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FOCUS

On Benefits

In This Issue

The Dilemmas of Defining "Dependent"

As a board member of the American Benefits Council, we and other employers are urging Congress to spare employee benefit plans from unintended consequences of the *Working Families Tax Relief Act of 2004.* This legislation changed the definition of dependent under Internal Revenue Code section 152.

Although the Internal Revenue Service issued Notice 2004-78 to reassure employers, certain plans — namely, health savings accounts and dependent care assistance programs — remain potentially affected. As a result, dependents who do not meet the new definition (e.g., over age 19 by the end of the year or 24 if a student) with gross income above $3,200 in 2005 would not be eligible for tax-favored benefits under these plans. A technical corrections bill has been introduced to remedy that rule, but action is not expected until 2006.

Pension Reform Expected Soon

The *Los Angeles Times* reports that expectations are growing for the next Congress to be "benefits active" — particularly with pension reform. A number of leading pension experts are optimistic that Congress will pass pension reform legislation during the next congressional session.

Among the problems is the need for legislative guidance about hybrid pension plans and a replacement for the 30-year Treasury bond rate. The *Times* quotes American Benefits Council President James Klein as saying

that pension legislation in this Congress is likely to address a broad range of issues. "Rarely are there freestanding pension bills. Usually, pension reform is passed when it's included in a broader piece of legislation," Klein notes.

Republican leaders like Congressman John Boehner (R-Ohio) say Congress must take definitive action in the upcoming session, otherwise "the impact on worker retirement security could be devastating." Cash balance plans and the degree to which they discriminate against older workers will no doubt draw much attention.

Does Your SPD Accurately Explain FMLA?

The Family Medical Leave Act (FMLA) contains an important exception when fewer than 50 employees work within a 75-mile radius of the employee's location. Under this rule, an employer may be subject to FMLA, but certain employees working in remote locations may not be covered by the law. A case decided by the Seventh Circuit emphasizes how important it is for employers to communicate this special FMLA rule before enforcing it.

In *Thomas v. Pearle Vision Inc.*, 251 F.3d 1132 (2001), a worker who would not have been eligible for FMLA because of the 75-mile radius rule successfully sued her employer to enforce FMLA protections. The court said that because the Pearle Vision Summary Plan Description (SPD) gave a general explanation of FMLA and failed to note that some employees could be ineligible; this communicated a promise that all employees were fully eligible for FMLA. The court reasoned that if an employer wanted to avail itself of the 75-mile radius rule, it could have drafted its SPD to mention that rule. The Seventh Circuit includes: Illinois, Indiana, and Wisconsin.

Most importantly, employers should be aware that to the extent any benefit provision, employer policy, or employment law is misstated — courts are very likely to construe that language against the employer and in favor of the individual.

California: Domestic Partners Covered or Not?

The *California Insurance Equality Act* (Assembly Bill 2208) gives domestic partners special rights to access insurance. California law also imposes upon registered domestic partners the same responsibilities, obligations and duties that spouses have under state law. Employers around the country are asking if AB 2208 means that they have to provide coverage for the domestic partners of their employees if they provide the coverage for the spouses of employees.

What AB 2208 Does *Not* Require

States can enact laws that regulate insurance carriers, but they may not implement laws which directly tell employers how to operate any benefit program subject to ERISA. AB 2208 — just like any other state requirement — does *not* require employers to offer benefits to domestic partners. That is true whether or not the employer is a California employer, whether or not the employees are residents of California, and

whether or not the coverage is insured. ERISA pre-empts any state law that requires the provision of benefits to any person or any group. (The Hawaii law that mandates group medical benefits is a special exception to the preemption doctrine which was directly built into ERISA.)

California cannot mandate that the employer pay the costs for domestic partner coverage. If domestic partner coverage is extended other payment issues will surface. Specifically, because of the federal tax laws, the employee must pay contributions towards the cost of domestic partner coverage on after-tax basis. If the employer pays the costs, the employer must impute the value of the benefit to the employee and include it as taxable income on the employee's W-2.

AB 2208 *prohibits the insurer* from asking for proof of the relationship unless it also asks for similar proof from married couples. The bill *does not prohibit the employer* from asking for that proof. This may provide an additional safeguard, and likely provoke complaints from affected employees, but such documentation is not completely prohibited.

