

LEGISLATIVE UPDATE

IN THIS ISSUE

Deadlines

Federal Developments

- Final Regulations on the use of Electronic Media for Benefit Notices, Elections and Consents
- SEC Disclosure of Executive and Director’s Benefits
- Requirements under TRICARE
- Wal-Mart’s \$4 Prescription Drug Program – How it Affects Employers

State Updates

- California
- Massachusetts
- Nevada

FINAL REGULATIONS ON THE USE OF ELECTRONIC MEDIA FOR BENEFIT NOTICES, ELECTIONS AND CONSENTS

The Treasury Department and IRS recently issued final regulations on using electronic media for providing certain notices to employee benefit plan participants and permitting participants to transmit certain elections or consents electronically. The regulations reflect the provisions of the Electronic Signatures in Global and National Commerce Act (E-SIGN).

What is covered?

The final regulations establish standards for the use of electronic media by all employee benefit plans. This includes: qualified retirement plans, accident and health plans, section 125 cafeteria plans, education assistance programs, qualified transportation fringe benefit programs, health savings accounts (HSAs), 403(a) and 403(b) annuity contracts, simplified employee pensions (SEPs), 408(p) simple retirement plans, and 457(b) eligible governmental plans.

What is not covered?

These regulations do not apply to any notice, election, consent, disclosure, or obligations required under the provisions of title I or IV of ERISA. The Department of Labor (DOL) has issued guidelines for electronic communications with respect to summary plan descriptions (SPDs), summary annual reports (SARs), COBRA notices, and all other notice, election, consent, or disclosure requirements under DOL Reg. § 2520.104b-1(c).

Notices

The final regulations provide two methods for providing notice. The first method, called the Consumer Consent Method is mandated by the Electronic Signatures in Global and National Commerce (E-SIGN) Act. An electronic system used to provide a notice:

- must obtain the recipient's affirmative consent to receive the notice electronically in a manner that demonstrates the recipient can access the applicable notice in the relevant electronic format;
- must provide a pre-consent disclosure statement to the recipient that provides information about the recipient's right to request a paper copy of the notice and the hardware and software requirements needed to access and retain the notice, among other things; and
- must permit a potential recipient to withdraw consent before the notice is delivered.

The second Alternative Method provides an exemption to the Consumer Consent Method, if the recipient is "effectively able" to access the electronic medium used to provide the notice, and if the recipient is advised, at the time of distribution, that he or she may request a paper copy at no charge. Also, the regulations require the electronic transmission to alert the recipient to the significance of the information in the notice (including identification of the subject matter of the notice), and provide any instructions needed to access the notice, in a manner that is readily understandable.

Elections

With respect to participant elections, the following requirements must be satisfied:

- the participant must be "effectively able" to access the electronic medium in order to make the participant election;
- the electronic system must be reasonably designed to preclude any one, other than the appropriate person, from making a participant election (e.g. Using a login number or PIN code);
- the electronic system must provide the participant making a participant election with a reasonable opportunity to review, confirm, modify or rescind the terms of the election before it becomes effective; and
- the individual making the election must receive confirmation.

An election will not be deemed as made available if the participant is not "effectively able" to access the electronic medium

Certain elections, such as Qualified Joint Survivor Annuity (QJSA) waivers by a participant's spouse, must be witnessed by a plan representative or a notary public. The regulations state that electronic notarizations, in accordance to E-SIGN and any applicable state law, will not be denied legal effect if the signature is witnessed in the physical presence of a plan representative or notary public.

Record Maintenance

It will be important for plans to maintain records of electronic notices and elections. The legal effect of an electronic notice or election may be denied or lack enforceability if it is not maintained for later verification.

Effective Date

These regulations apply to applicable notices provided and to participant elections made on or after January 1, 2007. However, there is retroactive protection for electronic notices distributed and participant elections made on or after October 1, 2000, and before January 1, 2007, in a manner consistent with the final regulations.

SEC DISCLOSURE OF EXECUTIVE AND DIRECTOR BENEFITS

The Securities and Exchange Commission has issued final regulations that update the public disclosure rules for executive and director compensation. The new rules apply to any Form 8-K filed with the SEC on or after November 7, 2006; and any Form 10-K or registration statement filed with the SEC on or after December 15, 2006.

