Quarterly Review

Vol XVIII; Number 3 — *October, 2008*

From the Desk of the Editor

I considered featuring an article on the current economic crisis and its impact on health care or vice versa. However, as I began writing, my comments seemed not just redundant to every other article in the news, but also premature given the November elections. Instead something more tangible and predictable, like the Treasury Business Plan, seemed better suited. There are slightly over a dozen issues we are monitoring for you. I noticed there was no entry in Treasury's Plan on issuing the Final §125 regs, so I assume that's just a given for this fall/winter.

Congress was busy this quarter, and there are several articles in this issue that clarify the impact of new legislation. Mental Health Parity and Bicycle Commuting seem like strange bedfellows; both were tucked into the recent Economic Stabilization Act. In the recent Adoptions Act, there's been more tinkering with the Section 152 definition of dependent; it appears that the ban on married dependents has been restored for purposes of health coverage for dependents who are not qualifying relatives. I included an excellent article in a recent EBIA Weekly on the subject and Muriel and I will be issuing additional follow-up later. You will find a few cost of living adjustments (COLAs) included. We will be issuing a Benefits Alert toward the end of the year when we have all cost of living adjustments so that you have one document to reference.

Since the 1980s FBMC has helped employers administer defined contribution plans, through its wholly-owned subsidiary Vista Management Company (VMC). I have included several articles of interest – one from VMC's newsletter. This is enrollment time for many of you and if you are looking for creative ways to persuade employees to invest in their futures this article may give you some ideas.

On behalf of everyone at FBMC, best wishes on the upcoming holidays – hard to believe but they are just around the corner.

Enjoy, Trish

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FBMC Partners Financially Sound

Gingy Sampson, Partner Relationship Manager

Given the recent economic fluctuations, it has become increasingly important for FBMC to monitor the financial health of our partners and vendors. We use a multi-tiered approach: first we inquire directly with our partner contacts for updates and their assessments; then we validate by constantly monitoring insurance rating agencies and mainstream media as well as our partners' press release pages. Important information, garnered from this process, is analyzed and the results posted on the FBMCwiki for constant review by all internal decision-makers. As of this writing all partners and vendors remain in strong standing with rating criterias set by the industry as well as FBMC.

Years ago we made the decision to only recommend to clients products from vendors with **A.M. Best Company** "A- (excellent)" rating or higher. **A.M. Best Company** is the leading provider of ratings, news and financial data for the insurance industry worldwide and **Best's Ratings** are recognized as the benchmark for assessing the financial strength of insurance related organizations and the credit quality of their obligations. This process has served us well; in addition to being a benefits administrator, we are also one of the 100 largest brokers of voluntary insurance products.

Feature Article

2008 – 2009 Priority Guidance Plan Department of Treasury

Trish Neely, CFCI

On September 10th, the IRS and Treasury released their 08/09 Priority Guidance Plan containing 314 projects to be completed from July 2008 to June 2009. The agencies invite public input and the resulting plan is based upon those items of greatest interest to taxpayers, tax practitioners and industry groups. The published plan provides us with a basis to begin monitoring items which could potentially impact our industry, our plan, our clients and friends. As the Agencies update the plan throughout the year to reflect additional public comments, new legislation and/or other factors (for example, changes in the economy), we will update the following items we will be watching with interest and reporting to you in this newsletter.

- Final regulations under §401(a)(9) related to minimum distribution rules for governmental plans
- Revenue procedure on §403(b) prototype plan documents
- Revenue ruling to obsolete §403(b) Internal Revenue Bulletin guidance no longer applicable
- Guidance on special issues relating to rollovers from qualified retirement plans to Roth IRAs
- Notice on retirement plan provision of the HEART Act
- Final regulations on automatic enrollment as added by 2006 Pension Protection Act
- Guidance on additional issues on HSAs
- Guidance under §105 of the Heroes Earnings and Relief (HEART) Act regarding treatment of military differential pay as wages
- Guidance under §4980B regarding calculation of applicable premium for COBRA continuation
- Final regulations on HOPE Act changes to §4980B with respect to comparable ER contributions to HSAs
- Proposed regulations under §4980B on the interaction of §4980B and §125 with respect to comparable ER contributions to HSAs
- Temporary regulations implementing the Genetic Information Nondiscrimination Act (GINA)
- Guidance addressing significant issues under §152 addressing the definition of dependent
- Revenue Ruling providing guidance on reinsurance arrangements

For a copy of the complete Priority Guidance Plan, log onto www.irs.gov/irs/content/0,,id=101098,00.html or contact Treasury at 202.622.2960.

