Throughout last year, many federal regulations involving health and welfare benefit plans were issued or became effective. In this article, we’ll review provisions that require action in 2009 or in which an effective date was delayed until later this year. Topics include flexible spending accounts, dependent definitional changes, commuter and transit benefits, health benefits, and health savings accounts.

Flexible Spending Accounts

Debit Card Guidance. Debit cards have become a preferred method of health plan reimbursement for many plan participants. Over the years, regulations have spelled out where participants may use their health plan debit cards. The original guidance from the IRS limited use to merchants with a health care-related merchant category code, but later notices eased that rule. IRS Notice 2007-02 provided that after January 1, 2009, participants couldn’t use the cards at merchants with a drugstore or pharmacy merchant category code unless (a) the store participated in a new auto-adjudication mechanism called the inventory information approval system (IIAS) or (b) at least 90 percent of the individual store’s gross receipts in the prior taxable year came from medical care items. Many pharmacies and drugstores cannot satisfy the 90 percent requirement and therefore must implement an IIAS. Fortunately, on December 4, 2008, the IRS issued Notice 2008-104, which delayed the effective date of this rule for six more months, until July 1, 2009.

The net result is that all merchants with a drugstore or pharmacy merchant category code are still considered health care providers through June 30, 2009, without regard to the level of gross sales that represent medical expenses. More specifically, the health debit card can still process (even without an IIAS) at pharmacies and drugstores as long as other substantiation requirements in the original guidance (such as copay match or “pay and chase”) are in place.

Qualified Reservist Distributions. The Heroes Earnings Assistance and Relief Tax Act of 2008 (Heart Act) took effect on June 18, 2008. It amended Internal Revenue Code Section 125 and other sections to permit plan sponsors to amend their cafeteria plans and health FSAs to make a cash distribution of unused health FSA benefits (qualified reservist distributions) to certain health FSA participants called to active duty indefinitely or for 180 days or more (qualified reservists).

The IRS issued Notice 2008-82 in October 2008 to clarify questions about the distribution and also established a limited retroactive amendment period, which ends December 31, 2009, and may be retroactively effective for qualified reservist distributions elected on or after June 18, 2008. Qualified reservists called to duty before June 18, 2008, may still qualify for a qualified reservist distribution to the extent that (a) they requested a qualified distribution no later than June 18, 2008, and (b) the plan year has not ended. You can access IRS Notice 2008-82 at www.irs.gov/irb/2008-41_IRB/ar09.html.
Dependent Definitional Changes

Children of Divorced or Separated Parents. On July 2, 2008, the IRS issued final regulations revising Code Section 152(e), which sets forth rules that determine which parent may claim a child for income tax purposes if the parents are divorced or separated. Generally, only the custodial parent may claim a child for income tax purposes; however, Section 152(e) provides a means for a custodial parent to release the right to the exemption and allow the noncustodial parent to claim the child. For health benefits, Code Section 105(b) and Rev. Rul. 2008-48 indicate that both parents may claim a child to whom Code Section 152(e) applies. For dependent care FSAs, only the custodial parent may be reimbursed for eligible custodial care expenses, without regard to who claims the child under Section 152(e). The final regulations made clarifications such as how to determine who is the custodial parent in joint custody situations.


Michelle’s Law. Michelle’s Law applies to virtually all health insurers and group health plans (whether self-funded or insured) that provide dependent coverage to students at post-secondary institutions. Michelle’s Law applies when a dependent child would lose required student status due to a change in student status because of the medically necessary absence. Clarifying guidance is needed.

Commuter/Transit Benefits


Bicycle Commuter Benefit. The economic stabilization act enacted on October 3 included a bicycle commuter benefit to the transportation fringe benefit rules in Code Section 132(f). Under the bicycle commuter benefit, an employee may be reimbursed annually on a tax-free basis up to $20 for each month that is a qualified bicycle commuting month. The bicycle commuter benefit is effective January 1, 2009.
Benefits & Compensation Law Alert January 2009

Health Benefits

Mental Health and Substance Abuse Parity. On October 3, 2008, President Bush signed into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 as part of the Emergency Economic Stabilization Act of 2008. This Act significantly affects employer-sponsored health plans that offer mental health and/or substance abuse benefits with cost and treatment limitations that are more restrictive than for other medical and surgical benefits.

