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THE CICOTTE LAW FIRM LLC

ERISA AND EMPLOYEE BENEFITS + CORPORATE

MARCH 2009 NEWSLETTER

INSIDE THIS ISSUE:

NEW LEGISLATION DEADLINES AND CORPORATE DUTIES

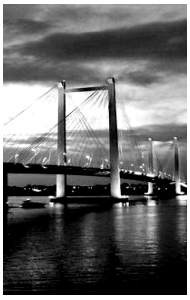
Given the current political and economic climate, employers should be aware of several important items of legislation and business practices that require immediate action.

Several new laws affecting employers were passed in Feb. 2009. The stimulus bill, i.e. the American Recovery and Reinvestment Act of 2009 ("ARRA"), includes important COBRA continuation coverage and HIPAA provisions that include Apr. 2009 deadlines for employers. Employers subject to COBRA now must subsidize 65% of the cost of continuation coverage for "involuntarily terminated" former employees and their beneficiaries for 9 months. HIPAA security and privacy rules have been extended to business associates handling private health information and have increased civil and criminal penalties for violations.

CHIPRA, which extends CHIP programs, was passed Feb. 4, 2009, and requires employers to give special enrollment rights to certain low-income children and some of their families.

Amendments to qualified retirement plans required by Code §415 must be adopted soon.

Boards of directors should take a hard look at their risk management oversight duties, especially management of financial risks, given the current market. Corporations should also review new e-proxy and e-verify rules.



Spring presents new opportunities to stay ahead of swiftly-approaching legal changes affecting your company.

We've recently moved to a new location at 7025 W. Grandridge Blvd., Kennewick, WA, 99336. Please feel free to contact us with questions you may have concerning this issue's topics.

415 AMENDMENTS REMINDER

The U.S. Treasury adopted comprehensive final regulations regarding Code §415 limits on benefits and contributions in Apr. of 2007, with an effective date of Jan. 1, 2008 for plans with a calendar plan and limitation year.

The regulations change computations of limits and the definition of compensation used for calculating limits. The definition of compensation has changed especially regarding post-severance compensation.

The rules affect other areas as well. They regulate an employee's freedom to defer post-severance compensation. Under the regulations, defined contribution plans may not allocate amounts in excess of §415 limits. 401(k) plans may not accept deferrals from post-severance payments that are not compensation for calculating §415 limits. Defined benefit plans subject to §411 may not accrue participant benefits exceeding the §415 limits.

To comply with the new §415 regulations, the time for plans to adopt amendments is soon approaching. For single employer, calendar year plans, the deadline is the extended due date of the employer's 2008 tax return.

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COBRA COVERAGE REQUIREMENTS UNDER ARRA, PT. 1

Employers should take immediate action in providing notices and updating procedures to comply with COBRA continuation coverage provisions in the recently passed stimulus bill, the American Recovery and Reinvestment Act of 2009 ("ARRA"). COBRA is affected in three significant ways by ARRA, which provides: (1) a COBRA premium subsidy; (2) a special COBRA election period; and (3) a tax credit to employers providing subsidies. Employers must take action by Apr. 18, 2009.

Premium subsidy.
ARRA allows assistance eligible individuals ("AEIs")—former covered employees who were "involuntarily terminated" between Sept. 1, 2008 and Dec. 31, 2009 and their qualified beneficiaries—to elect COBRA continuation coverage and pay only 35% of their COBRA premiums for up to 9 months.

Eligibility. To qualify as an AEI eligible for the COBRA premium subsidy, individuals must: (1) become eligible for COBRA coverage following the qualifying event of an "**involuntary termination**" taking place between Sept. 1, 2008 through Dec. 31, 2009; (2) **elect COBRA coverage** when first offered or during the "special election period" (see below); and, (3) **not have eligibility for other group coverage**, such as Medicare or group health coverage under another plan (such as a spouse's).

