ALERT

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EB IN '08: A LOOK BACK

Legislators and regulators were busy in 2008, as existing rules were adjusted and expanded and new rules enacted, mostly on the federal level, but also by state and local offices. We highlight the top legal and regulatory stories of the year.

- Expanded Federal Requirements
  - Additional Military Service-Related Leave Under FMLA
  - New FMLA Regulations
  - ADA Amendments Act Redefines Disability
  - Mental Health Parity Requirements Expanded and Extended to Substance Abuse
  - Medicare Secondary Payer Reporting Requirement
  - New Tax Break for Bicycle Commuting Benefits
  - Rules For Offering Waiver Incentives to TRICARE-Eligible Employees
  - Plans Must Use National Provider Identifiers in Electronic Transactions

- New Federal Laws
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- Cafeteria Plan Proposed Regulations: To Amend or Not to Amend?

- Health Savings Account Guidance
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  - HSA Contribution Limits and the Full Contribution Rule
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- Notices for Medicare Part D Revised (Twice!)

- State and Local Laws Bedevil Employers
  - Massachusetts and San Francisco Mandates
  - Extended Dependent Age Mandates
  - Recognition of Same-Sex Marriages
  - Paid Leave Mandates Enacted

EXPANDED FEDERAL REQUIREMENTS

Some of the most significant developments during 2008 built on existing federal laws.

ADDITIONAL MILITARY SERVICE-RELATED LEAVE UNDER FMLA

Legislation adopted last January addressed the needs of military families by granting FMLA leave rights in two additional circumstances.

- Employers must provide caregiver leave of up to 26 weeks for an employee who is needed to care for a family member who was injured or became ill while on active military duty. These provisions became effective on January 28, 2008, the day that President Bush signed the legislation.

- Employers must grant active duty leave of up to 12 weeks to employees who have a "qualifying exigency" arising from a family member being called to or engaged in active military duty. The provisions went into effect January 16, 2009, the effective date of final regulations defining qualifying exigency (see the discussion of FMLA regulations below).

For more information, see *Employee Benefits Alert*, Issue 126, "FMLA Amended to Provide Leave to Military Families."

NEW FMLA REGULATIONS

On the heels of the FMLA amendments that added military family leaves, the Department of Labor (DOL) issued proposed revisions to existing FMLA regulations. Reflecting 15 years of court cases and numerous comments, the proposed rules included many changes and clarifications, including:

- Changes to the FMLA medical certification requirements
- Changes to the intermittent leave requirements
- Clarification of the term "serious health condition"
- Clarification of the circumstance under which paid leave may be used during FMLA leave
- Revisions to the employer and employee notification requirements

For more information, see *HR Focus*, Issue 1, "More FMLA Changes on the Way."

The DOL made few changes to the proposed regulations when it issued its final FMLA rules in November. It did, however, add provisions addressing the two types of military family leave – caregiver leave and active duty leave – that were added to the FMLA in January 2008. Compliance with the final FMLA regulations is required starting January 16, 2009.

For more information, see *HR Focus*, Special Issue, December 2008, "Department of Labor Issues New FMLA Regulations."

ADA AMENDMENTS ACT REDEFINES DISABILITY

Enacted in September, the ADA Amendments Act significantly expanded the group that qualifies for protection under the Americans with Disabilities Act (ADA). Starting January 1, 2009, the amendments make it much easier to qualify under the ADA's definition of disability. The amendments did not change the protections that the ADA provides to those with disabilities. The ADA protections simply apply to more individuals. For more information, see *HR Focus*, Special Issue, October 2008, "Americans With Disabilities Act Amended to Provide More Protection to Disabled."

Some have expressed concern that, under the expanded definition of disability, certain common health plan exclusions (such as those for hearing aids or treatment of infertility) will violate the ADA. While the Equal Employment Opportunity Commission (EEOC) may yet interpret the ADA amendments as having that effect, right now, it is not apparent that employers must eliminate these provisions. Employers generally are taking a wait-and-see approach.