In brief, the Act extends parity law provisions (both current and in the Act) to substance abuse benefits, as defined in the plan. A plan’s financial requirements (such as deductibles, copayments, and out-of-pocket expenses), treatment limitations, and out-of-network coverage must be applied to mental health and substance abuse benefits on the same basis as they are to the plan’s medical and surgical benefits. The Act also contains exemptions and required disclosures.

The Act becomes effective the first day of the plan year beginning one year after the date of enactment, which means January 1, 2010, for calendar year plans. For plans maintained under collective bargaining agreements (CBAs) ratified before October 3, 2008, the Act will not apply to plan years beginning before the later of (a) the date on which the last CBA relating to the plan terminates (determined without regard to any extension agreed to after the enactment of the Wellstone Act) or (b) January 1, 2010.

Newborns and Mothers Health Protection Act. Final regulations on the Newborns and Mothers Health Protection Act (NMHPA) were issued on October 20, 2008, and are effective for plan years beginning on or after January 1, 2009. The regulations finalize, without change, interim and final NMHPA regulations issued in 1998 but clarify the definition of attending provider and how nongovernmental plans may give notice of post-childbirth hospitalization benefits. The regulations are available at http://edocket.access.gpo.gov/2008/pdf/E8-24666.pdf.

Health Savings Accounts


IRA Rollover. The IRS also issued Notice 2008-51, which provides detailed guidance regarding qualified HSA funding distributions. The notice is available at http://ustreas.gov/offices/public-affairs/hsa/pdf/n-08-51.pdf.

Calculating the Maximum Contribution. IRS Notice 2008-52 provides significant detail on how the maximum HSA contribution is calculated, with special emphasis on the “full contribution rule.” You can access IRS Notice 2008-52 at http://treasury.gov/offices/public-affairs/hsa/pdf/n-08-52.pdf.

Courts Tackle Lifetime Retiree Health Benefits

Two recent cases, one from the federal Sixth Circuit Court of Appeals and the other from the state of Washington’s highest court, both upheld the right of retirees to continue to receive promised health benefits that their unions negotiated in collective bargaining agreements with their former employers. Although the Sixth Circuit opinion was unanimous and the Washington Supreme Court ruled 5-4 in favor of employees, both cases signal continuing litigation over benefits promised in better economic times but employers contend weigh them down when the economy turns sour. Bankruptcy courts may have the final say.

Sixth Circuit Case: 46-Year-Old Benefit

The Sixth Circuit case was brought in the Eastern District of Michigan as a class action by the United Auto Workers union and retired hourly employees of auto parts manufacturer Rockwell International Corp. and its successor companies. The employer established retiree health coverage in a 1962 CBA, paying for half of the cost of benefits, and began paying the entire cost three years later. Retirees and their eligible dependents, including surviving spouses, were covered, regardless of whether the retirees received company pension benefits. The core language on the retiree health benefit remained virtually the same in 12 separate CBAs between 1968 and 2000.

The employer began making unilateral changes to the retiree health benefit in 2001, when it froze reimbursements on Medicare Part B premiums, a change that raised retirees’ expenses by several hundred dollars a year. In 2003, the employer unilaterally ended dental, vision, and hearing-aid coverage for retirees and also raised deductibles, copays, and out-of-pocket maximums.

The UAW and the retirees then brought their lawsuit, claiming that the unilateral changes violated the Labor Management Relations Act (LMRA) and ERISA. When the employer said in 2005 that it would eliminate all health benefits in 2006 for retirees, dependents, and surviving spouses age
65 and older, the UAW and retirees asked the court for a preliminary injunction to keep the benefits intact. The court not only granted the preliminary injunction, but also granted the retirees a summary judgment in the entire case, meaning the retirees won their case as a matter of law, without the need to go to trial. Needless to say, the employer appealed.

