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2006 YEAR-END LEGISLATIVE UPDATE

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FEDERAL LEGISLATION

WOMEN'S HEALTH AND CANCER RIGHTS ACT ANNUAL NOTIFICATION REQUIREMENT

The federal law that went into effect on October 21, 1998 amended ERISA and Public Health statutes to require individual and group health plans that provide coverage for medically necessary mastectomies to also provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and

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- Treatment of physical complications of all stages of mastectomy, including lymph edemas.

This coverage is provided in consultation with the attending physician and the patient, and is subject to the annual deductibles and coinsurance provisions consistent with those established for other benefits under the plan.

Notification Requirements
Plans must notify all participants on an annual basis of the provisions of the law. The notices must be delivered in accordance with the Department of Labor's ERISA disclosure regulations applicable to furnishing summary plan descriptions. This means that notices may be delivered by first class mail, hand delivery to an employee at his or her worksite, or any other means of delivery prescribed by the Department of Labor.

Responsibility for Notification
Group health plans and insurance companies are responsible for notifying new enrollees and participants of the provisions of the Women's Health and Cancer Rights Act. In order to avoid duplication, employers will not have to furnish notices if insurance companies satisfy the notification requirements. Most HMO's and fully insured plans will issue notices to participants, relieving employers of this obligation. In self-funded plans, the employer will be responsible of notifying all participants and new enrollees under the Plan of the provisions of this law.

Click here to view a Sample WHCRA Notice

HIPAA PRIVACY NOTICE DISTRIBUTION REMINDER FOR SMALL GROUP HEALTH PLANS

Under the Health Insurance Portability and Accountability Act of 1986, group health plans are required to notify plan participants no less frequently than once every three years of the availability of the HIPAA privacy notice and how to obtain a copy. On April 14, 2006, large group health plans reached their third year anniversary to distribute the privacy notice, or a reminder informing plan participants of their right to receive a Privacy Notice.

For small group health plans (i.e. less than $5 million in annual gross receipts or claims paid), the HIPAA Privacy Rules were originally effective on April 14, 2004. Unless the privacy notice has been re-issued in the interim, small group health plans will be required to send the notice or a reminder again to plan participants next year, before April 14, 2007.

If an employer's health plans are fully insured, and the employer does not create or receive protected health information, then the insurer is responsible for distributing the privacy notice or reminder. However, if the employer has one or more self-funded plans (for example, self-funded dental, vision, or health care spending account plans), the employer is responsible for distributing the privacy notice or reminder to plan participants. If a third party administrator is administering the plan, check with

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the administrator to see if it will be distributing the privacy notice or reminder on the employer's behalf.

The privacy notice or reminder can be distributed by mail to plan participants at their home; if a reminder is being used, it can be included in a plan newsletter or other publication. E-mail distribution is not sufficient for this purpose, unless the employer has written consent from each participant agreeing to receive electronic communications. For a sample Privacy Notice visit CyberSure.

HHS ISSUES FINAL REGULATIONS ON HIPAA PENALTIES EFFECTIVE MARCH 16, 2006

The U.S. Department of Health and Human Services issued final regulations in February 2006 for imposing civil money penalties on covered entities that violate the portability, privacy, or security standards or other requirements of the Health Insurance Portability and Accountability Act. The regulations were effective March 16, 2006. For more information please see the March Legislative Update.

CAFETERIA PLAN DEVELOPMENTS

IRS Notice 2006-69 – Guidance on Dependent Care Assistance Plans and Debit Card Use under HRAs and FSAs.

Dependent Care Assistance Plans (DCAP)

- Provides dependent care assistance plans can reimburse pre-school or similar programs below the kindergarten level, before and after school care, summer day camps specializing in a particular activity, and transportation to camp or after-school program if provided by a child caregiver.
- Expenses must apply to a period when employee and spouse are at work with the exception of short or temporary absences. If expenses are paid for on a weekly basis, employee is not required to allocate expenses between days worked and not worked as long as the employee worked part of the week.