To comply with the new rules, human resources professionals should first work with the company’s general counsel or corporate law attorney to identify the executives and directors with respect to whom public disclosure is required. This group will generally include the company’s chief executive officer, chief financial officer, three to five other highly compensated executives, and all members of the company’s board of directors.

The next step will be to compile data about the different forms of compensation that these individuals receive from the company. In addition to cash and equity compensation, human resources professionals must identify and value “all other compensation,” which includes the dollar value of life insurance and “perquisites and other personal benefits.” The regulations do not define the term “perquisites and other personal benefits,” but the preamble to the regulations does set forth the following guidelines:

- An item is not a perquisite or personal benefit if it is integrally and directly related to the performance of the executive’s duties (for example, use of a Blackberry device or laptop computer).
- Otherwise, an item is a perquisite or personal benefit if it confers a direct or indirect benefit that has a personal aspect, without regard to whether it may be provided for some business reason or for the convenience of the company, unless it is generally available on a non-discriminatory basis to all employees.
- Perquisites or personal benefits should be valued based on their aggregate incremental cost to the company.

Based on these guidelines, it would be reasonable to conclude that health and welfare benefits that cover only executives and/or directors must be treated as a



“perquisite or other personal benefit” under the disclosure rules. Examples include an executive-only health insurance plan and director-only medical examinations. In each case, the human resources professional must determine the cost of the coverage to the company, not the value of the benefit to the executive or director. For example, life insurance coverage would be valued by the premiums paid by the company during the year, not the dollar amount of life insurance proceeds payable upon an executive’s death.

The final step will be to determine whether the dollar value of all “perquisites and other personal benefits” exceeds \$10,000. If this threshold is met by a particular officer or director, then the SEC requires disclosure of (i) their aggregate dollar value, and (ii) a description of each particular benefit treated as a perquisite or other personal benefit, for the officer or director. It is not necessary to disclose the dollar value of each “perquisite or other personal benefit,” unless the value of a particular perquisite or benefit is at least \$25,000 (or, if greater, ten percent of the total value of all perquisites and other personal benefits).

For example, if the CEO’s perquisites and other personal benefits for the year are valued at \$8,000, then no disclosure is required by the SEC. On the other hand, if their value is \$12,000, then the \$12,000 value must be disclosed, along with a short description of each benefit that is being treated as a perquisite or other personal benefit. It would not be necessary to disclose the value of any particular perquisite or benefit, because none of them has a value of at least \$25,000.

**TWO NEW HEALTH PLAN MANDATES:
INCENTIVE PROHIBITION AND NONDISCRIMINATION
REQUIREMENTS UNDER TRICARE**

TRICARE is the federal government’s health care program for certain active-duty and retired service members and dependents. On October 17, 2006, President Bush signed the appropriations bill that included provisions affecting the relationship between group health plans and TRICARE. These provisions are intended to limit the ability of employers to shift their health care costs to the TRICARE program.

Effective January 1, 2008:

- An employer may not offer a TRICARE Eligible Employee any financial or other incentive for the TRICARE Eligible Employee not to enroll (or to terminate enrollment) in the employer’s group health plan. In applying this rule, the similar provisions prohibiting financial and other incentives for purposes of the Medicare Secondary Payer (“MSP”) rules shall apply to TRICARE.
- A TRICARE Eligible Employee must be given the opportunity to elect to participate in the group health plan offered by his or her employer in the same manner and to the same extent as similarly situated employees of the employer who are not TRICARE Eligible Employees.

These provisions apply to all employers, including state and local governments, who have 20 or more employees.

**WAL-MART’S \$4 GENERIC PRESCRIPTION
DRUG PROGRAM-
HOW IT AFFECTS EMPLOYERS**

Wal-Mart announced in November that it is selling a 30-day supply of 331 different types of generic prescription drugs for \$4.00 to customers in 27 states – Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, South Dakota, Texas, Vermont, and Virginia. The \$4 prescriptions are available in-person, on-line, or by telephone (but not by mail-order) for in-person pickup in those states. The program includes Albuterol (for asthma), Amoxicillin (antibiotic), Atenolol (beta blocker), Fluoxetine (antidepressant), Lisinopril (for high-blood pressure), Loratadine (for allergies), and Prednisone (anti-inflammatory).