MENTAL HEALTH PARITY REQUIREMENTS EXPANDED AND EXTENDED TO SUBSTANCE ABUSE

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Wellstone Act) might have drawn more attention if it had not been enacted as part of October's financial system bailout, the Emergency Economic Stabilization Act of 2008 (EESA). (For information on other EESA provisions affecting benefits programs, see *HR Focus*, Issue 16, "Key Benefit Provisions in the Emergency Economic Stabilization Act of 2008.")

The Wellstone Act added to the requirements of the 1996 Mental Health Parity Act (MHPA). It is sometimes characterized as providing "full" or "real" parity because:

- It extended parity requirements to substance use disorder benefits in addition to mental health benefits.
- It prohibits applying financial requirements (e.g., copayments and deductibles) or treatment limitations (e.g., annual limits on outpatient visits or hospital days) to mental health or substance use disorders unless those requirements and limitations are no more restrictive than those that apply to most medical and surgical benefits. The act also maintained the MHPA's ban on lower annual or lifetime dollar limits for mental health benefits.

The new Wellstone Act requirements generally are effective for calendar year plans starting January 1, 2010. For most other plans, they are effective for plan years starting after October 3, 2009. For more information, see *HR Focus*, Issue 14, "Mental Health Parity Act."

MEDICARE SECONDARY PAYER REPORTING REQUIREMENT

In 2008, benefits professionals prepared to comply with a 2007 federal law requiring insurers and TPAs that administer group health plan benefits to gather and report certain information about plans and participants to the federal Centers for Medicare and Medicaid Services (CMS). (If a group health plan is self-funded and administered entirely by the employer with no third-party assistance, the reporting burden falls on the employer.) The information is intended to assist CMS with enforcement of the Medicare Secondary Payer rules under which employer plans generally must be the primary payer for employees and their dependents who have both employer coverage and Medicare. The reporting requirement is effective January 1, 2009.

The law leaves it to CMS to dictate what information must be reported, how often, in what form and by what means. In August 2008, CMS announced that instead of issuing regulations on the reporting requirements, it would provide reporting instructions on its website. Since that announcement, we have received details of the reporting requirements in sporadic installments. As insurers and TPAs digested these instructions, they began demanding that employers turn over to them various information about plan participants and their dependents. Because the reporting obligation generally rests on insurers and TPAs, it is unclear how noncompliance with the reporting requirement might affect employers that sponsor group health plans. For more information, see *HR Focus*, Issue 17, "CMS: New Data Collection Requirements to Enforce MSP."

NEW TAX BREAK FOR BICYCLE COMMUTING BENEFITS

A new type of qualified transportation benefit was buried deep within the EESA: a bicycle commuting fringe benefit. The EESA amended the tax code provisions that allow employers to provide tax-free mass transit passes and parking so that, starting January 1, 2009, employers may reimburse employees on a tax-free basis for certain bicycle commuting expenses. The maximum annual reimbursement is $20 multiplied by the number of months during the calendar year in which the employee regularly uses a bicycle for a substantial portion of the travel from home to work. Reimbursable expenses include the cost of purchasing, repairing and storing a bicycle. The benefit is limited, however, because an employee cannot receive reimbursement for bicycling expenses during any month in which the employee receives other qualified transportation fringe benefits. For more information, see *HR Focus,* Issue 17, "New Bicycle Commuter Benefit."

RULES FOR OFFERING WAIVER INCENTIVES TO TRICARE-ELIGIBLE EMPLOYEES

Starting in 2008, federal law generally prohibited employers from offering TRICARE-eligible employees any financial or other incentives to drop (or not enroll in) an employer-sponsored group health plan that would provide primary coverage. Like Medicare, TRICARE coverage for veterans generally is the secondary payer for individuals with health coverage through employment. Early in 2008, the Department of Defense (which administers TRICARE) issued proposed regulations that make an exception to the general rule prohibiting incentives to waive employer coverage. The proposed regulations would allow employers to include TRICARE-eligible employees in certain broad-based programs that provide incentives for employees to waive coverage under the employer's health plan. For more information, see *HR Focus*, Issue 1, "TRICARE-Eligible Employees."

