THE WAGNER LAW GROUP

A PROFESSIONAL CORPORATION

Legal Updates in the ERISA & Employee Benefits World

ERISA, Employee Benefits and Executive Compensation Law

January 2011

Table of Contents

The Wagner Law Group News

Television Appearances

Below are recent television appearances by The Wagner Law Group.

NBC News - 9News.com, **"Flexible Spending Account: Use It or Lose It,"** Marcia Wagner, December 28, 2010

Fox News - The Strategy Room (with anchor Tracy Byrnes), **"New 401(k) Rules: What You Need to Know,"** Marcia Wagner, November 19, 2010

This Newsletter is intended to provide you with an overview of the recent Health Care Reform litigation and regulation, and other events affecting welfare benefit plans and employment law.

For health and welfare plans, Health Care Reform continues to be the hot topic with the IRS, Department of Labor and Department of Health and Human Services continuing to issue additional guidance on the implementation of the law, even while it is being subject to numerous legal challenges in court.

The Newsletter also provides the cost of living adjustments for 2011 for both retirement and health and welfare plans.

If you have any questions or seek our counsel, please contact any of **The Wagner Law Group attorneys**, specialists in ERISA, employee benefits and executive compensation.

Best Regards,

Marcia Wagner

Healthcare Reform Act

Three Courts Rule on Constitutionality of Health Care Reform

A federal court in Virginia has ruled that a key provision of the Patient Protection and Affordable Care Act of 2010 (PPACA or the Health Care Reform Act) is unconstitutional. In his opinion, Judge Henry E. Hudson of the Federal District Court in Richmond ruled that the PPACA's individual mandate-which requires most Americans to obtain health insurance or face a monetary penalty-exceeds the limits of the federal government's authority. Judge Hudson further commented that "neither the Supreme Court nor any federal circuit court of appeals has extended [the U.S. Constitution's] Commerce Clause powers to [permit Congress to] compel an individual to involuntarily enter the stream of commerce by purchasing a commodity in a private market."

Judge Hudson's decision stems from a lawsuit filed by Virginia's Attorney General Kenneth Cuccinelli. In his complaint, Cuccinelli contends that it has "never been held that the Commerce Clause can be used to require citizens to buy goods or services."

In his 42-page decision, Judge Hudson determined that the individual mandate "is neither within the letter nor spirit of the Constitution," and that allowing Congress to exert such authority "would invite unbridled exercise of federal...powers."

Nevertheless, despite this finding, Judge Hudson refused to grant Cuccinelli's request to enjoin the ongoing implementation of the law pending appeal, meaning that the ruling will have virtually no impact on the PPACA at this time.

Recent Seminars

Below are links to seminar material that The Wagner Law Group recently presented.

"What is New in DC: The Most Critical Items to the Obama Administration," Marcia Wagner, 1st Global Conference, November 15, 2010 in San Antonio, TX

"What is New in DC: The Most Critical Items to the Obama Administration," Marcia Wagner, NRP 2010 Annual Conference, November 6, 2010 in Palm Springs, CA

Articles Published

Below are links to recently published articles written by The Wagner Law Group.

"What Chance of Repealing Health Care Reform in the New Congress?" Alvin Lurie, ***Benefits Link***, December 30, 2010

"Voluntary Correction Program for Nonqualified Deferred Compensation Document Failures," Marcia Wagner, ***401 (k) Advisor***, December 2010

"Re-Defining Moment. DoL Proposes Broadening the Definition of Fiduciary," Marcia Wagner, ***Planadviser***, November-December 2010

"Health Care Reform Overview," Marcia Wagner, ***National Healthcare Reform Magazine***, December 6, 2010

"Exercising Fiduciary Authority and Control Over the Investment Menu in §403(b) Plans Subject to ERISA," Marcia Wagner, ***Tax Management Compensation Planning Journal***, November 5, 2010

"Court Ruling on Mutual Fund Fees to 401(k) Plans," Marcia Wagner, ***401(k)***

Judge Hudson's decision is the first to declare any portion of the PPACA unconstitutional. Previously, two federal judges had ruled the PPACA was constitutionally valid.

