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Voluntary Correction Program Changes

For years there has been an uneasy truce between sponsors of qualified retirement plans and Internal Revenue Service agents. Why? Because of a lone penalty for a plan not in perfect compliance: disqualification. Disqualification — a draconian punishment — could result in years of tax deductions being reversed, with accompanying interest and penalties, on both the plan sponsor and plan participants. This could be so devastating to employees that Internal Revenue Service agents were reluctant to use this “nuclear penalty.” So, disqualification was rarely invoked except in truly egregious circumstances. This left many plan sponsors both complacent and insecure about their plans’ qualification status.

Many employers, and some of their advisors, began embracing a “don’t ask, don’t tell” approach to plan compliance. There was a reluctance to look too closely for fear of finding a problem that could trigger an audit. Many plans that were not in compliance had long-standing problems that could have exploded under a particular set of circumstances. In reality, negotiations with IRS auditors often resulted in reduced penalties, *if* it could be shown that the plan sponsor was diligent and took efforts to address errors.

The uneasy truce started to fade about ten years ago. The IRS first issued rules so employers would come forward voluntarily, pay a penalty tax, and fix their plans without fear of disqualification.

This process, the Employee Plans Compliance Resolution System (EPCRS), has been updated to allow plans that have failed to make amends through one of the following correctional programs:

- Self-Correction Program (SCP) for operational failures,
- Voluntary Correction Program (VCP), for operational, plan document, and nondiscrimination failures, and adoption of a 401(k) plan by an ineligible employer, and
- Correction on Audit Program (Audit CAP) for failures identified on audit.

With any of these programs, additional taxes and penalties associated with plan disqualification will be avoided, making the fix much more palatable — even if the cost to fix the problem is high.

With the opportunity to fix a plan, employers can take a more active role knowing

that there are ways to comply without incurring huge costs. Plus, the IRS has stated many times that it intends to be much more aggressive with plan sponsors who do not avail themselves of the various methods of getting their plans into compliance.

ECPRS Changes

The IRS has recently introduced changes in Revenue Procedure 2006-27 that could make EPCRS even easier to use. The changes that may have the most impact are as follows:

If the plan sponsor corrects the plan failures fully in accordance with EPCRS, the plan will be treated as satisfying the applicable provisions for FICA and FUTA taxes (as well as the income tax). This change will further reduce the potential tax penalties associated with plan disqualification.

EPCRS is expanded to include terminating “orphan plans”: benefit programs that have not been properly terminated before an employer goes out of business. The new rules provide for leniency for full correction and a waiver of the VCP fee in appropriate cases.

In situations where the plan permits plan loans operationally but does not have the appropriate plan loan language, a correction method has been created.

An alternative correction method exists for a failure to obtain spousal consent — a particularly sticky issue for many employer-sponsored plans.

Several other taxes and fees are reduced by:

- Expanding the number of excise taxes that the IRS may not pursue,
- Lowering the compliance fee for a plan that only fails to satisfy the minimum distribution rules for 50 or fewer employees, and
- Reducing the compliance fee for a plan that only fails to timely adopt certain plan amendments.

Most importantly, if a plan violation relates to a failure to properly amend the plan and that problem is discovered during audit, the applicable fee under EPCRS will likely be even greater than before. Employers who find problems with their qualified retirement plans should quickly review the findings with their advisors and seek methods under EPCRS to fix those issues.

Variations on Mandating Health Coverage

Following Maryland’s “Fair Share” law, which generally mandates health care coverage contributions by employers with more than 10,000 employees, a bill pending in the New York Assembly would require businesses with 100 or more workers to contribute \$3 per employee-hour worked to employees’ health insurance. Lobbying efforts on both sides have concentrated on the Senate, which has a Republican majority that struggles to find a balance between its business and labor constituents.

So far only one major business has come out in support of it, and the majority of New York businesses are urging Senate Majority Leader Joseph Bruno to vote against it. Bruno has already noted that the current state of competition in the health insurance market is “unfair” and “inequitable,” because some businesses pay for their employees’ health insurance while others rely on state-sponsored programs. Opponents of the bill say that it will cause some businesses to cut jobs or hurt their ability to expand. Legal challenges to the “Fair Share” law are expected in Maryland as some experts assert that the controversial statute exceeds the scope of state legislative authority.

