Medicare Part D-eligible individuals whether their prescription drug coverage is at least actuarially equivalent to Medicare Part D coverage. Centers for Medicaid and Medicare Services (CMS) issued revised model notices that should be used after June 15, 2008. Plan sponsors should update their Medicare Part D creditable coverage notices to reflect the recent changes.
- **Dependent Definition:** Ongoing efforts to tweak the definition of "dependent" under the tax rules present challenges for health and welfare plans. In October 2008, the Fostering Connections to Success and Increasing Adoptions Act of 2008 was enacted. It requires that a "qualifying child" be unmarried and younger than the individual claiming the child as a dependent. If no parent claims the child as a dependent, another taxpayer may claim the child as a dependent, but the other

taxpayer must have a higher adjusted gross income than either of the parents. Employers with plans that specifically track the actual section 152 language to define an eligible dependent need to consider whether plan changes are needed to ensure that coverage is restricted to the intended class of dependents. Plan documentation and employee communications should be reviewed to ensure that they accurately reflect these legislative changes and support the plan sponsor's intent.

- ***Final Regulations Regarding Children of Divorced or Separated Parents:*** In August 2008, the IRS issued Revenue Procedure 2008-48 describing the circumstances under which the IRS will treat a child of parents who are divorced, separated, or living apart as the dependent of both parents for purposes of the Internal Revenue Code related to medical expenses, medical coverage, and certain other employee benefits, when the custodial parent has not released the claim to the exemption for the child. Consequently, dependents of divorced parents can be covered by either parent's employee benefit plan on a tax-preferred basis, and the employer of the parent providing the coverage will not have to impute income on the value of coverage. Generally, Revenue Procedure 2008-48 is effective immediately.
- ***Expanded FMLA Leave:*** The National Defense Authorization Act for Fiscal Year 2008 (NDAA) amended the Family and Medical Leave Act (FMLA), expanding the leave entitlements for the families of servicemembers. Under the new provisions, an employee who is the spouse, son, daughter, parent, or next of kin of a servicemember with a serious injury or illness is entitled to 26 weeks of protected leave to provide care for the servicemember. This provision went into effect on January 28, 2008. The NDAA also expands the reasons an eligible employee can take 12 weeks of FMLA protected leave to include any "qualifying exigency" related to a spouse, son, daughter, or parent being on active duty or being called to impending active duty in the military. This second provision will technically go into effect once the Department of Labor (DOL) issues regulations, but until then employers are encouraged to make a good-faith effort to provide this type of leave to eligible employees. A copy of our LawFlash discussing the expansion of FMLA leave for the families of servicemembers can be found at http://www.morganlewis.com/pubs/LEPG_FMLAArmedForces_LF_31jan08.pdf.
- ***Medicare Mandatory Reporting:*** The Medicare, Medicaid, and SCHIP Extension Act of 2007 added new mandatory reporting requirements for group health plans. Group health plan insurers or third-party administrators, as well as plan administrators and fiduciaries of self-insured and self-administered group health plans, are required to submit required data elements electronically, on a quarterly basis, to help CMS identify when the group health plans are primary to Medicare. Plan sponsors should request adequate assurances in writing that their insurers or third-party administrators are assuming responsibility for the data collection and reporting process. Plan sponsors currently in negotiations with service providers should negotiate the cost and responsibility for the data collection and reporting process and ensure that the responsibility for the process is clearly stated in the service agreement. On August 1, 2008, CMS published a Supporting Statement that outlines the required data elements. The effective date for group health plans is January 1, 2009. Similar reporting requirements apply to nongroup health plans (liability insurance, no-fault insurance, and workers' compensation programs) which become effective July 1, 2009. CMS offers supporting materials for registration and specific data elements on their website at www.cms.hhs.gov/MandatoryInsRep/. A copy of our LawFlash explaining the Medicare mandatory reporting rules in greater detail can be found at http://www.morganlewis.com/pubs/EB_MedicareSecondaryPayer_LF_12sept08.pdf.