In November, Judge Norman K. Moon of Federal District Court in Lynchburg granted the federal government's motion to dismiss a lawsuit brought by Liberty University challenging the PPACA's constitutionality. Liberty contended that that the Constitution's Commerce Clause does not permit Congress to force Americans to purchase a commercial product such as health insurance, and that by doing so, the PPACA impermissibly regulates inactivity. Judge Moon disagreed with Liberty, ruling that a person's choice to not purchase health insurance is "far from 'inactivity,'" and that "by choosing to forego insurance, plaintiffs are making an economic decision to try to pay for health care services later, out of pocket, rather than now, through the purchase of insurance."

In October, Judge George C. Steeh of Federal District Court in Detroit also upheld the individual mandate as constitutional, and denied a request for an injunction against the PPACA. Judge Steeh's ruling was in response to a lawsuit brought by the Thomas More Law Center and four individuals who objected to the individual mandate, claiming that Congress has no authority to regulate persons who decide not to participate in the health insurance market. In his opinion, Judge Steeh wrote that the individual mandate provision "which addresses economic decisions regarding health-care services that everyone eventually, and inevitably, will need, is a reasonable means of effectuating Congress's goal."

Most legal experts agree that the Supreme Court will ultimately resolve the conflicting legal philosophies expressed in these decisions. Indeed, Judge Hudson acknowledged as much in his opinion by writing that "the final word will undoubtedly reside with a higher court."

Grandfather Rules Revised

The IRS, Department of Labor ("DOL") and Department of Health and Human Services ("HHS") have amended the Health Care Reform Act's grandfather rules to permit group health plans to maintain grandfathered status even if the plan changes insurance contracts.

PPACA contains many provisions affecting plan design and operations. However, some of these provisions do not apply to group health plans while they are in grandfathered status.These provisions include the following which would otherwise generally be effective for calendar year plans as of January 1, 2011:

- Group health plans must provide for certain preventative care without cost sharing requirements.
- Emergency care services must be provided at the in-network rate, without prior authorization and without regard to whether the emergency health care provider is a participating provider.
- Participants may select primary care providers, including pediatric care providers, and OB/GYNs, from any such provider who participates in the plan's network.
- Insured group health plans will be subject to nondiscrimination rules similar to those currently in effect for self funded plans. (The effective date of this provision has been delayed-see below.)
- Both insured and self funded group health care plans must provide "effective" internal and external claims review processes.

Under the agencies' original rules, a plan would lose its grandfathered status if it "enters into a new policy, certificate, or contract of insurance" after March 23, 2010. Grandfather status will also be lost if the plan:

- eliminates substantially all benefits to diagnose or treat a specific illness (e.g., if a plan provides treatment for a particular mental illness which consists of counseling and prescription drugs, and then eliminates counseling benefits, the plan would lose its grandfather protection);
- increases the participants' fixed percentage co-insurance requirements (e.g., increasing a co-pay from 20% to 30%);
- increases fixed dollar amount cost sharing requirements (e.g., deductibles or out-of-pocket expenses) beyond a specified amount based on medical inflation plus

Advisor, November 2010

"Selecting Benchmarking Services to Help Meet Fiduciary Requirements," Marcia Wagner, ***Compensation & Benefits Review***, October 2010

"FBAR Rules for Employee Benefit Plans," Marcia Wagner, ***Law Firm Partnership & Benefits Report***, October 2010

"IRS Determination Letter Program for Tax-Qualified Retirement Plans," Marcia Wagner, ***401(k) Advisor***, October 2010

"ERISA Fiduciary Rules and Target-Date Funds," Marcia Wagner, ***PlanAdviser***, September-October 2010

Webinars & Podcasts

Below is a recently conducted webinar by The Wagner Law Group.

"Fee Transparency and Best Practices for Plan Sponsors," Marcia Wagner, Legg Mason Webinar, December 14, 2010

"What is New in DC: The Most Critical Items to the Obama Administration," Marcia Wagner, John Hancock Retirement Services 'Ask the Expert' Webinar, December 7, 2010

"What You Need To Know About Health Care Compliance," Barry Newman, HighRoads, Inc., November 17, 2010

"Congressional and Regulatory Changes to Target Date Funds," Marcia Wagner, BNA Webinar on Target Date Funds, October 27, 2010

15%;
- increases co-payment amounts more than the rate of medical inflation plus 15%, or if greater, by $5.00;·decreases the employer contribution for any tier of coverage by more than 5% (e.g., decreasing the employer's share of premiums from 60% to 50%); or
- imposes certain new annual limits on benefits.