PLANS MUST USE NATIONAL PROVIDER IDENTIFIERS IN ELECTRONIC TRANSACTIONS

The NPI – a unique 10-digit identification number for a health care provider – is one of the standard identifiers that health plans and other covered entities must use, according to federal rules, when carrying out certain electronic transactions. May 23, 2008 was the deadline for health plans to fully comply with the HIPAA NPI requirements. For more information, see *HR Focus,* Issue 3, "Yet Another HIPAA Compliance Deadline."

NEW FEDERAL LAWS

In addition to building on existing requirements, 2008 legislation also created entirely new obligations for employer health plans.

GENETIC INFORMATION NONDISCRIMINATION ACT

The Genetic Information Nondiscrimination Act of 2007 (GINA), which became law in May 2008, prohibits employment discrimination based on genetic information, as well as most employer and insurer requests, requirements and purchases of genetic information. GINA echoes existing HIPAA provisions that preclude discrimination against individuals based on genetic information with respect to health plan eligibility, premiums or contributions. GINA goes one step further and prohibits plans from requiring individuals to meet genetic testing requirements in order to obtain coverage. In addition, GINA prohibits discrimination by insurers based on genetic information when setting premiums or contributions for group health insurance. GINA also requires revision of the HIPAA privacy rules so that using genetic information for underwriting purposes is no longer permitted.

GINA's group health plan provisions will apply to plan years starting after May 21, 2009 (January 1, 2010 for calendar year plans). For more information, see *HR Focus,* Issue 5, "President Signs Genetic Information Nondiscrimination Act of 2007 (GINA)."

MICHELLE'S LAW

Under Michelle's Law, a group health plan cannot terminate a child's coverage for loss of full-time student status if the change in status is due to a "medically necessary leave of absence." A group health plan may be required to allow such a child to remain covered as an employee's dependent for up to a year after the leave of absence begins. Coverage may end earlier if another reason for termination arises. The law also includes rules about the notices that employers send requiring employees to submit proof of full-time student status.

Michelle's Law is effective for calendar year plans starting January 1, 2010 or plan years beginning after October 9, 2009. For more information, see *HR Focus,* Issue 16, "Michelle's Law Signed into Law."

HEART ACT

The Heroes Earnings Assistance and Relief Tax Act (HEART Act) included several provisions affecting retirement and death benefits for veterans and their families. It also included an amendment to the rules governing cafeteria plans with health flexible spending arrangements (FSAs). As health FSA sponsors know, health FSAs can only make distributions for qualifying medical expenses, and unused balances must be forfeited at year-end under the IRS "use it or lose it" rule. The HEART Act gives an employer the option to amend its health FSA to allow a cash payment of an individual's unused health FSA balance if he or she is called to active duty. Several special conditions must be met. For example, the participant must be called to military duty of more than 179 days. IRS guidance issued during 2008 provides details on these conditions and the steps a plan must take in order to allow these cash-out payments. For more information, see *HR Focus,* Issue 9, "HEART Starts Pumping Relief to Veterans and Their Families" and *HR Focus,* Issue16, "IRS Notice Provides Guidance on Health FSA Distributions Under the HEART Act."

The health FSA provisions of the HEART Act are *optional* for employers. Nothing requires employers to amend their plans to allow for these cash-outs.

DOL CHECKLIST FOR WELLNESS PROGRAMS

Wellness took center stage for many HR professionals in 2008 as a strategy to lower costs for employers while improving the health of employees. Wellness programs often provide incentives for employees to meet health goals (e.g., cholesterol below 200 or blood pressure below 140/85). The incentives frequently involve health plan premium discounts or benefit enhancements. Under HIPAA's nondiscrimination rules, such health plan incentives are prohibited unless they meet several conditions, including:

- Alternative wellness goals must be offered to individuals for whom meeting the health standards would be medically inadvisable or unreasonably difficult due to a health condition.
- Maximum incentives must be limited.