EEOC Falters in Effort To Keep Up

The *Washington Post* is reporting complaints from Labor unions and civil rights groups that the U.S. Equal Employment Opportunity Commission (EEOC) has fallen behind in its enforcement of federal civil rights laws in the workplace. The number of cases in the agency's backlog could reach beyond 45,000 in the next fiscal year: more than 6,000 over its 2005 backlog.

Critics assert that perceived problems stem from a reduction in financial support called for in President Bush's 2007 budget plan. The new budget is projected to reduce the EEOC's funding by \$4 million. An EEOC spokesman noted that all federal agencies are feeling the pinch as the Bush Administration continues to focus its money and efforts on Homeland Security and Defense Departments.

Capping Cancer Drug Costs

The *Wall Street Journal* reports that some cancer drug makers are concerned that the high price of cancer drugs will bring on a public relations nightmare like that experienced by makers of AIDS drugs. Although the cost of cancer drugs has always been higher than other types of drugs, prices in recent years have been skyrocketing.

Some private insurers and employers are requiring patients to pay ten to 50 percent of the cost of these expensive drugs and patients are becoming more vocal. The *Medicare Modernization Act of 2003* has changed Medicare drug reimbursement rates and so reimbursements are in line with drugs' actual selling prices. This means that physicians and hospitals can no longer afford to forgive Medicare co-payments and those who happen to have the highest rates of incidences of the disease, are now paying thousands of dollars out of their own pockets.

Some pharmaceutical and biotech companies are considering price caps and other cost containment measures. A few notable proposed ideas include establishing an annual patient price cap, setting an annual ceiling on individual patients' drug-treatment costs (beyond which companies would provide the drug free of charge or at a steep discount) and directing patients who exceed the cap and meet income guidelines to an independent charitable program that would provide the drug free, or at a fraction of the price.

Costly Healthcare Prevents Enrollment

The on-line journal *Benefits.com* reports that the rising cost of medical care is preventing workers from enrolling in employer-subsidized insurance. The article cites a new Robert Wood Johnson Foundation study which shows, among workers who were eligible for employer-sponsored coverage, three million fewer enrolled in it in 2003 than in 1998.

Researchers indicated that premium increases accounted for much of that drop. Their findings show that individual premiums increased more than 40 percent over that five-year period. Though the average employee's share of the premium cost remained unchanged at 18 percent from 1998 to 2003, and employers paid the remaining 82 percent, employees found themselves unable to afford coverage.

Nationwide, more than half of uninsured adults cite the cost of coverage as the reason they are uninsured. Approximately 25 percent of uninsured adults report losing coverage when they lost a job or changed jobs, and 17 percent said that either their employer did not offer coverage or they were ineligible.

Are COBRA Premium Hikes Transferable?

A *FOCUS on Benefits* reader recently relayed this scenario. The employer uses a calendar year COBRA premium determination period. New rates for COBRA qualified beneficiaries are announced each December. This year, the insurance company said that it will not know the new premiums until March. This leads to a reasonable question — if the insurer raises the premiums in the middle of the determination period, can the plan sponsor pass that premium increase to qualified beneficiaries?

Under COBRA, premiums must be determined for a 12-month period and this decision must be made before the determination period begins. According to the IRS regulations, the only exceptions to passing through changes in premiums are:

The plan can require an increase if it was not requiring employees to pay the full premium during the determination period and decided to start charging the full applicable premium;

An individual becomes eligible for the COBRA disability extension and the employer wishes to charge up to 150 percent of the applicable premium instead of 102 percent; or

The qualified beneficiary changes coverage under the plan (e.g. moves from single to family coverage), which results in a corresponding change in the governing premium. (The plan is allowed, but not required, to charge any applicable premium increase.)

Nothing in COBRA prohibits a third-party (such as an insurance carrier) from increasing the rates charged to the employer for all participants, including COBRA participants, mid-year. Unfortunately, such rate changes do not allow for adjustments to the applicable premium during the determination period.