However, employers responded that the rule regarding new insurance policies placed insured plans at a disadvantage because:

- self-insured plans can change administrators and stop loss insurers without the loss of grandfathered status;
- insurers were given an unfair advantage in negotiations since employers could not look to contract with another insurer without risking loss of grandfathered status; and
- an employer could lose grandfathered status simply because an insurer stopped offering coverage in its particular market.

The agencies responded by amending the interim regulations to provide that a group health plan does not cease to be a grandfathered plan merely because the plan enters into a new policy, as long as it does not violate any of the other rules for maintaining grandfathered status.

To maintain grandfathered status, a plan that enters into a new policy must provide the new insurer with documentation of the plan's current terms (including benefits, cost sharing, employer contributions and annual limits) which is "sufficient to determine" whether any change has been made to the plan that would negate grandfathered status.

Curiously, this new rule only applies to new group health insurance contracts that are effective after November 14, 2010. Therefore, for example, if a plan enters into an agreement with an insurer on September 28, 2010 for a new policy that becomes effective January 1, 2011, the plan will maintain its grandfathered status. However, if the plan entered into the same agreement on July 1, 2010 with an issuer for a new policy that was effective on September 1, 2010, then the plan would cease to be a grandfathered plan.

Required Notices

Under the PPACA, almost all employers will find themselves facing special, one-time procedures.

For many employers, the first step in complying with Health Care Reform involves the distribution of one or more newly-required notices to plan participants and other individuals. The number of notices that must be distributed will depend on the status and nature of their group health plan, as well as specific plan provisions and their plan's health care benefit delivery system. The new notices include the following:

- *Grandfathered Health Plan Notice.* A notice stating that the employer believes its group health plan is a "grandfathered" health plan and, therefore, not subject to various provisions of the Health Care Reform Act. The notice must also provide contact information for questions and complaints.
- *Special Enrollment Notice for Certain Children Who Aged Out.* A notice that the group health plan will cover children of participants until age 26, and that a there will be a one-time, 30-day open enrollment period for adult children who are currently not covered by the plan, including those who lost coverage because of age, and those who will first become eligible for plan participation because of the changes to the law.
- *Patient Protection Notice.* A notice on patient protections regarding the right to select primary care providers, including pediatric care providers, from any provider participating in the plan's network. The notice must also provide that a referral is not required for obstetrical or gynecological care provided by a physician who is participating in the network.
- *Lifetime Limits Notice.* A notice that the lifetime limits of the group health plan are

Quoted Articles

Below are links to recently published articles quoting The Wagner Law Group.

"The Economy in 2010: Stories You May Have Missed," Marcia Wagner, ***PBS NewsHour***, December 30, 2010

"Industry Execs Laud Latest Target-Date Proposal," Marcia Wagner, ***Pensions & Investments***, December 8, 2010

"Legg Mason Entertains Advisors, Distributors and Reporters," Marcia Wagner, ***MutualFundWire.com***, December 3, 2010

"Labor Department Proposes Target Date 401 (k) Rules," Marcia Wagner, ***CNBC***, November 29, 2010

"Labor Department Proposes Target Date 401(k) Rules," Marcia Wagner, ***ABC News***, November 29, 2010

"Labor Department Proposes More Target Date Disclosure," Marcia Wagner, ***Chicago Breaking News***, November 29, 2010

"Labor Department Proposes Target Date 401(k) Rules," Marcia Wagner, ***Yahoo! Finance***, November 29, 2010

"DOL Floats Disclosure Rule For 401(k) Target Date Funds," Marcia Wagner, ***Investment News***, November 29, 2010

"Financial Advisers Fear Possible Rollover Rules," Marcia Wagner, ***Investment News***, November 16, 2010

"Plan Sponsor's Duty to Avoid Conflicts of Interest," Marcia Wagner, ***The Teachers Advocate***, November 10, 2010

no longer applicable and that a one-time, 30-day open enrollment opportunity will be available to participants and beneficiaries who left the plan because they had reached the previously applicable lifetime limit.

