

ACTS OF CONGRESS AND THEIR AFFECT **ON YOUR WELFARE BENEFITS PLAN**

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Legislation requiring updates of most health plan documents and forms:

- Change in Definition of "Dependent" under IRC § 152

Legislation and other guidance not requiring formal plan amendments, but requiring certain compliance measures:

- Extension of Benefits under USERRA
 - Comparison to COBRA
- Updates on Health Savings Accounts, Health Flexible Spending Accounts & Health Reimbursement Arrangements
 - Overview of Same
- Medicare Part D - Prescription Benefits

SECTION 152 DEPENDENT DEFINITION CHANGE

Sources of Law

- Working Family Tax Relief Act of 2004 ("WFTRA"), Public Law No. 108-311 (signed into law by President Bush on October 10, 2004)

Impact

- The Act has changed the definition of "dependent" under the Internal Revenue Code ("IRC") § 152
- Unless otherwise provided, the new definition of "dependent" must be used throughout the IRC, which includes health coverage (§§ 105 and 106), cafeteria plans (§ 125), and dependent care assistance programs (§ 129)

New Definition

Section 152 now classifies a "Dependent" as a "Qualifying Child" or a "Qualifying Relative."

- To be a Qualifying Child,¹ the child must:
 - Have the same place of abode as the taxpayer/employee for greater than one-half of the taxable year;
 - Meet an **age requirement** (under 19 years of age at the end of the taxable year or under age 24 if a student - however, these age limits do not apply if the qualifying child is disabled); and
 - Have not provided over half of his/her own support
- To be a Qualifying Relative, the individual must:
 - Be a relative (including a child who is not a qualifying child above, ie, over the age requirements) **or** an individual with the same principal place of abode as the taxpayer/employee and is a member of taxpayer's household (significantly, this can include domestic partners);
 - Have **gross income of less than the exemption amount** (\$3,200 for 2005) (exception for health plans);
 - Have more than half of his/her support be provided by the taxpayer; and
 - Must not be a qualifying child of *any* taxpayer
- Divorced / Separated Parents Exception

¹ A "qualifying child" can include a child of the taxpayer, a descendant of that child, or sibling or step-sibling of the taxpayer, including descendants of those individuals. Section 152(c)(2). The definition of "child" within the IRC includes an eligible foster child who was placed with the taxpayer by an authorized placement agency or by a judgment, decree or order of a court of competent jurisdiction. Section 152(f)(1).

Affect on Health Coverage

- To avoid taxation on benefits to dependents, the dependents must meet the § 152 definitions of qualifying child or qualifying relative above
- Specific exemption to the \$3,200 gross income limitation:
 - Congress excepted this requirement for health coverage under § 105² and a similar change will soon be made to the regulations under § 106.³ A taxpayer/employee will not be charged for amounts received under a health plan (§ 105) or for employer contributions to such health plan (§ 106) for coverage provided to a qualifying relative who makes over \$3,200 (as long as the qualifying relative meets the other requirements of § 152 as outlined above)
- However, any plan specifically referring to § 152 (without qualifying language) could pull in the \$3,200 gross income limitation

Affect on Dependent Care Assistance Programs ("DCAPs")

- Pursuant to IRC § 129, DCAPs must comply with both § 152 and § 21.
- Section 21 also modified by WFTRA, allows reimbursement only for "Qualifying Individuals"
- Qualifying Individual must be either:
 - Qualifying Child of the taxpayer (as defined in § 152(a)(1)) who is under the age of 13; or
 - spouse or dependent of taxpayer (as defined in § 152) who:
 - is physically/mentally incapable of self care, and
 - has the same principal place of abode for greater than one-half of the taxable year
- No exception from the \$3,200 gross income limitation within § 152
 - Disabled parents or other disabled relatives previously covered under a DCAP but who make over \$3,200 (through pension benefits or otherwise) can no longer be covered
 - Otherwise, employees who request reimbursement for them must be taxed

Action You Should Take

- Have your plan documents reviewed and updated

² Under Section 105(b), gross income does not include amounts received for medical care for the taxpayer or his Section 152 dependent or spouse. Therefore, in order to avoid taxation, the dependents must fall into either the definition of "qualifying relative" or "qualifying child." However, Congress stated that Section 152(d)(1)(B), the \$3,200 exemption amount, would not be considered.

