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Massachusetts Mandatory Health Insurance

A law signed by Massachusetts Governor Mitt Romney (R) would require every resident in the state to obtain health insurance by July 1, 2007 or forfeit their individual state tax exemptions and pay fines.

As promised, the Governor did exercise his line-item veto power to strike eight sections from the law. One example: Romney had adamantly opposed any additional state taxes on businesses so, as expected, axed a provision that would require companies to pay \$295 per employee per year for not providing health coverage. Massachusetts lawmakers have said they will override any changes made by the Governor, particularly any involving this provision. Other states, concerned with the same problems with the uninsured, have been paying close attention to this legislation.

Although this new Massachusetts law has captured media attention, the law is likely to have only a limited effect due to ERISA's preemption power. Self-funded plans are unlikely to be affected because the power to regulate these plans belongs to the federal government. So, it seems probable that any provision in the Massachusetts statute that makes ERISA plans deliver a health benefit will eventually be struck down in court. ERISA does contain an important exception for insured programs, so, to the extent the new law represents a direct mandate, it would be preempted by ERISA.

With employers routinely paying 10 to 20 times \$295 for health coverage, it seems improbable the state will find meaningful health coverage at that price. Knowing it's impossible to get something for nothing, taxes will surely have to be raised. It also seems likely that health care will be rationed — particularly if significant numbers of employers choose to let the state takeover by terminating their group health plans.

Enforcing Newborn Enrollment

In two recent court cases, parents failed to submit an enrollment form on time. (Within 31 days of birth for newborns.) When claims for the newborns' care were denied, various parties claimed that the health plans were obligated to provide coverage despite the failure to enroll. In one case, the court rejected the parent's contention that submitting a reimbursement form listing her infant gave notice of her intent to enroll her newborn child.

In the second case, the newborn incurred more than \$600,000 in medical expenses and the hospital argued that the plan could not deny claims based on the failure to enroll. The hospital asserted that the plan knew, or should have known, of the baby's medical problems and had a duty to notify the parents of the enrollment procedure. The court rejected that argument.

Plans must notify employees of their special enrollment rights at or before the time enrollment is offered. This outcome might have been different if the plans had not provided the required notice. It is always advisable to state in plan materials that enrollment is required and that no coverage will be provided unless enrollment is completed on time in the way specified by the plan.

IRS: 2005-2006 Priority Guidance Plan

The Treasury Department and the IRS have jointly updated their 2005-2006 Priority Guidance Plan. This update clarifies the status of the original 2005-2006 Priority Guidance Plan (published last August). Although the update may indicate that a particular item on the plan has been completed, the IRS notes that it is possible that one or more additional follow-up projects may be completed in the plan year relating to that item. The update also addressed other guidance, some of which has been published. Key items include:

- Additional guidance on debit cards, including cards used for employer-provided medical expense reimbursements and cards used for qualified transportation fringes under Internal Revenue Code (IRC) Section 132.
- Proposed regulations on cafeteria plans under IRC Section 125, updated for statutory changes and additional guidance.
- Proposed regulations under IRC Section 152 regarding the definition of dependent; and the release of a claim for exemption for a child of divorced or separated parents.
- Regulations under IRC Section 4980G on employer comparable contributions to Health Savings Accounts (HSAs).
- Comprehensive final regulations regarding the limitations on benefits and contributions under IRC Section 415.

Banking on Your Retirement

The Federal Deposit Insurance Corporation (FDIC) announced that it is increasing the insurance coverage of some retirement accounts from \$100,000 to \$250,000. This adjustment comes from a new federal law that boosts the coverage for the first time in 25 years.

The increase took effect on April 1 for retirement account deposits at FDIC insured banks and savings and loans. The increased protection will apply to Roth individual retirement accounts, self-directed Keogh accounts, Section 457 Plan accounts for state government employees and Section 401(k) accounts. The change will particularly benefit account holders who would open a second retirement account at a different bank when their first account exceeded the \$100,000 insurance limit. Coverage limits of \$100,000 on other deposit accounts will not change. For more information, visit www.fdic.gov.

COBRA Retirees: Prescription Drug Subsidy

The Centers for Medicare and Medicaid Services (CMS) has determined that certain COBRA retirees may be included on the list accompanying a request for a prescription drug subsidy payment from Medicare. Specifically, a qualifying covered retiree must be a Part D *eligible* individual (enrolled in Medicare Part A or B), must *not* be enrolled in Medicare Part D, and must *not* have coverage through the sponsor's plan because of current employment status. The plan itself must also meet the actuarial equivalency test to qualify for the subsidy payment.