Most employers use lower deductibles and/or co-pays to encourage covered individuals to buy lower-priced generic prescription drugs. Wal-Mart’s program creates an opportunity, though, for employers to save even more. Here are some questions and answers regarding the adoption of a “Wal-Mart strategy”:

- Can an employer require that covered individuals purchase these generic prescription drugs at Wal-Mart? An employer with a group health insurance policy might run afoul of state insurance laws if it “amends” the policy in this way. Also, the benefit of lower prescription drug costs would accrue directly to the insurance carrier and not to the employer (although the employer might see lower insurance premiums in the future).
- What if the employer encourages (but does not require) covered individuals to take advantage of Wal-Mart’s program by publicizing its availability? The same concerns would apply if the employer plan is insured.
- What if the employer’s group health plan is self-insured? The plan is not subject to state insurance laws, so the employer could adopt a plan amendment requiring covered individuals to buy their generic prescription drugs at Wal-Mart. The employer would benefit directly from lower plan costs in this way. However, if Wal-Mart is ever negligent in filling a prescription and injures a covered individual, then the employer’s plan could face liability for having such a requirement in place.
- What if the employer with the self-insured plan just publicizes the availability of Wal-Mart’s program? This strategy may be the easiest way for an employer to obtain lower costs immediately while minimizing the potential for personal injury litigation.

- Finally, can group health plans (whether insured or self-insured) continue to charge covered individuals more than \$4 for these generic prescription drugs? The answer depends on the facts of each case. Under federal ERISA law, plans that charge covered individuals more than a drug’s cost have committed a prohibited transaction, and may be in violation of fiduciary duties. The plan may be able to avoid these problems by showing that the cost of generic drugs to the plan exceeded the amount charged to covered individuals. The plan may also need to show that it was prudent to obtain generic drugs from a source other than Wal-Mart.

STATE DEVELOPMENTS

CALIFORNIA

**SAN FRANCISCO
VOTERS MANDATE EMPLOYER PAID SICK LEAVE**

Measure F, which was 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.

MASSACHUSETTS

**MASSACHUSETTS HEALTHCARE REFORM-
CHANGES MADE IN OCTOBER 2006**

On October 26, the Governor of Massachusetts signed technical-corrections legislation affecting Massachusetts healthcare reform that was adopted earlier in 2006. Here is a summary of changes affecting employers:

- The original legislation required employers to adopt a cafeteria plan, which enables employees to make pre-tax contributions for their healthcare coverage. The revised law becomes effective on July 1, 2007 (not January 1, 2007, as originally announced).
- The original legislation required every employer doing business in the state to complete a "health insurance responsibility disclosure" (HIRD) form under oath. The law also required the state division of healthcare finance and policy to coordinate with the state department of revenue in collecting these documents from employers. The revised law requires employers to complete and return the HIRD form to the state only if they have more than 10 employees. An employer that knowingly falsifies or fails to file the HIRD form may be punished with a fine of not less than \$1,000 or more than \$5,000. These provisions become effective on January 1, 2007, and the first HIRD forms must be filed with the state in the spring of 2007.
- The open enrollment period for state residents to obtain health insurance through the state's connector program will take place May 1 to July 31, 2007 (not March 1 to May 31, 2007, as originally announced).
- Effective January 1, 2008, employers are required to provide a written statement of creditable coverage to everyone covered under the employer's group health plan. Statements must be furnished by no later than January 31 of each year, and will be used as proof of coverage for purposes of the state income tax return. A separate written summary must be sent to the commissioner of revenue. These employer obligations can be delegated to an insurance carrier or service provider. The penalty for noncompliance is \$50 per individual, not to exceed \$50,000 per year per violator.

NEVADA

NEW MINIMUM WAGE LAW

Nevada voters this month passed a constitutional amendment that establishes a two-tiered minimum wage system in Nevada. 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.

A “qualified health plan” is defined as a plan where employees and their dependents are covered at a cost to the employee that does not exceed 10% of the employee’s gross taxable income. For example, health insurance for an employee who makes \$10,000 a year must cost less than \$1000 in yearly premiums. It remains unclear how an employer is to address a situation where a minimum wage employee’s gross income fluctuates on a frequent basis, thus making it difficult to determine whether the premium is less than 10% of their annual salary. ABD has contacted the Nevada State Labor Commissioner to clarify this question and will provide guidance to client on an as-needed basis.

The new minimum wage law goes into effect on November 28, 2006.

This Legislative Update is provided for informational purposes only, and must not be construed as legal or tax advice. Please contact your ABD representative to determine how the content of this Legislative Update may impact your employee benefit plans.