News Briefs

§125 Regs Delayed

Trish Neely, CFCI

The IRS issued New Proposed Cafeteria Plan Rules last August with an expected effective date of 1/1/2009. Speaking at the recent ECFC conference Kevin Knopf, from Treasury told the conference attendees that while he expected the new final regulations to be issued this fall, the effective date would be 2010 rather than this coming January, 2009. On a positive note, this means an additional year to work through the details of the new non-discrimination testing requirements.

MMD Notices Due

Trish Neely, CFCI

Annual Medicare Part D (MMD) Notices to plan participants are due no later than November 15th (regardless of your plan year). The Notice is used to inform Medicare-eligible employees and/or their Medicare-eligible dependents whether their prescription drug program is comparable to or better than the RX program available through Medicare.

A Medicare-eligible individual risks paying a higher premium through Medicare in the future if he/she remains in an employer-sponsored RX program that currently provides less benefit than Medicare.

HEART Act Procedures Implemented

Kim Farris
Julia Hylton

FBMC Operations is ready for the HEART Act and we have made the procedure relatively simple for the employer and the reservist & family:

- The reservist requests a Qualified Reservist Distribution (QRD) from his/her employer by submitting his/her orders;
- The employer completes its section of a QRD Form prepared by FBMC and submits to FBMC;
- FBMC processes the distribution using a unique service code and then prepares the payment to the reservist or includes on the next scheduled claims file to the employer for payment to the reservist.
- FBMC completes its section of the QRD Form and returns to the employer for W-2 reporting.

If you have a Qualified Reservist Distribution, please contact Claims Manager, Julia Hylton at jhylton@fbmc-benefits.com for a copy of the QRD Form.

The Heroes Earning Assistance and Relief Tax (HEART) Act makes changes to some of the rules governing 1) health flexible spending arrangements (HFSA), 2) Café Plans, and 3) other non-health benefits. To help military personnel called to active duty, plan sponsors **may** make a cash distribution of unused HFSA benefits to eligible reservists without disqualifying their cafeteria plans. The distribution, which the Act refers to as qualified reservist distributions (QRD) is completely voluntary. If a plan sponsor decides to offer this, an amendment must be made to existing plan documents. FBMC has prepared a plan amendment for clients' use. Client's have until 12/31/2009 to amend their plans and the effective date may be made retroactive to the date of the first QRD. For assistance in preparing a plan amendment contact tneely@fbmc.com.

Bicycle Commuting Added to §132(f)

Trish Neely, CFCI

Tucked within the recent economic stabilization legislation was a new fringe benefit: - ***bicycle commuting***. The benefit is not a surprise since it has been on and off the table for discussion for several years; what may be a surprise is that the final product is an employer paid benefit only. So while Employers may reimburse employees on a tax-free basis up to a monthly maximum, the benefit cannot be funded with Employee pre-tax salary reductions. The maximum benefit toward eligible expenses incurred is $20 per month for each month the employee uses his/her bike for a **substantial** portion of travel to and from work (no, substantial is not defined). Unlike other fringe benefits, the amount will not be indexed for cost of living adjustments. Details are minimal but what we do know is that eligible expenses include cost of purchasing a bike, bike improvements, repair, and storage. Reimbursements must be submitted and made no later than 3 months following the calendar year in which expenses are incurred.

§132 COLAs Issued

2009	Monthly Contribution Limits
$120	Commuter and Transit Pass
$230	Qualified Parking
$20	Bicycle Commuting (new)

QTB Card Guidance Delayed
Revenue Notice 2008-74

Trish Neely, CFCI
Kendall Hall

As some transit systems continue to experience technology barriers to achieving compliance, the effective date has been delayed to 1/2010 on previous IRS Guidance which paved the way for the use of electronic payment cards as transit expense **vouchers.**

Using the card as a voucher would eliminate the need for full substantiation and certification of the expense and keep down the costs of administering the program. But it appears that setting up the card properly means more than just restricting the card to certain merchant category codes or coming up with a QTB reporting system (ala IIAS for medical expenses). Using the card as a voucher may require a card with separate purses for different types of QTB expenses, or a single purpose card. We do know from informal guidance that using a card that is not configured properly to be used as a voucher prior to 1/2010 is not recommended.

For questions about card technology in general, contact khall@fbmc.com.

Health Care Issues & Trends

Newborns' & Moms' Health Protection Act (NMHPA) of 1996, Final Rules

Trish Neely, CFCI

The US Department of Labor (DOL), Treasury, and Department of Health & Human Services (DHHS) published final rules that provide guidance in complying with the provisions of NMHPA. The rules, published in the Federal Register on 10/20/2008, are effective with plans on or after 1/1/2009 and replace interim final rules adopted in 1998. The reason for the near immediate effective date is that in general the interim rules are the final rules. An important clarification is to the definition of attending provider – it does not include a plan, hospital, managed care organization, or other issuer. Another clarification is to the applicability to state law and under what circumstances state law trumps the Act.