CMS has determined that the subsidy payment covers those who otherwise qualify as long as the COBRA coverage is not related to the current employment status of the employee. For example, if COBRA coverage is due to termination of employment or the death of the employee, there is no "current employment status" and the COBRA recipient may be considered a qualifying covered retiree. However, if the COBRA continuation coverage is due to divorce and the employee continues to be employed after the date of the divorce, then the spouse is considered to be receiving COBRA continuation on the basis of current employment status.

This new guidance may impact some employers in a positive way. In order for the subsidy to be paid, an actuary must certify that the plan passes an actuarial equivalence test. If the only individuals for whom the sponsor is claiming the subsidy are COBRA individuals, the plan will likely fail the actuarial equivalence test. If the COBRA individuals are part of a larger group, the contributions for all subsidy-eligible individuals may be blended for testing purposes and the actuarial equivalence test may well be passed. The equivalency test will have to be repeated if the plan sponsor chooses to include qualifying COBRA individuals when applying for the subsidy payment. For detailed information about Medicare Part D and the applicable testing requirements, please see *Willis EB Alert #34, #42, and #46*.

Group Health Plan Flex Credits and FMLA

Early this year the DOL released an opinion letter stating that an employer must continue to provide employees on leave under the *Family and Medical Leave Act* (FMLA) the same contributions (or flex credits) available to workers participating in the employer's cafeteria plan.

Background

In this situation, the employer was providing a flat monthly amount to employees participating in its cafeteria plan. This amount, called an "allotment," was then used to pay the premiums for group health coverage. If any balance remained, the employee could use it to pay the premiums for dental, disability, and life insurance, or receive it as taxable compensation.

Analysis

Generally, if an employee goes on FMLA leave, an employer must maintain the employee's group health coverage at the same level and under the same conditions as if the employee had remained continuously employed for the duration of the leave. So, it was the DOL's opinion that "employees taking unpaid FMLA leave must have that portion of their cafeteria plan allotment allocated to group health insurance (including dental) premiums paid by the [employer] in the same amount as paid prior to the start of FMLA leave."

Because the allotment is provided for group health coverage when employees are actively at work, the employer may not recover those payments for FMLA leave periods when the employee returns to work. The DOL repeated that any entitlement during FMLA leave to benefits other than group health benefits, is determined by the employer's policies for other types of leave. If such benefits are continued during FMLA leave, the employer is permitted to recover the employee's share of premium payments upon the employee's return to work.

Issue Spotlight: Enforcing Subrogation

Debate has raged over whether or not subrogation may be enforced by a plan ever since the January 2002 Supreme Court decision in the case of *Great-West Life & Annuity Insurance Co. v. Knudson*. The Court in *Great-West* denied the plan sponsor's reimbursement claim, but at the same time upheld a sponsor's right of subrogation as a category of claim that is enforceable under ERISA. The court attempted to clarify that certain actions taken to solidify a group health plan's subrogation claim can either be legal in nature (barring subrogation) or equitable in nature (permitting subrogation).

What is subrogation?

Subrogation allows the plan to "step into the shoes" of the injured party and obtain the same legal rights that the injured party is entitled to receive.

Example: Joe's car is insured by the Giant Insurance Company. Bill has too much to drink at his Mardi Gras party and crashes into Joe's car. Joe could sue Bill for damages, but in this case Giant pays damages on Joe's car and since he is not hurt, Joe decides not to sue Bill. However, since Bill was at fault, Giant wants to recover its costs. The insurance policy includes a provision that allows Giant to take Bill to court (with or without Joe) to recover that money from Bill.

To enforce their subrogation rights a subrogation clause must appear in plan documents. If it is missing or is not clear, courts are unlikely to find in favor of the plan.

A 2005 case, *Cossey v. Associates' Health and Welfare Plan*, 2005 U.S. Dist. LEXIS 4800 dealt with this issue. In this case, after the plan participant's spouse was injured in an automobile accident the health plan informed the spouse that it would cover the incurred medical claims only after she completed and signed the plan's subrogation forms. When the spouse and her attorney refused to sign the subrogation forms, the plan refused to cover her medical claims. After that, the injured party sued the plan claiming that the subrogation terms were not included in the legal plan document.

The court reviewed the wrapper document and determined that since it referenced elements that did not exist, there was no formal plan document backing up the SPD. So, in addition to the ERISA issues raised by not maintaining a plan document, the plan was not able to enforce any subrogation rights it thought it had.

On the other hand, consider what happened in the 2006 case of *Borden v. Blue Cross and Blue Shield of Western New York*, W.D.N.Y., No. 05-CV-251S (February 21, 2006). The court in that case considered whether or not the plan's failure to waive its right to subrogation (at the request of the injured party) was a breach of the employer's fiduciary duty.