³ The regulations under Section 106 state that gross income does not include amounts an employer paid towards health insurance for the taxpayer, spouse or Section 152 dependent. Treas. Regs. Section 1.106-1. Although the regulations have yet to be modified to exclude the exemption amount limitation, Notice 2004-79 has been issued in the meantime to reach this end. Therefore, a taxpayer whose employer pays for health insurance premiums for Section 152 dependents that make over \$3,200 will *not* be taxed on the amount of employer contribution.

EXTENSION OF BENEFITS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT ("USERRA")

Sources of Law

- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
 - 38 U.S.C. § 4301 *et seq*
 - enacted on October 13, 1994
- Veterans Benefits Improvement Act of 2004
 - Pub. L. No. 108-454, §§ 201 and 203 (2004)
 - amended USERRA by extending continuation of coverage from 18 to 24 months

Employers Subject to USERRA

- The term “employer” is broadly defined to mean any entity that pays salaries or wages for work performed or that “has control over employment opportunities”
- All public and private employers in the United States⁴
- No minimum size requirement or other exemption⁵

USERRA Provides Minimum Protection

- Other laws, policies, and contracts providing greater rights still apply (ie, COBRA, if applicable; employer policies, CBAs, employee benefits plans)
- USERRA supersedes any laws or agreements providing fewer rights

Notice of Right to USERRA Coverage

- Posting of USERRA Rights Notice as of March 10, 2005
 - <http://www.dol.gov/vets/programs/userra/poster.pdf>
 - See attached

Basic Requirements

USERRA establishes reemployment⁶ and benefits rights for employees who serve or have served in the “uniformed services,” including:

- The right to continue coverage under the employer’s group health plans while the employee is absent from work due to uniformed service;
- Guaranteed reemployment following completion of the employee’s uniformed service;⁷ and

⁴ Specifically includes all governmental employers, including state and federal governments, and any successor to any employer

⁵ Even church plans (which generally are exempt from ERISA and COBRA) and small employers must comply with USERRA

⁶ USERRA also prohibits employers from discriminating against employees or job applicants because of past, current, or future uniformed service obligations.

- Immediate reinstatement in an employer's group health plans if coverage was terminated as a result of uniformed service and the employee is reemployed following the completion of uniformed service

For an employee to be entitled to these USERRA rights, the following must be met:

- The employee's absence from work must be for "service in the uniformed services";⁸
- The employee must give the employer advance notice of the employee's absence from work (if possible);
- The employee's absence from work may not exceed five years (subject to certain exceptions); and
- The employee's uniformed service must not have been terminated for "dishonorable" or other undesirable conduct

Continuation of Coverage

- Length of USERRA Coverage
 - 24 months for elections on or after December 10, 2004 (18 months for elections prior to December 10, 2004)
- Early Termination of USERRA
 - If employee fails to report back to work (or apply for reemployment) within the time period required⁹
 - Failure to pay premiums (although not specifically mentioned in statute)
 - Undesirable conduct (court-martial and dishonorable discharge)
- Premium to be charged
 - No more than usual (if period of uniformed service less than 31 days)
 - 102% of full premium - same as COBRA premium (if service more than 30 days)
 - No specified due date
- Separate from COBRA, but must be offered in conjunction if COBRA applies

⁷ An employee applying for reemployment following the completion of uniformed service must report to work within specified timeframes after the employee's uniformed service ends and must provide appropriate documentation upon request.

⁸ "Service in the uniformed services" means "the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty, and a period for which a person is absent from employment for the purpose of performing [certain funeral honors duty]." 38 U.S.C. § 4303(13). "Uniformed services" means "the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency." 38 U.S.C. § 4303(16).

