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More DOL Guidance for Health Savings Accounts

Health Savings Accounts (HSAs) are individual employee accounts established under Internal Revenue Code Section 223 that are used to pay or reimburse qualified medical expenses of eligible individuals.

In 2004, and again in 2006, the Department of Labor (DOL) issued HSA guidance through Field Assistance Bulletin 2004-01 and Field Assistance Bulletin 2006-02. The guidance in these bulletins provides employers with much insight into the rules surrounding HSA administration.

FAB 2004-01

The 2004 Field Assistance Bulletin (FAB) set out the following general rule, and then attached several refinements. *Employer contributions to an HSA will not convert the HSA into an ERISA plan as long as the establishment of the HSA is completely voluntary.*

The 2004 FAB then outlined actions that an employer must avoid if the HSA is to be considered completely voluntary. Those actions included the following:

- Employers cannot restrict an employee's ability to move HSA funds from one HSA to another;
- Employers cannot impose utilization rules on HSAs if those rules are more restrictive than Code Section 223;
- Employers may not make or influence employees' investment decisions with respect to funds contributed to an HSA;
- Employers cannot advertise the HSA as an employee welfare benefit plan established or maintained by the employer;
- Employers cannot receive any payment or compensation in connection with an HSA.

FAB 2006-02

This FAB clarifies that an employer may follow one of two alternatives, each of which will allow the HSA to avoid being considered an ERISA-covered plan.

- The first alternative is for the HSA to be offered as a voluntary benefit that is exempt from ERISA under a regulation that mandates the following:
 - ⇒ No employer contributions toward the HSA;
 - ⇒ Participation in the HSA is completely voluntary for employees;
 - ⇒ The employer does not endorse the HSA, but permits advertising about the HSA and collects (and forwards) employee contributions to the HSA; and
 - ⇒ The employer receives no consideration in connection with the HSA.

- The second alternative permits the following employer actions:
 - ⇒ Unilaterally opening an HSA for an employee and making employer contributions to the HSA;
 - ⇒ Limiting the number of HSA providers that advertise their services to employees (The employer may even choose one HSA provider to which the employer will forward its contributions.);
 - ⇒ Selecting an HSA provider offering only a small selection of investment options (If the employer chooses to direct its contributions to only one HSA provider, that provider must offer a “reasonable choice” of more than one investment option.);
 - ⇒ Paying HSA fees that employees would normally be required to pay;
 - ⇒ Realizing lower FICA and FUTA obligations because employees are lowering their taxable wage base by contributing to an HSA.

The FAB notes that if an employer receives discounts on non-HSA products from its HSA vendors, those discounts would constitute employer compensation, making the HSA subject to ERISA, and the discounts would likely be viewed as prohibited transactions.

An HSA provider may offer a cash incentive to employees in exchange for their establishing an HSA. This exception to the prohibited transaction rules would require the vendor to deposit the incentive into the individual’s HSA.

As with ERISA-governed benefits, employers must promptly transmit participants’ HSA contributions to the HSA vendor, even if the HSA is not deemed to be an ERISA plan.

The final point in the 2006 FAB addressed credit cards associated with an HSA account. The FAB stated that it is okay to direct HSA funds to a credit card vendor as reimbursement for HSA expenses paid with such a card.

Employers still do not have formal guidance about whether or not they may establish an HSA for an employee at open enrollment through a “negative election.” However, a key representative of the Employee Benefits Security Administration said the DOL is not planning any more Q&A responses in the near future. Instead, it is turning its attention toward case-by-case issues rather than providing more generic information to employers on this subject.

Standard Mileage Rates for 2007

The Internal Revenue Service recently issued the standard mileage rates for 2007. These rates are used by employees as well as self-employed individuals in calculating the deductible costs of operating an automobile for business. Standard mileage rates were also announced for use of an automobile for charitable purposes and to obtain medical care or to move. The new rates will be in effect starting January 1, 2007.



- The standard mileage rates for taxpayers deducting automobile costs for business purposes will increase from 44.5 cents per mile in 2006 to 48.5 cents per mile for 2007.
- The IRS said that the rate for taxpayers deducting automobile use in order to obtain medical care or as part of a move would increase from 18 cents per mile in 2006 to 20 cents per mile in 2007.
- The deduction for charitable use of an automobile will remain at 14 cents per mile in 2007. This is a rate set by statute.