Many California insurance companies have told us that the only way to avoid domestic partner coverage is to eliminate spousal coverage. Consequently, in situations where the insurance carrier drafts the contract, it may be that employers will end up with domestic partner coverage added to the policy even if they do not apply for it. On the other hand, just because a policy provision is stipulated in the contract, that does not force the employers to offer that coverage to participants.

When is AB 2208 effective?

AB 2208 is effective for any life, accident, or LTD policy that is issued, amended, delivered, or renewed on or after January 1, 2005. For group health policies, it becomes effective only for policies that are issued, amended, delivered, or renewed *after* January 1, 2005. Calendar year contracts for group medical benefits generally do not have to comply until January 1, 2006.

What should employers do now?

California is again putting its employers in a difficult position. Employers with insured plans may find themselves offering domestic partner coverage because the insurance contracts do not offer another option. Employers may require full payment for domestic partner coverage by the employee. The employer is also able to require proof of registration of the domestic partner relationship, even if the employer does not require similar proof of married couples. Employers who choose either option should prepare themselves for the inevitable questions from affected employees.

Is there a more aggressive position?

Again, this new California law applies to *insurance carriers*. Consequently, one option might be to amend the plan document to stipulate that although the insurance contract makes domestic partner coverage available employees will *not* be allowed to elect it. Implementing such a rule would require that all plan communications and documentation be written to preclude domestic partner enrollment.

Of course, such a decision will be controversial, and the employer may be inviting a legal challenge. Although t employer can rely on ERISA preemption as its defense, the courts have not always embraced a

uniform position on the ERISA preemption analysis. Some jurisdictions tend to support preemption more strongly than others, but we expect that the employer would prevail in their assertion that California cannot dictate the benefit participation terms of its ERISA plan. Nevertheless, we suspect most employers will want to avoid potential lawsuits regardless of their odds of prevailing.

Conclusion

Many newspaper reports, radio talk show programs and TV reports distort what the law will do by using general terms and misleading "sound bytes." As employees pick up on sound bytes which appear to showcase a new law that extends domestic partner coverage, it's easy to see how they might seek to challenge an employer who holds a different view of the law.

The bottom line is that employers still hold the power to make the plan benefit decisions believed to best suit the organization. Whether employers choose to offer domestic partner benefits or decline to offer such benefits they have a legal foundation on which to base and defend their decision, if they choose to ignore the politics of that decision.

Pensions Outperformed 401(k) Plans

As reported in the *Wall Street Journal*, a national employer survey found that traditional pension plans outperformed 401(k) plans between 2000 and 2002. Experts agree that pension plans perform better because they are closely managed, while 401(k) plans are rarely monitored by the individual investors that have them. Many individual investors have strategies for investing, but some fail to implement them timely or at all. Pension plan managers are constantly reviewing portfolios and realigning them with stated investment strategies, striving to appropriately diversify the portfolio.

The publication *Employee Benefit News* reports that another recent study indicates that pension plans experienced no growth in 2004. Many pension fund managers remain cautious in their economic outlooks, but target returns are still projected at between eight percent and nine percent. However, as bond yields continue to climb, defined benefit pension plans could benefit, and companies could see a decline in their retirement liabilities. Many fund managers are using asset-to-liability analyses to guide their investment decisions.

Those employers seeking new managers should examine the investing style of each manager for its active or passive attributes, seek out managers with complementary skill sets to those already in place, examine the manager's performance in other funds, and examine whether poor performances are due to market cycles before passing judgment. All employers should hire money managers with long-term goals in mind, rather than follow the trends of the moment.

COBRA: What Does it Really Cost?

Over 150 companies administering COBRA for more than the 20,000 former employees and dependents responded to a 2004 survey. The findings show that average claims costs for COBRA users exceeded costs for active employees by about *46 percent.*

The same survey identified the following five primary COBRA difficulties:

- Cost of coverage, both for the employer and the employee;
- Collecting premium payments;
- Keeping up with the recordkeeping burdens associated with continuation of coverage;
- Notifying employees and other beneficiaries and being notified by them of COBRA eligibility and changes; and
- Communicating the plan to participants and beneficiaries.