In order to determine which notices must be distributed by a particular plan, an employer will first have to determine if its plan is protected by grandfather status. It then must determine which notices are applicable to its plan, based on current benefits (e.g., does the plan currently have a lifetime maximum) and benefit delivery system (e.g., does the plan have network providers). Finally, it must determine who should receive these notices and ensure that the notices are distributed by means of a government-approved method. For most employers, the distribution requirements for these notices can initially be met by including the notices in the open enrollment materials. This would be in addition to other annual notice requirements (e.g., the Women's Healthcare Notice and the Medicare Part D Notice).

DOL has posted on its website the model notices that are required under the Patient Protection and Affordable Care Act. They are:

- **Model Notice on Patient Protections regarding the selection of primary care providers, pediatric care providers and OB/GYNs**
- **Model Notice on Lifetime Limits No Longer Applying and Enrollment Opportunity**
- **Model Notice of Opportunity to Enroll in Connection with Extension of Dependent Coverage to Age 26**
- **Model Notice for Grandfathered plans**

DOL's website now includes additional information on the notification requirement for grandfathered plans under which an employer must notify participants and beneficiaries that it believes its plan is a "grandfathered" health plan and, therefore, not subject to various provisions of the Health Care Reform Act.

According to DOL, the grandfather plan disclosure requirement is met if the notice is provided whenever a summary of benefits is provided to participants and beneficiaries, such as during open enrollment, when an SPD is distributed, or upon other opportunities to enroll in the plan. However, it is not necessary to include the notice with each plan communication, such as with an EOB.

Internal and External Review Requirements

The IRS, DOL and HHS have issued interim final regulations regarding the PPACA requirement that non-grandfathered plans provide "effective" internal and external claims review processes.

In general, an affected plan will be in compliance with the new the internal claims and appeals process requirements if it complies with the current claims requirements under DOL regulations.

However, the regulations add six new requirements to the current DOL claims procedure. These new requirements are:

- An expanded definition of an "adverse benefit determination" to include a retroactive rescission of coverage as well as a denial of, reduction of, termination of, or failure to provide a benefit payment based on: an adverse determination of an individual's plan eligibility; a determination that a benefit is not covered; the imposition of a preexisting condition exclusion; or a determination that a benefit is experimental or not medically necessary (effective for plan years beginning on or after September 23, 2010).
- A requirement that urgent care claims be determined and communicated within 24 hours of receipt (effective July 1, 2011).
- A requirement that the plan must provide the claimant with any new or additional evidence considered by the plan and the rationale for a claims denial based on that evidence, giving the claimant a reasonable chance to respond (effective for plan

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The Wagner Law Group Description

The Wagner Law Group, A Professional Corporation, is a nationally recognized ERISA, employee benefits and executive compensation firm.

Established in 1996, The Wagner Law Group has 16 attorneys engaged exclusively in employee benefits law. The firm is among the largest ERISA boutiques in the country. The practice is national in scope, with clients in more than 30 states and several foreign countries.

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years beginning on or after September 23, 2010).

- To remove any conflict of interest, the plan must ensure that the hiring or compensation of a decision maker must not be based on the likelihood that the individual will support a denial of benefits (effective for plan years beginning on or after September 23, 2010).
- The plan must issue notices to enrollees, in a "culturally and linguistically appropriate manner." Also, the notification of a negative benefit determination must include, among other things, the reason for the adverse benefit determination, a description of internal and external reviews, and the availability of any applicable office of health insurance consumer assistance (effective July 1, 2011).
- The plan is required to continue ongoing treatments pending the outcome of any internal appeal (effective for plan years beginning on or after September 23, 2010).

The regulations also provide that if a plan fails to comply with these internal review requirements the claimant is deemed to have exhausted the internal claims process and may initiate an external review.

The external review requirement will be met if the plan is subject to a state external review process that applies to, and is binding on, the plan through its insurer, if the process meets the consumer protection provisions of the National Association of Insurance Commissioners Uniform Model Act. The regulations say that Health and Human Services will determine whether a state's external review process meets these requirements or if the process qualifies under a transition rule.