The IRS states that higher prices for both vehicles and fuel during the year ending in October 2006 caused the jump in mileage rates. For additional information on these standard mileage rates, see Revenue Procedure 2006-49.

2006 Kaiser Survey: Health Insurance Cost Slow

According to the 2006 Kaiser Annual Employers Health Benefits Survey, insurance premiums in 2006 slowed to 7.7 percent growth compared to last year's 9.2 percent increase. The survey points out that this year's survey results indicated the weakest rate of premium growth since 2000.

The following information was reported for this year's increase in premiums:

Average premium for family coverage:	\$11,480
Average premium for single coverage:	\$ 4,242

Premiums for family coverage have increased by 87 percent in the past six years. The survey reported that the main reasons for the premium increases include expensive medical technology, increasing profits for insurers and health care organizations, and a lack of competition in the health care system. Health insurance premiums continue to outpace inflation and average wage increases.

"While premiums didn't rise as fast as they have in recent years, working people don't feel like they are getting any relief at all because their premiums have been rising so much faster than their paychecks," said Kaiser Foundation President and CEO Drew E. Altman, Ph.D. Further he stated, "To working people and business owners, a reduction in an already very high rate of increase just means you're still paying more."

Since 2000, yearly contributions from employees have increased by \$293 for single coverage and by \$1,354 for family coverage.

The 2006 survey included 3,159 randomly-selected public and private firms with three or more employees (2,122 of which responded to the full survey and 1,037 of which responded to an additional question about offering coverage).

Emerging Benefit Trends

Virtually all employers are facing the effects of double-digit cost increases associated with their medical plans. Prescription drugs, an aging worker population, and the federal and state regulatory environment are often cited as the key reasons behind this cost escalation. These factors are forcing many employers to re-examine their current benefit strategies. Which tactics are gaining the most attention?

The following is a list of what may be regarded as the top areas of benefit planning for 2007:

- **Benefit cost control:** Cost containment appears to be the single most important issue to employers. Some high-tech industries are concerned about losing skilled employees. As a result they



have tried to protect workers from absorbing any direct hit on cost increases. Although many employees have been asked to shoulder more of the cost increases, some employers have gone to great lengths to avoid passing increases to workers.

- **Voluntary benefits:** One increasingly popular strategy allows workers to participate in a wide array of benefits on an employee-pay-all basis. If structured correctly, voluntary arrangements allow employers to make benefits available to workers without incurring the usual compliance burdens. Several industry studies demonstrate that voluntary benefits such as additional LTD, life, home or auto coverage truly offer mutual advantages for employers and employees.
- **Terminating retiree coverage:** Employers that still provide retiree coverage are ending their programs or curtailing retiree benefits. A case in the Third Circuit that limits a plan sponsor's ability to distinguish between retiree classes caused some employers to pull the plug on their retiree programs. The EEOC subsequently issued guidance specifically recognizing an employer's ability to make such distinctions (but those regulations have been put on hold until a lawsuit by the AARP that challenges the regulation, is resolved). Additionally, Medicare reform legislation includes special incentives to entice employers to maintain retiree benefits.
- **Long-term care (LTC) insurance:** The country's aging workforce has promoted great interest in eldercare arrangements made possible through the use of LTC insurance. Possible federal tax code adjustments to promote LTC benefits are expected to bolster interest in these benefits.
- **Domestic partners:** Although not recognized for favorable tax treatment at the federal level, coverage for domestic partners continues to gain attention. States are also becoming increasingly active in promoting available coverage for domestic partners (e.g., California, Vermont and Massachusetts). It is important to note that, while employers choosing to offer domestic partner coverage have not generally reported significant plan cost increases, they should be aware of related compliance issues that may surface.

Real-Life Experience: Dependent Care FSAs

This article centers on two related questions regarding Dependent Care Flexible Spending Accounts (FSAs). The answers are interesting, and the Internal Revenue Service (IRS) rationale may be useful in addressing similar questions.

Scenario one

Husband (employee) and wife are enrolled in a Dependent Care FSA. They have a child with severe medical problems. The boy's medical condition has several times required him to be absent from the day care center for up to several weeks at a time. While the child has been at home for special treatments and detailed care, the day care center has charged the parents the monthly fee. The day care center stated that the fee was to hold the child's space in the day care center.

Is the fee paid to the day care center during the child's absence reimbursable under the Dependent Care FSA?