**A Matter of Intention**

To the district court, the main issue was whether the union and the employer intended to provide lifetime retiree health coverage and expressed their intention in the explicit language of the CBAs. The court found that the parties did have that intention and expressed it in the contract, citing evidence that included, among other things, the context of the CBA; written “lifetime” assurances to employees, retirees, and dependents; decades of booklets and summary plan descriptions promising that health benefits would continue during retirement; and oral assurance of lifetime coverage from company officials.

The appeals court approached the issue from the standpoint of vesting, namely, whether the employer and union intended the retiree health benefits to vest when they signed the CBA. Unlike pension benefits, retiree health and welfare benefits vest only if parties intended that result when they signed the labor agreement. If health coverage has vested, any unilateral termination violates Section 301 of LMRA. On the other hand, employers are free to unilaterally terminate unvested benefits upon expiration of the CBA.

Under the leading Sixth Circuit case on vesting of benefits, the court was to determine vesting based on the intention of the parties as shown in the CBA. The case also recognized an inference of an intention to vest retiree health benefits. Later case law seemed to back away from the inference, saying it would be recognized only if the CBA and other evidence showed an intent to vest.

The court of appeals examined the CBA and agreed with the district court that the parties intended the health benefits to vest. It said that the district court correctly ruled that the CBA contained language (namely, that the health benefits an employee has at retirement . . . shall continue thereafter) that previous cases had found to indicate an intent to vest.

**Durational Language**

The employer’s position throughout was that durational language in the CBA had limited health benefits to the term of the CBA. The durational language provided that the CBA’s insurance provisions “shall continue in effect until the termination of the Collective Bargaining Agreement of which this is a part.” The district court found that because this clause didn’t specifically refer to retiree benefits, it spoke only generally to the length of the CBA. Moreover, the district court noted that this particular employer’s pension plan contained a virtually identical durational clause, and the employer acknowledged that the pension plan was vested. Why would the employer use virtually the same language in two parts of the CBA and maintain that it had one meaning in one part and another meaning elsewhere, the district court asked. The appeals court upheld the district court’s ruling on durational language as consistent with 6th Circuit precedent. The retirees retained their right to the health benefits. *Cole v. ArvinMeritor, Inc.*, Sixth Circuit U.S. Court of Appeals, Case No. 06-2224, decided on December 16, 2008.

**Washington Supreme Court Weighs In**

The Washington case involved the Port of Seattle’s 1997 CBA with the International Longshore and Warehouse Union, Local 9. The CBA provided that employees who retired after age 62 with sufficient years of service would receive retiree health benefits under a special welfare trust agreement. Retiree costs under the plan were low; a 62-year-old retiree with 15 years of service, for example, would pay $20.35 per month. In early 2003, after the 1997 CBA expired, the port announced that it would no longer contribute to the plan. Benefits would still be available, but under the port’s own plan and at much greater cost, between about $400-$482 per month.

A group of nine current and retired employees sued the port, arguing that they had a permanent vested right in the retiree medical benefits provided under the original plan at the original low cost. In a 5-4 decision, the Washington Supreme Court agreed, finding that the 1997 CBA gave the retirees a vested right in the plan’s health benefits, which the court viewed as a form of deferred compensation.

**Expansive CBA Language, Expectations**

The majority focused on language in the CBA in which the port had agreed to “maintain the current level of medical, welfare, dental and related benefits during the duration of this contract and . . . continue to provide the same level of coverage currently provided to eligible employees, eligible retirees, and dependents.” The court interpreted the italicized language as a promise to provide “eligible retirees” with retiree medical benefits at 1997 levels and at 1997 costs.
The court also placed great weight on employee expectations. It noted that under its precedent, retirement benefits vest when created if they are considered “compensatory.” In determining whether benefits are compensatory, the court focused on the employees’ expectations at the time the retirement benefits were conferred rather than the express language of the contract.