To put these clarifications and several others in context, it may be helpful to review NMHPA's provisions. The primary purpose of the 1996 Act was to protect Newborns and Moms from being discharged from hospital care too early following childbirth. At the foundation was (is) a general rule that group health plans or health insurance issuers (for individual coverage) cannot restrict benefits for a hospital length

of stay in connection with childbirth to less than 48 hours, or 96 hours in the case of cesarean section. The interim final rule passed two years later:

- Provided that the attending ***provider*** determines that an admission is in connection with childbirth;
- Provided an exception to the general 48-hr rule if the attending provider and the Mother agree to an earlier discharge;
  *Herein lays the significance of the clarification of who the attending provider is and who it is not - it's **not** the health plan, the hospital, or the issuer.*
- Determined that the hospital stay begins (the clock starts ticking) at the time of delivery and not at the time of admission or start of labor;
- Clarified within the authorization and pre-certification requirements that a health plan or issuer may not require pre-authorization to prescribe a hospital length of stay that is subject to the general rule;
- Explained that cost-sharing rates must be consistent throughout the 48 or 96-hr stay, and not less for a shorter stay;
- Stated the prohibitions of offering incentives or disincentives to Mothers or to attending ***providers*** to encourage a shorter stay;
- Included the statutory notice provisions under ERISA and PHS; and
- Included an exception to the Act's requirements if a given state's laws meets any of three criteria:
  1. 48-hr or 96-hr length of stay requirement following childbirth;
  2. require coverage in accordance with established professional guidelines; or
  3. require length of stay decisions to be left up to attending provider and mother.

In response to comments in the ten years since the interim final rules were adopted, these final rules add or clarify:

To the suggestion that the final rules make clear that the definition of attending provider does **not** include a plan, hospital, managed care organization of other issuer:

- *The final regs adopt the suggestion and such clarification is included in the preamble. The final rules repeat the interim rules definition that the attending provider is restricted to an **individual** who is licensed under applicable state law to provide maternal or pediatric care and who is **directly** responsible for providing such care to the mother or newborn. [emphasis added]*

To the comment that the rule required birthing centers or other non-hospital facilities to comply with the 48-hr stay minimum:

- *The agencies clarify that the final regs do not require non-hospitals or other facilities to provide particular lengths of stay.*

To comments regarding compensation or incentives:

- *The agencies reply that they devoted "considerable resources and time" on trying to develop rules to distinguish between arrangements that would give attending providers an **incentive to deliver health care services efficiently** that would not also create or lead to **incentives to discharge patients early**. However, the final rule adopted the interim rule unchanged with the comment that "any additional rules developed would have been of only marginal value" yet would have been so elaborate as to impose "heavy administrative burdens" on the parties.*

To comments regarding issuing guidelines to insurers rather than **dictating** specific language in the disclosure statements:

- *"Specific language ensures the substantive adequacy of the notices", and since insurers have presumably already incorporated the language, "continuing to require the same language is the simplest approach."*
- *The final regs did clarify that electronic delivery is ok and also that the notice can be included in the plan document or other benefit materials.*

To objections that issuers in states that have enacted **one** of three types of state laws would arguably be exempt from several of the Act's requirements:

- *The final rules confirm that it is not necessary for states' laws to include all of the federal provisions in order for health insurance coverage in those states to be excepted from the federal requirements. [emphasis added]*

  Note: With the exception of nonfederal governmental plans that have opted out of the Public Health Services Act, **self-insured plans** in all states generally are required to comply with NMHPA's federal requirements.

To the question if less favorable cost sharing for the 48- or 96-hr stay could be applied where individuals fail to give advance notice upon admission for the services or providers related to the stay if such a penalty applies in other situations:

- *A plan could apply less favorable cost sharing in connection with childbirth if the individual failed to satisfy the plan's advance notice requirements; however, any variance must apply consistently throughout the stay. Again the agencies are ensuring that there is no inducement or incentive to release early.*

A copy of the full text is available at:
http://edocket.access.gpo.gov/2008/pdf/E8-24666.pdf

True Mental Health Parity Required

Trish Neely, CFCI

Included in the economic stabilization legislation recently signed by President Bush was the Mental Health Parity & Addiction Equity Act of 2008. This Act expands and amends the existing Mental Health Parity Act and removed the Act's sunset provision. The legislation clarifies that group health plans are prohibited from adopting mental health or substance abuse benefits with treatment limitations, financial requirements, benefit caps, or out-of-network limitations that are less generous than for other types of benefits in the health plan.

It is important to note that this federal Act does not mandate inclusion of mental health or substance abuse benefits; however, states' insurance laws may have such mandates in effect for insured plans. The federal parity act requires that if the group plan has mental health or substance abuse benefits in place (either voluntarily or by state mandate) then there must be true parity with other benefits. Plan sponsors and their medical providers must begin reviewing their group health plans now to bring them into compliance. The Act is effective for plans beginning on or after 10/9/2009.