- **Expansion of the ADA:** Under the ADA Amendments Act of 2008, effective January 1, 2009, any condition that substantially limits a major life activity will be considered a disability, even if the individual can offset or compensate for the disability with mitigating measures such as hearing aids or artificial limbs. The new law prohibits consideration of mitigating measures such as medication, medical supplies, etc., but not eyeglasses and corrective lenses, in the determination of whether an impairment substantially limits a major life activity. Employers will need to review their employment practices and procedures and the scope of the “reasonable accommodations” made for disabled employees to make sure that they are in compliance with the new law. A copy of our LawFlash discussing the expansion of the ADA can be found at http://morganlewis.com/pubs/LEPG_AmericansWithDisabilitiesActExpanding_26sept08.pdf
- **Health Savings Accounts:** In 2008, the IRS finalized regulations for Health Savings Accounts (HSAs) that explain how to apply the requirement that a comparable contribution be made for every HSA participant in the same class. The IRS also released Notice 2008-59, which provides plan sponsors with a new set of formal questions and answers on HSAs. Notice 2008-59 clarifies rules regarding HSAs as they relate to eligible individuals, high-deductible health plans, contributions, distributions, prohibited transactions, and administration. Plan sponsors should ensure compliance with this new guidance.
- **New Fee Disclosure Rules:** The Employee Retirement Income Security Act (ERISA) provides relief from the prohibited transaction rules for contracts or arrangements for the provision of services between an ERISA plan and a party in interest. In order to be eligible for this relief, the contract or arrangement must be reasonable, the services must be necessary for the establishment or operation of the plan, and the plan cannot pay more than reasonable compensation for the services. The DOL issued proposed regulations that govern the service provider fee disclosures that must be included in the service provider contract in order for the contract to be considered reasonable under ERISA. If adopted in their current form, the proposed regulations would take effect in 2009. In the meantime, plan sponsors should identify service provider contracts subject to the new rules.
- **Bicycle Commuting Benefit:** Starting January 2009, employers have the option to provide employees with reimbursement of certain bicycle commuting expenses free of federal taxes. Up to \$20 may be provided for each month that an employee regularly uses a bicycle for a substantial portion of travel between work and home. An employee receiving bicycle benefits cannot receive other commuter fringe benefits for van pooling, parking, or public transit. This benefit cannot be offered as part of a cafeteria plan and employees cannot pay for this benefit with salary reductions.
- **Mental Health Parity:** The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 requires that full parity be established between mental health/substance abuse benefits and the medical/surgical benefits offered under a group health plan. The new law requires parity when such benefits are offered but does not require plans to provide mental health or substance abuse benefits. This requirement generally becomes effective for large group health plans, including self-funded, fully insured, and governmental plans, on the first plan year on or after October 2, 2009 (January 1, 2010 for calendar year plans). The effective date for plans maintained pursuant to one or more collective bargaining agreements is the later of (i) the date on which the collective bargaining agreement relating to the plan terminates (determined without regard to any extension) or (ii) January 1, 2010.