Involuntary termination. The text of ARRA does not define the term "involuntary termination." Events such as an employer-initiated layoff (according to the IRS) or being told not to come back to work until further notice (according to the DOL) definitely qualify as involuntary terminations. The term likely includes being placed on recall status with no work hours. Whether a termination due to death or disability is an "involuntary termination" is unclear. If a layoff is for "gross misconduct" (a very high standard), it would not qualify as an "involuntary termination." The 65% COBRA premium subsidy would NOT be available for other COBRA qualifying events, such as voluntary termination, divorce or legal separation, or loss of dependent status.

Time to make election. AEIs have 60 days after receiving notice to elect the COBRA premium assistance coverage, even under the special COBRA election period, otherwise they lose all rights to COBRA benefits. However, if the employer decides to offer a less expensive enrollment option available to all plan participants, AEIs have 90 days to elect COBRA premium assistance coverage.

Option to enroll in less costly plan. Plan sponsors are permitted, but not required, to allow AEI's to switch medical plan options or enroll in a medical plan option other than the option the individual was enrolled in on the day before the qualifying event, so long as the option is less expensive and is not coverage under an FSA, coverage providing services at an on-site medical facility, or coverage that provides only dental, vision, counseling, or referral services. If a different enrollment option is made available, an AEI is permitted to change coverage options under the plan in conjunction with electing COBRA continuation coverage. If the less costly option is provided, eligible involuntarily terminated employees must be given a 90-day period to change options, starting from the date the plan provides notice of right to change enrollment.

Payment. The premium reduction permits AEIs to pay only 35% of their COBRA premium. The base amount that is used to calculate an AEI's reduced COBRA premium is the premium that the AEI would have been required to pay for COBRA continuation coverage under pre-ARRA law—generally 102% of the employer's premium. Example: James is laid off from work and is eligible to elect COBRA continuation coverage. While James was employed, Jemes' health coverage cost his employer $100 per month. Under pre-ARRA law, James' COBRA premium after termina-

"COBRA is affected in three significant ways by ARRA: it provides for a COBRA premium subsidy, a special COBRA election period, and a tax credit to employers providing COBRA premium subsidies"

COBRA COVERAGE REQUIREMENTS UNDER ARRA, PT. 2

tion was $102 per month (i.e., 102% of the employer's $100 premium). Under ARRA, James elects COBRA premium assistance and thus has to pay only 35% of the $102 premium, i.e., $35.70. The $66.30 balance must be paid by James' former employer.

End date of premium reduction. COBRA premium assistance for an AEI ends when an AEI fails to remit at least 35% of the COBRA premium due, when an AEI becomes eligible for Medicare or other group health coverage, or the earliest of: (i) 9 months after the date the AEI became eligible for subsidy, i.e. 9 months after the first day of the first month that the subsidy becomes available to the AEI, (ii) an AEI's COBRA expiration date, i.e. the date following the expiration of the maximum period of COBRA continuation coverage required, OR (iii) the date following the expiration of the period of the continuation coverage ARRA allows.

Special COBRA election period

ARRA grants a special COBRA election opportunity to those former employees involuntarily terminated between Sept. 1, 2008 and Feb. 17, 2009 and their qualified beneficiaries to elect COBRA continuation coverage at a 35% premium rate. This election is available even if the involuntarily terminated employee or qualified beneficiary refused to take COBRA coverage previously or allowed their COBRA coverage to expire. If elected, COBRA coverage begins during the first regular coverage period beginning on or after Feb. 17, 2009 (generally Mar. 1, 2009) and extends through the remainder of the original COBRA period, with the 35% COBRA premium subsidy available for up to 9 months. The 63-day "preexisting conditions limitations" rule under HIPAA must be disregarded for those electing coverage during the special election period. Once given notice of the special election period, those eligible have 60 days to elect coverage (90 if less expensive enrollment option is given).