The agencies have released a notice that provides interim rules for non-grandfathered, self-funded group health plans that are not subject to a state external review process. Basically, these plans can comply with the external review process requirement if they either:

- *Voluntarily comply with a state external review process.* A state may choose to expand access to its external review process to plans that are not subject to the applicable state laws (such as self-funded plans), and those plans may voluntarily choose to comply with the state process; or
- *Comply with DOL Technical Release 2010-01.* This Technical Release establishes the standards for external review that self-funded plans will have to follow, including: the procedures for requesting an external review; a preliminary review; referral to an independent review organization; and the procedures for an expedited external review (when the timeframe for an expedited internal review, or regular external review, would seriously jeopardize the life or health of the claimant).

In most instances, the plan's insurer or third party administrator will be contractually responsible for complying with both the internal and external review procedures. Only self funded, self administered plans will be responsible for their own review procedures. Nevertheless, employers of non-grandfathered plans should be aware of these new requirements and be able to either explain the new procedures or direct participants to someone who is able to do so.

Discrimination Rules for Insured Plans

For many employers, one of the most significant new provisions of the PPACA is the requirement that insured, non-grandfathered plans may not discriminate in favor of highly compensated employees. (Similar rules are already in effect for self-insured plans.) If an insured group health plan fails to comply with this provision, the plan or plan sponsor may be subject to an excise tax of $100 per day with respect to each individual to whom such failure relates, or to a civil action to compel the employer to provide nondiscriminatory benefits.

However, in Notice 2011-1, IRS has delayed the effective date of this non-discrimination rule, stating that "because regulatory guidance is essential to the operation of the statutory provisions, the Treasury Department and the IRS, as well as the Departments of Labor and Health and Human Services have determined that compliance with [the non-

discrimination provision] should not be required (and thus, any sanctions for failure to comply do not apply) until after regulations or other administrative guidance of general applicability have been issued...in order to provide insured group health plan sponsors time to implement any changes required as a result of the regulations or other guidance."

Based on the IRS's prior "progress" with regulations pertaining to discrimination in self-insured plans (which began decades ago and is still a work in progress), and the complete failure of the Section 89 discrimination rules for all group health plans (Internal Revenue Code Section 89 was subsequently repealed), it should be safe to say that the latest round of discrimination rule-making (and accompanying penalties) for insured plans, will not take effect for several years to come, if ever.

Cafeteria Plans

Under the PPACA, effective January 1, 2011, health care flexible spending account plans and health reimbursement account plans will no longer be permitted to reimburse plan participants for expenses relating to non-prescribed, over-the-counter medications (with the exception of insulin). Health savings accounts and Archer medical savings accounts will not be able to reimburse the cost of these over-the-counter medications on a tax-exempt basis.

IRS has now issued guidance on this new restriction in Notice 2010-59. The guidance notes that while the new rules apply to over-the-counter medicines, if an individual obtains a prescription for these drugs, they are still reimbursable. Also, the new restriction only applies to medicines and drugs, and not to: equipment such as crutches; supplies such as bandages; and diagnostic devises such as blood sugar testing kits. These items will remain reimbursable as long as they meet the Internal Revenue Code definition for medical care expenses.

The guidance goes on to explain that the new restriction applies to all expenses incurred on or after January 1, 2011, regardless of when the money was set aside in the health care account. For purposes of this rule, all plans must comply on January 1, 2011, regardless of their plan year and regardless of whether the plan has a 2½ month grace period for health care expenses after the end of the plan year. However, all over-the-counter expenses that were incurred prior to January 1, 2011 can be reimbursed after that date.

IRS notes that many cafeteria plans may need to be amended to conform to the new restriction.

Generally, under IRS proposed regulations, a cafeteria plan may not be retroactively amended. However, for purposes of this restriction, IRS will permit a retroactive amendment if it is adopted no later than June 30, 2011.

COBRA

The Department of Labor has released a Fact Sheet for COBRA qualified beneficiaries whose 65% COBRA premium subsidy is about to expire. Of particular significance, **the Fact Sheet** specifically tells qualified beneficiaries that "Plans are not required to remind you or bill you for the increased [premium] amount and not making the full payment within the correct time period can result in the cancelation of your COBRA Coverage."

Employers may wish to distribute this Fact Sheet to employees who are reaching the 15th month of their COBRA subsidy and also to those who may be losing eligibility for the subsidy because they will become eligible for coverage under another employer's group health plan.

HITECH

The Department of Health and Human Services ("HHS") has withdrawn its regulations on the breach notification rules of the Health Information Technology for Economic and Clinical Health ("HITECH") Act which is part of the American Recovery and Reinvestment Act of 2009.