The court reasoned that retiree benefits are simply a form of deferred compensation, stating that welfare benefits “make up part of the core compensatory benefits package” employers offer to employees. Thus, employees have a “legitimate expectation” that retirement benefits vest when conferred as compensation through a CBA.

The port argued that even if the rights had vested, there was no right to perpetual coverage under the plan. It pointed out that it had always reserved the right to cancel the plan, a point that was clearly communicated to the employees in the summary plan description.

**Durational Language**

According to the plan, it would automatically terminate upon the expiration of “all collective bargaining agreements and special agreements requiring the payment of contributions to the Trust Fund.” In addition, it specifically provided that its board of trustees could change eligibility rules, reduce benefits, or eliminate the plan entirely. The port argued that the additional terms showed there was never any intention to provide perpetual benefits at 1997 levels and costs.

The port’s argument failed, according to the majority, because it incorrectly assumed that the terms of the trust fund agreement could limit the port’s underlying CBA obligation to provide the benefits conferred in the agreement. In the majority’s view, the only language that mattered was the CBA promise to provide “the same level of benefits.”

**Vigorous Dissent**

Four justices dissented, arguing that retiree health benefits are not deferred compensation. The dissenting justices argued that the majority’s ruling “would impose a vesting requirement on all employment relationships where health care coverage is provided to employees, thereby usurping the parties’ right to address retirees’ coverage by private contract.” The dissent further cautioned that the majority’s ruling would result in many employers simply ceasing to provide retiree health care benefits to avoid the possibility of incurring an obligation to provide benefits for life.

Finally, the dissent noted that while the plan in question was exempt from the Employee Retirement Income Security Act, the court could still look to case law interpreting the Act. According to the dissent, an examination of ERISA would have been relevant because when creating the Act, Congress decided not to impose a vesting requirement for health and welfare benefits to avoid the “onerous burden” it would place on employers. Because the CBA didn’t contain “clear and express language” demonstrating the intent to vest rights to lifetime health care benefits, the dissenters would have found for the port. *Navlet v. Port of Seattle*, No. 78866-9, 2008 WL 4595162 (Wash., Oct. 16, 2008).

**Bottom Line**

It’s too early to determine if this case will have the far-reaching effects foreseen by the four dissenting justices. For one thing, retiree medical plans governed by ERISA wouldn’t be subject to the same analysis because ERISA requires that any right to a fixed level of lifetime health benefits must be stated in the plan documents in clear and express language. Nonetheless, in light of this decision, all Washington employers would be prudent to review their policy and plan documents. Other employers may want to review their policy, plan documents, and any applicable state laws as well. ♦

**GINA Creates New Pitfalls for Wellness Programs**

The Genetic Information Nondiscrimination Act (GINA) will become effective for employment purposes on November 21, 2009, and for group health plans for plan years beginning January 1, 2010. You need to understand your obligations and limitations under this broad new law. That’s particularly true for employers that offer wellness programs because GINA creates new complications and magnifies some existing ones.

**Limits on Acquiring Genetic Information**

GINA prohibits the acquisition of genetic information, including family history, by employers for nearly all employment purposes, including the design and administration of benefit programs. One of the few exceptions to that blanket prohibition is for a “bona fide wellness program.”

As with the other exceptions, even when the acquisition of genetic information is permitted, it must be done only under limited circumstances. The most important limitations include the following:
• Genetic information can be acquired when an employee provides previous, knowing, voluntary, and written authorization.

• Only the employee (or a family member, when applicable) and the health care professional may know about the information (including the results of any genetic testing).

• The employer cannot be informed of any individualized information (if the information is part of a health study, it can be shared with the employer in aggregate terms only, with no specific identities revealed).

One result of the limitations noted by some preventive health care practitioners is that no one can be compelled to take a genetic test, even as part of a general health care program included in a wellness program.

In most respects, the operation of a wellness program under GINA will not be changed, except that violations of confidentiality and other provisions of the Act will be subject to much more significant sanctions and damages than in the past. A violation of GINA is exactly like a violation of Title VII or the Americans with Disabilities Act (ADA). That will almost certainly create a higher level of watchfulness and security.