Early in 2008, the DOL issued a checklist of criteria that wellness programs must meet in order to comply with HIPAA nondiscrimination regulations. While the checklist mostly confirmed previous guidance, it also included two items that give plans more leeway in designing wellness incentives. In one item, the DOL explained how health-related incentives

can be combined with non-health-related incentives to encourage program participation. In the other, the DOL confirmed that discrimination in wellness programs is in fact permissible – when the program discriminates in favor of individuals with health problems. For more information, see *Employee Benefits Alert*, Issue 128, "More Guidance, More Flexibility on Wellness Programs."

CAFETERIA PLAN PROPOSED REGULATIONS: TO AMEND OR NOT TO AMEND?

The IRS issued proposed regulations on cafeteria plans in August of 2007 (see *Employee Benefits Alert*, Issue 116, "IRS Releases Proposed Cafeteria Plan Regulations") with a proposed effective date of January 1, 2009. As it became clear that the IRS would not finalize the proposed regulations during 2008, many employers became concerned that they would need to amend their cafeteria plans before the proposed January 1, 2009 effective date.

Informal comments of IRS officials have indicated that the rules, once final, will be effective for plan years starting on or after January 1, 2010, but the IRS has not provided any official confirmation. For a discussion of the options employers may want to consider, see *HR Focus*, Issue 12, "Proposed IRS Rules: Time to Review Cafeteria Plans?"

HEALTH SAVINGS ACCOUNT GUIDANCE

Consumer-directed health care plans continue to attract employers seeking to rein in health care costs by means other than cost-shifting to employees. Health savings accounts (HSAs) are appealing for their unique combination of tax advantages and employee ownership and control. In 2008, the IRS added to the extensive guidance it has issued on HSAs.

REGULATIONS ON COMPARABLE CONTRIBUTIONS TWEAKED

Employers contributing to employees' HSAs are required to make comparable contributions to similarly situated employees' HSAs, and IRS rules explain in detail how this requirement applies. The IRS resolved confusion over comparable contributions in two situations:

- When eligible employees do not establish their HSAs by the end of the year (or fail to notify the employer that they have done so)
- When the employer accelerates contributions to one or more employees' HSAs in order to provide funds for medical expenses incurred early in the year

Employers who make their HSA contributions through a Section 125 cafeteria plan (or who allow employees to make pre-tax contributions to their HSAs through a Section 125 cafeteria plan) are not subject to the comparable contributions requirements or the IRS rules interpreting them. For more information, see *HR Focus*, Issue 4, "Finalized Rules on Comparable Contributions to HSAs."

HSA CONTRIBUTION LIMITS AND THE FULL CONTRIBUTION RULE

The IRS issued guidance on maximum HSA contribution limits, explaining the "full contribution" rule. Normally, the annual contribution limit is prorated based on the number of months during the year that an individual is eligible for

HSA contributions. According to the full contribution rule, the maximum statutory limit for a full year applies to an individual who meets the rule's requirements even if the individual was not eligible for HSA contributions throughout the year. For more information, see *HR Focus*, Issue 7, "IRS Issues Guidance on HSA Contribution Limits."

A GRAB-BAG OF GUIDANCE

The IRS issued more Q&A guidance on day-to-day operational questions. This collection – popularly referred to as the grab-bag guidance – addressed several issues that affect employers' efforts to maintain HSA-compatible plans. Topics included:

- HSA contribution limits when an individual switches mid-year from family to individual coverage
- Benefit exclusions or limitations that may prevent a plan from qualifying as the HDHP coverage that an individual must have in order to qualify for HSA contributions
- When hospital indemnity coverage, on-site health clinic availability, and health FSA or health reimbursement arrangement (HRA) participation will interfere with eligibility for tax-favored HSA contributions
- Timing issues relating to employer contributions to an employee's HSA
- An employer's ability to recoup contributions it makes to an employee's HSA

For more information, see *HR Focus*, Issue 8, "HSA Guidance: Keep Those Contributions Tax-Free."