Under HITECH, if there is a security breach due to unsecured protected health information ("PHI"), the covered entity or business associate must notify each individual whose information may have been accessed or disclosed. HHS and "prominent media outlets" must also be notified of breaches involving more than 500 residents in a particular area. If fewer than 500 individuals are involved in the breach, the covered entity would have to keep a record of the breaches and submit the list to HHS annually.

HHS issued final regulations on the required breach notices in 2009. Now, however, "HHS is withdrawing the breach notification final rule...to allow for further consideration, given the Department's experience to date in administering the regulations."

One reason for the withdrawal is that under the HHS regulations, a breach had to be reported only if it is determined that the breach causes a significant risk of harm to an individual's finances or reputation. Many commentators said this provision gave too much discretion to the party that was responsible for the breach in the first place, because that party would be the entity which determines if the breach resulted in "a significant risk of harm."

Meanwhile, HHS has also issued proposed regulations for the amendments to the HIPAA Security and Privacy Rules under HITECH.

The HIPAA Security Rules require administrative, physical and technical safeguards for PHI, and includes training requirements to enable employees to protect electronic systems and data from unauthorized access. These safeguards previously applied only to "covered entities" (e.g., group health plans and insurers) but now they will apply directly to business associates. (In general terms, a business associate is a service provider that uses PHI to perform its services for a covered entity.)

Under HITECH, the HIPAA Privacy Rules now directly apply to business associates as well. This includes the requirement to have and follow a business associate agreement ("BAA"). Previously, it was the covered entity's responsibility to identify all business associates and have a valid BAA in place (e.g., a business associate did not need to determine if it was a business associate). Now, the business associate will have the same responsibilities, and be subject to the same penalties, as the covered entity.

Under the proposed regulations, a subcontractor of a business associate can also be a business associate that must comply with the same security and privacy requirements and can be liable for a violation of these requirements. Therefore, the first business associate (not the covered entity) must "obtain satisfactory assurances through a written contract or other arrangement" that its subcontractor will comply with HIPAA.

Although a business associate is now directly liable under the law for a HIPAA violation, a covered entity would still be liable for a violation by its business associate even though it has a valid BAA in place and even if it did not know of a pattern or practice of violation.

Because all BAAs will have to be amended to encompass the new rules, the proposed regulations provide for an 18-month transition period beyond the compliance date in the final regulations (when they are issued), during which covered entities and business associates need not revise their current BAA. The proposed regulations do not provide model language for a revised BAA.

In addition, the proposed regulations specify that business associates may use and disclose protected health information only as permitted or required by their contract or by law. The regulations also refine the definition of the "minimum necessary" disclosure requirements. They generally prohibit the sale of PHI and use of PHI for marketing and fundraising purposes. The proposed rules also expand the rights of individuals to access their own PHI or to restrict the disclosure of PHI to health plans. They also discuss the new, enhanced penalty provisions and provide standards on the assessment of penalties. The proposed regulations would also make changes to the definition of a "business associate" that, generally, will not affect group health plans.

The HITECH amendments and new regulations will necessitate a revision of a covered

entity's Notice of Privacy Practices. However, HHS has recognized that the revision and distribution of these notices will impose a significant burden on group health plans and has asked for assistance in establishing a method of compliance that would reduce the burden.

With the exception of the delayed BAA compliance deadline that was previously noted, HHS will give covered entities and business associates 180 days after the date in the final regulations to comply with the new rules.

FMLA

The Department of Labor has issued a "clarification" of the definition of a "son or daughter" under the Family and Medical Leave Act. Under the FMLA, in general terms, employers with 50 or more employees in a single or nearby locations must provide up to 12 weeks of unpaid leave during a 12-month period so an employee, among other things, can bond with a newborn or newly adopted son or daughter or care for the child when he or she has a serious health condition.

In its clarification, DOL noted that the term "son or daughter" includes "a child of a person standing in loco parentis" regardless of the biological or legal relationship to the child. Therefore "the key in determining whether the relationship of in loco parentis is established is found in the intention of the person...to assume the status of a parent toward the child." Also, the employee need not provide both day-to-day care and financial support to be eligible for FMLA leave.

