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#### **CMS Disclosure Notices Revised**

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* required that all plan sponsors provide creditable or non-creditable disclosure notices to Part D eligible individuals covered by any of their health plans. Part D eligible individuals who do not enroll in a Medicare prescription drug plan when first eligible will likely pay a higher premium later — unless he or she has coverage at least as good as the Medicare standard Part D benefit creditable coverage and does not have a break in such coverage of 63 days or longer. Now employers can use the model notices from the Centers for Medicare and Medicaid Services (CMS) to communicate whether their health plan prescription drug coverage is “creditable.”

Employers do not need to redistribute previous notices; they should use the new format and guidance for notices distributed on or after May 1, 2006. CMS' newest guidance includes the following changes:

- Revised model creditable and non-creditable generic notices;
- New model personalized disclosure notice (adaptable for indicating creditable or non-creditable coverage); and
- New definition of integrated health plan for creditable coverage simplified determination test.

The new notices and guidance are available on the CMS Web site at [http://www.cms.hhs.gov/CreditableCoverage/02\\_CCafterMay15.asp](http://www.cms.hhs.gov/CreditableCoverage/02_CCafterMay15.asp).

*Willis EB Alert #66* has more details about the revised notice. You may also want to review *Willis EB Alerts #34, #38, #42, and #46* for related information. Please contact your Willis representative to obtain any of our *Alerts*.

#### **IRS Issues Proposed Regulations Governing DCAP**

The IRS has published new proposed regulations on dependent care expenses.

The proposed regulations discuss what expenses are eligible for the dependent care tax credit which in turn affects what is eligible for reimbursement under an employer-sponsored dependent care spending account (DCAP). The new guidance, which can be used immediately, replaces IRS regulations issued 22 years ago. In general, the proposed rules have incorporated various amendments that have been enacted since the rules were originally issued and they provide important clarifications in regard to some issues.

Some highlights include:

- Expenses for programs at the kindergarten level and above are primarily for education and are, therefore, generally not employment-related expenses.
- Expenses for day camps and other similar programs, even if they specialize in a particular activity (e.g. computers, sports, etc.), may be for the care of a qualifying individual and considered employment-related expenses.
- Taxpayers who work part-time must allocate expenses between the days worked and those not worked. If the taxpayer is required to pay for dependent care expenses on a weekly or longer basis, though, such an allocation is not required. This would also be applicable for an employee who is absent from work for a short period of time such as due to a vacation.

### **Redefining Dependent Child Laws**

The *Wall Street Journal* recently reported that state legislators are increasingly passing laws that require extension of coverage for dependent children. Currently, more than 20 states have passed such laws or are considering similar legislation.

- In May, New Jersey legislation requires insurers to cover dependent children to age 30.
- Colorado's legislation, effective this past January, requires insurers to offer parents the option of continuing coverage for dependent children to age 25. The state is also considering legislation that would extend coverage to grandchildren.
- Maine just enacted legislation to provide coverage until age 24 to those dependent children who leave school due to illness or injury.

Many of these new laws require coverage for dependents older than age 23 or 24. In some instances, the extension is not tied to the dependent's student status or financial dependency. In other states, the extension is tied to circumstances such as someone taking a medical leave of absence from school or for full-time students whose studies are interrupted by military duty.

These legislative measures generally represent state efforts to reduce the growing number of uninsured. According to a recent study by the Kaiser Family Foundation, young adults between the ages of 19 and 34 are the fastest growing segment of the uninsured population. Although adding a dependent may increase benefit plan costs for employers, legislators anticipate it will be significantly less than someone in the targeted age category obtaining an individual policy. It is their hope that making coverage more affordable will reduce the number of uninsured.

According to the Kaiser Foundation, health care premiums rose an average of nine percent last year and were up eleven percent in 2004. Some fear that a further increase in the cost of insurance may stop some employers from providing coverage altogether. Because the state laws discussed in this article

are insurance mandates, self-funded plans are generally unaffected.