U.S. SUPREME COURT DECISION ON REVIEWING CLAIMS

The U.S. Supreme Court held that when one party both reviews claims and provides the funds to pay them, the claims decisions made by that party are not entitled to as much deference as decisions made by a financially disinterested claims reviewer. Exactly how much less deference will be determined by lower courts as they apply the principles set by the Court. The Court's rationale provides some clues for plan administrators who are trying to ensure that their claim denials are respected in the event of a legal challenge. For more information, see *HR Focus*, Issue 9, "Managing Claims and Plan Funds Is a Conflict of Interest: Court Ruling."

MEDICARE PART D NOTICES REVISED (TWICE!)

CMS revised the notices employers must send out explaining whether prescription drug coverage is equivalent (creditable) or not equivalent (non-creditable) to the standard Medicare Part D prescription drug benefit. Employers that sponsor group health plans are required to distribute these notices when certain events occur and at least once each year. The first revision occurred mid-2008, as explained in *HR Focus*, Issue 9, "CMS Revises Medicare Part D/Creditable Coverage Disclosure Form."

CMS has now posted another set of revised forms for use after January 1, 2009. It has also revised the document that provides guidance on the disclosure requirements. These revised items are available at the CMS website. We expect to provide commentary on these changes in a future *Alert*.

STATE AND LOCAL LAWS BEDEVIL EMPLOYERS

State and local legislators adopted various laws affecting employee benefits in 2008, including various measures intended to make health care coverage more widely available and affordable. The laws that drew the most attention fell into three categories:

- Mandated employer health coverage (pay-or-play laws)
- Extended dependent age mandates
- Laws recognizing domestic partnerships and same-sex marriages
- Paid-leave mandates

These laws cause particular concern for employers that operate in several jurisdictions. Federal preemption of these laws under the Employee Retirement Income Security Act (ERISA) provides these employers some protection against multiple, inconsistent requirements, but the extent of that protection is not always clear.

MASSACHUSETTS AND SAN FRANCISCO MANDATES

Massachusetts and San Francisco employers were especially hard hit by mandates in 2008.

While the Massachusetts' Health Care Reform Act (HCRA) has been in effect since 2007, several regulatory developments under this law during 2008 had Massachusetts employers scrambling to revise their health benefits and put procedures in place to meet reporting and recordkeeping requirements.

- The HCRA requires employers to make a "fair and reasonable" contribution toward the cost of employees' health coverage or pay an assessment. Employers are also required to file reports. Final regulations implementing this requirement made it considerably more difficult for employers.
  - The final regulations converted the reporting and payment requirements from an annual obligation to a quarterly obligation, starting with Q4 of 2008.
  - The regulations raised the bar for determining whether an employer has made a fair and reasonable contribution.

- The HCRA includes a separate mandate for individuals, requiring most Massachusetts residents 18 or older to obtain health coverage or be subject to tax penalties. Regulations were issued in October that, effective January 1, 2009, set minimum standards for individuals' health coverage. While employers are not required to provide coverage that complies with the minimum standards, many employees expect to comply with the mandate by enrolling in employer-sponsored coverage and they will put pressure on their employers to offer coverage that complies.

For additional information on Massachusetts' fair and reasonable contribution regulations, see *HR Focus*, Issue 15, "Massachusetts Health Care Reform Act: Fair Share Contribution Requirements More Onerous." For additional information on the Massachusetts minimum standards for individual coverage, see *EB News Flash*, October 22, 2008: "Massachusetts Adopts Final Minimum Creditable Coverage Regulations" and *EB News Flash*, December 3, 2008: "Massachusetts Connector's Guidance on MCC Certification" (both available from your Willis HRH representative).

