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HSA Comparability Rules

Recently proposed regulations clarify and expand the comparability rules in previous Health Savings Account (HSA) guidance. Although employers are not required to fund HSAs, those that do must do it in a nondiscriminatory or "comparable" manner. This means if an employer contributes to any employee's HSA the employer must make comparable contributions available to all comparable participating employees.

Put side by side, the comparability rules' simplicity is more appealing than traditional nondiscrimination rules and the testing involved. However, the comparability obligations may preclude plan sponsors from giving a financial boost to lower earning individuals.

For an employee to be comparable he or she must have the same category of coverage under the High Deductible Health Plan (HDHP) and be in the same category of employment (e.g. full-time, part-time). Contributions are comparable if they are either the same dollar amount or the same percentage of the deductible under the HDHP.

Proposed regulations include the following:

- Categories of employment for comparability purposes include only current full-time employees, and part-time employees, and former employees (except for those former employees under the employer's HDHP because of an election under COBRA). The rules apply separately to each of these categories of employees.

- In addition, the proposed regulations will permit making contributions (subject to the 125 nondiscrimination rules) through a cafeteria plan. A proposed exception for these contributions would allow employers to indirectly make different HAS contributions for participation in wellness, disease management or health assessment programs.

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- There are three contribution funding methods available: pre-funding, pay-as-you-go, and on a look-back basis. Each method has specific rules for proper application.

Failure to satisfy the comparability test means the employer pays an excise tax equal to 35 percent of the aggregate amount contributed to health accounts for that period. The proposed rules cover topics on calculating comparable contributions, the procedures for making comparable contributions, and the exception to the rules that cafeteria plans receive. These proposed regulations will apply to employer contributions made on or after the date of the final regulations published in the *Federal Register*. Pending the issuance of the final regulations, taxpayers may rely upon the proposed regulations. Additional information about HSAs can be found in the *Willis EB Alert #25*.

HSA Limit Projections for 2006

Health Savings Accounts (HSAs) were created as part of the *Medicare Modernization Act of 2003* and were first available in 2004. The legislation limited the amount that could be put into an HSA in any one year and required HSAs to be coupled with high deductible health plans (HDHPs).

HDHPs must meet minimum deductible levels and maximum out-of-pocket levels each year. Participants who are over 55 can add a catch-up contribution to their HSA. Figures will change annually based on cost-of-living adjustments. One exception: catch-up contributions will increase in $100 increments until 2009 when they reach $1,000 at which time they will be indexed too.

While the 2006 figures have not been finalized, Willis, through its American Benefits Council membership, has learned that projections have been developed. The following projected figures may help when in planning for 2006:

- Maximum annual HSA contribution:
  $2,700 for individual coverage (2005 - $2,560)
  $5,450 for family coverage (2005 - $5,250)

- Minimum deductibles for HDHP:
  $1,050 for individual coverage (2005 - $1,000)
  $2,100 for family coverage (2005- $2,000)

- Maximum out-of-pocket for HDHP:
  $5,250 for individual coverage (2005 - $5,100)
  $10,500 for family coverage (2005 - $10,200)

- Catch-up contributions:
  $700 per account (2005 - $600)

Because HSA limits are expected to change annually it makes sense to build some flexibility into your plan design. For instance, if you use a $1000 deductible it would have to change for 2006. Instead, if you were to use an $1100 or $1200 deductible, the plan might be able to go a couple of years without adjusting deductibles and confusing the participants — as well as causing them to complain.

Hurricane Katrina Hits Benefits

Hurricane Katrina's effects reach beyond its storm ravaged geographic area. As workers across the

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nation rush to volunteer to help storm victims, employers are left with many questions about how to handle the employee benefits. Many Alabama, Louisiana, and Mississippi employers are unsure how to fulfill their legal notice requirements or how they may even contact their employees. Here are several key issues that plan sponsors should be aware of.

Employees Working in the Relief Effort

When employees who are members of the armed services are called to serve in the federal Katrina response, the protections of the *Uniformed Services Employment and Reemployment Rights Act of 1994* (USERRA) likely apply. USERRA applies to members of the armed forces, as reservists, and as members of the commissioned corps of the Public Health Service. The *Bioterrorism Preparedness and Response Act* extended USERRA's protection to members of the National Disaster Medical System which includes Disaster Medical Assistance Teams, Disaster Mortuary Operational Response Teams, Veterinary Medical Assistance Teams, National Pharmacy Response Teams, and National Nurse Response Teams.

Employees covered under USERRA must be protected from job discrimination and have benefits while on leave if they meet the following conditions:

- The employee holds a civilian job and has a reasonable expectation that employment will continue indefinitely;
- The employee provides advance notification that he or she plans to leave for service (in cases of emergency, the notice requirement is excused);
- The employee does not serve for more than a five-year cumulative time period in active federal service;
- The employee must be released honorably from the federal service (from the armed forces or the National Disaster Medical System);
- The employee must return to work in a timely fashion after release from federal service.