### **Health Savings Accounts Gaining Popularity**

According to the America's Health Insurance Plans (AHIP), participation in health savings accounts (HSAs) and related high deductible health plans (HDHPs) has more than tripled in a ten-month period, although the study did not breakdown where growth was strongest, it shows the beginnings of large employers' movement toward offering HSAs.

Legislative observers anticipate lots of congressional debate regarding proposals to increase HSA contribution limits. Current HSA limits are up to \$2,700 (or their deductible amount, whichever is lower), for single coverage and \$5,450 (or the amount of the deductible, whichever is less) for family coverage.

Another factor that could further increase HSA interest will be the outcome of the Bush administration's proposal to eliminate all taxes on out-of-pocket spending through HSAs and allow employers to contribute more money to HSAs of chronically ill employees. To view the full report, visit the AHIP Center for Policy Research [www.ahipresearch.org](http://www.ahipresearch.org).

### **States Examining Medicaid Programs for Cost Savings**

Market forces obviously drive up health care costs and affect all purchasers of health coverage — public and private. State Medicaid programs are being hit particularly hard because these market forces are occurring at a time when many states are facing budgetary challenges. To address the problem, the *Wall Street Journal* notes that some states want to stretch the value of their services by revising their Medicaid programs to offer a more modest selection of benefits to a larger group of people.

As states begin reducing benefits for certain groups, the private sector will be left to fill in coverage gaps. For example, we anticipate that states will more aggressively pursue opportunities to shift children who receive Medicaid to employer-sponsored plans by using National Medical Support Notices (state-issued notices that operate like qualified medical child support orders). In this way, a state has the power to require that children are enrolled in the employer plan of parents who qualify for employer-sponsored health coverage, even if a child is not living with the employee/parent.

### **Requirements Require Consistency**

Employers who are tightening health plan eligibility requirements should take note of a recent court case involving a dispute about a dependent child's eligibility for health coverage. The plan provided that "eligible dependents" included children who were primarily dependent on the employee for support. And it went on to define children as including "natural children — provided the child is claimed as a dependent on the eligible employee's federal income tax return."

The employer in this case asked an employee to provide his federal income tax return in order to prove that he claimed his enrolled child as a tax dependent. Under the employer's interpretation of the plan, the child's coverage could be terminated if the employee did not provide the requested return, or if it did not show that the child was claimed as a dependent.

However, a federal appeals court interpreted this provision differently. It concluded that providing a tax return was just one means that an employee could use to prove that a child met the plan's eligibility re-

quirements. The court noted that the employer's previous plan administration supported this interpretation because the employer usually did *not* require employees to provide their tax returns in order to show their children's eligibility.

The court's ruling demonstrates the importance of careful drafting and even-handed enforcement of eligibility requirements. When an employer is taking steps to audit eligibility, and to remove ineligible dependents, these factors become even more important. It is also important to keep in mind that eligibility provisions are not within the exclusive control of the employer if the plan is insured. In that case, state laws may mandate including certain dependents.

### **EAPs: ERISA and COBRA Implications**

We were recently asked whether Employee Assistance Programs (EAPs) are employee benefit plans for purposes of ERISA coverage. The employer in this situation was mainly concerned about sponsor complying with ERISA's reporting and disclosure requirements. Historically, this company had just assumed that its program was not an ERISA plan and had not complied with ERISA.

#### **ERISA Background**

A welfare plan, as governed by ERISA, is defined to include a plan established or maintained by an employer for the purpose of providing medical and other benefits (such as benefits in the event of disability, accidents, and death, to list a few). The DOL has generally found that EAPs can be ERISA plans.

For example, the DOL has found that "mental health services" can constitute medical benefits for ERISA purposes. So, EAPs that offer counseling benefits often fall into the ERISA plan category. It is important to note that offering an ERISA-type benefit is only part of the analysis. The pivotal follow-up question becomes whether the EAP program is considered to be "established or maintained" by the employer.