This means that, for example, "an employee who will share equally in the raising of a child with the child's biological parent would be entitled to leave for the child's birth." Similarly, a grandparent who takes in a grandchild and assumes ongoing responsibility for raising the child because the parents are incapable of providing care, would be entitled to leave.

DOL says that an employer may require the employee to provide reasonable documentation or statement of the family relationship. However, "a simple statement asserting that the requisite family relationship exists is all that is needed."

GINA

The Equal Employment Opportunity Commission has issued final regulations on the Genetic Information Nondiscrimination Act of 2008 ("GINA").

Under GINA, employers cannot make employment decisions such as "hiring, discharge, compensation, terms, conditions or privileges of employment" based on genetic information. In addition, health insurers and employers' group health plans cannot deny coverage or require higher premiums or contributions based genetic information.

GINA also restricts the acquisition and disclosure of genetic information. In general, an employer cannot acquire genetic information unless it is necessary to comply with the Family and Medical Leave Act, the Americans with Disabilities Act or similar state laws, or when it is required for law enforcement purposes. The disclosure rules are to be consistent with, but separate from, those found in the HIPAA privacy rules. Disclosure may also be made: to an individual who requests his own genetic information; to government agencies; or, in compliance with a court order.

However, the law does not ban the use of genetic information for long-term care and disability policies and does not affect insurers' ability to take pre-existing conditions into account when making coverage or pricing decisions.

Also, GINA permits employers to request genetic information as part of a voluntary wellness program. This exception applies when:

- the provision of genetic information by the individual is voluntary and those who refuse to provide the information are not penalized;
- the employee provides "knowing, voluntary and written" authorization;
- individually identified genetic information is provided only to the employee (or family member), or to licensed health care professionals and board certified genetic counselors involved in providing such wellness services; and

- any individually identifiable genetic information is available only for the purpose of such services and is not disclosed to the employer except in aggregate terms that do not disclose the identity of specific individuals.

Separate regulations affecting health insurers were issued last year by the Departments of Labor and Health and Human Services.

Cost of Living Adjustments

	2011	2010
Maximum annual payout from a defined benefit plan at or after age 62 (plan year ending in stated calendar year)	$195,000*	$195,000*
Maximum annual contribution to an individual's defined contribution account (plan year ending in stated calendar year)	$49,000**	$49,000**
Maximum Section 401(k), 403(b) and 457(b) elective deferrals	$16,500***	$16,500***
Section 414(v)(2)(B)(i) catch-up limit for individuals aged 50 and older	$5,500***	$5,500***
Maximum amount of annual compensation that can be taken into account for determining benefits or contributions under a qualified plan (plan year beginning in stated calendar year)	$ 245,000	$245,000
Test to identify highly compensated employees, based on compensation in preceding year (plan year beginning in stated year determines "highly compensated" status for next plan year)	$110,000	$110,000
Wage Base For Social Security Tax	$106,800	$106,800
Wage Base For Medicare	No Limit	No Limit
Amount of compensation to be a "key" employee	$160,000	$160,000
Maximum Social Security Benefit at Social Security Normal Retirement Age	$2,366/month	$2,346/month
Earnings Test - Early Retirement (Age 62) (Amounts that Can Be Earned before Benefits Are Cut)	$14,160/year	$14,160/year
PBGC maximum monthly guaranteed life annuity at age 65	$4,500/month	$4,500/month

Maximum exclusion for adoption assistance plan	$13,360	$12,170
Long term care premiums treated as medical expenses: • Age 40 or less • Age 41-50 • Age 51-60 • Age 61-70 • Older than 70	 $340 $640 $1,270 $3,390 $4,240	 $330 $620 $1,230 $3,290 $4,110
Qualified transportation benefits: • Parking expenses • Transit pass or commuter vehicle	 $230 $230	 $230 $230
Health savings accounts: • Maximum contribution-single	$3,050	$3,050
• Maximum contribution-family	$6,150	$6,150
• Maximum out of pocket expense-single	$5,950	$5,950
• Maximum out of pocket expense-family	$11,900	$11,900
• Minimum deductible for high deductible health plan-single	$1,200	$1,200
• Maximum deductible for high deductible health plan-family	$2,400	$2,400

* There are late-retirement adjustments for benefits starting after age 65.
** Plus "catch-up" contributions.
*** These are calendar year limitations.