To the extent that an employee does not meet the above requirements or if the employee *volunteers* to leave work, then USERRA will not provide protection for the employee's action. However, the employee may qualify for FMLA leave or other discretionary leave under a company policy. Moreover, if individuals are called into recovery service by the state, employers are obliged to follow state laws. Consequently, employees may be protected by state statutes.

Retirement Fund Leniency

Congress has passed the *Katrina Emergency Tax Relief Act of 2005* and the President's signature is expected soon. This will allow individuals to access their retirement accounts in order to help rebuild their lives in the wake of the storm. Specifically, it will permit penalty-free distributions of up to $100,000. Normally, distributions of this nature would be subject to a ten percent premature distribution penalty. The new law also provides a longer time period for paying income taxes associated with early distributions. A one-year deferral of loan payments that are due any time between August 25, 2005 and December 31, 2006.

Congressional relief will apply to any distributions or loans made between August 25, 2005 and January 1, 2007 to participants who live in the Katrina disaster areas. To qualify, participants must have their principal residence in a disaster area and must have actually sustained a hurricane-related economic loss. The *Katrina Tax Relief Act* also provides tax credits to employers that continue to pay affected employees.

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HIPAA Privacy Concerns

HIPAA privacy concerns apply to "covered entities" as defined under the HIPAA regulations. Covered entities are medical care providers and employer group health plans (as distinguished from employers). Privacy regulations prohibit covered entities from sharing protected health information except with approved parties. Even in situations where use of protected health information is authorized, the rules impose a duty that only the minimum necessary information be shared.

Accordingly, the Department of Health and Human Services (HHS) has released a bulletin describing the freedom with which health care providers can respond in emergency situations. The following information on HIPAA privacy is published directly from the HHS bulletin and outlines that patient information can be shared by health care providers and health plans in all of the following ways:

Treatment: Health care providers can share patient information as necessary to provide treatment. This includes the following:

- Sharing information with other providers (including hospitals and clinics),
- Referring patients for treatment (including linking patients to providers in areas where a patient has relocated), and
- Coordinating patient care with others (such as emergency relief workers or others that help find appropriate health services).

Notification: Health care providers can share patient information as necessary to identify, locate and notify family members, guardians, or anyone else responsible for the individual's care or the individual's location, general condition, or death.

The health care provider should get verbal permission from individuals. When possible if the individual is incapacitated or not available, providers may share information if, in their professional judgment, doing so is in the patient's best interest.

- When necessary, the hospital may notify the police, the press, or the public at large to the extent necessary to help locate, identify or otherwise notify family members and others as to the location and general condition of their loved ones.

- When a health care provider is sharing information with disaster relief organizations as authorized by law to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if it would interfere with the organization's ability to respond to the emergency.

Imminent Danger: Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public.

Facility Directory: Health care facilities maintaining a patients directory can tell people who ask about individuals whether the individual is at the facility, their location in the facility, and general condition.

Form 5500 Extension

The U.S. Department of Labor (DOL) is extending the deadline for filing Form 5500 annual report/returns for plans affected by the hurricane damage in Alabama, Louisiana and Mississippi. Consequently, any reports required to be filed between August 29, 2005 and January 3, 2006 will be granted an automatic extension until January 3, 2006.

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Specifically the extension applies to:

- Employee benefit plans, banks, and insurance companies located in counties designated as federal disaster areas; and
- Plan administrators located outside the disaster areas that are unable to obtain information necessary to file from service providers, banks, or insurance companies located within the disaster areas.

Plan filers entitled to this extension must check Part I, Box D on the 5500 (or Part 1 on the Form 5500-EZ) and attach a statement to the form indicating that the hurricane necessitated the extension. If the forms are filed late because a service provider, bank, or insurance company is unable to provide necessary information before the original due date, the filing must include the name of the entity and the federal disaster county in which it is located.

Donating Vacation or Paid Time Off

Treasury and Internal Revenue Service officials have announced special relief intended to support leave-based donation programs to aid hurricane victims. Under these programs, employees may donate their vacation, sick or personal leave in exchange for employer cash payments made to qualified tax-exempt organizations providing relief for the hurricane victims.

Under Notice 2005-68, workers can choose to give up their leave in exchange for employer cash payments made before January 1, 2007, to qualified tax-exempt organizations. Although employees forfeit their vacation time, they will not have to include the donated leave in income. Additionally, employers will be permitted to deduct the amount of the cash payment from their taxes.