The plan participant, Richard Borden, was injured in a motorcycle accident. As a result, Borden's employer (and health insurance provider) Blue Cross, paid approximately \$55,000 in medical expenses. Borden's employer's health insurance policy included a subrogation provision, but Borden asked his employer to waive its right to subrogation so that Borden could collect a \$100,000 settlement from the insurance company of the person deemed at-fault in the accident. Blue Cross refused to waive its subrogation rights.

The issue was eventually moved to a federal court because the question involved the plan's right to subrogation under ERISA and that court ultimately dismissed Borden's claim. In the end, the court ruled that the plan could enforce its subrogation rights and recover its costs from the party that caused the accident.

These cases are a reminder that plan language will play a pivotal role in enforcement. If the subrogation provision in the *Borden* case had provided for less than an unqualified right of subrogation, then the court may have found that there was no such right in the first place.

Pandemic Planning Procrastination

The industry publication *Insurance Journal* reports the findings of a prominent survey regarding disaster planning. The study indicated that companies in Asia are the best prepared for a pandemic, with the U.S. lagging behind both Asia and Europe. Only about 20 percent of companies surveyed have budgeted for pandemic preparedness, and less than half have actually established a business continuity plan for when a pandemic strikes — despite 70 percent of businesses agreeing that a pandemic would result in profit losses.

A small group of businesses indicated a pandemic would increase demand for their products and services, including businesses in the insurance, pharmaceutical, and telecommunications sectors.

State Health Care Costs May Dwarf Pensions

Individual states in the U.S. may soon find that what it costs them to provide medical care for retired state employees will dwarf how much they pay for their retirement benefits, according to a report issued by the Rockefeller Institute of Government.

Many companies are slashing both health and pension benefits, especially in struggling industries such as airlines and autos. Generally it is much more difficult for states to make similar cuts, at least for unionized employees, because such a move can require changing current laws. For example, New Jersey expects to pay more than \$1 billion to provide health care for both its current and retired employees. By fiscal 2010, statistics show that New Jersey will spend 25 percent more on retiree health care than on medical coverage for its current workers.

New York City Mayor Michael Bloomberg (R) has gotten off to an early start at earmarking funds for retiree health plan purposes. Over the next two years, the mayor wants to set aside \$2 billion for this future liability, which he forecasts at \$50 billion.

Nonprofit Hospital's Plan is Not ERISA Exempt

It is a popular misconception that plans sponsored by nonprofit and charitable organizations are automatically exempt from ERISA. Unfortunately, that is not the rule. Aside from plans sponsored by governmental entities, the only other ERISA exemption based on the type of employer is the exemption for church plans. A recent case considered ERISA's definition of church plans in the context of a long-term disability plan sponsored by a nonprofit hospital that had some affiliation with the Baptist church.

The arguments for finding that the plan was an ERISA-exempt church plan were:

- The hospital was a charitable organization.
- The hospital shared common religious convictions with the Baptist church.
- Leaders of the hospital were required to be members of Baptist churches.

Despite these arguments, the Eighth Circuit Court of Appeals found against church plan status because the Baptist church was no longer involved in appointing or approving the hospital's board members. Also, only a limited group of hospital employees were required to be Baptist church members.

ERISA exemptions are very narrow and many organizations with religious affiliations do not qualify for the exemption. Even if an organization does qualify, state laws will usually govern the organization's plan. Unfortunately, state law standards for benefit plan operations are not well-defined, so it is difficult to know what compliance entails. So it is often recommended that the employer operate the plan according to ERISA standards. The Eighth Circuit Court of Appeals includes: Arkansas, Iowa, Minnesota, Missouri, Nebraska, North Dakota and South Dakota.

Since You Asked: Pro-Rating COBRA Premiums

A *FOCUS* reader recently asked: A qualified beneficiary receiving self-only coverage under a client's health plan died on the 17th of the month. He had paid the full COBRA premium for that month. The COBRA administrator said that COBRA requires a pro-rata refund of the month's premium because no coverage will be provided after the 17th. Is the COBRA administrator correct?

Although it is usually best for an employer to interpret COBRA rules conservatively, we believe that this interpretation may be overly cautious. Plans are required to allow qualified beneficiaries to pay for their COBRA coverage in monthly installments. Although plans can offer options for more or less frequent payments, the basic unit is one month. If the employer uses the monthly payment plan and does not otherwise pro-rate premiums, it probably is not required to do so in this case. However, if the plan pro-rates premiums in other situations it should also do so in this situation.

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
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