Where an employer simply announces an Employee Assistance Program, it is not offering an ERISA plan. If an employer does not employ any counselors, in-house or otherwise, and provides only referrals to counselors, then no ERISA plan exists.

On the other hand, if an employer directly or indirectly provides counseling, or by hiring a counselor, or if the employer administers or advertises these benefits, the program may become an ERISA program.

#### **COBRA Background**

To the extent that an EAP is found to be maintained by an employer and provides medical care, it will be a group health plan subject to COBRA. An employer which fails to offer qualified beneficiaries the right to continue coverage (or access) to such an EAP program risks the full-range of COBRA penalties that would apply if COBRA were not offered on the employer's regular medical plan.

Plan sponsors may wish to limit their involvement with EAPs to avoid transforming such programs into ERISA plans. As the employer pointed out in this case, it had simply assumed that the plan was exempt from ERISA. The unexpected ERISA connection may cause some employers to question the benefit of EAPs. However, other effective and efficient solutions are available such as incorporating the EAP into an ERISA wrapper document.

## **HIPAA Privacy Rule: No Private Rights**

What happens when HIPAA privacy rules are violated? Who has a cause of action and against whom? A recent case explored these issues and found that an individual does not have a private cause of action for claimed violations of the HIPAA privacy rule.

In the case of *Runkle v. Gonzales*, No. 04-0714 (D.D.C. 2005) an FBI agent sued his employer on various counts, including a violation of the HIPAA privacy rule. Runkle alleged that his employer improperly disclosed information about his medical history to others in the workplace. The employee claimed that the results of his psychological fitness-for-duty evaluations were reviewed by his supervisors and subsequently disclosed to others in the employee's chain of command.

The court ultimately found that HIPAA does not grant individuals a private right of action. Accordingly, the court dismissed the employee's HIPAA privacy claim. The court also rejected the Runkle's argument that a federal court case supported his claim that an individual can sue under the HIPAA privacy rule. Although ERISA does provide for a private right of action, Runkle failed to allege that he was participant, beneficiary, or fiduciary of an ERISA plan (probably because he participated in a plan sponsored by the federal government and therefore not subject to ERISA), so he was not permitted to bring a suit under ERISA's civil enforcement provisions.

Since the same information could be considered employment records in one context and "protected health information" in another, this case serves as an important reminder to employers to make sure that employee health information is sufficiently protected from unauthorized use and disclosure.

Although HIPAA itself does not include a private right of action, individuals can avail themselves of the right to make HIPAA privacy complaints to the Health and Human Services Office for Civil Rights. Individuals may also find additional legal remedies under state law if privacy rights are recognized by the state and possibly under ERISA if the plan fails to follow the privacy obligations contained within the plan document.

## **Self-Inflicted Injury: Covered or Not?**

Many self-funded plans exclude coverage for self-inflicted injuries. A self-inflicted injury is typically one that would result from a suicide, an attempted suicide or reckless behavior. Also, a self-inflicted injury could be sustained during the commission of a felony, such as in states where driving under the influence or while intoxicated is considered a felonious act. However, Department of Labor rules stipulate requirements which could render such exclusions unenforceable.

HIPAA's nondiscrimination rules include a provision prohibiting discrimination based on a source-of-injury. Under this exclusion, a group health plan may not deny benefits provided for treatment of an injury if the injury results from a medical condition (physical or mental).

We suggest that self-inflicted injury exclusions be thoroughly examined because these injuries are frequently linked to mental health conditions. If a plan sponsor chooses to leave that exclusion in the plan document, then the employer should at least realize that the provision may not be enforceable. At a minimum, applicable HIPAA rules would require a plan sponsor to examine the facts and circumstances and determine whether the self-inflicted injury resulted from a medical condition such as depression.

A plan may exclude coverage for injuries that do not result from a medical condition, such as injuries sustained in high-risk activities (such as skiing or bungee jumping). Interestingly, although the HIPAA

rules prevent a plan from excluding someone from eligibility based on the fact that he pursues a high-risk activity, an injury resulting from the high-risk activity may be excluded.