Other Leave Requirements

FMLA regulations generally provide that an employer may terminate or lay off employees on FMLA leave as long as the employer can show that the termination was not related to the employee taking FMLA leave. If the employee is able to prove that he would have been reinstated, reassigned, transferred, or permitted to telecommute if not for taking the FMLA leave, then federal law requires that protected leave and benefits continue until exhausted. Employers should be very careful to treat similarly-situated employees the same.

State law requirements may apply if the leave available under state law is more generous than FMLA, or if the employer is not already subject to federal leave requirements.

COBRA Notifications and Payments

COBRA requires that notices and election forms be sent to the individual's last known address. This can be a problem when homes are destroyed and mail service disrupted, but employers should continue to send required COBRA materials to an employee's last known address unless the employer is informed otherwise by the employee. Employees must register their new addresses with the postal service in order to receive forwarded mail, so an employer's best distribution method is to send notices to the last known address for forwarding.

COBRA payments may be similarly affected by postal service problems. Consequently, the Department of Labor and the Internal Revenue Service have announced special relief for hurricane victims. For affected individuals only, the period from August 29, 2005 through January 3, 2006 must be disregarded when determining the COBRA election period of a qualified beneficiary; whether a qualified beneficiary's

COBRA premium payments are timely; or the date by which individuals must notify a plan of a qualifying event or determination of disability. The same period of time is disregarded in an employer's favor when determining the date by which affected plans must provide COBRA election notices.

Provision of Health Insurance Coverage

When a business interruption occurs and employees are no longer working, employee benefits do not automatically continue. The plan documents (or the insurance certificate of coverage for fully-insured benefits) ultimately control and will precisely state the length of time that benefits will continue. Normally, the most generous plan provisions provide health coverage through the end of the month in which the employee ceases working for the company. After that time period, coverage may terminate and COBRA notices (if a plan is subject to COBRA) must be distributed.

IRS Mileage Rate Increase

The IRS normally updates the mileage rates once a year but events have prompted the agency to step out of its routine, officials said. Citing the steep climb in gasoline prices, the Internal Revenue Service has announced an increase in the optional standard mileage rates for the final four months of 2005.

The rate — which is the amount employers may deduct for the reimbursement of employees who use their own cars for company business — will increase to 48.5 cents a mile for all business miles driven between September 1 and December 31, 2005. That represents a rate increase of eight cents for the first eight months of this year.

With some oil analysts predicting a decline in gas prices over coming months, the IRS said it would hold off setting the 2006 rate until closer to January. Tax experts are cautioning that next year's official rate could end up less than 48.5 cents.

Association Health Plans: Good or Bad?

A proposal in the Senate (S. B. 406) would allow small businesses to form associations in order to qualify for group health insurance. Proponents say that this would make affordable health insurance easier to obtain for many workers, but critics believe that it may simply create inadequate health plans. Opponents, add that the freedom from regulation that such associations have might deprive the insured of channels to improve their care.

In spite of the intent of the bill, the nature of health insurance may not allow for premiums and costs to be reduced — especially with a large portion of insurance premiums paying for actual care. The Association Health Plan (AHP) bill, which has strong support from the Bush Administration, passed the U.S. House with a 263 to 165 vote, with 36 Democrats voting for the measure. The question remains whether the Senate, which has failed to pass similar bills in the past, will approve the measure this time around.

The Senate bill generally defines AHPs as group health plans whose sponsors are trade, industry, professional, chamber of commerce, or similar business associations and which have been certified by the Department of Labor (DOL). Under the bill, AHPs must meet certain participation and coverage requirements. All employers participating in the AHP must be members or affiliated members of the sponsor, and all individuals in the plan must be active or retired employees, owners, officers, directors, partners, or their beneficiaries. Discrimination is prohibited and all employers who are members of the association must be eligible to participate. All coverage options, if geographically available, must be made ac-

cessible to eligible employers. Individuals cannot be excluded from enrolling in the plan or charged a higher premium because of their health status. AHPs must also meet certain reserve requirements and institute solvency protections.

ADA: Is Cancer a Disability?

New EEOC guidance — the fourth in a series of question-and-answer documents about disabilities in the workplace — explains how the Americans With Disabilities Act (ADA) might apply to job applicants and employees who have or had cancer. In particular, this guide explains:

- When cancer is a disability under the ADA;
- When an employer may ask an applicant or employee questions about his or her cancer and how it should treat voluntary disclosures;
- What types of reasonable accommodations employees with cancer may need; and,
- How employers can ensure that they do not discriminate against applicants and employees with cancer.

The government reports that about half of the one million Americans diagnosed with cancer are working adults. The agency's guidance helps determine whether cancer limits major life activities of workers and if reasonable accommodations are required to keep those diagnosed with cancer working. You may view the new EEOC guidance through the following link: http://www.eeoc.gov/facts/cancer.html

Lawsuits Over Company Stock

Are plan participants allowed to bring a fiduciary claim against the plan sponsor based on the performance of the company stock in the 401(k) plan?