Exceptions. The legislation does not apply to small employers (50 or fewer employees). The Act contains a provision whereby an employer may request an exemption if upon implementing the Act's provisions it can demonstrate (actuarially) a 2% increase in rates during the first year; or 1% for subsequent years. The exemption is for one year at a time. In practice this means complying with the Act, if rates increase an employer may apply for a one year exemption; next year comply with the Act again, if rates increase apply for another exemption, and so forth.

Michelle's Law

Trish Neely, CFCI

October 9, 2008, Congress enacted a law to restrict when a group health plan may terminate coverage for a covered "dependent child." Congress was responding to a highly publicized story of a student who died shortly after graduation, due in part to her refusal to quit school as her doctor's recommended because doing so would have terminated her health coverage under her parents plan. The law is effective for plan years beginning on or after 10/9/2009.

For purposes of the law the "dependent child" must have been a student enrolled in post-secondary education immediately before the medical leave of absence. Under the law, a health plan may not terminate the "dependent" for one year following the first day of the medically necessary leave, or the date that the coverage would otherwise have terminated, whichever is earlier. The law also requires that group health plans include notice of the requirements along with any notice regarding certifying student status for plan coverage.

Retirement Plan Services

***Editor's Note**. We know that getting employees to participate can be challenging even if the employer offers a matching contribution of some value. Your human resource or benefits staff may find the following excerpts from an article published in the July issue of VMC's 401(k) News of value as a communication tool.*

Small Sacrifices Today

Al Strickland, Registered Representative

Most of us feel like we are between a rock and a hard place. On the one hand, there are reports indicating we aren't saving enough to last through our golden years. On the other hand, we have daily reminders that the cost of living is going up e.g., gas, groceries, healthcare, etc. To add to these worries are the continuous discussions about inflation and the uncertain future of Social Security benefits. Is that enough gloom and doom for you? Is there a way out?

Well, short of winning the lottery, and having better odds is something called a "Defined Contribution Plan." It allows you to invest money, to postpone paying taxes and has a potential to make an inflation-beating return on your investment. It can put you on the path to financial independence, which leads to retirement security. See, retirement, or rather, the ability to retire from having to work has everything to do with money and a sustained supply of it. If you believe that it's difficult to live on what you earn now, how about living on 50 percent less – NOW?

With hurricane preparedness, we are told to have a plan – water, food, etc., a safe room, determine beforehand an escape route. You know the drill. You have to have a plan as well for financial independence today in preparation for retirement tomorrow. The question is, "Are you working your plan?"

Here's an example of small sacrifices. If you gave up a $5 cup of coffee a week, invested it into your [defined contribution] plan and it grew at a hypothetical six percent per year growth in value, it may produce an additional $10,000 to your nest egg in 20 years! One less trip to Starbucks, skip a luncheon and bring a can of soup to work once a week and you could increase your $50 monthly contribution to $90. You may have potentially increased your nest egg by $20,000. A little

sacrifice today will go a long way for making those later years "golden!"

Here is the big challenge: leave it alone. Let it grow. No loans, no cutting back on your contributions. Live a little below your means and keep looking for those little sacrifices to increase your contributions even more! That will make life a whole lot easier down the road.

Remember, the alternative to not making those little sacrifices and making sound financial decisions today, is putting up with your new boss fresh out of college when you're 72. No thanks; I'd rather be fishing!

VMC is a wholly owned subsidiary of FBMC and is a registered broker dealer. The examples used do not reflect any specific investment which may fluctuate.

A 401(k) Electronic Payment Card?

Patrick Peters

A new type of electronic payment card – a 401(k) Card is in the news; of course we were curious and decided to take a closer look. It works like a debit card to give a participant access to his/her 401(k) funds through an approved loan. But then it functions like a credit card when it comes time to pay back the loan in installments *with interest and fees*. *(Loans can take a huge chunk out of the investment **nest egg**.)* Here are some of the pitfalls with the use of the 401(k) Card:

Interest and fees: Most 401(k) plans that offer loans charge interest – usually a couple of percentage points over prime. There may be fees associated with the Card itself – annual card fee, card setup fees, cash advance charge with each transaction at an ATM or bank and other normal card fees – replacement card fees, etc.

Lower investment return: Once a loan is taken, the money is set aside into an interest bearing account such as a money market – separate from one's investments. If you were to take a loan, the returns in this account may or may not be as high as those that your other 401(k) assets could earn.

Tax consequences for Repayment Failures: If a participant defaults on their loan, the loan may be treated as a plan distribution that would be subject to income tax. If the participant is below 59 ½ an additional 10% penalty shall apply.