⁹ When service less than 31 days: Report to work at the beginning of the first regularly scheduled work period on the day following the end of service. When service is more than 30 days but less than 181 days: Submit an application for reemployment not later than 14 days after the completion of the service. When service is more than 180 days: Submit an application for reemployment not later than 90 days after the completion of the service. Different requirements if injured, ill, or for examination for fitness to perform service.

Differences from COBRA

- Applicability
 - Like COBRA, applies to group health plans, including HRAs and health FSAs
 - More broad than COBRA - Applies to employers with less than 20 employees; church plans
 - More broad than COBRA - Applies to employee and dependents (COBRA only to employee, spouse and dependent children)
 - Less broad than COBRA - USERRA only applies when "employee" in uniformed service; however, COBRA may apply when spouse or dependent child in uniformed service (unpaid leave of absence)
- If covered under both, must comply with both
 - Must provide broadest rights
- Election Notices:
 - USERRA silent
 - Do not forget COBRA notices (\$110 per day statutory penalty for failure to do so)
- Election Periods
 - USERRA silent
 - COBRA 60 day period
- Amount of Premiums
 - USERRA - no more than usual if less than 31 days (thereafter, 102% of premium)
 - COBRA - 102% of premium
- Date Premiums Due
 - USERRA silent
 - COBRA requires payment within 45 days of election
- Duration of Coverage
 - USERRA 24 months
 - COBRA 18/29/36
- Open Enrollment Rights
 - USERRA silent
 - Required under COBRA
- Health FSA Limited Continuation of Coverage
 - Doesn't apply under USERRA (therefore, employee has full 24 months of health FSA with potential re-enrollment rights)
 - In certain circumstances, limited for COBRA
 - Only underspent accounts
 - Only until end of current plan year
- Cancellation of Coverage
 - USERRA: for failure to reapply to work or for undesirable conduct (N/A to COBRA)

- COBRA: many circumstances, including obtaining other group health plan coverage or becoming entitled to Medicare (N/A to USERRA)
 - Be careful, even though may cancel coverage under one statute, may not be able to under the other...
- No specific election procedures under USERRA
 - No specific election period / time limit
 - Health plans may develop reasonable procedures
- Only Employee can elect USERRA (no independent election rights of dependents)
- Plans should clarify
 - If both COBRA and USERRA apply, an election for continuation coverage will be an election to take concurrent COBRA/USERRA coverage

Administering Concurrent COBRA/USERRA Coverage

- Prepare a USERRA continuation notice to be attached to front of COBRA election form explaining USERRA's protections and that election will be under both COBRA and USERRA
- USERRA may require continued coverage to be offered to an employee's covered dependent (not spouse or child) who is not a qualified beneficiary with COBRA rights
- If the person's uniformed service is for less than 31 days, do not require payment of the full COBRA premium
- If a qualified beneficiary becomes entitled to Medicare or becomes covered by another group health plan, do not terminate the qualified beneficiary's continuation coverage as would be permitted under COBRA as USERRA does not permit it
- If a person on leave for uniformed service fails to return to work within the time required by USERRA or is separated or discharged from service in a manner that would allow termination of USERRA coverage, do not terminate continuation coverage; COBRA does not allow for termination of coverage before the end of the COBRA maximum coverage period in these circumstances
- Allow person on leave for uniformed service to change coverage or add dependents at open enrollment to the same extent such actions are permitted for similarly situated active employees, as required under COBRA
- Do not require payment of the initial premium before expiration of the COBRA 45-day initial premium payment period, even if the period of uniformed service is less than 31 days
- If an employee's premium is not timely paid, be careful about terminating continuation coverage for nonpayment. USERRA does not expressly permit termination of coverage for nonpayment
- All health FSA participants with USERRA coverage should be allowed to elect the health FSA for the entire maximum USERRA coverage period (regardless of whether their accounts are overspent or underspent), even if the health FSA qualifies for the limited COBRA obligation
- Do not terminate the individual's coverage unless termination is permitted under both laws (COBRA and USERRA have different maximum coverage periods)