In informal remarks, the IRS has stated that such a fee is *not* reimbursable if the child has stayed at home under the care of a parent while absent from the day care center. Because the Dependent Care FSA is only available in order to allow a parent to be at work, the IRS would apply a very strict interpretation to this situation if a parent has been caring for the child.

Scenario two

The logo for Willis, consisting of the word "Willis" in a large, blue, serif font.

Husband (employee) and wife are enrolled in a Dependent Care FSA. They pay a registration fee to add their infant child to a waiting list for a day care center, but the child is not yet enrolled at the day care center.

Is this registration fee reimbursable under the Dependent Care FSA?

Yes, the registration fee is reimbursable if the fee is required in order to obtain child care (even if in the future) at the day care center. However, the registration fee is only reimbursable *after* obtaining child care services so both parents can be at work.

International Pension Plan Interplay

American companies that employ British workers may wish to consider the implications of the interplay between pension programs it sponsors and other possible benefit sources. The *London Times* notes that British citizens working overseas must ensure that they maintain their U.K. national insurance contributions if they hope to draw on their full right of payment upon retirement. Under national law, a male worker in the U.K. has to build up 44 complete years of contributions to qualify for a full pension; for females that is 39 years.

In some cases problems emerge because U.K. companies with workers abroad expect those workers to make pension contributions out of their own salaries (which are often higher than workers performing similar jobs in their home country). Overseas workers sometimes presume incorrectly that their employer makes pension contributions. The article quotes one expert as stating, "For the UK expatriate there is still no real universal international pension plan to replicate schemes at home. For a large number of experts, especially in Asia, the Middle East and the former Soviet countries, the first thoughts they will give to making further pension contributions will come after meeting an offshore financial adviser — often in a bar in Moscow or Tokyo. Many of these are paid by commission only and often there is little or no regulation to control what they are selling." The author notes that one solution is for expatriates to keep up their contributions through a voluntary payment which is typically less than ten pounds a week for a single worker.

Often employers in other countries, such as the United States, offer retirement benefits through some sort of scheme that meets the host country requirements. However, these benefits typically do not meet the requirements for the ex-pat's home country. So, the taxation or the legality of payments to those ex-pats when they return home may be in question. In all such arrangements, employers will want to consider actions that achieve optimal results.

401(k) Fee Change Legislation

Financial industry lobbyists and attorneys in favor of an amendment relaxing fee limitations for investment advice to 401(k) participants are worrying about the legislation's fate. Industry publication *Pension & Investments* says that most observers believe that, although Republicans are more likely to back the law, it is doubtful that they will do anything about it this year because the provision in question was the result of a tenuous compromise. Democrats are unlikely to support the law because they believe that the investment advice provision may create conflicts of interest. At the heart of the matter is a regulatory provision in the recent *Pension Protection Act* that requires money managers giving direct advice to 401(k) participants to charge a flat fee for the service regardless of what investment options are eventually selected.

The financial industry believes that flexibility should be permitted as long as the compensation of the firm's advisor is the same no matter what options the plan participant chooses. Currently, money

managers can offer participants advice about their own products if an independently certified computer model is used for asset mixes and choosing managers. Under the new law, if the computer chooses the manager's product, the manager can charge different levels of compensation. "The industry would like to see Congress provide some kind of clarification, either through technical corrections or other statement of intent, regarding fee-leveling," said a spokesman for the Securities Industry Association.

HIPAA Nondiscrimination Rules and Eligibility

An employer wants to tighten up its group health plan's eligibility provision to save money. It would like to implement an eligibility provision stating that "all disabled dependent children must have been covered under the group health plan at age 19 in order to continue coverage under the group health plan." This provision would, in effect, exclude the disabled dependents of new hires who are older than age 19.

Does such a provision violate the HIPAA non-discrimination rules which prohibit discrimination based upon health status?

HIPAA prohibits discrimination with regard to eligibility or premium contributions if the eligibility or premium contributions are based upon specified health status-related factors such as:

- Health status
- Medical condition (physical and mental illness)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability
- Disability

While a plan may impose certain preexisting condition exclusions, it cannot consider health status factors in the following situations:

- Enrollment
- Effective date of coverage
- Waiting or affiliation periods
- Late or special enrollments
- Eligibility for benefit packages
- Continued eligibility
- Termination of coverage

HIPAA rules permit a plan to discriminate in favor of individuals who have adverse health conditions, enabling a plan sponsor to *continue* coverage for disabled dependents who have reached the plan's limiting age. However, the plan's refusal to provide the extended coverage to all disabled individuals does not necessarily mean that the plan is discriminating against disabled individuals.