No payback of Loan through Payroll: Unlike regular 401(k) loan repayments that are made through the employer's payroll system on a post-tax basis; 401(k) Card loan paybacks are not made by automatic payroll deduction. The participant must initiate repayment manually via check, wire transfer or automatic deduction from their bank account.

Tapping into investments with loans prior to retirement may adversely affect investment returns and the ability to reach investment objectives. Making the loan process more convenient through a 401(k) Card is not in our customers' best interest. We won't be adding a MyFBMC 401(k) Card any time soon.

Retirement Plan COLAs Issued

Holly Hance

RETIREMENT VEHICLES (§§ 401(K); 403(B); 457; IRA)

2009	2008	Annual Limits
$16,500	$15,500	Elective Deferrals 401(k) & 403(b) *excludes adjustments & catch ups*
$16,500	$15,500	Limits for 457(b)(2) and 457(c)(1) *excludes catch ups*
$5,500	$5,000	Catch up Deferrals (401(k), 403(b), and 457 plans
$5,000	$5,000	IRA - *individuals aged 49 or below*
$6,000	$6,000	IRA – *individuals aged 50 or above*

GUEST ARTICLES

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ADOPTIONS ACT NARROWS THE DEFINITION OF QUALIFYING CHILD UNDER CODE SECTION 152

(This copyrighted article originally appeared in the 10/09/2008 EBIA Weekly and is reproduced with the permission of EBIA.)

[Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351 (Oct. 7, 2008)] For a copy: http://frwebgate.access.gpo.gov/cgi-

bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h6893enr.txt.pdf

President Bush has signed into law legislation that includes a provision limiting who can be considered a "qualifying child" under the definition of dependent in Code Section 152. (Under Code Section 152, a person is considered a dependent only if he or she is either a qualifying relative or a qualifying child.) The legislation, known as the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Adoptions Act), primarily makes changes to the Social Security Act relating to adoptions and foster care. Those changes include, among other things, allowing states to make assistance payments to relatives who become legal guardians of children for whom they have cared as foster parents, improving efforts to keep siblings together when they are removed from their homes, providing federal resources for tribal foster care, and increasing incentives for special needs and older child adoptions. In addition to those provisions, however, the Adoptions Act also revises Code Section 152(c), the portion of the Code that defines who is a qualifying child.

The legislation makes three changes to Code Section 152(c):

==> Child Must Be Younger Than Taxpayer. Currently, a qualifying child generally must be under age 19 or be a student under age 24 at the end of the calendar year in which the taxpayer's tax year begins to be considered a qualifying child for that tax year. The Adoptions Act adds a requirement that a qualifying child must be younger than the taxpayer.

==> Child Must Be Unmarried. Code Section 152(b)(2) currently prohibits an individual from being considered a dependent if the individual filed a joint return with his or her spouse for the taxable year beginning in the same calendar year as the taxpayer's tax year. The Adoptions Act inserts a similar limitation into the definition of qualifying child.

==> Child May Be Dependent of Nonparent With Higher Income Than Any Parent. Generally, if an individual may be considered the qualifying child of both a nonparent and a parent, the individual will be treated as the qualifying child of the parent. The Adoptions Act changes that rule, however, allowing an individual to be treated as the qualifying child of a nonparent if (1) no parent claims the individual as a qualifying child and (2) the nonparent has a higher adjusted gross income than any parent.

These changes are effective for taxable years beginning after 2008. In addition to these changes, the Adoptions Act amends the child tax credit under Code Section 24 to limit its definition of qualifying child to persons for whom the taxpayer could take a deduction under Code Section 151 (a rule which effectively imports the revised Code Section 152(c) definition of qualifying child into Code Section 24). Finally, the Adoptions Act adds a new disclosure requirement, obligating states to inform individuals who are adopting or considering adopting a child in foster care that they may be eligible for the federal tax credit for adoption expenses under Code Section 23.

EBIA Comment: The Adoptions Act refers to its provision amending Code Section 152 as a clarification of the Code's uniform definition of a child, but the remarks of the Act's sponsor in the House suggest that the changes are meant to close loopholes in the dependent definition and thereby raise revenue to offset the cost of the Social Security Act changes. One surprise in the Act is its impact on a provision in Code Section 105(b). For purposes of determining who can receive tax-free health coverage, Code Section 105(b) currently waives the ban on married dependents that appears in Code Section 152(b)(2). The waiver does not apply to any requirements of Code Section 152(c), however, so the ban on married dependents appears to have been restored for purposes of tax-free health coverage for dependents who are not qualifying relatives. Plan sponsors will want to consider how this change affects their plans, including whether plan amendments may be needed. For more information, see EBIA's Cafeteria Plans manual at Section XI.D ("Who is a Qualifying Child Under Code Section 152?"); EBIA's Consumer Driven Health Care manual at Section XXII.C ("Tax-Free Benefits May Be Provided Only to Employees, Former Employees, and Their Eligible Spouses/Dependents"); and EBIA's Fringe Benefits manual at Section IX.D ("Code Section 23 Adoption Tax Credit Is Also Available: How It Works").