Debit Care Use under a HRA and/or Health FSA Plan

- No substantiation is necessary for multiple co-payments made with debit card as long as the reimbursed amount is an exact multiple of no more than five (5) times the co-payment.
- Inventory information approval system, effective 1/1/07, permits card to be used at any merchant location, healthcare vendor, or healthcare provider to pay for items with SKU numbers that represent qualified medical expenses.
- No substantiation is necessary when the debit card expense is substantiated by a third party, i.e. insurance carrier or TPA.
- Prohibition against self-certification provides that expense cannot be reimbursed based on participants e-mail, fax, or other document created by the participant.
- Debit cared may only pay for dependent care services that have already been provided.

For a detailed discussion of the new debit card and DCAP Plans click here.

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INTERNAL REVENUE SERVICE AND DEPARTMENT OF THE TREASURY

2007 LIMITS ON BENEFITS AND COMPENSATION

Each year the IRS publishes annual limits on certain benefit plans and programs. These limits will usually change on an annual basis and are meant to reflect changes in laws and inflation.

ABD has prepared a chart for clients that lists the 2007 "IRS Limits on Benefits and Compensation". To view this table, **please click here**.

HEALTH SAVINGS ACCOUNTS

- Maximum HSA annual contribution limits:
  - Single coverage- the lesser of $2,850 or the plan's deductible (2006 lesser of $2,700 or plan's deductible)
  - Family Coverage- the lesser of $5,650 or the plan's deductible (2006 lesser of $5,450 or plan's deductible)

- HDHP Definition:
  - Minimum deductible of:

Individual coverage	$1,100	(2006 is $1050)
Family coverage	$2,200	(2006 is $2100)

- Max. Annual Out-of-Pocket Expense for In-Network Benefits:

Individual coverage	$5,500	(2006 is $5,250)
Family coverage	$11,000	(2006 is $10,500)

ANNUAL REPORTING REQUIREMENTS FOR GROUP TERM LIFE INSURANCE. For 2007, the Table 1 rates used to determine the cost of group term life insurance in excess of $50,000 have not changed. This cost is determined on the basis of the amount of employer paid life insurance provided during the calendar year, then reported on the employee's W-2 form. To view the Table I, please **click here**.

DEPARTMENT OF LABOR ISSUES GUIDANCE ON HSA ADMINISTRATION

On October 27, 2006, the Department of Labor's Employee Benefits Security Administration (EBSA) issued Field Assistance Bulletin (FAB) 2006-2. The bulletin was intended to provide additional guidance in relation to employer practices that could make a health savings account (HSA) subject to ERISA. Back in 2004, the EBSA issued FAB 2004-01, which explained that HSAs, for the most part, would not constitute employee welfare benefit plans covered by Title I of ERISA, when employer involvement with the HSA is limited.

FAB 2006-2 provided the necessary clarifications for employers, outlining the actions employers could take without subjecting their HSA plans to ERISA. These are:

- Unilaterally opening and contributing to employees' HSAs
- Limiting the number of HSA providers allowed to market HSA products to employees and select a single HSA provider
- Limiting HSA investment choices to those available for 401(k) investments or offering a "reasonable choice of investment options" (i.e., more than one option)
- Paying account or other associated fees on behalf of employees

However, employers may not restrict their employees' ability to transfer funds to another HSA.

FAB 2006-2 also clarified that in those identified situations when ERISA does not apply, HSAs at all times remain subject to the prohibited transaction provisions of the IRC. The prohibited transactions include the following:

- Employers must promptly transfer employee and/or employer contributions to participants' HSAs. Unreasonable delays could cause the fiduciary and prohibited transaction rules to come into play.
- HSA providers may offer to deposit cash into an HSA as incentive to employees to establish an HSA account without triggering a prohibited transaction.
- Employers may not receive a discount on other products that may be available from their HSA vendor.

This new guidance has provided employers with the assistance they need to help them administer the programs they desire without subjecting themselves to ERISA.

MEDICARE

DISTRIBUTION OF NOTICES OF CREDITABLE AND NON-CREDITABLE COVERAGE- 11/15/2006

Employers are required to distribute the Medicare Notices of Creditable and Non-Creditable Coverage Notice(s) on an annual basis to covered plan participants (active employees, retirees, COBRA participants, severed employees, their spouses and children) who are eligible for Medicare or who are covered by Medicare. The Notices must be issued no later than November 15 of each year, unless the employer's prescription drug changes prior to this date.