As Congress considers COBRA expansion as a way to reduce the number of uninsured, it will be important for Congress to remember that COBRA is *not* cost neutral. COBRA users — as corroborated by the study noted above — tend to be intense benefit users that represent a significant expense for employers. We will continue to emphasize that reality to Washington lawmakers.

Deaths Due to Obesity Exaggerated

The Centers for Disease Control and Prevention says that its widely publicized estimate that 400,000 Americans die each year from obesity is wrong and that it will submit a new, lower figure to the *Journal of the American Medical Association.* The corrected number is expected to be approximately 100,000 — about one-fourth the original estimate. Nevertheless, the controversy swirling around that figure of 400,000 deaths continues.

The *Wall Street Journal* recently reported on this controversy. Positions range from "if obesity is a leading cause of death, more money should be spent to try to prevent it" to "the more money that goes to fighting obesity, the less that will be available for other programs."

Questioning the original number of obesity deaths cited last year, one medical expert noted that with two million deaths a year in the United States, 70 percent of which are among people over 65, virtually every younger person who dies would have to die from obesity. "The numbers simply don't add up," he said.

Benefits for Gay *Couples* or *Spouses*?

In an ironic twist, the *Boston Globe* reports that large employers in Massachusetts are eliminating health benefits for unmarried gay couples now that Massachusetts permits them to marry.

Several large employers, including IBM and Raytheon among others, have indicated that is opposite sex couples have to marry to get the benefits, so do gay couples. A gay rights group argues that since the benefits are subject to federal income tax for gay married couples and not for opposite sex couples that they are not equivalent — even if the gay couples marry. Employers who are dropping the benefits contend that with marriage being a legal option for same-sex couples that they should be held to the same

standard as the rest of their employees. This policy change still appears to be an exception but it might catch on if marriage remains a legal option for gay couples.

Issue Spotlight: FMLA for Spouse Co-workers

FMLA regulations state that spouses who work for the same employer are limited to a *combined* 12 weeks of leave in a 12-month period to care for a sick parent. The 12-week combined limit does not apply when the sick parent's only relationship to an employee is as a parent-in-law. The regulations state that an employee's "parent" generally does not include a parent-in-law, so an employee is not entitled to FMLA leave to care for a parent-in-law.

A special situation arises when employees share a parent. For example, if they have the same mother. Consider when this rule could apply. If one spouse's parent took care of the other spouse during childhood, that parent probably stood "*in loco parentis*" (Latin for "acting as a parent"). There does not need to be any blood relationship or legal responsibility for an individual to be treated as a parent under this rule. If an employee's parent acted as a foster parent to the employee's spouse, each spouse could take FMLA leave to care for that same parent. In the case of spouses working for the same employer, they would be limited to a combined total of 12 weeks' leave in a 12-month period to care for that parent.

The combined 12-week limit for spouses working for the same employer also applies in the case of leave taken to care for a new child.

In other situations each spouse has his or her own entitlement to FMLA leave, even if both spouses work for the same employer.

Since You Asked: Do Uncashed Checks Pose a HIPAA Problem?

A *FOCUS on Benefits* reader recently asked if privacy requirements of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) may impose duties which appear to violate state law.

Specifically, the employer was in the process of terminating a health plan. The employer took all the correct procedural steps to shut down the plan, but found that it still held nearly two dozen uncashed participant claim checks. Under applicable HIPAA privacy rules, the unclaimed checks fit the definition of protected health information (PHI). Complicating matters, the employer had a duty under state law to turn over any unclaimed property to the state. This employer worried that compliance would place them in violation of HIPAA.

We believe the employer need not worry in this situation. Although HIPAA prohibits employers from sharing any protected health information — which definitely includes workers' names or other data that would be found on unclaimed check payments for health claims — employers are not generally required to turn over the specific checks containing PHI. The TPA (acting on the employer's behalf) may simply remit money in the amount of the claim and state that the funds represented proceeds from the employer's benefit program. Further, HIPAA does allow for the sharing of employees' medical reimbursement checks with state organizations, under Section 164.502 and 164.512 which allows disclosures of protected

health information for “treatment, payment, *and healthcare operations activities*.” So, turning over checks may not pose a problem after all.

However, a record of the disclosure must be maintained when handing over checks to the state. In any event, the best approach would be to send a separate check representing the same amounts.

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