Contributing Editors: EBIA Staff.

NEW VETERANS' BENEFITS LAW AMENDS USERRA TO EXPEDITE ENFORCEMENT AND ADDRESS STATUTE OF LIMITATIONS ISSUE

(This copyrighted article originally appeared in the 10/16/2008 EBIA Weekly and is reproduced with the permission of EBIA.)

[Veterans' Benefits Improvement Act of 2008, Pub. L. No. 110-389 (Oct. 10, 2008)] For a copy: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:s3023enr.txt.pdf

On October 10, 2008, President Bush signed into law the Veterans' Benefits Improvement Act of 2008, which includes provisions to improve compensation and pension, housing, labor and education, and insurance benefits for veterans. Among the Act's changes, as

discussed below, are several noteworthy amendments to the enforcement provisions of the Uniformed Services Employment and Reemployment Rights Act (USERRA), and a new penalty provision under the Service members Civil Relief Act (SCRA).

==> Deadlines for Enforcement Process. A person with a claim under USERRA regarding employment or reemployment rights or benefits can file a complaint with the DOL (in addition to other enforcement rights). The Act adds deadlines to expedite this enforcement process. For example, under the Act the DOL has five days after it receives a person's complaint to notify the person of his or her rights, and it must complete its investigation and give written notice of the results within 90 days after the complaint is received.

==> No Statutes of Limitations. Prior to the Act, USERRA expressly prohibited the application of state--but not federal--statutes of limitations. At least one court concluded that the four-year general federal statute of limitations applied to USERRA actions. (That case was reversed on other grounds.) Settling the issue, the Act amends USERRA to provide that there is no limit on the period for filing a complaint or claim with the DOL, the Merit Systems Protection Board (for complaints against a federal employer), or a federal or state court.

==> Penalty for Violating Interest-Rate Cap on Loans (Including 401(k) Plan Loans). In addition to the USERRA-related changes, the Act amends the maximum interest-rate rules under the SCRA (see our article at http://www.ebia.com/WeeklyArchives/401k/Statutes/16429 (Premium Access subscription required)). Among other things, the SCRA provides that the interest rate on loans incurred before a service member enters military service--including 401(k) plan loans--must be capped at six percent during the service member's period of military service. The Act adds a new criminal penalty for knowing violations of the interest-rate limit.

EBIA Comment: Whether the new deadlines imposed by the Act will actually expedite USERRA enforcement is unclear, since the Act does not include any penalty for failure to meet those deadlines. However, the Act also includes expanded reporting requirements for the enforcement process, suggesting that Congress has a keen interest in improving USERRA enforcement and that additional Congressional action might follow if the speed and quality of enforcement do not improve. In addition, the Act requires training for federal executive agency human resources personnel on USERRA rights. Finally, the Act's statute of limitations provision is a welcome clarification which apparently was requested by the DOL and, according to the legislative history, reflects the original intent of Congress. For more information, see EBIA's Group Health Plan Mandates manual at Section XVIII.L ("Uniformed Services Employment and Reemployment Rights Act (USERRA): Enforcement"); see also EBIA's 401(k) Plans manual at Sections XXXIX.M ("Special Issues: USERRA and Other Military-Service Related Rules: Enforcement") and XXI.L.2 ("Special Rules for Participants on Military Leave: Reduced Interest Rate").

Contributing Editors: EBIA Staff.

QUALIFIED BENEFICIARY'S INCAPACITY MAY EXTEND PREMIUM PAYMENT DEADLINE AND REQUIRE REINSTATEMENT OF COBRA

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[Manthos v. Jefferson Parish, 2008 WL 3914988 (E.D. La. 2008)]

The employee in this case was terminated from his job after filing an EEOC complaint under the Americans with Disabilities Act (ADA). The employee elected COBRA and made his initial premium payment on time. Before the deadline for the next payment, however, the employee suffered a head injury allegedly causing drowsiness and confusion. He failed to make the next payment, and his COBRA coverage was terminated. He learned about this after contacting the third-party administrator for his employer's plan, who explained that the employer had discretion to accept a late payment. When contacted, the employer's benefit administrator told the employee that late payments were occasionally accepted and that he should submit a doctor's letter regarding his condition. When he did so, however, the administrator told him that federal law and employer policies prohibited late payments. (Later, the employer also rejected an attempt by the employee's attorney to pay the late premiums.) The employee then filed another EEOC complaint alleging that his COBRA coverage had been terminated in retaliation for the earlier EEOC complaint. He later filed suit against the employer.