Possible Options

Although no express authority exists, it may be possible to reasonably “estimate” the applicable rate increase before the start of the determination period and announce the new amount as the applicable premium for the year. Instead of charging the new premium immediately, the plan sponsor should continue charging the usual premium for the first few months of the year and then adjust upward to the amount noted before the determination period. If the actual premium increase is lower than the rate announced by the plan, the plan sponsor would only raise the COBRA premium to match the insurance company rate. If the premium increase that arrives is higher than the rate announced by the plan, the plan sponsor at least salvages the ability to recover part of increased cost. This strategy, though not tested to our knowledge in the courts, seems to be a way of allowing the plan sponsor to “put its foot in the door” to reserve the ability to adjust premiums while it has the opportunity.

Changing the determination period to run on a 12-month period beginning each March 1 is another option. Again, there is no direct regulatory authority for changing a determination period, but there also is no requirement that the determination period be either the same as the policy year or the plan year. If a plan sponsor took this route, it should continue to operate on the March 1 determination year for at least the next two years.

Note that a plan can never charge more than the “applicable premium”. So, in the rare event that the premium is decreased, the new applicable premium would be lower for COBRA participants because total plan costs would be lower. This is because applicable COBRA coverage rules direct that any premium decrease must be passed immediately through — *without* regard for the determination period.

Since You Asked: Common Law Spouse Coverage

At last count, there were about a dozen states that recognize common law marriage if the couple meets criteria set forth under state law. We often field questions about common law spouses and their eligibility for coverage under an employer's group medical plan.

Self-funded plan sponsors may decide how or if they want to cover common law spouses. This is because self-funded plans can rely on ERISA preemption to overrule any pertinent state law. In order to enforce an exclusion of common law spouses, the employer must actually operate a group health plan that specifically contains the exclusion language in its plan document and the plan's SPD. Insured plans must depend on the state law definition of "spouse" and how the insurer includes (or excludes) common law spouses.

As a practical matter, many plans fail to exclude common law spouses. A typical plan might operate under a rule that requires it to provide coverage for any spouse that is recognized by state law — which may entitle common law spouses to health coverage. Whether a self-funded plan excludes common law spouses is ultimately a plan design issue. In many cases, excluding coverage for common law spouses proves helpful because trying to get to the underlying facts about whether a spouse truly is a common law spouse is simply too difficult.

One method for determining common law marital status that seems to work fairly well is to check retirement plans and any life insurance plan designations. Although it costs employees little or nothing to claim someone as a common law spouse for medical plan purposes, there is an undeniable cost associated with having a bona fide spouse where a retirement plan is at issue. Within the retirement plan context, spouses hold a variety of rights — including the power to restrict distributions from the plan. If the individuals are not truly living as spouses, the employee will likely object to giving the other person the right to veto beneficiary designations that are to someone other than the spouse. So, a check of the retirement plans can sometimes turn up questionable claims of common law relationships.

Issue Spotlight: FMLA; In-Laws and Other Family Members

Since the inception of FMLA back in the early 1990's, the Department of Labor (DOL) has released a string of DOL opinion letters that clarify a number of FMLA definitions and issues. Specifically, the agency's comments shed light on how the FMLA applies to the parents-in-law, spouses, and siblings. For example, DOL guidance clarifies that parents-in-laws are not considered family members under FMLA: even if a mother-in-law or father-in-law is a "legal ward" of an employee.

The definition of "spouse" has received special attention and refinement over the years. A spouse must be of the *opposite* sex for purposes of FMLA on a federal level. The DOL definition of spouse is taken from the federal *Defense of Marriage Act* (DOMA). Under the DOMA, Congress said that a spouse must be a partner of the opposite sex and that the two must be legally married (or recognized as common-law spouses by the state).

Spouses employed at the same company are granted a combined total of 12 weeks of leave under FMLA. If a husband and wife both work for the same employer and both are entitled to leave for birth or care after the birth of a child, (or for placement for adoption or foster care or to care for the child after placement), or to care for a sick parent with a serious health condition — the combined total leave taken by the husband and wife for the same event is limited to 12 work weeks during any 12-month period.

Because the law does not limit the FMLA time available to siblings, the DOL says that each sibling can be entitled to 12 weeks of FMLA leave to care for ill parents. Each sibling is entitled to the full 12 weeks even if the time is devoted to caring for the same parent, and even if the leaves are requested at the same time.

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