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Impact of New York's Same-Sex Marriage Law on Employee Benefits and Related Tax Issues

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On June 24, 2011, New York became the sixth state to legalize same-sex marriage when Governor Andrew Cuomo signed into law the Marriage Equality Act (the "Act"). The effective date of the Act was July 24, 2011. Prior to July 24, 2011, New York allowed for recognition of legal same-sex marriages performed in other states. Same-sex marriage is legal in Connecticut, Iowa, Massachusetts, New Hampshire, Vermont, and Washington. D.C. In addition, California continues to recognize same-sex marriages performed during the period in which same-sex marriage was legal in California (June 16 through November 4, 2008). Effective July 24, 2011, same-sex spouses who are married in New York are entitled to the same benefits previously provided to same-sex married spouses legally married outside of New York.

Primary Changes Made By the Act

The primary changes made by the Act include the following:

- An application for a marriage license in New York will not be denied on the ground that the parties are of the same sex;
- A marriage that is otherwise valid will be valid regardless of whether the parties to the marriage are of the same or opposite sex;
- Government treatment or legal status, effect, right, benefit, privilege, protection or responsibility relating to marriage in New York will not differ based on the parties to the marriage being or having been of the same sex rather than an opposite sex.

Impact on Employee Benefit Plans

Under the federal Defense of Marriage Act (DOMA), same-sex marriages are not recognized as valid under any federal statute, including the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (the "Code"). DOMA provides that the term "spouse" can only refer to married persons of the opposite sex. Thus, the impact of the Act on employee benefits offered by plan sponsors, as with other state laws that recognize same-sex marriages, depends primarily on the type of plan and the plan's specific provisions.

Self-Funded Health and Welfare Plans

Self-funded health and welfare plans are subject to ERISA, which generally preempts state laws. Therefore, self-funded health and welfare plans are not required to provide benefits to same-sex spouses married under the Act. For self-funded group health plans, the terms of the benefit plan will dictate whether same-sex spouses of employees are eligible for

coverage. Nevertheless, some plan sponsors may intentionally choose to extend spousal coverage to same-sex spouses in self-funded group health plans. Additionally, self-funded plans may unintentionally provide benefits to same-sex spouses. For example, a health and welfare plan that provides benefits for an employee's spouse without defining that term or that defines spouse as a "legal spouse" or "the person to whom the employee is lawfully married" may be interpreted to provide benefits to same-sex spouses. Consequently, plans sponsors should review each plan's definition of spouse to determine whether the plan provides benefits to same-sex spouses or may be interpreted to do so. If the plan's provisions do not reflect the plan sponsor's intent regarding benefits for same-sex spouses, the plan's definition should be revised and clarified.

Fully Insured Health and Welfare Plans

ERISA preemption does not apply to insured health and welfare plans. Consequently, insured health and welfare plans provided pursuant to insurance policies that are subject to New York insurance laws must treat same-sex spouses the same as opposite sex spouses. For example, although a plan may not be required to cover spouses, if the plan does cover opposite-sex spouses, it may now be required to cover same-sex spouses. As a result of a directive issued by former Governor Paterson in 2008 (and pursuant to a Circular Letter issued by the New York Insurance Department as a consequence of that directive), New York State law already required that same-sex spouses (validly married in other states or jurisdictions) must be treated the same as opposite-sex spouses. Now, same-sex spouses who are married in New York will receive similar treatment. However, plan sponsors with insurance policies issued in states other than New York may not be subject to New York law. Employers should review the underlying insurance policies to determine whether New York law applies.

Whether a plan is fully or self-insured, COBRA health continuation coverage requirements arise out of federal law and generally are not subject to the requirements of the Act. This means that COBRA rights for spouses generally apply to opposite-sex spouses rather than same-sex spouses. However, an employer may voluntarily provide COBRA-like benefits to same-sex spouses.

Tax Implications

For federal income tax purposes, as required by DOMA, health and welfare benefits provided to same-sex spouses are taxable to the employee unless the same-sex spouse qualifies as a dependent under the Code. Therefore, employers must impute income to the employee for federal income tax purposes equal to the fair market value of the health coverage provided to a same-sex spouse. Generally, employers with fully insured health plans determine the fair market value of coverage by calculating the difference between the amount an employer would contribute for the employee alone and the amount the employer would contribute for a couple or family. Employers with self-insured plans generally determine the fair market value of health coverage based upon COBRA coverage rates.