In this decision, relying on another reported case, the court held that a qualified beneficiary's mental impairment suspended the time for making COBRA payments until the affected individual recovered or a legal guardian was appointed. Although the degree of impairment in the other case was far greater, the court said that its reasoning was still persuasive. The court held that, under the circumstances, the late payment was not a legitimate reason for terminating the employee's COBRA coverage because the employee had raised sufficient evidence of his incapacity. The court, therefore, allowed the COBRA-related claims to go to trial.

EBIA Comment: Several courts have held that physical or mental incapacity can suspend otherwise applicable

COBRA payment deadlines. COBRA plans should, therefore, have procedures in place to address claims of incapacity in connection with late payments. Given the court's ruling, the employee in this case will receive a further hearing on his COBRA claim. If he can prove sufficient incapacity, his COBRA coverage could be reinstated back to the date it was originally terminated, allowing him to recover unreimbursed medical expenses during the 18-month coverage period that would otherwise have applied. In addition, of course, if the employee can show that the employer's termination of COBRA was retaliatory under the ADA, further damages might be available there. For more information, see EBIA's COBRA manual at Section XXII.A.6.c ("Incapacity of Qualified Beneficiary May Suspend Grace Period").

Contributing Editors: EBIA Staff.

EBIA Weekly
QUESTIONS OF THE WEEK

Editor's Comment. *The following EBIA Question of the Week is one we receive often. As the workforce ages, it will become increasingly more important for plan sponsors/employers to understand the dos and don'ts of operating a health plan in compliance with Medicare's provisions, particularly the secondary payer rules.*

QUESTION: Many of our Medicare-entitled employees are eligible for our company's major medical plan. We have heard that group health plans cannot take Medicare entitlement "into account." What does this mean?

ANSWER: Under the Medicare Secondary Payer (MSP) rules, a group health plan generally may not take into account the age-based Medicare entitlement of an individual (or the individual's spouse) or the disability-based Medicare entitlement of an individual (or the individual's family member) who is covered under the plan by virtue of the individual's current employment status. Nor may it take into account the Medicare eligibility or entitlement of individuals with end-stage renal disease (ESRD). In addition, the plan must provide a current employee or a current employee's spouse who is age 65 or older with the same benefits, under the same conditions, as are provided to employees and spouses who are under age 65. Plans are also generally prohibited from differentiating in the benefits provided between ESRD patients and other individuals covered under the plan based on the existence of ESRD, the need for renal dialysis, or in any other manner. (Certain small employers have been given an exception from some, but not all, of these provisions.) An individual has current employment status if he or she is actively working as an employee, is the employer (in the case of a self-employed individual), or is associated with the employer in a business relationship. Certain other individuals who aren't actively working may also be in current employment status for this purpose (e.g., individuals receiving disability benefits from an employer for up to six months). Former employees and their family members who are participating in a group health plan generally won't be subject to the MSP requirements for Medicare entitlement based on age or disability.

The following are some examples of actions that generally constitute an impermissible "taking into account" under the MSP regulations (1) failing to pay primary as required by the MSP rules (usually, if an individual is covered under a group health plan and Medicare, the group health plan pays primary and Medicare pays secondary, although the rules vary according to the reason for an individual's Medicare entitlement and the employer's size); (2) terminating coverage because the individual has become entitled to Medicare, except as permitted under COBRA; (3) imposing limitations on benefits for Medicare-entitled individuals that don't apply to others enrolled in the plan (e.g., providing less-comprehensive health care coverage); (4) charging a Medicare-entitled individual higher premiums or requiring the individual to wait longer for coverage to begin; and (5) offering coverage that is secondary to Medicare to individuals entitled to Medicare.

However, a group health plan may make benefit distinctions among categories of individuals. If the plan makes distinctions based on length of time employed, occupation, marital status, or similar categories, then it may make the same distinctions among the same categories of Medicare-entitled individuals whose coverage is based on current employment status. Note also that employers are generally prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment in, a group health plan that is (or would be) primary to Medicare.

For more information, see EBIA's Group Health Plan Mandates manual at Sections XXIV.D ("Group Health Plans May Not 'Take Into Account' Medicare Entitlement") and XXIV.E ("Exceptions for Certain Small Employers"); see also EBIA's COBRA manual at Section XXX ("Special Issues: COBRA and Medicare").

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QUESTION: We are reemploying an employee who has returned from service in the uniformed services. She

chose not to continue her health plan coverage when she left for her service. We know that we must reinstate her coverage, but can you provide more details about USERRA's reinstatement requirements?

ANSWER: As you already know, under USERRA, an employer must promptly reemploy an employee if the employee meets certain eligibility criteria upon completing a period of uniformed service. In addition, the employee is entitled to reinstatement in the employer's health plan upon reemployment, if coverage was terminated by reason of the uniformed service. The DOL has taken the position that employers using third-party insurance to provide health coverage are obligated to negotiate USERRA-compliant coverage to avoid liability for failure to properly reinstate coverage.