A plan is permitted to discriminate "in favor of" disabled individuals that satisfy the plan's eligibility provision. Consequently, many plans offer continued eligibility to disabled dependents. Such continued coverage (after reaching the limiting age) would be contingent upon an individual being covered by the plan before he/she became ineligible for coverage due to age. As such, the dependent's ineligibility would *not* relate to his/her disability, but rather to his/her age.

The *Americans with Disabilities Act* (ADA) prohibits discrimination based upon disability. In addition, the ADA includes an “association clause” that provides certain protections for non-disabled employees because of their association with a disabled individual. The above situation may raise certain ADA concerns for some employers. However, it appears that this particular issue has not yet been litigated.

We contacted the Department of Justice and the Equal Employment Opportunity Commission for informal opinions about the above scenario, and both confirmed that the proposed plan change would likely be allowed. It was also specifically noted that since the eligibility provision determines coverage without regard to an individual’s health status or disability, the proposed eligibility provision should not run afoul of the ADA.

Wal-Mart Adds More States to Drug Plan

Wal-Mart has introduced a generic prescription drug program in Florida under which it will cut prices on some of its generic drugs to four dollars for a 30-day supply. Just weeks after instituting the program, Wal-Mart has announced that, due to customer demand, it is accelerating its expansion plans. Wal-Mart reports that within four days of rolling out the program beyond its pilot program in Florida to fourteen added states, its pharmacies had filled more than 152,000 new prescriptions.

The program is now available in 27 states. The states are Alaska, Alabama, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, South Dakota, Texas, Vermont and Virginia. The company plans to expand the program to other states as quickly as possible.

Benefits Communication Mistakes

Accurate Summary Plan Descriptions (SPDs) and other plan communications were addressed in a recent District Court case in Minnesota, *Greeley v. Fairview Health Servs.*, 2006 U.S. Dist. LEXIS 47019 (D. Minn. 2006). Fairview Health Services distributed a memo in February 1998 describing enhanced benefits under its long term disability (LTD) plan. The memo incorrectly stated that benefits would continue until at least age 67 (and possibly longer depending on the age at which the individual became disabled). The memo also mentioned that a detailed description of the plan would be mailed separately. That never happened.

Later that year, Dan Greeley applied for and was approved for disability benefits. Greeley hired an attorney to assist with his application, and the attorney was given a copy of the LTD plan document dated October 1996. This document stated that disability benefits are provided to age 65 or 70, or for one to five years depending on the disability. In 2001, Greeley inquired about the age at which disability payments ended, thinking he might be eligible to continue receiving benefits until age 70. A human resources employee of the company responded that the benefits ended at age 65, as stated in the insurance contract.

Two years later, in October 2003, Greeley’s attorney sent an unanswered letter requesting assurances that Greeley’s benefits would continue to age 67. When Greeley reached age 65 in October 2004, he received a letter stating his benefits were exhausted, and he filed suit a few months later.

After determining that Greeley’s claim was filed in a timely manner, the court focused on the SPD. The legal effect of an SPD’s content is determined by how well the SPD meets ERISA’s requirements for SPDs. The court concluded that the legal plan document and the February 1998 memo constituted a faulty SPD. Accordingly, the beneficiary “must generally show that he relied on or was prejudiced by the SPD’s description of the plan’s benefits” in order to recover benefits.



While Greeley would have filed his disability application despite the faulty SPD, the court determined that “the consequences of a faulty SPD must be placed on the employer because the individual employee is powerless to affect the drafting and less equipped to absorb the financial hardship of the employer’s errors.” Moreover, the court noted that the company did not correct its error. Finding that “the nonpayment of two years of disability benefits is a significant harm,” the Court ruled in favor of Greeley on his ERISA claim for benefits until age 67. Attorney fees were not awarded to Greeley, as the Court concluded there was no evidence of bad faith by either party.

Although the reference to age 67 never made it into the plan document and SPD, the statement had been communicated to employees, it was included in the only communication about the enhanced benefit, and it was never corrected. Courts tend to side with the employee in cases such as this, so plan sponsors should promptly correct and redistribute any communications that contain errors.

U.S. Benefit Office Locations

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	Cincinnati, OH (513) 762-7661	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
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