Eligibility under another plan

Individuals do not qualify as an AEI eligible for COBRA premium reduction assistance if they are eligible for other group health coverage, even if the individual has not enrolled for such coverage. Eligibility for coverage under Medicaid or another group health plan, whether as a benefitting employee or as a qualified beneficiary disqualifies individuals from claiming COBRA premium assistance under ARRA. Vision, dental, FSA, or on-site medical facility coverage would NOT disqualify an individual.

Income limits and tax consequences

There is a phase-out of eligibility which increases some high-income individuals' tax liability if they receive COBRA premium assistance. If individuals with modified adjusted gross income over $145,000 ($290,000 for joint filers) receive the subsidy, the subsidy must be recaptured as a tax liability dollar-for-dollar. If individuals with modified adjusted gross income over $125,000 ($250,000 for joint filers) receive the subsidy, a portion of the subsidy will be proportionately recaptured as an additional tax liability. To avoid recapture, ARRA permits high-income AEI's to permanently waive the right to the premium reduction. That waiver cannot be revoked.

Expedited review if denied assistance

Individuals denied treatment as AEIs and thus denied eligibility for COBRA premium reduction can request an expedited review of the denial by the Department of Labor ("DOL"), who must make a determination within 15 business days of the receipt of a completed request for review. The DOL is currently developing an official application and process for these appeals.

Employers required to participate

Employers subject to COBRA are those with 20 or more employees. States with laws similar to COBRA ("mini-COBRA" laws) are required to offer COBRA premium assistance coverage under ARRA, such as California, where insurers provide coverage for small employers).

Tax credit to employers giving COBRA subsidy

ARRA allows employers to receive a tax credit

"Employers required to participate in COBRA premium subsidy have over 20 employees or those required by applicable state law"

COBRA COVERAGE REQUIREMENTS UNDER ARRA, PT. 3

for COBRA premium assistance payments made. Employers subject to COBRA or similar State laws that receive a 35% COBRA premium payment from an AEI are then required to pay the remaining 65% of the AEI's COBRA premium payment. This employer payment of 65% may be claimed as a tax credit on line 12 of the employer's Form 941 quarterly employment tax return. When taking the credit, employers may decide whether to offset payroll tax deposits or claim subsidies as an overpayment at the end of the quarter.

Documentation required for employers taking credit. To receive the COBRA premium assistance tax credit, employers must keep careful documentation, including: (1) information on receipt, including dates and amounts, of the AEI's 35% share of the premium; (2) for insured plans, copy of invoice or other supporting statement from the insurance carrier and proof of timely payment of the full premium to the insurance carrier required under COBRA; (3) in the case of a self-insured plan, proof of the premium amount and proof of the coverage provided to AEIs; (4) attestation of involuntary termination, including the date of the involuntary termination (which must be during the period from Sept. 1, 2008, to Dec. 31, 2009), for each covered employee whose involuntary termination is the basis for eligibility for the subsidy; (5) proof of each AEI's eligibility for COBRA coverage at any time during the period from Sept. 1, 2008, to Dec. 31, 2009, and election of COBRA coverage; and, (6) a record of the SSN's of all covered employees, the amount of the subsidy reimbursed with respect to each covered employee, and whether the subsidy was for 1 individual or 2 or more individuals.

Notice requirements

The DOL's model notices are available at http://www.dol.gov/ebsa/COBRAmodelnotice.html.

Enhanced/revised COBRA notice. Employers are required to give a revised COBRA election notice, or a supplemental document to be sent with COBRA election notices, explaining the availability of the COBRA premium reduction to AEIs. The enhanced notice must be given to all qualified beneficiaries, not just covered employees, with a COBRA-qualifying event between Sept. 1, 2008 and Dec. 31, 2009. Notice must be to all those with COBRA qualifying events, not just those qualifying for COBRA due to an involuntary termination. Notice is due 60 days after the event or by Apr. 18, 2009.