- ***Michelle's Law:*** On October 9, 2008 President Bush signed H.R. 2851, commonly referred to as "Michelle's Law." Michelle's Law applies to both large and small group health plans, including self-funded and fully insured governmental plans, and requires group health plans to continue coverage for dependent college students who take medically necessary medical leave for up to one year or, if earlier, the date on which coverage would otherwise end under the plan. Michelle's Law is effective for plan years beginning on or after October 8, 2009 (January 1, 2010 for calendar year plans). Amendments to comply with Michelle's Law should be adopted before the rules take effect (December 31, 2009 for calendar year plans). A copy of our LawFlash explaining Michelle's Law in greater detail can be found at http://morganlewis.com/pubs/EB_LF_MichellesLaw_14oct08.pdf.
- ***Genetic Information:*** The Genetic Information Nondiscrimination Act of 2008 (GINA) bans the use of genetic information for health insurance and employment purposes. Title I of GINA prohibits group health plans and health insurance issuers from discriminating on the basis of genetic information with respect to eligibility, premiums, and contributions, and applies to group health plans for plan years beginning after May 21, 2009 (January 1, 2010 for calendar plan years). Title II of GINA also prohibits employers from discriminating on the basis of genetic information in employment decisions and acquiring genetic information except in limited circumstances (that will impact wellness programs), and is effective on November 21, 2009. Under GINA it appears that a health risk assessment coupled with premium discounts, credits, or additional care cannot include questions regarding the manifestations of a genetic disease or disorder of family members. Group health plan amendments to comply with GINA should be adopted before the rules take effect (December 31, 2009 for calendar year plans). A copy of our LawFlash explaining GINA in greater detail can be found at http://www.morganlewis.com/pubs/LEPG_GeneticInformation_LF_22may08.pdf.
- ***FSA Distributions for Reservists:*** The Heroes Earning Assistance and Relief Tax Act of 2008 (HEART Act) allows plans to offer "qualified reservist distributions" of unused amounts in health flexible spending accounts (FSAs) to reservists ordered or called to active duty for at least 180 days or on an indefinite basis. The relief applies to distributions on or after June 18, 2008. Employers who choose to accommodate these distributions must amend plan documents before making distributions. An employee must request a qualified reservist distribution *on or after* the date of the order to call to active duty, and before the last day of the plan year (or grace period, if applicable) during which the order or call to active duty occurred. The employer must receive a copy of the order or call to active duty (or extension thereof) to confirm compliance with the 180-day/indefinite requirement. The qualified reservist distributions (minus any after-tax contributions such as Consolidated Omnibus Budget Reconciliation Act (COBRA) payments) are reportable as taxable wages. In addition to document and reporting changes, plan sponsors offering these distributions to their reservists-employees will need to issue summaries of material modifications and plan to update summary plan descriptions. The IRS issued Notice 2008-82, which provides guidance on the technical aspects of qualified reservist distributions. The comment period on IRS Notice 2008-82 ends on January 12, 2009.

State Developments

- ***San Francisco Health Care Ordinance:*** The San Francisco Health Care Ordinance (Ordinance) requires covered employers to make healthcare expenditures for their covered employees. On September 30, the Ninth Circuit U.S. Court of Appeals upheld the Ordinance, rejecting arguments by the Golden Gate Restaurant Association and the Department of Labor that the law is preempted

by ERISA. The decision is subject to an *en banc* rehearing, and is likely to be appealed to the U.S. Supreme Court if upheld on rehearing. The immediate effect of the Ninth Circuit decision is that employers should comply with the Ordinance. Employers with few employees in San Francisco may find it easier to pay the required contribution to the city rather than amend or expand eligibility under their current health plan. Employers with a large number of employees in San Francisco may decide to add a Health Reimbursement Arrangement (HRA) for their San Francisco employees who are ineligible for coverage under the employer's group health plan. Employers that fail to comply with the Ordinance are subject to fines equal to 150% of the required contribution under the Ordinance. A copy of our LawFlash discussing the Ordinance and the Ninth Circuit decision can be found at http://morganlewis.com/pubs/EB_LF_SFHealthOrdinance_14oct08.pdf.

- **Same-Sex Marriage:** Same-sex marriages are legal in Connecticut and Massachusetts. The state of same-sex marriages in California is in flux with the passage of Proposition 8 on November 14, 2008, which defines marriage in California as a union between a man and a woman. In February 2008 the regional Appellate Division of the New York Supreme Court noted that the State of New York has historically recognized marriages legally consecrated in other jurisdictions except in the cases of incest or polygamy. Accordingly, the same recognition must be extended to same-sex marriages because the New York legislature has not enacted legislation to prohibit the recognition of same-sex marriages validly entered into outside of New York. The Iowa Supreme Court recently heard arguments regarding whether the state's ban on same-sex marriage is unconstitutional. Employers with insured health benefits in these states, or with domestic partner benefits, should review their benefits to see what changes may be required due to the continuing evolution of states' recognition of same-sex marriages.
- **Massachusetts Minimum Creditable Coverage Rules:** Starting January 1, 2009, Massachusetts residents 18 years of age and older who do not have health coverage that satisfies certain minimum creditable coverage requirements may be subject to tax penalties that could exceed \$900 per person. Massachusetts recently issued final regulations on these requirements, which enable employers to establish that their plans satisfy the minimum creditable coverage standards by demonstrating actuarial equivalence. The regulations also provide a delayed effective date for collectively bargained plans and liberalize rules for high-deductible health plans offered in conjunction with health savings accounts. Employers should review their health plan offerings in Massachusetts to determine whether or not their plans satisfy these new requirements.

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