Circumstances When Only One Law Would Apply

- Only USERRA applies (24 months) after COBRA's 18-month period expires
- Only COBRA applies (29 or 36 months) after USERRA expires
- Only USERRA applies if the employee makes an election to continue coverage after the end of the COBRA 60-day election period
- Only USERRA applies under a health FSA because the health FSA qualifies for the limited COBRA obligation (if the health FSA was not required to offer COBRA coverage to a participant because his or her account was “overspent” or the USERRA coverage period extends beyond the end of the plan year during which COBRA was required)
- Only USERRA applies for an employee’s dependent because that person is not the employee’s spouse or dependent child and therefore is not a qualified beneficiary with COBRA rights

OVERVIEW OF HEALTH FSA, HRA, AND HSA BENEFITS

Health FSAs & HRAs

- See Comparison Chart
- Need plan documents
- Differences from HSAs

HSA Basics

- An "eligible individual" means, with respect to any month, any individual who is
 - covered under a high-deductible health plan (HDHP) on the 1st day of month;
 - not covered by any non-HDHP (with certain exceptions for plans providing certain limited types of coverage);
 - not entitled to Medicare (generally, not yet reached age 65); and
 - not claimed as a dependent on another person's tax return
- An HDHP is a plan that meets the following:
 - For individual coverage, annual deductible of at least \$1,000 and annual out-of-pocket expenses not exceeding \$5,100
 - For family coverage annual deductible of at least \$2,000 and annual out-of-pocket expenses not exceeding \$10,200
- Cannot have any non-HDHP coverage (general HRA and health FSA coverage would disqualify an otherwise HSA eligible individual). However, certain exceptions exist:
 - Permitted coverage, permitted insurance, preventive care
 - Limited-Purpose Health FSA or HRA
 - Post-Deductible Health FSA or HRA
 - Suspended or Retirement HRA
- The maximum annual contribution is:
 - For individual coverage, the lesser of 100% of the annual deductible under the HDHP (minimum of \$1,000) but not more than \$2,650
 - For family coverage, the lesser of 100% of the annual deductible under the HDHP (minimum of \$2,000) but not more than \$5,250
 - Catch up contribution for individuals (and their spouses covered under the HDHP) between ages 55 and 65 is \$500 in calendar year 2004 (and increases in \$100 increments annually until it reaches \$1,000 in calendar year 2009)
- Penalties
 - Non-medical expense - taxed plus 10% penalty tax
 - Not comparable contributions - 35% excise tax to employer of the aggregate amount contributed by the employer to HSAs for that period (except in the case of distributions made after the account beneficiary's death, disability, or attaining age 65)

Recent Changes in HRA Guidance

- Revenue Ruling 2005-24
 - Confirms Prohibition on HRA Cashouts
 - Allows Employer to Contribute Vacation / Sick Pay to HRA
 - Only to retiring employee
 - Automatically/Mandatory
 - No option to receive vacation/sick pay in cash
 - No opinion as to whether this satisfies the nondiscrimination requirements of IRC § 105(h)

Recent Changes in HSA Guidance

- Revenue Ruling 2005-25
 - Clarifies that an individual who is "eligible" to contribute to an HSA under IRC § 223 will not become ineligible if the individual's spouse has non-HDHP family coverage as long as it does not cover the individual
 - The maximum contribution amount depends on whether the individual has self-only or family HDHP coverage