Special election COBRA notice. Within 60 days of ARRA's enactment (Apr. 18, 2009), employers must provide a new COBRA special election notice to all qualified beneficiaries, not just covered employees, who experienced a COBRA-qualifying event after Sept. 1, 2008, and who failed to elect COBRA coverage or elected COBRA and then subsequently discontinued coverage before Feb. 16, 2009. AEI's must be given 60 days from the date of special election notice is provided to elect COBRA coverage.

Employer checklist of tasks

To comply with ARRA's COBRA provisions, employers must: (1) decide whether to offer less expensive coverage; (2) determine who is eligible for COBRA premium assistance and special election; (3) prepare a special election notice; (4) send special election notice on or before Ap. 18, 2009 to all qualified beneficiaries; (5) revise existing COBRA notices or create a supplemental document describing availability of premium reduction to AEI's (model notices available mid-March); (6) send revised COBRA election notice concerning premium assistance to all qualified beneficiaries; (7) create procedures for refunding excess COBRA premiums or to offset future COBRA premiums for COBRA payments made in March and April 2009 by those who timely elect COBRA premium assistance; (8) create procedures to allow high-income individuals to permanently waive the subsidy; (9) create procedures for making 65% COBRA premium payments and claiming them as a tax credit; and, (10) update and amend plan documents.

"By April 18, 2009, employers must provide a new COBRA special election notice"

HITECH SECURITY PROVISIONS IN 2009 ARRA

ARRA's Health Information Technology and Clinical Health Act (HITECH), enacted Feb. 17, 2009, includes some major changes in privacy, security, and penalty requirements for business associates of covered entities. The Health Information Portability and Accountability Act (HIPAA)'s standards for security now not only apply to covered entities, but also to their business associates.

Before HITECH's enactment under ARRA, business associates of entities covered by HIPAA, including third party administrators, were not directly subject to HIPAA's regulations or penalties. Formerly, HIPAA's security and privacy provisions could be imposed on business associates by including them in contracts with covered entities. With the new HITECH privacy changes, all business associates now have direct responsibility and liability for a breach of privacy and can be made subject to civil and criminal penalties for failing to meet security standards. HITECH requires revision of all business associate agreements to contain HITECH's new privacy and security requirements. HITECH includes any entity providing transmission services as a business associate to an entity covered by HIPAA .

Any breach of privacy, or an incident of "unsecured protected health information" (a term coined but not explained fully in ARRA), requires notification within 60 days after discovery of the breach. The notification provision requires both covered entities and business associates to notify affected parties directly and individually in a timely manner, and to use appropriate public media for notification in cases involving over 500 individuals. HITECH's notification requirement applies only to a covered entity that maintains, retains, accesses, modifies, records, destroys, stores, or otherwise holds, uses, or discloses "unsecured private health information." Business associates must notify the covered entity of any breach and disclose what individuals were affected. The Secretary of HHS ("Secretary") will issue notice guidance within 180 days of HITECH's enactment.

"Unsecured private health information" is defined as private health information not secured through use of a technology or methodology specified by the Secretary. Guidance will be given by the Secretary within 180 days of HITECH's enactment and annually thereafter, specifying what technologies meet the standard of "secured private health information." If no guidance is issued, the required technology for having secured private health information will be created or sanctioned by an organization recognized by the American National Standards Institute.

HIPAA's criminal and civil penalties are now extended to any individual, whether or not an employee of a covered entity, who obtains or discloses private health information without authorization. Notification of breaches are required both by covered entities and business associates. Acts of "willful neglect" can warrant a formal investigation and possible civil penalties. Penalties have been increased under HITECH for violations. The maximum penalties for unknown acts, violations due to reasonable cause, and/or "willful neglect" have maximum caps of $50,000 per violation, and a cap of $1.5 million for violations of an identical requirement during a calendar year. HITECH raises penalties for all acts.