In one recent case, a court held that despite case law to the contrary, the plan participants could bring a suit on behalf of the plan — although the harm applied only to a subset of the participants. The lawsuit alleged that participants had been harmed because employer stock dropped from over $60 per share to less than $20 per share. Specifically, the plaintiffs claimed that the plan fiduciaries "breached their fiduciary duties of prudence, care, and loyalty by continuing to offer the Company Stock Fund as one of the savings plan alternatives when they knew that the company's stock price was unlawfully and artificially inflated."

The plaintiffs also alleged that the defendants failed to disclose negative material information about the company, inducing participants in the savings plan to elect to invest in the Company Stock Fund. Allegations include a complaint that some of the defendants "did not loyally serve the saving plan participants by taking steps to avoid a conflict of interest such as making appropriate public disclosures, divesting the savings plan of company stock, discontinuing further investments in company stock, consulting independent fiduciaries, or resigning as savings plan fiduciaries."

The allegations themselves have not yet been tested in court because the issue here centered only on whether the plaintiffs even had a right to sue on behalf of the plan. The court found that they did — although investing in the company stock was always at the individual's discretion. The court held that ERISA's fiduciary obligations do apply to the decision to offer the company stock in the plan.

Employers should be aware that their decisions, at least with respect to company stock (and there was nothing in the opinion to indicate that the holding was limited to company stock) will be reviewed with

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respect to whether the appropriate fiduciary responsibilities were met.

This case was decided in the Third Circuit. The Third Circuit includes: Delaware, New Jersey, Pennsylvania, and the Virgin Islands.

State Laws and HSA Interference

Many states have mandatory levels of coverage for insured plans. Such mandates can force carriers to offer coverage that may be considered something other than a high deductible health plan (HDHP), so individuals with such coverage may be ineligible to fund an HSA (Health Savings Account).

The question of state-mandated coverage interfering with HSA eligibility has been an on-going concern. So far, state mandates have not presented significant problems due to a special two-year transition period granted by the Treasury Department. That special rule expires on January 1, 2006. States that have not fixed those restrictions have to deal with the fallout of local mandates altering the nature of insurance policies so that those insurance products will not be considered HDHPs. Consequently, covered individuals in those states will be ineligible to fund HSAs. It's not yet clear in all states whether HSA accounts will be subject to state tax.

When HSA-based health plans first became available, laws in 17 states included "structural impediments" that made it difficult to pair an HDHP with a HSA. Today there are only two; New York and New Jersey. Observers note that legislators in both states are working to address the impediments.

Although HSA contributions are exempt from federal taxes, several states — Alabama, California, Maine, Massachusetts, New Jersey, Pennsylvania and Wisconsin — do not yet exempt HSA dollars from state taxes. Such laws could hinder adoption of the plans, or confuse account holders who are not familiar with the state-specific glitches. But most health insurers seem to be going out of their way to educate consumers about the effect laws in some states could have on their HSAs.

State laws are unlikely to have an impact on larger employers that make HSA-based plans available, since most large employers use self-funded plans that are not subject to state mandates. For more information about how state laws may affect HSA eligibility please see *Willis EB Alert #25 (Part 1)*.

Nickname Discrimination

The Ninth Circuit Court of Appeal has found that an apparently non-offensive nickname was racially motivated and therefore constituted race discrimination based on ancestry or ethnic characteristics. *El-Hakem v. BJY, Inc.,* (Ninth Cir., July 21, 2005) No. 03-35514, No. 03-35544, No. 04-35063. The court upheld a jury verdict against an engineering firm CEO who insisted on calling an employee, Mamdouh El-Hakem, "Manny" and "Hank," in an effort to westernize the employee's name.

El-Hakem, the plaintiff (who was Arabic), brought an action against his former employer and the CEO of the company for discrimination under Title VII of the Civil Rights Act of 1964, wrongful termination, and failure to pay wages under the Fair Labor Standards Act. El-Hakem's racial discrimination claims stemmed from the CEO's repeated references to El-Hakem as "Manny," and "Hank," despite El-Hakem's strenuous objections, on the basis that a "western" name would increase El-Hakem's chances for success. At trial, a jury found that the CEO intentionally discriminated against El-Hakem in his work environment and awarded him $15,000 in compensatory damages and $15,000 in punitive damages.

The Ninth Circuit rejected the employer's argument that "Manny" is not a racial epithet, finding "names

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are often a proxy for race and ethnicity." The court found that the CEO's repeated use of the name "Manny" over a one-year period was pervasive enough to create a hostile work environment. The Ninth Circuit includes: Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington, Guam, and the Northern Mariana Islands.

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