If your prescription drug coverage has changed or will change on January 1, 2007, be sure to review the benefit coverage to determine whether the plan is a "creditable" or "non-creditable" plan. If the plan is determined to be non-creditable, notices must be provided indicating its non-creditable status. If you are uncertain of the status of your prescription drug plan contact your insurance carrier, prescription drug vendor, or ABD representative for further information.

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DISCLOSURE TO CMS- DUE 60 DAYS AFTER PLAN RENEWAL

Group health plans must notify the Center for Medicare and Medicaid Services (CMS) regarding their prescription drug benefits 60 days following the beginning of the group's plan year (renewal year, contract year, filing year, etc.). According to guidance from CMS:

- The notice must be provided by group health plans with prescription drug coverage, including plans sponsored by employers, churches, and Federal, State and local governments.
- CMS has developed an electronic notice, at this time notice can only be given to CMS by completing the online form which is available at the following link: http://www.cms.hhs.gov/creditablecoverage. See last link in left column.
- Plan sponsors should submit one notice for their group plan, and list the number of benefit plan options available under the plan (e.g., HMO option, PPO option, POS option) that provide prescription drug coverage.
- When the CMS form asks for the name of the entity offering prescription drug coverage, list the name of the plan sponsor, not the name of an insurance carrier.
- When the CMS form asks for the number of individuals covered under the plan who are Medicare Part D eligible, provide a reasonable estimate of the number of individuals covered under the plan who are eligible for Medicare Part D as of the first day of the current plan year. This does not have to be an exact number, as the number may change throughout the year.

MEDICARE 2007 PREMIUMS AND DEDUCTIBLES

	2006	2007
Part B Premiums	$88.50	$93.50 *
Part B Deductible	$124	$131

* Effective January 1, 2007, Medicare Part B Premiums will be calculated based on the Medicare beneficiaries modified adjusted gross income for 2007. For a complete list of Medicare Part B Premium please refer to ABD's September Legislative Update.

MEDICARE SECONDARY PAYER RULES

The U.S. Department of Health and Human Services issued interim final regulations in February 2006 to reflect changes in the Medicare secondary payer program that were enacted into law by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The Medicare secondary payer program enables HHS to coordinate Medicare benefits with benefits under employer-sponsored group health plans. The regulations, which are effective April 25, 2006, re-affirm the government's position that Medicare is secondary to employer plans covering active employees and their dependents. For more information please click here for the March Legislative Update.

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TAX RELIEF AND HEALTH CARE ACT OF 2006 (HEALTH OPPORTUNITY PATIENT EMPOWERMENT ACT OF 2006)

As of December 13, 2006 this Act awaits the President's signature, which is expected by both houses. This Act will allow the following:

Rollovers from FSAs and HRAs into HSAs-rollover to be completed before 1/1/2012

- Only one rollover per participant is allowed under an HRA and Health FSA in the participant's lifetime. The employer must make the contribution directly to the employee's HSA .
- Rollover amount is not counted towards the HSA annual contribution limits, are not treated as taxable income and may not be claimed in the participant's tax returns as a contribution to an HSA.
- Maximum rollover amount is the lesser of balance in account on 9/21/06, or the date of the distribution.
- Following the rollover the participant must remain covered under a HDHP for 12 months counted from the date of the rollover ("testing period") in order to avoid distributions from being taxable (treated as income and subject to a 10% excise tax), unless the individual ceases to be an eligible participant due to the individual's disability or death.
- Employer must allow all employees covered under a HDHP of the employer to rollover HRA and/or Health FSA amounts into an HSA

HSAs and Health FSA $2^{1/2}$ Month Grace Periods: Effective January 1, 2007- Coverage under a Health FSA is disregarded for purposes of determining an individual's eligibility to contribute to an HSA for the upcoming plan year, if the participant has a balance of $0 in his Health FSA at the end of the plan year (not counting the 2 ½ month grace period) or rolls-over all unused Health FSA amounts into an HSA.

Repeal of Annual Deductible Limitations on HSA Contributions: Effective January 1, 2007

Repeals the requirement that the maximum contribution allowable under an HSA be the lesser of the High Deductible Health Plan's (HDHP) deductible or the amount determine by the IRS to be the annual maximum contribution. Effective January 1, 2007, the maximum HSA contribution will be based solely on the IRS annual contribution $2850 for an individual with single coverage and $5650 for an individual with family coverage (2007 limits).