Covered entities should notify their business associates of HITECH's changes concerning security, notification, and penalties, and begin working to revise their business associate contracts to reflect those changes.

"HITECH's new security requirements must be incorporated into business associate contracts"

CHIPRA REQUIRES SPECIAL ENROLLMENT AND NOTICE

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was signed into law on Feb. 4, 2009. Effective Apr. 9, 2009, CHIPRA extends the current Children's Health Insurance Program (CHIP) through Sept. 20, 2013. CHIP is both a federal and state program, providing health insurance to pregnant woman and children who do not qualify for Medicaid. States usually are allowed to design their own CHIP programs (i.e. SCHIPs), with few federal guidelines. CHIPRA is intended to grant insurance coverage to a greater number of previously uninsured children by enabling states to offer premium subsidies to employer-sponsored plans targeting low-income children through special enrollment. Increased taxes on tobacco products help fund the CHIP program. Group health plan sponsors must notify employees about their special enrollment rights under CHIPRA by Apr. 1, 2009.

Current premium assistance programs allow state CHIP's to grant coverage to CHIP participants through payment of the participant share of a premium under an employer-provided group health plan meeting certain restrictions. CHIPRA's new premium assistance program allows states to enroll eligible children, and for some cases their families, in "qualified employer coverage" in which CHIP will pay the employee's portion of the premium.

"Qualified employer coverage" is defined by the act as: (1) "creditable coverage" as defined by HIPAA, (2) coverage available to a reasonable classification of employees, per Code §105(h), and (3) coverage of which an employer provides 40% of the cost. Health FSAs and high deductible health plans are not included in the definition of "qualified employer coverage." However, both insured and self-insured plans are subject to the new regulations.

Special enrollment rights under HIPAA are also granted by CHIPRA, amending ERISA's HIPAA special enrollment rules, the Internal Revenue Code, and the Public Health Service Act. Group health plans are required to permit eligible employees enrolled in CHIP or Medicare to enroll in the group health plan within 60 days of loss of Medicare or CHIP eligibility. Additionally, plans must allow employees eligible under the plan's terms to enroll within 60 days of notice of eligibility for Medicare or CHIP premium assistance. These special enrollment rights take effect on Apr. 9, 2009. CHIPRA includes a provision requiring states to create a process enabling parents of children receiving premium assistance to disenroll from employer coverage during any month and subsequently enroll the child in the state's CHIP.

CHIPRA's premium assistance program is effective Apr. 1, 2009. Employers must determine how they will administer the new HIPAA special enrollment rules and review plan documents that may need to be amended. Employers should decide whether to opt out of direct state premium payments and how they will respond to employee requests to disenroll from the employer's group health plan.

Notice regarding CHIPRA, including description of the new premium assistance program, must be provided to participants in a summary plan description or other plan information. Model notices must be issued on or before Feb. 4, 2010 by the Department of Labor and Health and Human Services. Failure to meet notice requirements may result in a $100 per day penalty. Notice compliance will be required beginning the first plan year after the model notice is issued (Jan. 1, 2011 for calendar year plans).

"Group health plans are required to permit eligible employees enrolled in CHIP or Medicare to enroll in the group health plan within 60 days of loss of Medicare or CHIP eligibility"

RISK MANAGEMENT THROUGH BOARD OF DIRECTORS

Given the current economic climate, boards of directors must be very aware of and understand their general risk management oversight responsibilities. Boards are not necessarily responsible to take active roles in everyday risk management. However, boards should evaluate current company risk and consider taking precautions in order to fulfill their general risk management oversight responsibilities.

The board can identify current company risk management weaknesses by evaluating current company practices in information technology and intellectual property security, the adequacy of the company's current insurance, employment and HR practices, and what financial risks face the company.

Financial risks are the most important risk element to monitor in a weak economy. Reviewing allocation of company funds, the company's portfolio mix, and any suspect investments in mortgage-backed securities or weakened banks is essential. Directors should also review any risks apparent in the company's audit reports and SEC filings.