Imported Prescription Drugs

- Coverage provided under an employer's health plan is generally excluded from the employee's taxable income only if the coverage is for "medical care" as defined in IRC § 213(d)
- Health FSAs and HRAs are vehicles used to reimburse participants for certain "medicine and drugs," as defined under IRC § 213
- Medicine and drugs used for medical care may only be reimbursable if they are "legally procured" Treas. Reg. § 1.213-1(e)(2) (emphasis added)
- Imported prescription drugs are not "legally procured"
 - IRS Publication 502 (2004 version): "In general, you cannot include in your medical expenses the cost of a prescribed drug brought in (or ordered shipped) from another country, because you can only include the cost of a drug that was imported legally"
 - Food and Drug Administration (FDA): <http://www.fda.gov/ora/import/> - importation of drugs from Canada and other foreign countries remains illegal
 - Internal Revenue Service information letter - INFO 2005-0011 (released March 31, 2005): Taxpayers may not use IRC § 213 to deduct the cost of prescription drugs imported illegally from Canada and other countries
 - Does not mention reimbursements under health FSAs, HRAs, or HSAs, but it's a good starting point

MEDICARE PART D PRESCRIPTION BENEFITS

Sources of Law

- Medicare Prescription Drug Improvement and Modernization Act (“MMA”), enacted December 8, 2003

Medicare Prescription Drug Benefit (Part D)

- Beginning January 1, 2006, anyone eligible for Medicare will have the option of enrolling in Medicare Part D for a premium
- Standard Part D design
 - \$250 deductible
 - 75% coinsurance up to \$2,250
 - 95% coinsurance after the participant's true out-of-pocket costs hit \$3,600 (this can include out-of-pocket reimbursements for retirees from HSAs, MSAs and health FSAs which were employee funded)

Affected Employers

- If you offer prescription drug benefits to employees who are Part D eligible individuals, whether or not they are retired, you must comply with the Medicare Part D mandates

Eligible Individuals

- "Part D eligible individuals" are individuals who:
 - have coverage under Medicare Part A or Part B (even active employees can have Medicare coverage) and
 - live in a "service area" of a Part D plan (an area that meets certain pharmacy access standards)

Employer Options

Employers who offer prescription coverage in their group health plans may decide to do the following:

- Apply for a subsidy
 - If Part D eligible individuals enroll in an employer's retiree group health plan instead of enrolling in Medicare Part D, employer will receive a 28% subsidy
 - Employer must prove
 - gross value actuarially equivalence
 - net value actuarially equivalence of the employer's plan (after employee / retiree premiums) with the net value of Part D
 - Deadline for application is September 30, 2005

- Apply to become a Part D Plan ("PDP") or a Medicare Advantage Plan ("MA-PD").
 - Deadline for filing a Notice of Intent is March 23, 2005
 - Applications to CMS are due April 18, 2005
- Provide supplemental prescription benefit coverage, wrapping around the PDP or MA-PD
- Directly contracting with PDP or MA-PD sponsors

Notice of Creditable Coverage

Before November 15, 2005, group health plans offering prescription drug coverage *must disclose* to CMS and to all Part D-eligible individuals who are enrolled in or seeking to enroll in the group health plan coverage whether such coverage is "actuarially equivalent," ie, creditable.

- Coverage is creditable if its actuarial value equals or exceeds the actuarial value of standard prescription drug coverage under Part D
- Must show that group plan's total gross value is at least as valuable as the standard Part D coverage
- Notice must be provided to all Part D eligible persons, including active employees over age 65
- The notice must be provided:
 - prior to an individual's initial enrollment period for Part D;
 - prior to the effective date of enrollment in your company's prescription drug coverage and upon any change in its creditable status;
 - prior to the annual election period for Part D (which begins each November 15); and
 - upon the individual's request

Late Enrollment Penalty if Not Actuarially Equivalent

- Late enrollment penalty assessed to those persons enrolling in an employer's prescription plan which is not as valuable as the Part D coverage, instead of enrolling directly in the Medicare Part D coverage
- Therefore, important to notify Part D eligible persons of creditable coverage
- If Part D eligible person enrolls in employer plan (which is not at least actuarially equivalent to the Part D coverage) instead of Part D plan, a permanent late enrollment penalty of 1% of the premium is added to the premium for each month the person does not enroll in Part D

For More Information

- You may wish to review the following CMS and Medicare websites (www.cms.gov and www.medicare.gov) for related publications and updates