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Management Alert

Developments Affecting Health Plans

New Health Care Law Effective for Employers Doing Business in San Francisco

The San Francisco Health Care Security Ordinance requires certain employers doing business in San Francisco to make minimum health care expenditures for their covered employees working in San Francisco. "Covered employee" includes all employees (except highly compensated managerial, supervisory and confidential employees and those eligible for Medicare or veterans' health care benefits) who have worked 90 days and performed 10 or more hours of work (in 2008) within the geographic boundaries of the city and county of San Francisco. (The definition includes part-time, seasonal and other employees who may not presently be eligible under existing employer plans.) Employers may make the required health care expenditures in a variety of ways, such as purchasing health insurance coverage for their covered employees, making payments to the City of San Francisco Health Access Plan, or establishing health spending or medical reimbursement accounts. Covered employers will also be required to comply with certain recordkeeping and reporting requirements regarding their health care expenditures.

A U.S. District Court initially ruled that the San Francisco ordinance was preempted by ERISA and could not apply to self-funded employer plans, but in January the U.S. Court of Appeals for the 9th Circuit temporarily stayed that decision allowing the law to go into effect immediately. Although the full Ninth Circuit will review this decision on an expedited basis, covered employers have to decide whether to currently comply, or not comply and risk incurring penalties. Penalties include administrative penalties of up to 1½ times the total required expenditures plus simple annual interest up to 10% (not to exceed $1,000 per employee for each week), and civil penalties in like amounts, plus attorneys' fees and costs of enforcement. The law was effective January 9, 2008 for employers with 50 or more employees, and as of April 1, 2008 it will apply to for-profit employers with as few as 20 employees.

EEOC Issues Regulations Permitting Supplemental Coverage for Retirees

After years of legal challenges, the Equal Employment Opportunity Commission (EEOC) on December 26, 2007 published final regulations that recognize an employer's right to coordinate retiree health programs with Medicare coverage. These regulations were proposed in 2003, but could not be finalized until a lawsuit trying to block the implementation of the rules was decided.

The EEOC's final regulations allow an employer to alter or reduce its retiree health coverage when an employee

becomes eligible for Medicare or a similar state-sponsored program. Therefore, as retirees turn age 65 and become eligible for Medicare, employers are essentially permitted to provide coverage to retirees that only supplements Medicare. The EEOC proposed the regulation under an exception to the Age Discrimination in Employment Act (ADEA) because it found that not allowing differing coverage for retirees over age 65 would discourage employers from providing any retiree health coverage at all because of the cost of covering employees over age 65. The Third Circuit Court of Appeals, in a decision published in February 2007, agreed with the EEOC that the proposed regulations provided a reasonable exception permitted under the ADEA. This decision cleared the way for the EEOC to publish the final regulations.

AARP has filed a petition seeking U.S. Supreme Court review of the Third Circuit's decision. Unless the U.S. Supreme Court overturns the Third Circuit's decision, employers may rely on the final regulations and coordinate retiree medical with Medicare.

New Medicare Secondary Payer Reporting Requirement

Effective January 1, 2009, group health plans will be required to comply with a new Medicare Secondary Payer reporting law under the Medicare, Medicaid and SCHIP Extension Act of 2007 (Pub. L. 110-173). The new law requires plan administrators, insurers, third party administrators and fiduciaries to identify situations when the plan is primary to Medicare (*i.e.* plan pays before Medicare), and to submit this information to the Department of Health and Human Services (HHS). While insurers will perform this reporting requirement for insured plans, the plan administrator or fiduciary of self-insured plans will be responsible for collecting and reporting the required information, unless this responsibility is outsourced to a third party administrator.

A plan administrator, insurer, third party administrator or fiduciary who does not comply with the new reporting requirements will be subject to a civil monetary penalty of $1,000 for each day of non compliance for each individual for whom the required information was not reported.

As soon as HHS issues regulations, we will update you on the required content of the reports, as well as the required format and timing of the reporting to ensure proper compliance.

Revised Definition of Dependent

The Internal Revenue Service recently issued Notice 2008-5 which provided guidance as to whether an individual is a "qualifying relative" with respect to the definition of a dependent under Internal Revenue Code Section 152(d). Before the Notice was issued, a child could be an individual's dependent only if the child was "not the qualifying child of another taxpayer." The Notice clarified, however, that if the child is a qualifying child of a person who either (i) is not required to file a tax return, or (ii) only files a tax refund to claim taxes withheld, then he or she could still be considered another taxpayer's dependent. While the Notice does not explicitly apply to welfare benefit plans, it could affect the definition of "dependent," and thus the class of individuals eligible to participate in the plan.

If you have any questions regarding this Management Alert, please contact the Seyfarth Shaw attorney with whom you work, or any Employee Benefits attorney on our website, www.seyfarth.com.

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