On July 29, 2011 the New York State Department of Taxation and Finance issued a technical guidance memo ("Memo") that provides guidance with respect to the Act's impact on New York's personal income taxes (TSB-M-11(8)(C) available here). The Memo provides that same-sex married couples must file New York State personal income tax returns using a married filing status (e.g., married filing jointly, married filing separately), even though their marital status is not recognized for federal tax purposes. In addition, to compute their New York tax, same-sex married couples must recompute their federal income tax (e.g., their federal income, deductions and credits) as if they were married for federal income tax purposes.

Same-sex married couples who are married as of December 31, 2011 will be considered married for the entire year and they must file their returns using a married filing status in tax year 2011. However, the Act is not retroactive. A same-sex couple who was legally married in another state prior to July 24, 2011, is not married for New York tax purposes until July 24, 2011, and may not use a married filing status prior to the 2011 tax year.

Retirement Plans

Retirement benefits are generally governed by ERISA and the Code and therefore are not affected by the Act. Therefore, same-sex couples are excluded from many federal pension protections and benefits including qualified joint and survivor annuities, qualified preretirement survivor annuities, spousal consents, minimum required distributions, rollover distributions, hardship distributions, and qualified domestic relations orders. Nevertheless, plan sponsors may design a plan to intentionally provide benefits to same-sex spouses. For example, some plan sponsors have voluntarily chosen to provide pre-retirement survivor annuity benefits and various joint and survivor annuity options to same-sex spouses. Accordingly, plan sponsors may want to review plan documents to clarify that federally-required spousal benefits are not available to same-sex spouses and to implement plan design changes to provide same-sex couples with similar alternatives.

What Now?

With the passage of the Act, employers should expect an increase in requests for spousal benefit coverage from employees who have legally married their same-sex partners. Employers with a presence in New York should consider the following to determine whether revisions to their employee benefit plans are necessary to comply with the Act:

- Review existing HR policies (including employee handbooks) to assess the current rights of same-sex spouses and consider any required or desired changes;
- Review benefit plan documents, summary plan descriptions, insurance contracts, benefit forms, and administrative procedures to determine the current rights of same-sex spouses and consider any required or desired changes;
- Review any domestic partner policy and any other employer policy that might be affected by the Act;
- Coordinate with insurance providers and third party administrators and the payroll department to address taxation issues; and
- Communicate benefit plan changes made pursuant to the Act to employees and their family members.

King & Spalding is happy to assist you with any questions you may have regarding compliance with the Act.

HHS Expands Preventative Care Requirements for Women

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Overview:

Non-grandfathered group and individual health plans, including insured and self-insured plans, will be required to cover certain recommended preventive services for women, effective for plan years beginning on or after August 1, 2012 (January 1, 2013 for calendar year plans). The services must be provided without any cost sharing. A limited exemption for certain religious employers is offered with regard to contraceptives.

Recommended Preventive Services

On July 14, 2010, the Departments of Labor, Treasury and Health and Human Services issued interim final rules describing the recommended preventative services that must be provided by non-grandfathered health plans pursuant to Section 2713 of the Public Health Services Act. These interim final rules were effective January 1, 2011 for calendar year plans and required non-grandfathered health plans to provide coverage for recommended preventative services without any cost sharing requirements, including counseling to reduce alcohol and tobacco abuse, screenings for diabetes, high blood pressure, cervical cancer and hepatitis B, certain immunizations and preventive care for children.

A recently issued amendment to the interim final rules expands the definition of recommended preventive services to include the following services for women:

Type of Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
Well-woman visits.	A well-woman preventive care visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other recommended preventive services listed in the HHS Guidelines for Health Insurance Coverage.	Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.
Screening for gestational diabetes.	Screening for gestational diabetes.	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Human papillomavirus testing.	High-risk human papillomavirus DNA testing in women with normal cytology results.	Screening should begin at 30 years of age and should occur no more frequently than every three years.
Counseling for sexually transmitted infections.	Counseling on sexually transmitted infections for all sexually active women.	Annual.
Counseling and screening for human immune-deficiency virus.	Counseling and screening for human immune-deficiency virus infection for all sexually active women.	Annual.
Contraceptive methods and counseling (with exemption for plans sponsored by certain religious employers)	Patient education and counseling for all women with reproductive capacity for all Food and Drug Administration approved contraceptive methods, including sterilization procedures.	As prescribed. Note: Abortifacient drugs are specifically excluded.
Breastfeeding support, supplies, and counseling.	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth.
Screening and counseling for interpersonal and domestic violence.	Screening and counseling for interpersonal and domestic violence.	Annual.

INSIGHT: Although the regulations indicate the preventive services are to be provided "with respect to women," many of the preventive services outlined affect both sexes. This appears to mean that, for example, men who seek counseling for domestic violence may be subject to cost sharing for the services provided, but women who seek the same service cannot be subject to cost sharing.