**Interplay with Other Laws**

Although most employers with wellness programs have become aware of GINA, the interaction of GINA with other laws may cause greater administrative and legal difficulties.

The Equal Employment Opportunity Commission (EEOC), under its authority to enforce the ADA, has offered important guidance for wellness programs. The agency has stated that participation in a wellness program must be voluntary, and the decision to participate in the program cannot be a factor in any employment-related decision or program. You can make disability-related inquiries that would otherwise be illicit under the ADA only if participation is voluntary, according to the EEOC. It may once have been possible to ask health questions that don’t implicate the ADA, but under the recent amendments to the Act (effective January 1, 2009), that option no longer seems open.

The EEOC has clarified that “voluntary” also means that when an incentive to join a wellness program is too good to refuse (a large discount on a health insurance premium, for example), the wellness program will no longer be considered “voluntary.” As a result, it will lose any protections provided to a truly voluntary program.

Even the IRS gets into the act. Incentives to join a wellness program, such as a cell phone or MP3 player, are considered imputed income to be reported by the employer. So even if the incentive satisfies the EEOC, the taxman may have problems with it. This is a developing area of the law; certain incentives, such as discounted gym fees, haven’t been regarded as taxable. We advise you to be watchful.

**New Hampshire Employers Adapt to Civil Unions**

Even before the recent one-year anniversary of the enactment of the civil-union law in New Hampshire, one prominent employer made several significant decisions affecting employees in same-sex relationships. The decisions illustrate issues that are emerging in other states with civil-union laws, issues that may await employers in other states in this evolving area of law.

**What Happens to Domestic-Partner Benefits?**

The University of New Hampshire (UNH) will terminate same-sex insurance benefits in July for couples who do not enter into a civil union. The university’s decision affects approximately 63 out of 4,300 total workers. UNH’s decision follows one made by the state earlier last year. Civil unions became available in New Hampshire for same-sex couples in January 2008.

One reason to change the benefits policy is to prevent claims of discrimination. Now that same-sex couples are able to enter into civil unions, employers are exposed to sexual-orientation discrimination claims if they deny domestic partner benefits to unmarried heterosexual couples but continue to provide them to same-sex couples who choose not to enter a civil union. Sexual-orientation discrimination in employee benefits is prohibited under New Hampshire law.

**Tax Bite from Federal-State Conflict**

UNH has also committed itself to remediying adverse tax consequences for couples who make the move to partner in a civil union and maintain their insurance benefits.

When the state of New Hampshire made a similar decision to phase out same-sex benefits, a number of state employees chose not to enter into civil unions or enroll in benefits because doing so added to their tax burden. Under federal law, the fair market value of benefits received by their civil-union partners would be counted as income to the employee for federal income tax purposes. Thus, those same-sex individuals’ income taxes would increase even though their salary technically did not.
This tax quirk is the result of a conflict in the law between states like Connecticut and New Hampshire, which have adopted marriage equality or civil unions, and the federal government, which doesn't recognize same-sex unions under the Defense of Marriage Act (DOMA).

UNH has decided to help same-sex couples facing this obstacle by paying the additional taxes they would face, around $800 to $1,200, depending on the health plan in which the employee is enrolled. Some employers may find this of interest if they are concerned about trying to put same-sex employees on even footing with their married coworkers.

More Change on the Horizon?

Just as employers are getting a handle on the new civil-union law, members of the New Hampshire Legislature are already considering ways to change it.

The Democratic lawmaker who sponsored the civil-union law has vowed to introduce a bill granting full marriage equality between same-sex and heterosexual couples. It’s important to remember, however, that any change will not undo the effect of federal law, which doesn’t recognize either same-sex marriage or civil unions.

On the other side of the aisle, a Republican representative plans to introduce a bill that would repeal the section of the law that allows same-sex marriages in other states to be recognized as civil unions in New Hampshire. Interestingly, he doesn’t seek the repeal of the law in its entirety.