Increase in Contribution Limits for Individuals Covered Under a HSA after the Beginning of the Year: Effective January 1, 2007

Participants becoming covered under a HDHP at a later time during the year are allowed to make HSA contributions for the entire year, even if the participant was not covered under a HDHP earlier in the year. The individual must remain covered in a

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HDHP for 12 months counted from the first day of the taxable year for which the individual made contributions to a HSA, unless the individual ceases to be an eligible participant due to their death or their disability. If an individual fails to be covered for 12 months under a HDHP, all contributions made for periods of time the individual was not covered under a HDHP are treated as taxable income and subject to a 10% excise tax.

Modification to the HSA Comparability Rules- Effective January 1, 2007

Modifies the comparability rules to allow employers to make higher contributions to HSAs of Non-Highly Compensated Employees than to the HSAs of Highly Compensated Employees. The employer must make the same contribution to the HSA of all Non-Highly Compensated employees in the same class (full time, part-time or union).

Rollovers from IRAs and Roth IRAs into HSAs- Effective January 1, 2007-

- Allows for a one -time rollover in an individual's lifetime from an IRA or Roth IRA into the individual's HSA.
- An individual is eligible to make one more distribution in their lifetime if the individual converts his coverage from single to family coverage.
- Amounts transferred into an HSA must be a direct trustee to trustee transfer
- All distributions from an IRA or Roth IRA are irrevocable once made
- Individuals making distributions from an IRA or Roth IRA to an HSA must remain covered under a HDHP for 12 months counted from the date of the distribution. Failure to remain covered under a HDHP for 12 months ("testing period") results in treating all distributions made to a HSA as taxable income subject to a 10% excise tax, unless participation in a HDHP ceases due to the individual's disability or death.
- The maximum disbursement from an IRA or Roth IRA is determined by the maximum contribution allowed under a HSA based on the individual's coverage election (single or family coverage) as determined annually by the IRS. Distributions from IRAs or Roth IRAs reduce the individual's maximum contribution to a HSA.
- Distributions to HSAs may not be claimed as deductions under the individual's tax returns and are not usually treated as taxable income.

Extends the Provisions of the Mental Health Parity Act Through December 31, 2007.

For more information on the federal Mental Health Parity Act, click here http://www.cms.hhs.gov/HealthInsReformforConsume/04_TheMentalHealthParityAct.asp

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STATE UPDATES

2007 STATE DISABILITY RATES AND BENEFITS

To view the 2007 disability contribution rates and benefits for states where disability coverage is mandated please **click here** "Highlights of State Disability Laws".

UPDATE ON 2006 DOMESTIC PARTNER ELECTION AND COURT OUTCOMES

A number of states addressed domestic partnerships in court decisions and in this year's mid-term elections. A synopsis of these developments follows:

Arizona
Voters **failed** to pass Proposition 107, which would have amended the constitution to prohibit any legal status for unmarried individuals and invalidate domestic partnerships recognized in Phoenix, Tucson, Scottsdale and Tempe.

Colorado
Voters **failed** to pass a referendum to legalize domestic partnerships and passed a constitutional amendment to define marriage as a union between a man and a woman.

Idaho
Voters **passed** a constitutional amendment that provides marriage is between a man and a woman is the only domestic legal union that shall be valid or recognized.

New Jersey
The New Jersey Supreme Court decided that under the equal protection guarantee of the New Jersey Constitution, committed same-sex couples must be afforded on equal terms the same rights and benefits enjoyed by opposite-sex couples under the civil marriage statutes. It is predicted that the New Jersey legislature will adopt civil unions in response to this decision.

South Carolina
Voters **passed** a constitutional amendment that provides marriage is between one man and one woman and no other domestic union would be recognized as valid or legal.

South Dakota
Voters **passed** a constitutional amendment that provides marriage is between one man and one woman and prohibits the legislature from recognizing civil unions, domestic partnerships, or other quasi-marital relationships regardless of sex.

Tennessee
Voters **passed** a constitutional amendment that defines marriage as a contract between one man and one woman.

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Virginia
Voters **passed** a constitutional amendment that defines marriage as a contract between one man and one woman and also bans future creation of marriage-like unions.