San Francisco employers had a roller coaster ride in 2008 regarding the San Francisco Health Care Security Ordinance (HCSO), under which medium and large businesses must make certain minimum contributions toward their San Francisco employees' health care. Employers can meet the requirement by providing health benefits or by paying into a

program maintained by the city. Late in 2007, a district court ruled that the employer mandate was preempted by ERISA and could not be enforced. A few days into 2008, however, the Ninth Circuit Court of Appeals allowed the city to enforce the HCSO while an appeal of the district court's ruling was pending. Therefore, most San Francisco employers were already complying with the HCSO in September when the appeal was decided in favor of the city. The Ninth Circuit's ruling, that ERISA does *not* preempt the HCSO, raises the specter of health benefits mandates from cities and states across the country. Appeals in this case are continuing.

For additional information about the lawsuit involving the HCSO, please see *Employee Benefits Alert*, Issue 125, "Appeals Court Revives San Francisco's Employer Healthcare Mandate." For additional information on ERISA preemption, please see *HR Focus*, Issue 8, "General Healthcare/ERISA Reform" and *HR Focus*, Issue 1, "DOL Weighs In On ERISA Preemption."

EXTENDED DEPENDENT AGE MANDATES

Raising the maximum age through which parents can cover their children as dependents continues to be a popular legislative trend. Several states enacted insurance mandates extending coverage for dependent children by raising the dependent age or removing the full-time student requirement. These mandates collide with ERISA preemption and federal tax laws in ways that create complexity for employers. In particular, the older dependent children for whom coverage is mandated by these laws often do not qualify as employees' dependents for purposes of receiving health coverage that is excluded from federal taxes. For more information, see *HR Focus*, Issue 12, "Over-Age and Under-Insured: Extending Benefits for Dependents."

RECOGNITION OF SAME-SEX MARRIAGES

In June 2008, a California court struck down the state's ban on same-sex marriage. About 18,000 same-sex couples got married before the ban was reinstated in November by an amendment to the state's constitution. In October, Connecticut also began allowing same-sex marriage. While New York does not allow same-sex marriage, it began recognizing same-sex marriages legally performed in other jurisdictions. These developments have prompted many questions about the effect of these laws on benefit plans. For additional information, see *HR Focus*, Issue 7, "Since You Asked: How Will Our Plan Be Affected by Same-Sex Marriage?" and *HR Focus*, Issue 8, "Since You Asked: How Will Our Plan Be Affected by Same-Sex Marriage? – Part Two."

PAID LEAVE MANDATES ENACTED

Paid leave was another popular legislative topic in 2008, with mandates being enacted in New Jersey, Washington D.C. and Milwaukee.

- In New Jersey, employees may take up to six weeks of paid family leave under the state's temporary disability insurance program. Beginning January 1, 2009, benefits funded entirely by employees through payroll deductions will become payable for qualifying leaves that begin on or after July 1, 2009. The leave will be available to employees to care for a family member with a serious health condition or to bond with a child during the first 12 months following the child's birth or adoption.

- Washington D.C. passed the Accrued Sick and Safe Leave Act of 2008. Depending on the size of the employer, employees will be entitled to 3-7 days of paid leave that can be used to cover an absence due to an illness, injury or medical condition of the employee or to the employee caring for a family member in need of medical care, including a child, parent, spouse or domestic partner. The paid leave can also be used for an employee or employee's family member who is a victim of stalking, domestic violence or sexual abuse and needs medical, social or legal services.

- Milwaukee's paid leave law was enacted by voter referendum. While specific details about the mandate are not yet available, people working in Milwaukee for employers with 10 or more employees are entitled to up to 72 hours of paid leave in a calendar year. For employers with fewer than 10 employees, the annual maximum is 40 hours. The leave can be used for an employee's or a family member's mental or physical illness, injury or medical condition, or for preventive care, medical diagnosis or treatment. The leave can also be used for an employee or family member who is a victim of stalking, domestic violence or sexual assault in order to receive medical, social or legal services.

For more information, see Willis HRH Employee Benefits Practice *Alert*, January 2009, "More Paid Leave Mandates."

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