Certain Religious Employers Exempt

Group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to cover contraceptive services. A religious employer is one that:

(1) has the teaching of religious values as its purpose;

(2) primarily employs persons who share its religious tenets;

(3) primarily serves persons who share its religious tenets; and

(4) is a non-profit organization under Internal Revenue Code section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii).

According to the HHS website and the preamble to the regulations, this definition of religious employer is modeled after the most common exemption used in 28 states that already require insurance companies to cover contraception.

INSIGHT: A religious employer that provides social services to persons not of the same religious tenets or performs mission work may have a difficult time satisfying the requirement that it "primarily" serves persons who share its religious tenets. The regulations provide no guidance on the meaning of "primarily."

Cost Sharing and Cost Control

Generally, if a recommended preventive service is provided in-network, a non-grandfathered plan cannot impose a cost sharing requirement on the service. Cost sharing may be imposed on recommended preventive services performed outside the network. A plan may also impose cost sharing requirements on treatments that are not a recommended preventive service, even if the treatment is a result of a recommended preventive service. For example, an HIV screening is a recommended preventive service, but treatment of HIV is not. Cost sharing includes, co-payments, coinsurance and deductibles.

The rules provide three examples of how cost sharing may be imposed on office visits.

1) If a recommended preventive service is billed separately from an office visit, the plan may impose cost sharing on the office visit.

2) If a recommended preventive service is not billed separately from the office visit and the primary reason for the office visit is the delivery of a recommended preventive service, the plan may not impose cost sharing on the office visit or the recommended preventive service.

3) If a recommended preventive service is not billed separately from the office visit and the primary reason for the office visit is <u>not</u> the delivery of a recommended preventive service, the plan may impose cost sharing on the entire office visit, including the recommended preventive service.

INSIGHT: If a doctor intends to avoid any revenue loss on office visit fees resulting from these new cost sharing requirements, it appears he or she could simply revise the office billing system to bill each office visit separately from any other recommended preventive service provided.

Plans retain the flexibility to control costs and promote efficient delivery of care by the use of reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive service to the extent not specified by the interim final rules. For example, a plan may impose cost sharing for branded drugs if a generic version is available and just as effective and safe.

Questions/Issues Remain

Prescription Required - The new rules appear to require a prescription for a recommended preventive service to be covered at no cost to the participant. This would exclude from coverage all FDA-approved over-the-counter medicine and contraceptives obtained without a prescription. In addition, the cost of renting a breast pump and nursing related supplies must be covered, if prescribed, but it is not clear if the cost to purchase a breast pump and related supplies would be covered.

Religious Employer Exemption - As discussed above, religious groups have expressed concern that church affiliated associations will have difficulty satisfying the exemption from coverage of contraceptive preventive services. HHS is accepting comments on the definition of religious employer until September 30, 2011. We would be glad to assist you in submitting your comments.

Mini-Med Plans with annual dollar limit waivers - Generally, a "mini-med plan" is a medical plan that has a low maximum annual benefit amount for a plan year. For example, the maximum benefit payable from the plan may be as low as $3,500. The low maximum benefit amount allows the employer to charge substantially lower monthly premiums so employees who may not otherwise be able to afford health insurance can afford at least a minimum amount of coverage. The required coverage of the recommended preventive services, at no cost to the employee, could present significant cost increases for these plans and possibly cause employers to re-evaluate providing the plans at all.

Plan Sponsor Next Steps

Review Plan Design - Plan sponsors will need to review their plan design with insurance providers and the delivery of services with vendors to determine what changes, if any, will be necessary. Additionally, the preamble to the regulations notes that state laws are not superseded by health care reform, so any additional requirements of state law remain in place.

Cost Analysis - Self-insured plan sponsors may want plan vendors to review benefit data and provide an estimate as to the potential cost increase due to the required coverage of the recommended preventive services at no cost to the employee.

We will be glad to assist you in reviewing your current plans for compliance with these newly issued rules.

Further Delay in Service Provider and Participant Fee Disclosure Requirements

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The Department of Labor has extended the effective dates of the fiduciary-level fee disclosure requirements under ERISA § 408(b)(2) (See August 2010 Benefits Insights)and the participant-level fee disclosure requirements under ERISA § 404(a) (See March 2011 Benefits Insights).

The final regulations delay the fiduciary-level fee disclosure to April 1, 2012. The initial participant-level fee disclosure must be furnished to participants no later than May 31, 2012 for calendar year plans. The quarterly participant-level fee disclosure must be furnished no later than August 14, 2012 for calendar year plans.

We would be glad to assist you in determining what disclosures will be required for your retirement plan and the applicable deadlines for those disclosures.

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