### **Since You Asked: FMLA Protections for Domestic Partners**

Massachusetts laws regarding marriage have generated numerous questions about the implications of same-gender marriage as it relates to benefit plans. One company recently asked what might happen if it chose to allow same-sex domestic partners to exercise FMLA rights.

The FMLA defines a “spouse” in Section 825.800 of the Labor Department’s FMLA regulations as:

“...a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides, including common-law spouses in states where it is recognized.”

Given controversial requirements under state law (for example, Massachusetts’ decision about same-sex marriage), how should this definition be interpreted and applied?

The *Defense of Marriage Act of 1996* (DOMA), as signed by President Clinton, arrived *after* the FMLA regulations were published. DOMA is a federal law providing that, when interpreting any federal statute, ruling, or regulation, a spouse can only be a person of the opposite gender. Consequently, a health plan cannot be required to recognize a same-gender spouse even if same-gender marriages are permitted under state law.

Although some might argue that FMLA regulations stipulate the use of “state law” to determine marital status, the appearance of DOMA trumps that regulatory definition. Even the Department of Labor acknowledges this fact.

So, if DOMA restricts FMLA to opposite-gender spouses — what does this mean for the employer who provides leave for same-gender spouses?

We believe that such leave cannot be designated as FMLA, so an employee who took the leave to care for a same-gender spouse could be entitled to double leave (24 weeks) — if leave were to be taken again in the same 12-month period for a purpose covered by the FMLA (such as care of a child or a parent).

This situation exposes the sometimes unexpected results which can occur from offering marital benefits for partners who, by legal definition, are not spouses.

## U.S. Benefit Office Locations

Anchorage, AK (907) 562-2266	Atlanta, GA (404) 224-5000	Austin, TX (800) 861-9851	Baltimore, MD (410) 527-1200
Birmingham, AL (205) 871-3871	Boise, ID (208) 340-0645	Boston, MA (617) 437-6900	Cary, NC (919) 459-3000
Charlotte, NC (704) 376-9161	Chicago, IL (312) 621-4700	Cleveland, OH (216) 861-9100	Columbus, OH (614) 766-8900
Dallas, TX (972) 385-9800	Denver, CO (303) 218-4020	Detroit, MI (248) 735-7580	Eugene, OR (541) 687-2222
Farmington, CT (860) 284-6137	Florham Park, NJ (973) 410-1022	Ft. Worth, TX (817) 335-2115	Grand Rapids, MI (616) 954-7829
Greenville, SC (864) 232-9999	Houston, TX (713) 625-1023	Jacksonville, FL (904) 355-4600	Knoxville, TN (865) 588-8101
Las Vegas, NV (702) 562-4335	Long Island, NY (516) 941-0260	Los Angeles, CA (213) 607-6300	Louisville, KY (502) 499-1891
Memphis, TN (901) 248-3100	Miami, FL (305) 373-8460	Milwaukee, WI (414) 271-9800	Minneapolis, MN (763) 302-7100
Mobile, AL (251) 433-0441	Mountain View, CA (650) 944-7000	Naples, FL (239) 514-2542	Nashville, TN (615) 872-3700
New Orleans, LA (504) 581-6151	New York, NY (212) 344-8888	Omaha, NE (402) 778-4851	Orlando, FL (407) 805-3005
Philadelphia, PA (610) 964-8700	Phoenix, AZ (602) 787-6000	Pittsburgh, PA (412) 586-1400	Portland, OR (503) 224-4155
Roswell, NM (505) 317-3397	St. Louis, MO (314) 721-8400	San Diego, CA (858) 678-2000	San Francisco, CA (415) 981-0600
San Juan, PR (787) 756-5880	Seattle, WA (206) 386-7400	Spokane, WA (206) 386-7400	Tampa, FL (813) 281-2095
Washington, DC (301) 530-5050	Wilmington, DE (302) 477-9640		

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