There are two rules to keep in mind regarding the timing of reinstatement. First, employers are allowed (but not required) to permit service members to delay reinstating coverage until a date that is later than the reemployment date. Before allowing delayed reinstatement, however, your company should confirm that its insurer or stop-loss carrier will honor such coverage. Second, in certain situations in which an employer cannot offer immediate reemployment, an employer is not required to reinstate coverage before an employee actually becomes reemployed.

Plan exclusions and waiting periods also raise special issues. Employers may not impose plan exclusions or waiting periods when reinstating coverage if the exclusion or waiting period would not have been imposed had coverage not been terminated by reason of uniformed service. Thus, if your employee had previously satisfied a preexisting condition exclusion or waiting period, such provisions may not be reapplied upon reinstatement. However, a plan may impose exclusions or waiting periods for certain injuries or illnesses that were incurred or aggravated while performing uniformed service. Of course, any exclusions must comply with HIPAA's nondiscrimination requirements.

You don't mention how long your employee was absent, but it's possible that the plan under which she was covered has been replaced with a new plan. USERRA's health coverage reinstatement provisions do not address these circumstances. It seems logical, however, that your employee would have the same reinstatement rights under a replacement plan that she would have had if the original plan were still in place. This is because the policy behind the reinstatement provision is to treat employees returning from USERRA leave as if their health coverage had not terminated as a result of their uniformed service. Nevertheless, your company should check with its insurer or stop-loss carrier to make sure the coverage will be provided.

For more information, see EBIA's Group Health Plan Mandates manual at Sections XVIII.F ("USERRA's Reemployment Requirements (a Precondition to Health Plan Reinstatement)"), and XVIII.G ("Health Plan Reinstatement Rights"); see also EBIA's HIPAA Portability, Privacy & Security manual at Sections VII ("HIPAA's Restrictions on Preexisting Condition Exclusions") and XI ("Nondiscrimination Rules for Group Health Plans").

Contributing Editors: EBIA Staff.

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QUESTION: One of our employees had a large medical claim denied under our group health plan. He is threatening to sue, but he had never filed an appeal under the plan's claims procedures. Can he do that?

ANSWER: Benefits litigation is typically filed after a claim has been processed all the way through the plan's claims procedures (including the procedures for appealing denied claims). This is because the courts require claimants to "exhaust" (i.e., use to completion) all available plan procedures before filing suit. (ERISA itself does not contain an express exhaustion requirement.) As a result, your employee should be precluded from suing until he has exhausted your procedures. Also, if the employee fails to file an appeal within the deadline set by your procedures, he should be precluded from suing at all, since at that point he will have missed the opportunity to exhaust the procedures.

The exhaustion requirement is, however, subject to certain exceptions. For example, it may be excused if the plan fails to adequately inform the claimant of plan procedures or the reasons for a benefit denial. It could also be excused if your plan's procedures aren't written in compliance with the DOL regulations (although it seems that most courts would require a pretty significant departure from the regulations before excusing a failure to exhaust on this basis). (We assume that your procedures are in substantial compliance with the regulations and that you can prove that you provided the employee with a claim denial notice, containing the information required by the DOL regulations, including information about the appeal deadline.) In addition, the exhaustion requirement generally applies only to a claim for benefits, as opposed to a claim to enforce other statutory rights (e.g., a breach of fiduciary duty claim). Some courts have also recognized other exceptions, for example, when resorting to the plan's claims procedures would be futile (but this is generally difficult to prove).

Finally, although not required by most courts, we recommend that SPDs, plan documents, and notices use mandatory language (i.e., the words "shall" or

"must," instead of "may") when describing the use of claims procedures. And special care should be taken with the model statement of ERISA rights, which some plan sponsors incorporate verbatim from the DOL's SPD regulations and which provides that a plan participant "may file suit in Federal court" when a benefit claim is denied. One court interpreted this language as permitting a claimant to file suit without exhausting the plan's claims procedures. Although other courts would disagree, it nevertheless seems advisable to add a reference in the model statement to the plan's claims procedures, with a warning about the need to exhaust claims procedures before filing suit.

For further discussion, see EBIA's ERISA Compliance manual at Sections XXXVI.B ("Exhaustion of Plan Administrative Claims Procedures"), XXXVI.C ("Standard of Judicial Review Applied to Benefit Decisions Under ERISA Plans"), and XXXVI.D ("Scope of Judicial Review of Benefit Decisions Under ERISA Plans"); see also Section XXXIV.B ("Group Health Claims: Effective Date and Consequences of Noncompliance").

Contributing Editors: EBIA Staff.
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