Wisconsin
Voters **passed** a constitutional amendment that defines marriage as a contract between one man and one woman and also bans future creation of marriage-like unions.

CALIFORNIA LEGISLATION

USE OF SOCIAL SECURITY NUMBERS ANNUAL NOTIFICATION REQUIREMENTS

Under SB 168, employers are required to notify their employees of their company's use and disclosure of Social Security Numbers. This notice must be distributed to employees no later than December 31, 2006. This notification requirement does not apply to cities or local governments. **For a sample notice click here.**

SAN FRANCISCO MANDATED EMPLOYER PAID SICK LEAVE

Measure F, which was recently passed November 7, 2006, by the voters of San Francisco, will require Employers to provide sick pay to all employees. Here is a quick breakdown of how the paid sick leave benefits will work.

- Every worker (full-time, part-time, temporary) will accrue 1 hour of sick pay for every 30 hours worked. Newly hired workers will have to satisfy a 90 day probationary period. Unions and Collective Bargaining Groups are excluded.

- Sick day accruals will have a cap of 72 hours for employers with 10 or more employees, and a cap of 40 hours for employers with less than 10 employees. Accruals can rollover from year to year up to the cap amounts.

- The sick time can be used for the employee, spouse, children, parents, legal guardians, domestic partners, siblings, grandparents, or one designated person not included in those categories.

Employers with a sick leave policy in place do not need to provide additional leave if the current policy meets the measure requirements.

The measure will go into effect February 5, 2007.

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THE SAN FRANCISCO HEALTH ACCESS PROGRAM (SF HAP)

The San Francisco Health Access Program was approved and will be moving forward with an implementation date of July 1, 2007. It will be administered by San Francisco Health Plan (SFHP) in partnership with the San Francisco Department of Public Health (DPH).

With the creation of the SF HAP and in conjunction with the Worker Health Care Security Ordinance (WHCSO), medium (20 to 49 employees) and large-sized (50 to 100+ employees) employers in San Francisco will be required to spend a minimum dollar amount per hour on healthcare for their employees. The 2006 amount which was provided by the San Francisco City Council, and was discussed in our July/August Legislative Update, will increase prior to the SF HAP implementation date in July 2007.

For subsequent years, this amount will continue to be increased by 5% through 2009 to accommodate unanticipated growth indices. The yearly rate will be multiplied by the number of hours each eligible employee works up to a monthly maximum of 172 hours.

The Employer Health Care Expenditure Rate Schedule is as follows:

Employers	7/01/07	1/01/08	3/31/08	1/01/09
100 + EEs	$1.68/hr	$1.76/hr		$1.85/hr
50 – 99 EEs	$1.11/hr	$1.17/hr		$1.23/hr
20 – 49 EEs	N/A	N/A	$1.17/hr	$1.23/hr

SF HAP has a phase one implementation goal of July 2007, with only a portion of the uninsured participating at the program's inception. In essence, the first phase-in period will serve as a program pilot, which will enable:

- testing and refinement of the program as necessary;
- adjustments to financing as cost data is generated;
- protection for San Francisco's legal and moral obligation to provide the lowest income residents access to care; and
- the introduction of participants into SF HAP efficiently, with as little friction as possible.

Although the SF HAP Provider Network has not been clearly defined, the **San Francisco Department of Public Health (DPH)** providers and hospitals will serve as the program's backbone.

A first draft of the regulations outlining the employer mandates will be issued for public comment on December 15, 2006.

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NEVADA LEGISLATION

NEW MINIMUM WAGE LAW

In November, Nevada voters passed a constitutional amendment that establishes a two-tiered minimum wage system. Employers who offer a qualified health insurance plan to their minimum wage employees can continue to pay $5.15 per hour, regardless of whether the employee elects the health insurance. Employers who do not offer a qualified plan are required to pay their minimum wage employees at least $6.15 per hour. Significant questions surround, among other issues, the definition of a “qualified health plan”. Nevada’s Labor Commissioner recently held an informal meeting seeking comments before preparing emergency interim regulations addressing the amendment. Additional analysis will be provided after those regulations have been issued.

This Legislative Update is provided for informational purposes only, and must not be construed as legal or tax advice. Please contact your legal or tax advisor regarding how this Legislative Update may apply to your employee benefit plans.