Precautions against unnecessary risk can be prevented by the board, by taking steps such as (1) creating risk management company policies, including policies for training, board makeup, and company and board communication; (2) creating periodic reports concerning company risks for board review; (3) carrying out regularly-established evaluations of risk to ascertain success of current risk management; and, (4) instituting a committee to review company risk management.

Boards of directors need to identify and review the risks specific to the companies for which they are responsible. Refreshing your company's board as to what legal responsibilities and fiduciary obligations they have to the company in terms of overseeing risk management will help to motivate the board to carefully evaluate the company's exposure to risk and help to position the company to best weather the current economy.

"Boards of directors need to identify and review the risks specific to the companies for which they are responsible"

E-PROXY COMPLIANCE REQUIRED AS OF JAN. 1, 2009

The SEC has permitted companies since Jul. 1, 2007 to meet proxy delivery obligations by (1) posting proxy materials, including annual reports, on the company's website and (2) mailing stockholders a notice advising them proxy materials are available. Effective Jan. 1, 2009, e-proxy compliance is required for all companies soliciting proxies, except for those solicitations which involve business combination transactions.

The mandatory e-proxy regulations allow companies to choose between two methods of compliance with the e-proxy rules. Companies may choose to: (1) produce proxy materials only on the internet, with notification, taking advantage of delivering everything necessary via the internet; or, (2) give a dual delivery of proxy materials via the internet and via mail, by posting proxy materials on the internet with notification, as well as physically mailing all proxy materials to stockholders. Prior to 2009, most companies used both the internet and mail, delivering full proxy materials via mail and also producing all proxy materials on the internet.

If companies wish to continue using both mail and internet to deliver, they are free to do so, though the rules require only posting proxy materials on an internet web site other than the SEC's EDGAR site and giving a physical notice of internet availability of proxy materials.

MENTAL HEALTH PARITY CHANGES EFFECTIVE IN 2010

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (the "Wellstone-Domenici Parity Act"), enacted in Oct. 3, 2008 as part of the Emergency Economic Stabilization Act, adds requirements to the Mental Health Parity Act of 1996 ("MHPA"). The Wellstone-Domenici Parity Act requires that all group health plan financial requirements and limitations of treatment that apply to mental health and substance use disorder benefits are no more restrictive than requirements and limitations placed on physical (i.e. medical or surgical) benefits. This creates significant changes in how mental health and substance abuse conditions are handled in employer plans, and require plan changes. These changes must be complied with starting Jan. 1, 2010.

The MPHA prevents large employers' (i.e. employers with over 50 employees) group health plans from placing lower plan limits for mental health benefits than those limits given for medical and surgical benefits. The Wellstone-Domenici Parity Act requires all group health plans with 50 or more employees, whether self-funded of fully ensured, that provide both physical and mental health/substance use benefits to ensure that all financial requirements and treatment limitations applicable to mental health and substance use disorder benefits are no more restrictive than those requirements placed on physical benefits.

The Wellstone-Domenici Parity Act differs from the 1996 MHPA by increasing mental health benefits protection, specifically by requiring parity of substance use disorders. The MHPA required parity coverage only for lifetime and annual dollar limits, but did not apply to benefits for substance use disorders.

Health plans may continue to deny coverage based on medical necessity or according to its coverage contract, as with the 1996 MHPA. As with the MHPA, health plans per the Wellstone-Domenici Parity Act may manage benefits under the plan's terms and conditions; however, the plan under the Wellstone-Domenici Parity Act must upon request make mental health and substance use disorder medical necessity criteria available to current or potential participants, beneficiaries, or providers.