No matter what moves New Hampshire or its neighbors make next on the issue, DOMA continues to limit rights of individuals in civil unions and same-sex marriages. There is much speculation about what changes, if any, may occur when President-elect Barack Obama, who opposes DOMA, takes office.

Bottom Line

Recognition of same-sex relationships by government is a roller coaster political issue in New Hampshire and across the country. New England states have been particularly active in the arena, with nearly all states now offering some form of benefits for same-sex partners. Those benefits range from full marriage rights to modest domestic partner recognition in some spheres (e.g., spousal visitation rights or domestic partner registries). By necessity, many employers must keep up with the patchwork of laws in this area — especially in New Hampshire, where out-of-state unions are recognized.

Government Briefs:
PPA Rules, HIPAA Guidance

Rules Issued on PPA Civil Penalties for Nondisclosure

The U.S. Department of Labor has issued a final regulation implementing its authority to assess civil penalties against plan administrators who fail to disclose certain documents to participants, beneficiaries, and others as required by ERISA, as amended by the Pension Protection Act (PPA).

The PPA established new disclosure provisions relating to the following: funding-based limits on benefit accruals and certain forms of benefit distributions; plan actuarial and financial reports; withdrawal liability of contributing employers; and participants’ rights and obligations under automatic contribution arrangements. The PPA gave the DOL authority to assess

And the Survey Says . . .

Employers trim salaries, 401(k) matches

Employers increasingly are examining salaries and benefits in efforts to manage costs, a recent survey from the HR consulting firm Watson Wyatt reveals. Nearly two in 10 employers — 19 percent — planned to freeze salaries in the next 12 months, and another 13 percent said they had already done so. Six percent planned to reduce salaries, and five percent said they had already made the cuts, while 43 percent of employers said they would increase communication on pay. And 61 percent cut merit increases from 3.8 percent to 2.5 percent. Regarding benefits, seven percent said they planned to decrease or eliminate company matches to 401(k)-type retirement savings plans; another three percent said they already had done so. The survey was conducted during the week of December 8, 2008, and includes responses from 117 companies across a variety of industries.
civil monetary penalties of up to $1,000 per day per violation against plan administrators for violations of the new disclosure requirements. The final regulation sets forth the administrative procedures for assessing and contesting such penalties and does not address the substantive provisions of the new disclosure requirements.

This final regulation was published in the January 2, 2009, Federal Register and can be found online at edocket.access.gpo.gov/2009/pdf/E8-31188.pdf. It takes effect on March 3, 2009.

**HIPAA Privacy Rule and Health Information Technology**

New HIPAA privacy rule guidance is available as part of a privacy and security toolkit developed by the Office of Civil Rights at the Department of Health and Human Services and available online at www.hhs.gov/ocr/hipaa/hit/. The guidance implements the Nationwide Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information. These new guidance documents discuss how the Privacy Rule can facilitate the electronic exchange of health information.

Individual segments of the guidance cover the following principles, along with frequently asked questions on each topic:

- Correction,
- Openness and transparency,
- Individual choice,
- Collection, use, and disclosure limitation,
- Safeguards, and
- Accountability.

Other topics include (1) the HIPAA privacy rule’s right of access and health information technology and (2) personal health records and the HIPAA privacy rule.

---

**For Your Benefit**

➤ **Illinois autism insurance bill**

Gov. Rod Blagojevich last month signed into law a measure mandating coverage for autism diagnosis and treatment. According to information on the Autism Society of Illinois web site, the measure requires that group and individual health insurance or managed care plans that are amended, delivered, issued, or renewed after December 12 must provide individuals under 21 years of age coverage for the diagnosis and treatment of autism-spectrum disorders if not already covered.

The maximum annual benefit under the law is $36,000, to be adjusted in later years for inflation. There are no limits on number of visits to a service provider. Those with the insurance will still have to meet deductibles, copayments, and other financial requirements, and the measure contains nondiscrimination provisions.

Covered treatments include psychiatric care, psychological care, and habilitative or rehabilitative care. Covered therapies include behavioral, speech, occupational, and physical therapies. The measure is SB0934.