Under the Wellstone-Domenici Parity Act, if a health plan provides out-of-network physical and mental/substance use disorder benefits, there must be parity in services provided. If a plan only provides out-of-network physical benefits, the Wellstone-Domenici Parity Act now requires plans to add out-of-network mental health and substance use disorder benefits with parity to out-of-network physical benefits. Thus, in-network payment of services for mental health and substance use now must be at the same rate of provision of in-network physical services.

43 states have already enacted parity laws; while not as comprehensive as the Wellstone-Domenici Parity Act, if the State provides less protection than the Federal Wellstone-Domenici Parity Act, it will be preempted. If a State's law gives more protection than the Wellstone-Domenici Parity Act, the State's law will not be preempted.

Health plans will be required to comply with the Wellstone-Domenici Parity Act starting Jan. 1, 2010. For collectively bargained plans, the effective date differs. Health plans will need to redesign coverage. Nearly all group health plans with 50 or more employees offer mental health and/or substance abuse benefits and will be required to comply with these changes. Plans should review and update plan procedures concerning the treatment of mental health and substance abuse claims.

"In-network payment of services for mental health and substance use now must be at the same rate of provision of in-network physical services"

MICHELLE'S LAW

The recently-enacted "Michelle's Law" extends existing health insurance coverage for dependent college students for up to one year in the event of a medically necessary leave of absence.

Group health plans are required to continue coverage for dependent college students taking a medically necessary medical leave of absence for up to one year, or, if earlier, the date coverage would otherwise end under the plan.

If certification of student status is required, any notice regarding a requirement for certification of student status must include a description of the requirements for continued coverage during a medically necessary leave.

A $100 per day excise tax may be assessed for failure to comply. Michelle's Law is effective for plan years beginning more than one year on or after Oct. 9, 2008 (Jan. 1, 2010 for calendar year plans) and to medically necessary leaves beginning during such plan years. Amendments should be adopted before the rules take effect (Dec. 31, 2009 for calendar year plans).

E-VERIFY

Effective May 21, 2009, federal contractors and their subcontractors will be required to use E-Verify if awarded a contract that includes the Federal Acquisition Regulation E-Verify clause (73 FR 67704). E-Verify is an electronic system operated by the Department of Homeland Security, in partnership with the Social Security Administration.

The purpose of the system is to confirm employment authorization administered by the U.S. Citizenship and Immigration Service. Requirements for compliance by contractors and subcontracts are: (1) enroll in E-Verify; (2) use E-Verify to confirm *all* new hires in addition to completing Form I-9; use E-Verify to confirm all existing employees directly working on the federal contract; and, (4) ensure all subcontractors and lower-tier subcontractors are appropriately using E-Verify. Improper use of E-Verify can result in debarment.

Employees' rights regarding E-Verify require employers to post a notice informing employees of (1) the employer's use of E-Verify, (2) any restrictions on E-Verify's use, and (3) procedures if a mismatch from an employee's I-9 and DHS and SSA Databases occurs. To learn more, visit the U.S. Citizenship & Immigration services website at http://www.uscis.gov and click E-Verify at bottom left of the page.

Firm Description

The Cicotte Law Firm is located in Kennewick, WA, and represents employers in several states in all aspects of benefits law, handling diverse employment, labor, tax and corporate matters.

The Firm's practice covers all areas relating to employee benefits, including designing "defined contribution-style" health plans (HRAs, HSAs, & FSAs), assistance with COBRA, HIPAA, and EGTRRA, advising on fiduciary responsibilities, maintaining legal compliance with non-discrimination requirements, analyzing unusual benefit claims, representing employers in labor relations matters where pension or welfare benefits are involved, advising on the federal tax implications of complex benefits-related issues, and examining the ERISA status of compensatory arrangements.

Other practice areas vital to corporate function available at the Firm include corporate formation, corporate compliance, negotiations, mergers and acquisitions, SEC compliance, and HR liaison activities.

The Firm is also able to assist companies with licensing agreements, non-compete agreements, and non-disclosure agreements.

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